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Mixing Oil and Water: Developing Integrated Treatment for People with the Co-Occurring Disorders of Mental Illness and Addiction

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1. Introduction

This chapter chronicles the shift in scientific assumptions and the ensuing consensus on treating people with a co-occurring mental illness and a substance misuse problem. In this chapter, the term *co-occurring disorder* refers to a person with both a mental illness and a substance use disorder. The paradigm shift and subsequent technology transfer in the fields of addictions and mental health is extremely important for the lessons learned in the effort to integrate the two modalities. There are lessons from the process of moving new ideas based on science into practice. These lessons give us direction for treatment and knowledge transfer in the future. And, finally there is a need to examine critically the underlying flaws that were exposed in the philosophy and practice tradition of both models when they were integrated.

Fundamentally, the attempt to develop and deliver appropriate treatment to persons with a co-occurring disorder illustrates one of the self-correcting mechanisms of science. Unchallenged, clinicians in mental health and substance abuse treatment would have had little motivation to examine the science underlying their practice. In the history of mental health and substance abuse treatment there have been few revolutionary changes in care and treatment that have made life better for people suffering from an addiction or mental illness. Based on a rapidly evolving science and a better understanding of the treatment needs of people with co-occurring disorders, the expectation at the turn of the 21st century was that by integrating the two models, effective treatment could be provided for people with a co-occurring disorder.

Driven by the growing number of persons identified with a co-occurring mental health and substance misuse disorder the *tipping point* had been reached by the mid 1990s. Declared a crisis in the United States, the number of people being identified as having a co-occurring disorder was estimated to be much higher than thought. The higher rates of failure in treatment and repeated treatment episodes were an unnecessary burden on the treatment community, individuals, families of people with co-occurring disorders, and the community in general. In 2002, Charles G. Curie, Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) announced that "addressing the needs of

persons with co-occurring disorders had become one of the highest priorities for the agency" (Center for Mental Health Services, 2004). The cost in human capital and the financial strain had become unacceptable. Events that followed, especially those predicated on the idea that the two fields of practice should be integrated, revealed a number of strengths and the effectiveness of some approaches; while at the same time exposing ideas and concepts used in both mental health and addiction treatment that are ineffective and harmful.

To begin this exposition on the evolution of knowledge and services for people with a co-occurring disorder, a brief review will examine the cause for the initial growth in awareness, development of consensus, and recommended treatment approaches for people with co-occurring disorders of mental illness and addiction. In the final section of this chapter, based on what we learned trying to combine the two traditions, Integrated Treatment (integrated mental health and addiction treatment interventions) will be deconstructed and an outline for a third treatment technology will be proposed. This proposal will provide a way forward to improve treatment outcomes of people with a co-occurring disorder as well as people with a mental health and addiction disorder.

Motivated by a growing awareness that people with a co-occurring disorder were being underserved, researchers and practitioners in the field of addictionology and mental health finally received support from two major government initiatives in the late 1990s; one in Canada, followed shortly by a major Federal program in the United States managed by SAMHSA. The program in the United States was supported by an infusion of Federal grant money to support a number of state Co-occurring State Incentive Grant (COSIG) projects. The SAMHSA initiative supported integrating the two treatment models. At SAMHSA, the consensus was that collaboration between professionals working in mental health and substance misuse treatment using their different approaches and interventions would complement each other and produce better outcomes for people treated for a co-occurring disorder. Instead, the effort to integrate the two treatment systems revealed flaws in philosophy and concepts in both models that are incompatible and ineffective.

2. A growing consensus

By the late 1970s, clinicians working in the mental health and substance abuse treatment communities were reporting anecdotal evidence of a large number of people who had both a mental illness and an addiction disorder. As research evidence accumulated, concern grew among policy makers, program planners, clinicians and support workers. The concern about the high prevalence of people with co-morbid disorders focused on treatment for these disorders: concerns about effectiveness of the treatment, other support services needed, and the cost of treatment during the lifetime of an individual with a co-occurring disorder. The early studies supported this concern. Evidence from researchers in the field of substance abuse treatment declared that people being treated for an addiction were much more difficult to treat when they presented with depression or anxiety (McLellan & Druley, 1977; Ritzler, Strauss, Vanord, & Kokes, 1977). By the 1980s, practitioners and researchers in mental health were reporting a growing number of other mental health disorders that were made more difficult to treat as a result of a concurrent substance abuse problem (de Leon, 1989).

Two major approaches (parallel and sequential treatment) that were thought to effectively treat people with the co-morbid problems of mental illness and substance abuse began to

emerge in the mid 1980s. Although, some mental health programs were making adjustments in the way services were delivered to better treat people with the co-occurring problem of substance abuse in the early 1980s, little in the way of specific programming for people with a co-occurring disorder had been developed. This began to change when a New York State outpatient psychiatric facility in 1984 implemented various interventions from the addiction treatment community, typically interventions used in Treatment Communities (Sciacca, 1991).

The circumstances that created the pressure for these changes involved a constant drumbeat from practitioners and clinicians in both fields, who wanted change and who were challenging the scientific duality of mental illness and addiction. During the 1980s, the chorus of dissenters became louder. Even so, the term 'dual diagnosis' referring to people with the co-morbid disorders of mental illness and addiction did not appear in the subject index of the journal of *Hospital and Community Psychiatry* until 1989. Drake and colleagues, in 1996, argued that naming the disorder was an important event. He points out that when the complexity of a co-occurring disorder was given a simple medical term, interest in problems caused by substance use among people with a mental disorder resulted in "a mandate for recognition and treatment" (Drake, Osher, & Bartels, 1996).

In the 1990s, substance abuse treatment programs were reporting somewhere between 50% and 75% of the people they treated also had a mental health problem. At the same time, mental health programs reported between 20% and 50% of the people they served had a co-occurring problem of substance use or abuse. The major treatment innovation during this period to accommodate people with a co-occurring disorder was from the addiction field where the modified Therapeutic Community (TC) for mentally ill chemical abusers was developed (Sacks, Sacks, De Leon, Bernhardt, & Staines, 1997). The modified TC basically added provisions for residents who needed to take psychotropic medication. On a positive note, it does give addicted people with a mental illness a safe place to stay while they struggled with the transition back to a life without their drug of choice to help modulate their mental illness.

On the mezzo level, an important event occurred in the United States in 1999. In what Kuhn (1962) called a "paradigm shift," in his seminal book, *The Structure of Scientific Revolutions,* a collaboration was established between the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD). Their stated purpose was to pursue scientifically based knowledge and treatment for people with a co-occurring disorder (NASMHPD-NASADAD, 1999). This national effort intended to: "foster improvements in treatment," "provide a classification of treatment settings," "reduce the stigma associated with both disorders'" and "increase the acceptance of substance abuse and mental health concerns as a standard part of healthcare information gathering."

Another major push forward came from a series of SAMHSA monograms, *SAMHSA's Report to Congress on the Treatment and Prevention of Co-Occurring Substance Abuse and Mental Disorders (SAMHSA, 2002). The President's New Freedom Commission on Mental Health Final Report(SAMHSA, 2003b); Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit (SAMHSA, 2003a), and Substance Abuse Treatment for Persons With Co-Occurring Disorders: A Treatment Improvement Protocol – TIP 42(SAMHSA, 2005); Overview Paper 3: Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders* (SAMHSA, 2006a). These and other SAMHSA publications have done much to fill the void caused by the dearth of information on people who experience a co-occurring disorder. This

was critical information for program planners, community developers and other decision makers. They were working in an environment where many states and public treatment facilities began trying to retool in an effort to provide more effective services for people admitted with a co-occurring disorder.

In the midst of producing these publications, SAMHSA at a more systems level asked for and received funding from the U.S. Congress to provide Co-Occurring State Incentive Grants (COSIG) to support state efforts to improve treatment for people with co-occurring disorders seeking treatment in their state. These initiative grants provided the following standards for service. Treatment services provided to people with a co-occurring disorder are to be:

1. consumer driven,
2. delivered from an integrated system of care that fosters an equitable distribution of services,
3. the best recovery practices available,
4. welcoming and based on a no wrong door concept (you're in the right place), and
5. culturally competent.

By the late 1990s, there was a consensus among leading experts in the fields of addiction and mental health treatment that sequential treatment (treatment from one provider, than treatment from another) or parallel treatment (treatment by two different providers at the same time) was not an effective and efficient model for with people with a co-occurring disorder (Clement et al., 1993). Instead of improving outcomes for people with a co-occurring disorder, over time the failure rate in treatment for people with a co-occurring disorder remained high. Subsequent research found that sequential and parallel treatment tended to plunge the person seeking treatment into a vicious cycle of treatment failures (Flynn, 2001). These high rates of failure were discouraging to consumers, counselors, and the politicians who had to find a way to pay for expensive and multiple treatment episodes (Cherry, Dillon, Hellman & Barney, 2007).

A consensus slowly formed around the idea that treating people for a co-occurring disorder using a parallel or sequential model of treatment was disjointed and ineffective. Individuals with complex, overlapping conditions were ill-prepared to negotiate disjointed and fragmented systems of care (SAMHSA, 2002). Based on his work, McGovern (2008) reported that as many as 50% of people with a co-occurring disorder never receive concurrent treatment for both disorders."

The implications for a failure to provide effective treatment are far-reaching. By way of an example, individuals with substance use and mental health disorders are highly overrepresented in the criminal justice system. Bureau of Justice Statistics in the United States report 74% of incarcerated individuals have a lifetime prevalence of substance use disorders and 49% report symptoms consistent with a diagnosable mental health condition. This is a rate that far surpasses those found in the general population (Peters, Bartoi & Sherman, 2008).

2.1 The solution: Integrative treatment

The solution, that was proposed, was to integrate the two treatment systems of mental health and substance abuse (Minkoff, 1993). It was believed both problems can be dealt with simultaneously using an integrative approach. Minkoff suggested collaboration between mental health and substance abuse clinicians when treating a person with a co-occurring

disorder. The model is based on concomitant treatment, using the concept of treatment stages in treatment planning, and employing interventions derived from the fields of mental health and substance abuse. During the 1990's integrated treatment continued to evolve, and several models of an integrated system of care were delineated (Drake & Mueser, 1996; Lehman & Dixon, 1995; Minkoff, 1991; Solomon, Zimberg, & Shollar, 1993).

Even though leading experts in both fields recommend integrating the two models, there are vital questions that need to be asked. Is an integrative model possible? Can these two traditions with their different philosophies and treatment modalities be combined effectively? And, just to be on the safe side, if neither technology nor a combination of both technologies are effective in treating people with a co-occurring disorder—what other technology is available? Before exploring these questions in more detail, it will be instructive to review a consensus definition of a co-occurring disorder and the numbers; the prevalence rate, and the demographic characteristics of people identified with a co-occurring disorder in the United States.

2.2 What is a co-occurring disorder

The clinical definition of a co-occurring disorder of mental illness and addiction began to take form in the mid-1990s. Roughly defined as the effect of a comorbid mental illness and substance misuse, the effect each has on the other was identified for the primary subgroups among people with a co-occurring disorder.

Researchers and consensus panels made a number of important observations based on assumptions of the day (SAMHSA, 1995; Landry et al., 1991a; Lehman, Myers & Corty, 1989; Meyer, 1986). These researchers and practitioners concluded that behaviors related to substance misuse could mimic psychiatric symptoms and even psychiatric disorders. The effect of substance misuse on the symptomology of a mental illness had also been observed to be related to the type of substance used, the amount of the substance used, and the chronicity of substance misuse. Acute and chronic substance misuse has also been shown to cause a mental illness to emerge or reemerge, and to increase the severity of an existing mental health disorder. Withdrawal from drugs or alcohol, in some people, has also been observed to produce psychiatric symptoms and diagnosable psychiatric disorders. Then again, substance use can have a number of positive benefits for some people with a mental illness. For some people, drugs and alcohol helps manage, reduce and can be used to hide severe psychiatric symptoms.

Among diagnosticians, mainly those who specialize in addiction assessment, psychiatric symptomatology (particularly mild symptoms) are often misidentified as drug-related. If a person presences at intake and reports any substance use in any amount, his or her dysfunctional and maladaptive behaviors, emotional and social problems are all too often attributed to alcohol and drug abuse and dependence. In the same way, a lack of engagement in treatment is often interpreted as an unwillingness to embrace sobriety. This may be an accurate analysis given a specific individual case, however, a person's treatment compliance and participation in a recovery program can also be affected by symptomatology associated with specific psychiatric diagnoses. The negative symptoms associated with schizophrenia, the lack of energy and interest associated with depression, and the fear of new situations associated with anxiety, at times, can make treatment or aftercare participation and compliance too stressful or distressing. The difference is that one interpretation blames the person; the other interpretation can be used to identify interventions to overcome the stress of participation in treatment.

In 2006, a COSIG committee was formed to forge a consensus on an operational definition of a person with a co-occurring disorder. An operational definition was needed so that people with a co-occurring disorder could be identified through screening and assessment. This type of definition would standardize the collection of data and provide a more accurate count of those being identified and treated with a co-occurring disorder. The major mistake with this approach for identifying the operational definition occurred when the committee agreed that the definition should be consistent with the conceptual underpinnings of the COSIG curriculum and training. This makes the definition tautological. The conceptual underpinning for a definition of a co-occurring disorder should be symptom and syndrome not an ideological construct that is a basis for curricula development and training.

The COSIG committee proposed a broad definition and three sub definitions. The committee used standard *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnostic criteria as a guide for developing their operational definition. In a broad sense, they suggested that a person with a co-occurring disorder is a person who meets the diagnostic criteria for a major Axis I Mental Disorder or Axis II Personality Disorder (a diagnosis not used in most of the world) and a major Substance Related Disorder. The criteria were fairly specific. Diagnoses of these disorders must occur simultaneously or within a one year time frame of each other. The figure below is a basic diagram of the co-occurring disorder definition, revealing that a portion of this population is accounted for by individuals who simultaneously present with both types of disorders and is also inclusive of individuals who present with both disorders in a relatively close proximity (one year).

Qualifying conditions in rendering diagnoses:

i. Substance Dependence Disorders that meet criteria for either early or sustained remission can be diagnosed and will be counted toward meeting the diagnostic parameters of the co-occurring disorders definition. Note: Use of controlled environments, drug replacement therapies, or intensive therapies for abstinence maintenance (substance disorder remission) should **not** be counted in the time period for remission. Such instances should be diagnosed as an active disorder and will be counted toward meeting the diagnostic parameters of the co-occurring disorders definition.
ii. Mental Health Disorders that are in remission due to the use of controlled environments, pharmacotherapy, or intensive psychosocial treatments should be diagnosed as the appropriate mental disorder that is in remission; and these disorders will be counted toward meeting the diagnostic parameters of the co-occurring disorders definition. (COSIG Clinical Protocol Committee, 2006, p.1)

2.3 Locus of care by quadrant of severity

Apart from specific diagnoses, when organized by severity of their mental health and substance abuse disorders, individuals with co-occurring disorders fall into one of four broad categories:

Category I. Less severe mental disorder/less severe substance disorder.

Category II. More severe mental disorder/less severe substance disorder.

Category III. Less severe mental disorder/more severe substance disorder.

Category IV. More severe mental disorder/more severe substance disorder.

Based on the severity of an individual's co-occurring disorder, people with co-occurring mental health and substance abuse disorders would receive treatment in one of the following settings:

Setting for Quadrant I. Primary care physicians, community health clinics; no care.
Setting for Quadrant II. Mental Health system (public and private).
Setting for Quadrant III. Substance Abuse system (public and private).
Setting for Quadrant IV. State hospitals, jails, Department of Corrections, forensic units, crisis facilities, and ER's.
Using this schema, a simplified categorization and severity of the co-occurring disorder can be easily matched with the locus of care and treatment. Theoretically, individuals at various stages of recovery from mental health and substance abuse disorders could move back and forth among these categories during the course of their treatment (See Figure 1).

Category III Severe SUD, Mild MI *Locus of Care* Addiction Treatment	Category IV Severe MI, Severe SUD *Locus of Care* Hospitals, Jails, ERs
Category I Mild MI, Mild SUD *Locus of Care* Primary Health Care	Category II Severe MI, Mild SUD *Locus of Care* Mental Health System

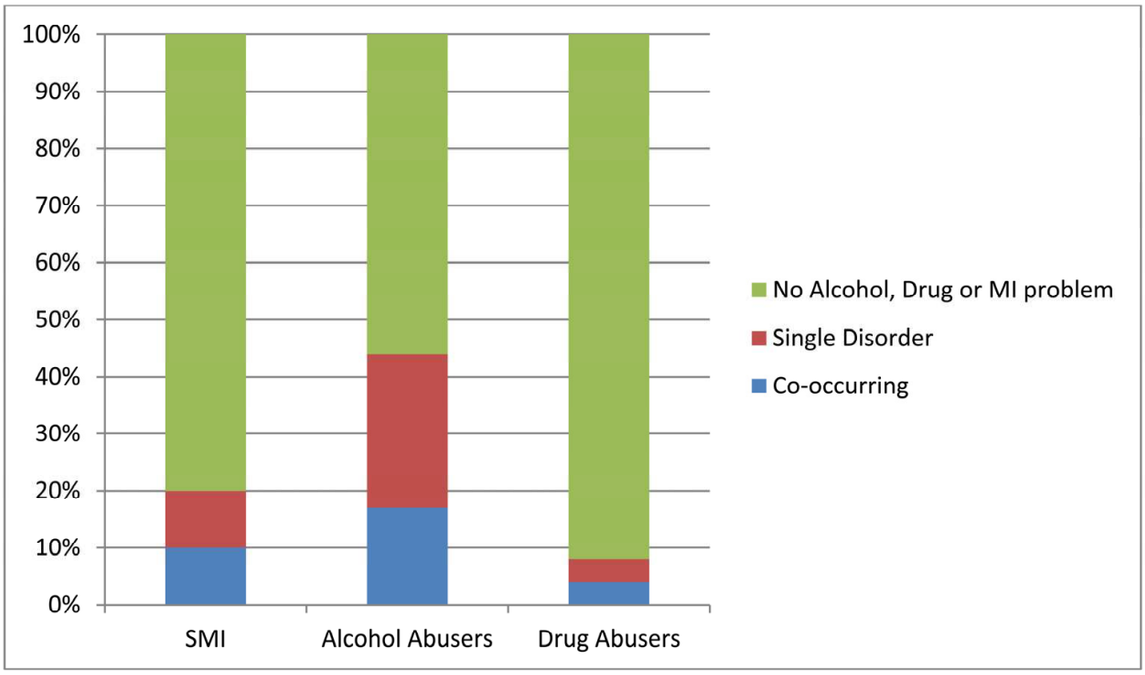
Fig. 1. The Four-Quadrant Model

3. The numbers

Epidemiological estimates of the number of people with a co-occurring disorder of mental health and substance misuse have changed over time. Despite the reality that there is a lack of undisputed data on the number of people with co-occurring disorders, there is no dispute about the gravity of the situation. In part, the absence of uniform numbers is related to the lack of knowledge among practitioners about co-occurring disorders and the lack of a universally accepted definition for a co-occurring disorder. Even so, the growing body of epidemiological studies consistently shows that the number of people with a co-occurring disorder is greater than once thought.
In the early 1990's, the prevalence of people in the United States with a mental health disorder, a substance use disorder, or a co-occurring disorder was estimated to be between 28% and 30%. This estimate was based on two epidemiologic surveys, one in the 1980's, the Epidemiologic Catchment Area (ECA) study (Robins & Regier, 1991), and the other, the National Comorbidity Survey (NCS) conducted in the early 1990s (Kessler et al., 1994). These epidemiologic surveys used a standard definition of mental illness found in the *Diagnostic and Statistical Manual of Mental Disorders* (i.e., DSM-III and DSM-IIIR). These surveys estimated that during a one-year period, about 19% of the adults or some 38 to 40 million people had a diagnosable mental disorder. Approximately, 3% had both a mental illness and an addictive disorder; and roughly 6% had an addictive disorder alone (Regier et al., 1993; Kessler et al., 1994).
Studies that followed continued to add to the growing empirical data on the number of people needing treatment for a co-occurring disorder. Research from the substance abuse treatment community suggested that between 50% and 75% of the people they treated also had an obvious mental health problem(s). Mental health researchers studying the co-occurring population in their treatment facilities found between 20% and 50% of the people

being treated had a co-occurring problem of substance abuse or dependence (Sacks, Sacks, De Leon, Bernhardt, & Staines, 1997). As epidemiological data from the accumulating studies begins to stabilize, the best estimate in the early years of the 21st century is that about 1 in 4 adults in the United States had been diagnosed with a mental disorder, roughly 58,000,000 people. An estimated 5 million people out of that group of individuals had a co-occurring disorder (Kessler et al., 2005).

These national studies also reported that approximately 50% of people with a severe mental health disorder are also affected by substance misuse. Furthermore, 37% of alcohol abusers and 53% of drug abusers have at least one serious mental illness. Among all the people diagnosed with a mental illness in the United States, an estimated 29% abuse alcohol and drugs (See Figure 2)



Data compiled from: Robins & Regier, 1991; Kessler et al., 1994; Kessler et al., 2005; CSAT, 2007.

Fig. 2. Prevelance of Alcohol abusers, Drug abusers, Sever Mental Illness (SMI), and Co-occurring disorders in the U.S.

Among individuals with an addictive disorder that lasted at least 12 months, 42.7% reported at least one mental health disorder. Of those who reported a mental health disorder over the previous 12 months also reported at least one addictive disorder. Not surprisingly, the Epidemiologic Catchment Area survey found that people with a severe mental health disorder were at significant risk for developing a substance use disorder during their lifetime. For instance, 47% of people with a schizophrenic disorder also reported a substance misuse disorder. This percentage was over four times higher than what was found in the general population. Among people with a bipolar disorder, 61% had a substance misuse disorder. This percentage was over five times of that found in the general population. Overall, these studies indicate that among individuals experiencing a co-occurring disorder, psychiatric relapse is most often associated with the use of alcohol, marijuana, and cocaine.

Whereas, the most common cause for relapse among people addicted to alcohol or other drugs is the presence of an untreated psychiatric disorder.

3.1 Co-occurring disorders among adolescents

Research since the 1980s indicate that up to 80% of individuals entering publicly funded treatment for substance use disorders have one or more co-occurring psychiatric disorders. Yet only 16% of adults and 26% of adolescents have a co-occurring disorder documented in their intake assessments (Hills, 2007). Adolescents are another important population of individuals with a co-occurring disorder. Children and adolescents were ignored for the most part until the early 1990s. Previously, professional papers and monologues that describe the prevalence of children and adolescents with a co-occurring disorder were based on the rates, behavior, and treatment of co-occurring disorders in adults. Two major epidemiological studies in the early 1990s provided the initial demographic statistics on co-occurring disorders among children and adolescents. The two epidemiological studies, The Epidemiological Catchment Area Study (Robins & Regier, 1991), and the National Comorbidity Survey (Kessler et al., 1994) reported that almost half of adolescents, who were not receiving treatment for a mental health or substance misuse disorder, still met DSM criteria for a substance use disorder and DSM criteria for at least one psychiatric disorder.

In an epidemiological monogram published in the United States, called the New Freedom Commission on Mental Health (SAMHSA, 2003b), it was estimated that more than one in five children (21%) between the ages of 9 and 17 had a diagnosable mental health or substance use disorder associated with at least minimum impairment. An earlier investigation, the Methods for the Epidemiology of Child and Adolescent Mental Disorders (MECA) Study by Shaffer and associates in 1996, found that in many cases, onset of the disorders occurred in children as young as 7 to 11 years of age. Among children in this age group, an estimated 11% experienced significant emotional and behavioral problems at home, at school, and with peers. A smaller number of children and adolescents in this group (5%) experience severe mental health and substance misuse impairment (Shaffer et al., 1996).

Institutional settings for children with a co-occurring disorder are a special case. Studies have shown that mental health disorders were higher than expected among children and adolescents who were mired in the child welfare or juvenile justice system. The best numbers (Putnam, 2000) suggest that between 30% and 40% of the children who were in an out-of-home care placement had a serious mental health disorder. In a similar institutional setting, an estimated 70% of children and adolescents in the juvenile justice system in the United States met criteria for one or more mental health disorders

These numbers of adolescents (in these two institutional settings) with a co-occurring disorder indicate a major need for adolescent mental health, substance abuse, or more appropriately services for a co-occurring disorder. These institutions are government entities and agencies created and funded to care for children and adolescents who were removed from the supervision and care of their parents or custodian. These institutions are legally surrogate parents. Subsequently, the expectation is that all children in the care of these institutions who have a co-occurring disorder would receive at least minimal treatment. To the shame of the United States government, only 20% to 25 % receive mental health services. Even among children in these institutions who had insurance, as many as 75% of the children still had unmet mental health service needs (Kataoka, Zhang, & Wells, 2002).

Children and adolescents with substance use disorders fare no better. Use of alcohol and illicit drugs among children and adolescents has been estimated to be around 73% for alcohol and 27% for illicit drugs (SAMHSA, 2003a). By 2004, estimates were suggesting that approximately 1.4 million young people had a substance abuse problem that required treatment, but only 10% of those needing substance abuse treatment actually received any treatment at all (SAMHSA Office of Applied Studies, 2005). Among adolescents in substance abuse treatment, more recent studies have indicated that as many as 50% to 90% can be diagnosed with a co-occurring disorder (Reebye, Moretti, & Lessard, 1995; Roberts & Corcoran, 2005).

For illustration purposes, findings from studies that have focused on adolescent substance use patterns and treatment outcomes, when mental health issues are involved, help describe the complex nature of these comorbid disorders. Researchers studying adolescent substance abuse treatment suggest that there are critical differences between an adolescent in substance abuse treatment with only a substance abuse problem and adolescents with a co-occurring disorder. Children and adolescent with a co-occurring disorder tend to have an earlier onset of substance use, are more frequent users of substances, and can be expected to use substances over a longer period of time. They have increased rates of family, school, and legal problems than their peers, and these emotional and social relationship problems began at an earlier age (Libby, Orton, Stover, & Riggs, 2005; Kessler, Beglund, Demler, Jin & Walters, 2005; Rowe, Liddle, Greenbaum., & Henderson, 2004).

Other studies point to the complexity of treating children and adolescents with a co-occurring disorder at a substance abuse treatment program. These studies report that children and adolescents with a co-occurring disorder are significantly more likely to drop out of substance abuse treatment and have a poor long-term prognosis (Wise, Cuffe, & Fischer, 2001, Crowley et al. 1998). This is very similar to findings among adults who were treated in either a mental health facility or a substance abuse treatment program (SAMHSA, 2005). A common conclusion among practitioners and researchers is that working with adolescents who have a co-occurring disorder is more challenging than working with the child with only a mental health or only a substance abuse disorder (Rowe, Liddle, Greenbaum., & Henderson, 2004). At the beginning of the second decade of the 21st century, our understanding of co-occurring disorders among adolescents is still in its early stages. Much more needs to be done. Effective screening, assessment and effective treatment interventions are still in the future.

3.2 Putting a face on people with a co-occurring disorder

The typology presented here is based on intake data on more than 38,000 adult men and women who were assessed during intake or who were assessed and treated by 28 model agencies and four (4) control agencies between 2005 and 2008 in Oklahoma, U.S.A. This epidemiological study was one component of a state COSIG project to improve services for people with a co-occurring disorder. A focus group of professionals who were actively involved with treating people with a co-occurring disorder were recruited to help validate and refine the typology developed from this data.

To provide adequate treatment and services, knowing the prevailing rate of people with a co-occurring disorder is essential for any behavioral health service system (McGovern, Xie, Segal, Siembab, & Drake, 2006). Agencies need data on the prevalence so as to better allocate scarce resources. This includes, developing clinical and staff trainings on using "best practices" and developing other support services that will reduce the high rates of treatment

failure and relapse among people with a co-occurring disorder. Additionally, Drake and others (2005) have asked that research in the future investigate and refine interventions; and, that researchers continue to clarify a typology of people with co-occurring disorders. The following analysis provides a typology of people who were admitted for treatment with an indication of a co-occurring disorder.

3.3 People with a co-occurring disorder differ in many ways

When a clinician meets a person with the co-occurring disorders of mental illness and substance abuse at admission, people with a co-occurring disorder will probably have many of the following characteristics. One of the overarching impressions, based on these data is that people with a co-occurring disorder have more in common with each other than they do with people who seek treatment for only a mental health or an addiction disorder. As a group they are different in many important ways.

There was a difference in the percentage of people identified as having a co-occurring disorder between the model programs (defined as co-occurring treatment capable) and the control programs providing typical treatment. Model Program staff, over three years, identified approximately 38% of their clients as having an indication of a co-occurring disorder. The Control Programs identified discernibly fewer people as having a co-occurring disorder over the same period (average = 22%).

3.3.1 Differences by gender

Over the three years of data collection, there was only a slight change in the gender of those admitted to the model and control programs. As would be expected, there were more males admitted for treatment for a co-occurring disorder than females. Albeit, only slightly more males (52%) than females (48%) were admitted for treatment to the Model Programs. The Control Programs admitted slightly more females (53%) than males (47%). Men tend to be more challenging and defiant in treatment. The comprehensive training in treating people with a co-occurring disorder seems to have reduced staff resistance to treating men with more difficult behavioral problems.

3.3.2 Differences in age

There was no meaningful difference in age among people with a co-occurring disorder, and only a slight difference in the age of males and females. As a group, the age of men in this sample was approximately 36.5 years of age. Females with an indication of a co-occurring disorder were slightly younger (35 years of age). This appears to be a stable characteristic of people with a co-occurring disorder admitted to treatment in Oklahoma.

3.3.3 Difference in education

Education is important because one needs a minimal level of education to able to benefit from most treatment models. In these data, there was no significant difference in education between males with an indication of a co-occurring disorder and males without an indication of a co-occurring disorder. Women, however, with an indication of a co-occurring disorder had slightly less education than women without an indication of a co-occurring disorder. Educational levels tend to be a stable characteristic. Among men there is no significant difference in education. Conversely, women with a co-occurring disorder had slightly less education than women without an indication of a co-occurring disorder.

3.3.4 Difference in income

Income can be a determinant in treatment effectiveness. The average yearly reported income for all men ($7,358, U.S, Dollars) admitted to treatment was slightly higher than all women ($6,562, U.S, Dollars) admitted for treatment. The per capita income in the community where these people with a co-occurring disorder resided in 2008 was $38,415, U.S. Dollars. Clearly, co-occurring disorders that reach a level of severity that need treatment sorely interferes with an individual's ability to support themselves or a family.

3.3.5 Differences in homelessness

When a co-occurring disorder is so severe it interferes with one's ability to earn a living the repercussions can be devastating. Both men and women with an indication of a co-occurring disorder are at risk of becoming homeless. In this sample, 8% of people entering a treatment facility were homeless. Of the 6,300 people who were homeless, 2,960 (47%) of the homeless were individuals with an indication of a co-occurring disorder. Of these homeless individuals with an indication of a co-occurring disorder, 65% were male and 35% were female. About half of the homeless individuals entering treatment will have a co-occurring disorder. Men with an indication of a co-occurring disorder who are homeless will outnumber women who are homeless with a co-occurring disorder by 2 to 1. More intense case management services will be needed when a person with a co-occurring disorder enters treatment as a homeless person.

3.3.6 Differences in admission status

Admission status is important when designing a treatment plan in mental health and substance abuse treatment. In this study, the group of people with a co-occurring disorder had significantly *fewer* 'voluntary admissions' among men and women with an indication of a co-occurring disorder than people admitted for treatment without a co-occurring disorder. More men and women with an indication of a co-occurring disorder were admitted by 'court commitment.' More men and women with an indication of a co-occurring disorder were also admitted with 'emergency detention orders' (See Table 1).

Voluntary Admissions	NO COD	COD
Men	64%	34%
Women	75%	25%
Civil Commitment	NO COD	COD
Men	45%	55%
Women	70%	30%
Emergency Detention	NO COD	COD
Men	47%	53%
Women	60%	40%

Table 1. Admission Status

One can expect fewer men and women with an indication of a co-occurring disorder to be admitted voluntarily. Both men and women with an indication of a co-occurring disorder are likely to be admitted with some form of detention order. Both men and women with an indication of a co-occurring disorder are more likely to come into treatment as a result of legal intervention.

3.3.7 Difference in domestic violence

There was no significant difference among women diagnosed with a co-occurring disorder and women with only a mental health or addiction disorder in terms of domestic violence. Over 44% of women admitted for treatment in any facility where data was gathered reported having a history of domestic violence. Over 10% of women in this sample reported being battered while pregnant. Among the women on which we have data, 3.5% reported that they were the perpetrator of the domestic violence that they were involved in.

Among women admitted for treatment during the four years of this study, the rate of domestic violence tended to be similar year after year. The number of women reporting a history of domestic violence was stable over the four years of this study. As well, the number of women reported being battered while pregnant also remained stable over the four years of this study. In the professional literature researchers assert that domestic violence rates are higher among women with a mental illness or any substance misuse disorder than among women without significant behavioral problems. In the U.S. population at large, over their lifetime, 25% of women experience domestic violence (Tjaden, & Thoennes, 2000). The findings about the extent of domestic violence, in this study, are in line with the professional literature. In this study, domestic violence was over 50% higher among women entering treatment than women in the general population.

3.3.8 Difference in arrest history

A history of being jailed for behavior related to a mental illness or addiction is slightly more common for people admitted to treatment for a co-occurring disorder than people with only a mental illness or an addiction. Men and women with an indication of a co-occurring disorder were arrested more often 30 days before admission (2% were arrested) than men and women with *no* indication of a co-occurring disorder (1.2%).

3.3.9 Difference in people identified with a serious mental illness

At admission 66% of adult men and 68% of adult women in this sample were assessed as being seriously mentally ill. At discharge, 64% of adult men and 67% of adult women were assessed as still being seriously mentally ill. Within this group of women assessed as having a serious mental illness, 29% were also identified as having a co-occurring disorder. This is a ratio of 1 to 3.4 or 1 woman with an indication of a co-occurring disorder for every 3.4 women assessed as having a serious mental illness. n this group of men with a serious mental illness 41% also had an indication of a co-occurring disorder. This is a ratio of 1 to 2.4 or 1 man with an indication of a co-occurring disorder for every 2.4 men identified as seriously mentally ill.

3.3.10 Difference in GAF scores

The Global Assessment of Functioning (GAF) scale used in the mental health field is a numeric scale where zero (0) indicates the poorest level of functioning and 100 equals the highest possible level of functioning. It is a common behavioral health scale used by mental health clinicians and physicians in the United States. In the DSM-IV TR, it is described as a subjective scale to rate the social, occupational, and psychological functioning of adults. The range of scores reflects how well one is meeting various problems-in-living.

Men and women in this sample identified as having a co-occurring disorder were given significantly lower/worse GAF scores than men or women with *no* indication of a co-

occurring disorder. At discharge, nonetheless, there was no significant difference in the GAF score between people with an indication of a co-occurring disorder and those with *no* indication of a co-occurring disorder. This finding implies that, at least while in treatment, people with a co-occurring disorder (based on the judgment of clinicians) improved significantly.

The average GAF score for a person with no indication of a co-occurring disorder was significantly higher; the person was healthier (No COD GAF = 47, COD GAF = 41). At discharge, there was little or no difference in the GAF score between people with an indication of a co-occurring disorder and those with *no* indication of a co-occurring disorder (No COD GAF = 50.72, COD GAF = 49.45).

3.3.11 Differential DSM-IV TR diagnosis by discharge type and gender

Substance Use Spectrum Disorder: Over the four years of the study, on average 60% of men and women with an Axis I diagnosis of a substance use spectrum disorder completed treatment, while 18% left Against Clinical Advice (ACA).

Psychoses Spectrum Disorder: Approximately 68% of men and women with a psychoses spectrum disorder completed treatment. About 12% left ACA.

Mood Spectrum Disorder: In this group of men and women with an Axis I diagnosis of a mood spectrum disorder, 55% completed treatment; 20% left ACA.

Anxiety Spectrum Disorder: Among the men with an Axis I diagnosis of anxiety spectrum disorder: 22% completed treatment; 40% left ACA; 15% were administratively discharged. Women with an Axis I diagnosis of anxiety spectrum disorder did slightly worse in treatment; 20% completed treatment, but 44% left ACA.

Undeniably, the people in this treatment sample seeking mental health or substance abuse treatment and who were diagnosed with an anxiety spectrum disorder, were failing in treatment. This could be an anomaly, but the emotional and financial burden on both the individual and society is unacceptable. There is a critical need to investigate treatment effectiveness and outcomes of people in other settings who seek treatment for an anxiety spectrum disorder.

3.3.12 Discharge type among people with a co-occurring disorder and without a co-occurring disorder

Notwithstanding, the reality that completion of treatment at a treatment facility does not ensure long-term recovery; as well, leaving treatment ACA does not ensure relapse and readmission, men and women with an indication of a co-occurring disorder in this study tended to complete treatment more often and leave less often ACA.

Both men and women with an indication of a co-occurring disorder completed treatment significantly more often and left treatment ACA less often than people with no indication of a co-occurring disorder. These findings defy conventional wisdom and the impression of many practitioners and researchers that people with a co-occurring disorder are more difficult to treat than people with a single disorder of mental illness or addiction. In fact, both conditions may be accurate. People with a co-occurring disorder that enter treatment are serious about obtaining treatment for their disorders and so they persist in treatment and do complete treatment hoping that they will be able to overcome their mental health disorder and addiction. Despite their efforts, however, treatment for co-occurring disorders is less than effective and long-term positive outcomes tend to be dismal at best and harmful at worst (See Table 2).

Discharge Type	Completed Treatment	Left ACA
Men No COD	44%	30%
Men COD	62%	16%
Women No COD	38%	35%
Women COD	58%	20%

Table 2. Discharge Status

4. Moving science to service

Moving scientific discoveries to service, in a way that is sustainable, is more about changing the organization than it is about the science or the services provided. To describe how these scientific discoveries made their way into practice, the COSIG project, a SAMHSA initiative carried out in the United States between 2002 and 2011 can be used as a case study. In this construct, a logical role for a federal agency like SAMHSA is designing and funding programs to move *science to service.* The Annapolis Coalition report on the Behavioral Health Workforce, in the Executive Summary of that report (published by SAMHSA) entitled, *An Action Plan for Behavioral Health Workforce Development* delineated the problems caused by the 10 year lag time between the validation of an intervention and its use in the field (Hoge, et al. 2007).

To conceptualizing the *why* and *how* changes occurred, we begin with the knowledge that the COSIG Project was designed as an intentional change effort with specific goals and objectives. These goals and objectives were linked to measures and preferred outcomes that could be used and compared to observed changes. Moreover, using this approach, it was also possible to identify the tools (events, activities, and initiatives) used by the implementation teams in their attempt to make changes in these complex, large organizational systems and agencies that provide mental health and addiction treatment services.

In 2002, SAMHSA released a landmark report to Congress on Co-occurring Disorders that suggested a model of *integrated services and treatment* that was showing unprecedented success in the treatment of people with co-occurring disorders. The report and the subsequent money appropriated by Congress set the stage for the SAMHSA program called COSIG. The Congressional appropriation was used to provide funding, leadership, and support for state efforts. The COSIG project provided a one-time grant to fund States that wanted to develop or enhance their infrastructure to increase their state's capacity to provide accessible, effective, comprehensive, coordinated/integrated, and *evidence-based treatment* services to persons with co-occurring substance abuse and mental health disorders. The COSIG project was funded for 10 years (2002-2011) (Center for Substance Abuse Treatment, 2007).

4.1 Definition of evidence-based treatment

Practices and treatments in behavioral health that have been shown empirically to have statistically significant better outcomes are identified as Evidence-based Practice (EBP) and Evidence-based Treatment (EBT). For the professional organizations of behavioral health practitioners (e.g., American Psychological Association, the American Occupational Therapy

Association, American Nurses Association, the American Physical Therapists Association, and comparable organizations internationally) have made EBP not just a recommendation, but a practice requirement based on ethical principles.

Opponents of designating EBP interventions as the only acceptable standard for professional practice argue that all hard scientific evidence may not be applicable in real life. Knowing what a tested medication can do is entirely different from knowing what method works with an individual with a behavioral health issue. Treatment effectiveness depends on a host of ancillary factors, not the least of which is therapist's style, personality, and training (Thomas & Pring, 2004).

As demonstrated in this instance, moving science to service is a complex and laborious process. Changing large and even small organizations can be difficult, problematic, and even awkward. By nature, organizational change creates anomie within the organization. One of the responses to anomie (caused by the threat of change) is resistance from staff and administrators. Resistance to change from clinicians can be countered by presenting the science behind the need to change. Much more difficult, is resistance among administrators and bureaucrats. Although it sounds crude, more money and threat of job loss are the primary motivators for administrators and bureaucrats. If resistance cannot be assuaged, efforts to make positive changes will likely fail.

A metaphor that might help in understand how change occurs in large institutions such as SAMHSA and state health departments (as well as other government institutions, corporations and conglomerates, universities, and mega non-profit corporations) come from watching supertankers (Ultra-Large Crude Oil Carriers that weigh-in at 625,000 tons when full) navigate the Atlantic Ocean off the coast of Florida. Fundamentally, these institutions are indistinguishable from supertankers in terms of the energy and time it takes for them to make a significant course change. A friend whose fishing boat went down between South Florida and the Bahamas told of seeing one of these monster tankers coming toward his life boat. As it approached, the crew of the supertanker who had spotted him waved and shouted to him words he could not understand over the noise of the tanker. As it passed by, without even slowing down, he told me that he thought they had probably radioed the Coast Guard. As the supertanker disappeared over the horizon he said he began to lose hope of being rescued; he was only a speck in the ocean somewhere in the vast Bahamas triangle. He could not figure out why the crew of the supertanker had not stopped to pick him up. Then several hours later he again saw a supertanker coming from the other direction. It was the same tanker coming back for him. It had taken hours for the tanker to slowdown and miles of ocean for it to "come about". At a speed of about five knots it slowed enough to pick him up. Several hours later, after another slow looping turn, the tanker was back on course. It takes an excruciatingly long time to change course on these supertankers or in large institutions.

5. International co-occurring initiatives

While there was a concerted effort in the United States to develop and implement services for people with a co-occurring disorder, parallel initiatives were going on internationally. Even though, research and program development had a great deal more funding in the United States, countries around the world developed manuals, reports, and resource materials with recommendations for assessing and treating people with a co-occurring disorder. By the year 2000, funders and program planners globally had recognized that the

number of people with co-occurring disorders was much larger than they had thought and that treatment failure rates were extremely high. This was especially true in countries where mental health and substance abuse treatment costs were a substantial part of the national GDP. As the evidence grew about the rate of treatment, failure among people with a co-occurring disorder, the excessive and often wasted cost of treatment became a widespread political concern.

To make the point about the international response to the findings from epidemiological studies in different countries that the number of people with a co-occurring disorder was larger than had been known, events in Australia, Canada, and the United Kingdom will be briefly reviewed. What becomes evident from an international perspective is the scientific process was used by each country to study the problem. First, the majority of countries did an epidemiological study to identify the number of people who needed treatment. After establishing the need, groups of experts were organized to identify and recommend effective treatment approaches.

5.1 Australia

Early on, Australia was studying prevalence rates for people with a co-occurring disorder served by a vibrant addiction and mental health treatment community (Croton, 2004). In 2001, researchers also collected data on the overall prevalence of any mental health, substance use, and co-occurring disorder found among inmates in Australian prisons, one of the first studies of its kind. The prevalence of inmates with a mental disorder was 42.7%. The prevalence rate for any substance misuse disorder was 55.3%. With the exception of alcohol use disorders, women inmates had higher rates than men of mental illness and substance use disorders. The prevalence of a co-occurring mental illness and substance use disorders in the previous 12 months was 29% (46% among women vs. 25% among men). There was a significant association between cannabis use disorders and psychosis in men, but not women. There was also a significant association between affective disorders and co-occurring alcohol use disorders in women but not men (Butler, Indig, Allnutt & Mamoon, 2011).

In Australia, alcohol and drug treatment services and mental health services are administered and funded separately. Similar to organizational structure in other countries, separate funding lines provided little or no incentive for collaboration between the two groups of service providers. Previous national initiatives and funding schemas had attempted to minimize barriers to treatment and build strong partnerships between substance abuse treatment and mental health treatment practitioners. Nevertheless, a report by the Australian Institute of health and welfare in 2005 reported that despite previous efforts, people with comorbidity were still not being well served in Australia.

In the 2003–04 Federal Budget, the Australian Government allocated funding for the development of the National Comorbidity Initiative to improve service coordination and treatment outcomes for people with coexisting mental health and substance misuse disorders. One priority area for action under this initiative was to improve data systems and methods of collecting data within the alcohol and drug treatment facilities, and mental health agencies in Australia (AIHW, 2005).

5.2 Canada

When researchers and experts in mental health and substance abuse treatment in Canada realized that a large segment of the treatment population in both sectors had a co-occurring

disorder, the next issue was to examine treatment outcomes. As suspected, neither mental health treatment nor substance abuse treatment facilities in Canada provided optimum treatment. Supported by this information, attention turned to the treatment community's capacity to providing co-occurring services.

In 2000, the Canadian Minister of Health authorized Health Canada, a department of the Minister of Health, to form a working group and select a panel of experts from across Canada to synthesize best practice guidelines for providing treatment and services to people with a co-occurring disorder. The Canadian department was responding to the growing recognition that parallel or sequential treatment (treatment at two different facilities; one providing mental health services and the other providing substance abuse treatment) had failed. The panel of experts who identified best practices for this Canadian publication, *recommend* integrated treatment (integrated mental health and addiction treatment approaches) as a best practice in the treatment and care provided people with a co-occurring disorder (Centre for Addiction and Mental Health, 2002). It was a major step forward when the Canadian Minister of Health, in 2002, published the results of the work of the expert panel in the form of a monogram of resource materials and best practice assessment and treatment approaches that could be used to improve treatment and services for Canadians with a co-occurring disorder.

In the monogram entitled, *Best Practices: Concurrent Mental Health and Substance Use Disorders* (Centre for Addiction and Mental Health), research findings to that point were updated and synthesized, and specific recommendations were made for screening, assessment, and treatment in an effort to improve treatment outcomes for people with a co-occurring disorder. A national inventory of specialized concurrent disorders programs, entitled *National Program Inventory - Concurrent Mental Health and Substance Use Disorders* was also developed and published as a companion document. The monogram was written for managers and staff of mental health, substance abuse and integrated mental health and substance abuse service agencies. In addition, it provided micro level information and recommendations that practitioners in the community who were tasked with providing quality service to people presenting with concurrent mental health and substance use disorders could use in their practice (Centre for Addiction and Mental Health, 2002).

5.3 United Kingdom

Little was known in the United Kingdom about the prevalence of people with co-occurring disorders in 1997 when Virgo and associates (2001) set out to establish the baseline numbers. Inspired by research conducted in the United States (e.g., Kessler et al. 1996; Regier et al. 1990) up to that point, British studies had been limited to inner city London or to small groups of seriously mentally ill individuals. Moreover, the focus of the studies was on substance misuse and consumption rather than on prevalence or consequences (Menezes, 1996). This non-metropolitan United Kingdom study conducted by Virgo and associates was the first to establish the lifetime and point prevalence of substance abuse and dependence among all current seriously mentally ill patients of all branches of the National Health Services (NHS) Trust, not just those with psychosis.

The number of NHS patients with co-occurring disorders, at the time, was slightly smaller in this United Kingdom study than previously reported in the United States. Nonetheless, the findings related to consequences and characteristics of those with a co-occurring disorder were similar to that reported in the United States. In this study, 12% of the NHS

patients were identified with an adult mental illness, 12% met criteria for a substance abuse or dependence disorder, and 20% of those surveyed presenting with a serious mental illness were identified as having a co-occurring disorder. These percentages vary, however, depending on the service sector of NHS. The lowest percentage of those identified with a co-occurring disorder (10%) was found among people receiving rehabilitative services. Taking into consideration the need for rehabilitative services among people with a co-occurring disorder, 10% seems to be rather low. On the acute wards, the percentage of people with a co-occurring disorder was as high as 41%. Compared to other patients in the study, those with a co-occurring disorder were younger, were more often male, lived in less stable accommodations, were unemployed, and had more than one psychiatric diagnosis. They tended to report more crises in their life, more abuse by others, were a greater risk to themselves and others, and reported more alcohol and drug involvement. The drugs of abuse reported by co-occurring patients identified as having an adult mental health disorder were alcohol and cannabis. In the group of patients being treated for addiction, who are also identified as having a co-occurring problem, the preferred drugs were heroin and alcohol with a co-occurring depression (Virgo et al., 2001).

Once the prevalence rate among NHS patients was determined, research to identify the best approaches for training mental health teams to treat people with a co-occurring disorder began in the late 1990s. The result of this combined effort was the Pan-London Dissemination Project. This program was a "train the trainer" initiative designed to disseminate information on assessing and treating people with co-occurring disorders (Croton, 2004).

They were also similar initiatives and efforts in other countries to address the needs of their citizens with a co-occurring disorder. Informed by the extensive research in the United States, Germany (Hintz & Mann, 2006), Russia (Mathew et al., 2010), New Zealand (Scott et al., 2008) and other countries followed a similar path in their efforts to provide effective treatment and services for their people struggling with the co-occurring disorders of mental illness and addiction.

6. What if the two fields of practice are NOT compatible

In the history of science there are few if any examples of convenient solutions that were effective and efficient. Programmatically, Integrated Treatment was the easiest next step after Parallel and Sequential treatment models failed to improve outcomes for people with a co-occurring disorder. The fallacy or inconvenient truth in the way integrated treatment was conceptualized (as many practitioners pointed out on a blog called the *dualdx* listserv in 2006-07) the consensus among experts who focused on co-occurring disorders was that the treatment interventions from both treatment traditions were compatible—capable of existing or performing in a harmonious way with one another.

This is a critical assumption. What if the two treatment models are not compatible? What if they work in opposition when combined? What if integrating the two models of treatment is like trying to merge two partly dysfunctional systems? What if philosophically we are trying to do the equivalent of mixing oil and water? What if parallel and sequential treatment failed not because of the specific timing of deployment of the treatment types, but because they work one against the other when combined? For illustration purposes, what if the two treatment approaches are like many medications that cannot be taken together. These possibilities create a dilemma for clinicians, program developers, and funders. If

neither technology nor a combination of both technologies are effective in treating people with a co-occurring disorder—what other technology is available?

The answer to the first question, in my view, is that the two treatment modalities are not compatible and they cannot be integrated effectively unless treatment philosophies and policies in both fields are willing to change. Neither field has developed a set of treatment interventions sufficient to recommend either of them in whole.

The answer to the last question—rather than integrate the two systems of mental health and addiction treatment *in whole*, I would argue that an applied research approach be used to carefully select the best components from each field and weave them into a new and third technology. Pursuit of a synthesis of the best practice components in and of itself would go a long way in the development of a more effective and efficient treatment modality. During this process, it will be critical to identify best practices treatment approaches, interventions, and techniques that work and promote wellness for people in treatment. It will also be critical to identify, consciously discard, and then disseminate information on treatment and services that are ineffective, inefficient, and/or produce poor outcomes. Clinicians in the Behavioral Health related fields should be held responsible for disclosing information about their interventions in the same way that drug companies are supposed to reveal the side effects and negative outcomes of the treatments they sell.

To start this process, I recommend that clinicians discard the *paternalistic attitudes* endemic in mental health treatment (e.g., Angell, 2006; Sowers, 2005; Lefley, 1998). I also recommend that the *punitive approach* also referred to as the *conformational approach* that has been one of the distinguishing characteristics of substance abuse treatment be discarded as brutish because it does not meet the standards that define *best practices* (e.g., Quinn, Bodenhamer-Davis, & Koch, 2004; Dongier, 2005).

6.1 Paternalism is NOT Treatment

Clinicians in the field of mental health for the most part have a paternalistic orientation toward their "patients." They are trained in subtle ways to see a person with a mental illness as totally and permanently disabled. Moreover, paternalism among clinicians has a long and rich history.

Clinicians and mental health programs with a paternalistic orientation have few and limited expectations of people with a mental illness, other than the *patient* following the "doctor's orders" and being compliant (Sowers, 2005). By way of example, the perception of permanent disability is so ingrained the science and knowledge of mental health that the concept of *recovery (*a major part of the treatment for addiction) was not included into the mental health model of treatment until after mid-2005.

The hebetude that results from paternalism in mental health gone awry is a legacy of our past. When paternalism was the core of the clinical response to mental illness, people with a mental illness were locked away in mega mental hospitals in the United States for their care and protection. This approach to care and treatment, often referred to in modern times as milieu therapy, caused a secondary disorder where the resulting mental and physical lethargy was accurately named, "institutionalization" (Lamb & Oliphant, 1978).

The attitude of those in the mental health treatment community after the 1840's in the United States was that they were responsible for the *care* and treatment of people with a mental illness. In fact, the charge to the Superintendents of American Asylums in the late 1800s was to care for the physical and mental needs of those with a mental illness and to protect the public (Hurd, 1916).

This "care model" resulted in *institutional behavior*. Institutionalization is an adaptive behavior by people to survive in a situation where pervasive institutional controls result in the mental, emotional, and behavioral characteristics of learned helplessness (Lunt, 2004). Institutionalization of people with a mental disorder became ubiquitous after the American public asylum movement (started in the 1840s) degenerated into mega public mental hospitals where patient management, administration, and financial concerns replaced treatment and rehabilitation.

In the second half of the 20th Century, the attitude of many mental health practitioners toward patients and clients has been shaped by an illness perspective (Beers, 1909; Sowers, 2005). Cynical in nature, in part because of the legal pressure as a result of the "deinstitutionalization movement" in the 1970s, the "illness perspective" rationale went something like, 'Even though most people with a mental illness would be better off in a hospital, it does not mean that he or she has to be confined to a hospital to receive treatment.' Today practitioners are in agreement that a person with a mentally illness has as much right to be in the community when they are *stable* as anyone else (Lunt, 2004). A concept we can support; but a concept that is extremely difficult to operationalize using symptomatology. In particular, the term *stable* is difficult to operationalize when the influence of culture on behavior changes symptomatology that defines a diagnosis.

Although wrought with problems, the illness perspective created a climate that viewed institutional care as one of several levels of care including outpatient care. Nevertheless, one of the underlying messages to people with a mental disorder is that they are being supervised as much as treated by the clinicians who represent a rigid and intractable mental health treatment community. Services and treatment provided in this atmosphere leave the people being treated for a mental illness with little hope, power, or vision of what life will be like if their symptoms have diminished (Grenville, 2001).

Too often, one of the consequences of a therapeutic intervention for a person who is being treated for a mental disorder by paternalistic clinicians is the message it conveys. The message reinforces a belief on the part of the clinician and the person with a mental disorder that people with a mental disorder have a lifelong mental impairment that will always need care and treatment by professionals in the field of mental health. The more recent development of the 'community model,' as a way of providing mental health services outside of institutions and facilities has turned out to be merely another 'care model' that *institutionalizes* and makes *helpless* the people the system is trying to rehabilitate (Lunt, 2004). By including the concept of "recovery" as it is understood in the addiction field, in the treatment of people with a co-occurring disorder, the therapeutic message is exactly the opposite from the message conveyed by a paternal philosophy (Becker, Drake, & Naughton, 2005).

Practitioners in the field of medicine have a different view of treatment and care when it comes to physical injuries and illnesses. In the medical field, when a person has another episode or relapse with a medical problem, treatment is often required, but the person is expected to recover and continue on with their life. Similar to breaking a leg, surgery, or cancer, the expectation of practitioners and those with a co-occurring disorder should be that they will recover and resume their life as a student, an employee, an artist, an engineer, a mental health clinician, and so forth. All interactions and treatments need to be based on the expectation that the person will recover and resume or become engaged in a productive life.

Taking all this into consideration, there is little doubt that practitioners in the mental health field clearly differ from clinicians in the substance abuse treatment community on the issue

of "personal responsibility" (Wing, 1995). For better or worse, at least substance abuse counselors hold their clients accountable for their behavior even if the tools that substance abuse counselors offer are often useless. Counselors in mental health have little or no expectation of their clients, even when the tools they offer can be quite helpful in reducing symptoms associated with a mental illness (Lunt, 2004).

6.2 A punitive attitude and confrontation are NOT treatment

Since the late 1950s, what is known as traditional substance abuse treatment for the indigent and chronically addicted has been residential treatment that varied far from the clinical treatment path. For instance, if you walked onto a traditional Therapeutic Community, you would likely see a resident walking around wearing a diaper over his/her clothes with an oversized pacifier around his/her neck with a sign on the person's back reading, 'I won't grow-up.' Outside in the court yard you could very well see a woman with a shaved head digging a hole three feet deep and placing a penny at the bottom of the hole, filling in the hole and then digging the penny out again. These types of degrading punishments, called *therapeutic intervention* are used to demonstrate to the addict the fruitlessness of their addictive behavior. Similar castigation is called *therapy* in hundreds of Treatment Communities in the United States. States and the Federal government pay millions of dollars each year to Treatment Community programs to provide this type of punitive *treatment*. Logically, if punishing and being callous to people who are abusing drugs was a cure for their misuse there would be no drug abuse anywhere in the world. If the punitive approach worked, there would be fewer people in prison for drug possession and use.

Modern drug treatment, for all intent and purposes, began in the 1930's with the development of Alcoholics Anonymous (AA) and AA's use of the self-help group. AA and Narcotics Anonymous (NA) type self help groups use a non-judgmental passive approach. AA and NA members extend themselves to people who want help with their addiction. They do not compel a person to quit or give up their addiction. But, they support the person who is committed to overcoming their addiction. To its credit, over the years, many addicts have been helped by AA and NA. A large percentage of addicts, however, needed and continue to need more than AA and NA can offer. Because clinical treatment was expensive and admittedly not very successful, the next major change in the treatment of addiction was residential treatment provide by addicts in "recovery." The two best known programs are the Synanon model developed in the late 1950s and the Therapeutic Community model developed in the mid 1970's (Janzen, 2001).

The Synanon program and the Therapeutic Community (both closely related in philosophy and treatment) were a clear departure from the psychiatric and therapeutic treatment in general and specifically for the treatment of addiction. The Synanon and Therapeutic Community leaders largely rejected professional psychotherapeutic treatments with the exception of self-help groups. The preferred counselor was a recovering addict.

6.3 The Synanon model

The Synanon group started in 1958 in Santa Monica, California as a drug and alcohol rehabilitation program. Charles Dederich (1914 to 1997) the founder of Synanon gained national prominence for developing a program that could cure narcotic addiction. Not as well known is the reality that this treatment approach was not very successful and graduated few people who lived productive lives outside of the Synanon community. In

1967, Synanon leadership abolished "graduation" and offered itself as an alternative-lifestyle community. Later it became the Church of Synanon (Janzen, 2001; Yates, 2003).
By 1977, Synanon was being referred to as a cult that controlled members using what was called the "Synanon Game." A pseudo *therapeutic approach*, the "Synanon Game" involved members humiliating one another and being forced to expose their innermost weaknesses and fears. This was a distortion of the encounter group process. This approach is based on the premise that when challenged, people examine themselves and learn new ways of behaving (Kaplan & Broekaert, 2003).
At its peak in the mid 1970s, Synanon women were made to shave their heads, married couples were forced to break up and take new partners, males were forced to submit to vasectomies, and a number of women who became pregnant while living in the community were required to have abortions (Yates, 2003).
What began as a highly praised drug treatment program, ended when Synanon leaders became implicated in an attempted murder. Synanon was closed in 1991 because of megalomania and financial problems brought on by lawsuits and disputes with the Internal Revenue Service over its nonprofit status (Janzen, 2001).
This was not the end, however, of Synanon's influence. Programs based on the Synanon model sprang up across the United States for adolescent drug users. First called the "Seed," this program later operated under names such as *Straight Inc.*, *Safe Recovery, Kids Helping Kids, Growing Together of Lake Worth, and Pathway Family*. From 1976 to 1993 Straight, Inc. operated the world's largest chain of juvenile drug rehabilitation programs. They are reported to have treated as many as 50,000 adolescents. In 1974 the U.S. Senate "likened" the methods of The Seed to those used by North Korean brainwashers (ISCA, 2002).

6.4 The treatment community model

After being discredited, Synanon's concept of community treatment inexplicably became the foundation for the residential treatment approach called the Therapeutic Treatment Community model. The punitive attitude and retaliatory consequences that defined Synanon treatment were carried over in great part as treatment interventions used by Therapeutic Treatment Community counselors. The philosophy is based on the notion that if an addicted person is harshly challenged, they will examine themselves and learn new ways of coping without the substance. To paraphrase a drug counselor, "We can make life so horrible that giving up drugs is the lesser of two evils." As many working in the field of substance abuse treatment, I have witnessed people in a Therapeutic Treatment Community treated worse than people in prison. You could not legally treat people in U.S. prisons like the people in Therapeutic Treatment Community programs are treated. Such treatment would be unconstitutional.
To be fair, those who advocate for the Therapeutic Community model see the primary goal of a Therapeutic Treatment Community is to "foster personal growth." One accomplishes personal growth by "changing one's lifestyle" this is brought about through a community of concerned people working together to help themselves and each other. The Therapeutic Treatment Community is designed to be a highly structured environment "with defined boundaries, both moral and ethical." Personal growth is promoted by "community imposed sanctions and penalties, as well as earned advancement of status and privileges," which are perceived as "part of the recovery and growth process" (Charles & Eric, 2003). Hayton, (1998)defined a *therapeutic community* as a structured method and environment for changing

human behavior in the context of community life and responsibility (SAMHSA, 2006b). This sounds like a helpful and benign environment, but the description can also be used to describe a prison or jail.

In spite of its history, there is a consensus among experts that using a Modified Therapeutic Community model for treating people with a co-occurring disorder can be beneficial. To be fair, those who advocate using a Modified Therapeutic Community model for people with a co-occurring disorder, do *not* recommend using confrontational approaches and provide services that allow co-occurring clients to access and take medication while in treatment (Skinner, 2005).

The behavioral literature clearly differentiates between positive reinforcement and negative reinforcement, and punishment. The *punitive approach* has no place in the treatment of a person with a co-occurring disorder. The *punitive approach* does not come up to the standards of care proposed by SAMHSA in the publication, *Co-Occurring Disorders: Integrated Dual Disorders Treatment Implementation Resource Kit* (SAMSA, 2003a). As a component of a therapeutic milieu, the punitive approach has no empirical support.

7. A third technology

7.1 Why do we need a third technology?

Why do we need a third technology? We need a third technology for at least two compelling reasons. First, research consistently finds that mental health and substance abuse treatment, as they are practiced in 2012, are marginally effective. They are not efficient. Multiple relapse is the rule. The failure rate makes current treatment cost exorbitant. Second, as the brief history presented in this chapter again reminds us, the mental health and substance abuse treatment approaches are grounded in tradition, not in science. This is not to say that many of the interventions used in mental health and substance abuse treatment have not been tested. Most of the standard therapeutic interventions used have been investigated, some using the double-bind methodology. What is not included in the calculus when testing these interventions is the difficulty involved in testing the effectiveness of a traditional treatment technique. The influence of a tradition is subtle and affects the thinking of researchers and thus the formation of the research questions asked by the researchers. Without considering the history of the development of the two traditions, investigators and clinicians are at risk for thinking that the reason why specific interventions are used in mental health and addiction treatment is because they have met some standards such as "safe and effective." This could not be farther from the truth.

Since the 1950s, we have continually tweaked these traditional approaches. And, with each tweak the traditional approach is found to be more effective. Yet, outcome studies do not confirm that these short-term treatment successes actually manifest themselves in long time successful outcomes. The research showing a lack of long-term success is particularly distressing. Especially, if you consider that success in treatment is distorted because expectations are already so low almost any outcome of treatment that is slightly above being a vegetable is considered a successful outcome by today's standards.

A final argument would be philosophical. Using an analogy, I would compare efforts to continue to tweak the two traditions to make them seem to work better is similar to patching up an old rotten and a leaky roof. At some point, the roof is going to have to be replaced. There might be parts of the old roof that can be used in the new roof, but a point will be reached when the repairs cost more than replacing the roof. In the field of mental health and

substance abuse treatment, a growing cadre of practitioners and researchers believed that we have reached the point where something needs to change.

Among the problems that I had when radically changing technology at a substance abuse treatment facility to treat people with a co-occurring disorder was changing the addiction culture. As one would expect, some staff resisted any change. They were committed to the tradition, especially those staff "in recovery" who were also counselors and clinicians. Staff, however, are at a disadvantage. Administrators and supervisors extend or withhold rewards to change behavior. This was not the case among clients who came for treatment, or for the community of AA members. Those two groups of people were as resistant, or more resistant to change than staff.

7.1.1 No new treatment model has emerged

Mixing oil and water is not a solution. A third technology needs to be developed. A new treatment model specifically designed to treat people with a co-occurring disorder is needed to replace the *Integrated Treatment* model. The contorted rationale that was used to integrate mental health and addiction treatment modalities to develop the integrated treatment model is so intellectually dishonest one has to suspend a sense of reality to even imagine that the two are compatible in practice.

The panel of experts, involved in writing SAMHSA's Tip 9 clearly recognized the incompatibility of the two treatment fields. Given their combined experience, they agreed that the conflict between the two treatment modalities was largely responsible for the failure to provide effective treatment for people with the co-occurring disorders of mental illness and substance misuse. They wrote:

> For people with dual disorders, the attempt to obtain professional help can be bewildering and confusing. They may have problems arising within themselves as a result of their psychiatric and AOD use disorders as well as problems of external origin that derive from the conflicts and clashing philosophies of the mental health and addiction treatment systems.
>
> Historically, when patients in AOD treatment exhibited vivid and acute psychiatric symptoms, the symptoms were either: 1) unrecognized, 2) observed but were described as symptoms of intoxication or "acting-out behavior," or 3) accurately identified, prompting the patients to be discharged or referred to a mental health program. Virtually the same process occurred for patients in mental health treatment who exhibited vivid and acute symptoms of AOD use disorders. (p.11)

Yet, between the publication of Tip 9 and Tip 42, there was no reported work by the committee of experts on those two panels to address the issues of incompatibility. Even so, the panel of experts involved in the identification of interventions applicable to treating people with a co-occurring disorder continued to recommend integrated treatment. Basically, the recommendation was to combine the philosophies and techniques from each field and ignore their intrinsic differences.

7.2 Selecting the best components from each field

A limited number of variations on the Integrated Model promoted by SAMHSA have been proposed but no model proposed is based on deliberately selecting and discarding components from the interventions used to treat mental illness and substance abuse. All the same, even without this level of deliberation about interventions a number of addiction

treatment programs that simply modified their services to include psychotropic medication have shown improved outcomes when treating people with co-occurring disorders (SAMHSA, 2003c; Osher & Drake, 1996; Sacks et al., 1997; Sciacca & Thompson, 1996).

7.2.1 Components that seem to be compatible

- Clinicians from both fields are trained in the psychosocial model of behavior.
- Clinicians from both fields see a need for a continuum of care which embraces the value of a variety of treatment settings and program types in both public and private settings.
- Clinicians from both fields support the extremely important adjunct role played by self-help organizations in both fields.
- Clinicians from both fields accept case management and care management as an important component of treatment and care.
- Clinicians in both fields see the value of peers or professionals with lived experiences as a critical support in developing and implementing an individual's care and support plan;
- Genetic research to identify the cause of the behavioral disorder is important to both fields.
- The evolving recipient of care movements that periodically influence change in the delivery of treatment services has affected both fields, most often in mental health.
- The emerging professional perspective and training that gives a higher priority to more basic needs of food, shelter, clothing, work, friendship, etc. has affected the workforce issues in both fields;
- The ever-increasing role of pharmacologic therapy in the treatment of substance misuse, moves substance-abuse treatment closer to the mental health perspective on treatment.
- There is a growing recognition that family members and significant others, as a group may be in need of services themselves.
- There is a potential for a common, or at least a convergent treatment modality for both fields.

(SAMHSA, 1995, p. 14; Centre for Addiction and Mental Health, 2002, p. 70-71)

There is an increasing recognition of the overlap in the population needing help and the expressed needs of consumers for better continuity of care within and across the respective systems. Hopefully this recognition will motivate scrutiny of treatment failure, relapse, and less than optimal long-term treatment outcomes.

7.2.2 Components to discard

A first step that would go a long way to improving the treatment and services provided people with a co-occurring disorder would be to decriminalize mental illness and addiction. The underlying threat of arrest and confinement if one does not comply with the treatment recommendations of one's illness undermines the best intentions of the mental health and addiction treatment practitioners.

Clinicians in both fields rely too heavily on the correctional system for formal and informal social control. Forcing people into treatment, without it being absolutely necessary, results in resistance and defiance from the person designated with a mental health or substance misuse disorder. This should be replaced with a collaborative therapeutic and case management relationship.

Confrontation is never acceptable. Even using less than a confrontational approach, what some resource material refers to as “being direct” may feel like abuse to the person in

treatment. Identifying and pointing out irrational thinking, based on the perspective of the clinician, can result in a conflict between the clinician and client. Insisting on random alcohol and other drug tests when working with people with a co-occurring disorder can reduce the level of trust and harm the therapeutic relationship.

Consequences and contingencies are not therapeutic modalities. They belong to corrections and social control agencies. Making a person responsible for his or her behavior sounds good but when a person is responding to delusional thoughts, is this really being defiant? Should clinicians spend time keeping records of violations of rules? Who does it benefit when clients are made to experience consequences of their behavior; the client who learns from being punished? When is developing therapeutic insight less beneficial than breaking through denial?

Stigma is often cited as a reason why individuals do not seek treatment from mental health providers or from substance abuse treatment facilities. The community at large is often cited as the source of stigma. As important as stigma in the community, is stigma among professionals in the field of mental health and substance abuse treatment. To reduce the stigma, professionals must first advocate for the rights of individuals seeking treatment in their own professional organizations. In a community context, advocates and professionals need to promote public education and understanding. As long as stigma remains high among clinicians, however, it will be nearly impossible to change the minds and attitudes of people in the community at large.

Widespread use of residential treatment for substance misuse disorders and confinement at a mental health treatment facility needs to be radically curbed. This is a relic left over from the days of the asylum. Outpatient, day treatment, and self-help groups need to be better supported and expanded.

The resistance to sharing power with the client in a therapeutic relationship by clinicians, an antiquated paternal attitude, renders treatment planning less effective and distorts therapeutic intentions.

In the field of mental health, the reluctance of clinicians to work with paraprofessional with lived experience (people in recovery after experiencing a mental illness) denies clients a major source of understanding, empathy, and a view of a positive future for themselves and others who have suffered from a mental disorder. This also denies the clinician a positive view of people who have been treated for mental illness.

Mandated treatment needs to be discarded. Treatment should be offered and available as a tool or resource to help the person reach their life goals.

This is a short list and by no means comprehensive. This list will also grow and continue and expand as clinicians and researchers began to see people with a mental health and addiction disorder as people rather than people as their disorder. Disorders that too many clinicians believe need to be controlled and managed. Instead, when clinicians become more sensitive to the needs of people seeking treatment and view clients as living in a context normalized by ethnicity, culture, language, and education, both mental health and substance abuse treatment will become more effective.

7.2.3 Components to keep

The following is proposed as a starting point in the selection of the best treatment interventions from the mental health and substance abuse treatment fields. From the Mental Health treatment field we need to keep the knowledge of “symptomology” and information

about the course of a mental illness that has been developing since Moral Treatment was introduced by Philippe Pinel (1745-1826) and Jean-Baptiste Pussin (1745-1811) (Rousseau, 1990). From the Substance Abuse treatment field we need to keep the philosophy and concept of "recovery" (Lunt, 2004). In the substance abuse treatment community, people receiving treatment for substance abuse are not thought to need treatment for the rest of their lives. Although, not needing continual treatment for the rest of their lives (like a person with a mental illness), clinicians working in substance abuse treatment, Alcohol Anonymous (AA), and Narcotic Anonymous (NA) believe that a person who was once addicted will always be an addict and will need to be in recovery mode for the rest of their lives.

8. Synthesizing the two fields

In addition to using Kuhn's description of a "paradigm shift," to explain the shift in philosophical and clinical assumptions to include treatment for people with a co-occurring disorder, the emergence of treatment philosophies and interventions can be described as a process of "thesis, antithesis, and synthesis" (this construct is often incorrectly attributed to Hegelian theory) (Plant, 1999). Professional treatment by licensed clinician's could be thought of as the thesis. Treatment based on tradition derived from people who have experienced addiction could be the antithesis. The work of synthesizing the best components of the two fields can be used as an analytic tool in continuing the development of a third technology, a new model, perhaps simply called Behavioral Medicine.

The Society of Behavioral Medicine offers a beginning definition:

> Behavioral Medicine is the interdisciplinary field concerned with the development and integration of behavioral, psychosocial, and biomedical science knowledge and techniques relevant to the understanding of health and illness, and the application of this knowledge and these techniques to prevention, diagnosis, treatment and rehabilitation. (http://www.sbm.org/about/definition.html)

8.1 Consider a model using select components from both fields

In the mental health and drug addiction treatment systems that I have been associated with and that I have evaluated, all too often it is not the service needs of the individual that drive the treatment system; it is the treatment system that drives and determines the treatment services available and ultimately provided the client. In the mid 1990s, an opportunity presented itself that allowed me to redesign a traditional Treatment Community model program so as to provide services and treatment for people with a co-occurring disorder. The treatment programming we developed (for lack of a better term, called the Sapient Model) combined empirically based practices with the best consensus based practices that were thought to be effective among people with a co-occurring disorder.

Treatment started with an engagement model that included motivational intake interviewing, activities to develop and maintain a bond between the person seeking treatment and the staff, the other residents, and the program philosophy of recovery as defined by "Bill and Bob" in the "Big Book." Individual and group therapy was based on cognitive behavioral techniques. Treatment included individual and group work on developing and maintaining relationships, and developing and maintaining social supports. Services included education about co-occurring disorders, case management, outpatient treatment, and help with housing and employment.

Psychiatric services were introduced and psychotropic medications became a common component in the overall treatment plan. One practice that was extremely useful with residents was the policy of negotiating treatment with those who did not believe that they needed psychotropic medication or did not want to take it. They wanted to recover on their own. If the treatment team believed medication was needed, the psychiatrist, the clinical director, and the person's individual therapist would meet with the resident and negotiate an agreement. Typically, it was an agreement that the person would not be asked to take medication, but if they relapsed, then they would work with the team and try medication if recommended to see if it helped.

Programming policy did not allow "encounter groups," "confrontational approaches," or playing "the game" by staff or residents. The confrontation approach had been the primary form of treatment before the program was redesigned. The policy created much consternation among the Certified Addiction Counselors and the proponents of the traditional treatment community.

This treatment community model intervention also called, "getting pulled-up" or "getting called on your s**t" can be extremely harmful. These approaches tend to encourage confrontation and punishment by counselors and confrontation between residents who can also call someone on their "s**t." This form of the treatment community life experience was replaced with a community experience of self governance. The Resident's Council made and negotiated program policy with the staff and administration. They advocated for services and provided valuable community service to the neighborhood where the treatment program was located.

Residents who broke rules were apprised of the consequences of their behavior and their responsibility for their behavior. The staff would determine appropriate consequences for the resident who broke the rules. This could range from housekeeping tasks, to starting treatment over at day one. If the person chose to accept the consequences, he or she would continue their treatment in the program. If the person chose to leave the program, he or she was asked to return to our treatment program when they were ready to resume treatment.

Another program policy that was discarded because it was counterproductive was the policy of discharging people who relapsed while in treatment. Relapse was considered the same as breaking any of the rules. The staff would determine appropriate consequences for the resident who relapsed, but a relapse would not bar the person from continuing in treatment. It is difficult to treat a person who has been "kicked" out of the program.

Another valuable policy encouraged residents who were discharged as a treatment success to return to our program for additional work on their recovery efforts if they relapsed. As a staff, we knew the person and believed that we would not have to start from square one. The typical policy among treatment community programs is that a resident who is discharged (whether they succeeded or failed) is not allowed to return to the program for any reason, even for a visit for at least one year. Obviously, this would keep people who failed treatment out of sight.

A related policy gave each resident the right to belong to the Program's alumni association. Everyone was asked to come back to the Program for monthly meetings.

Another helpful policy related to facilitators who brought AA and NA meetings into the treatment center. They were required to accept people into meetings who took medication for psychiatric problems. As the clinical director, I also met with several AA and NA rooms that residents attended and asked that they to be more understanding of people from our program that were taking medication for a mental illness.

As a retention model, the success is supported by State and Medicaid data that show a retention rate of around 90% for the first 30 days over a continuous four year period. Long-term success, however, was not as impressive as the engagement model. Long-term recovery was hampered by a lack of community support services available to residents who completed treatment. In many cases, the problem was obtaining and paying for expensive atypical psychotropics after the resident left treatment. A lack of programs to provide supportive housing and employment were also problematic. Even so, the recovery rate for residents, in the first year after discharge varied around 50% for residents over a three year period.

More recently, in 2004, I had the good fortune to become the evaluator of the Oklahoma Co-Occurring State Incentive Grant from SAMHSA. The grant supports efforts at the State level to integrate the mental health and substance abuse service systems. Analogous to my experiences, over the last 30 years, the knowledge base and conceptualization of treatment for people with a co-occurring disorder has evolved and continues to evolve.

Given my experience at this point, if I were redesigning the program today, I would also incorporate knowledge about the *stages of change* in both residential and outpatient treatment. I would also promote the development of self-help groups for people with a co-occurring disorder such as Double Trouble in Recovery, Dual Recovery and other self-help groups, both at the program level and in the community.

9. Conclusion: An emerging treatment model

The role played by SAMHSA using the COSIG project as a catalyst for a process that exposed both the strength, weaknesses, and points of philosophical incompatibility of the two traditions should not be underestimated even though it was probably happenstance. In particular, endorsing the Integrated Treatment model without addressing the differences and incompatible components in these traditional models created a crisis. This crisis although disturbing and creating havoc much like any major change, does give us the opportunity to rethink and realign concepts of treatment. Based on the accumulated knowledge from mental health and the treatment of addiction, and knowledge gained since the 1990s during a major effort to develop better treatment interventions for people with co-occurring disorder, that knowledge is available to begin to develop a modern, scientifically based third technology specifically designed for people wanting treatment for a co-occurring disorder.

10. References

AIHW. (2005). National comorbidity initiative: a review of data collections relating to people with coexisting substance use and mental health disorders. Cat. No. PHE 60. (Drug Statistics Series No. 14). Canberra: Australian Institute of Health and Welfare. Retrieved from: http://www.aihw.gov.au/publication-detail/?id=6442467722.

Angell, B., Mahoney, C. A., Martinez, N. I. (2006). Promoting Treatment Adherence in Assertive Community Treatment. *Social Service Review, 80*(3), 485-526.

Becker, D. R., Drake, R. E., & Naughton, W. J. (2005). Supported Employment for People with Co-occurring Disorders, *Psychiatric Rehabilitation Journal* (Vol. 28, pp. 332-338): Center for Psychiatric Rehabilitation.

Beers, C. (1908). A Mind That Found Itself. NY: Longman.

Butler, T., Indig, D., Allnutt, S., & Mamoon, H. (2011). Co-occurring mental illness and substance use disorder among Australian prisoners. Drug and Alcohol Review, 30(2), 188-194.

Cherry, A. L., Dillon, M. E., Hellman, C. & Barney, L. D. (2007). The AC-COD Screen: Rapid Detection of People with the Co-occurring Disorders of Substance Abuse, Mental Illness, Domestic Violence, and Trauma. Journal of Dual Diagnosis, 4(1), DOI: 10.1300.

Centre for Addiction and Mental Health. (2002). Best practices: concurrent mental health and substance use disorders. Ottawa: Health Canada.

Center for Mental Health Services (CMHS). (2004). Building Bridges: Co-Occurring Mental Illness and Addiction: Consumers and Service Providers, Policymakers, and Researchers in Dialogue. DHHS Pub. No. (SMA) 04-3892. Rockville, MD. Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2007). The Epidemiology of Co-Occurring Substance Use and Mental Disorders. COCE Overview Paper 8. DHHS Publication No. (SMA) 07-4308. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services.

Charles, K., & Eric, B. (2003). An introduction to research on the social impact of the therapeutic community for addiction. International Journal of Social Welfare, 12(3), 204-210.

Clement, J. A., Williams, E. B., & Waters, C. (1993). The client with substance abuse/mental illness: Mandate for collaboration. Archives of Psychiatric Nursing, 7(4), 189-196.

COSIG Clinical Protocol Committee. (May, 2006). Definition of the Co-occurring Disorders Population. Retrieved on July 25, 2011 from: http://www.cahsd.org/PDFs/Publications/CoOccuringDisorders%20DEFINITION.pdf.

Croton G. (2004). *Co-occurring mental health and substance use disorders: an investigation of service system modifications and initiatives designed to provide an integrated treatment response.* Wangaratta Australia: Northeast Health,. Retrieved from: http://www.dualdiagnosis.org.au/Croton_Fellowship_Co-occurring%20Disorders. Pdf.

Crowley, T., Mikulich, S., MacDonald, M., Young, S., & Zerbe, G. (1998). Substance dependent, conduct disordered adolescent males; Severity of diagnosis predicts two year outcome. *Drug and Alcohol Dependence, 49,* 225 – 237.

de Leon, G. (1989). Psychopathology and substance abuse: What is being learned from research in therapeutic communities. Journal of Psychoactive Drugs, 21(2), 177-188.

Dongier, M. (2005). Integrated Treatment for Dual Disorders. A Guide to Effective Practice. *Canadian Journal of Psychiatry, 50*(5), 299-300.

Drake, R. E., & Mueser, K. T. (1996). The course, treatment, and outcome of substance disorder in persons with severe mental illness., American Journal of Orthopsychiatry (Vol. 66, pp. 42).

Drake, R. E., Osher, F. C., & Bartels, S. J. (1996). The "dually diagnosed." In W. R. Breakey (Ed.), Integrated mental health services: Modern community psychiatry. (pp. 339-352): Oxford University Press.

Drake R. E., Brunette, M. F., Mueser, K. T., & Green, A. I. (2005). Management of patients with severe mental illness and co-occurring substance use disorder. *Minerva Psichiatrica, 46*(2), 119-132.

Flynn, B. K. (2001). The consumer/case manager working alliance and its relationship to dual-disordered client outcomes in a representative payee treatment program. Univ. Microfilms International.

Grenville, R. J. (2001). Unspoken voices: The experiences and preferences of adult mental health consumers regarding housing and supports., Univ Microfilms International.

Hayton, R. (1998). *The Therapeutic Community.* Kansas City, MO: Mid-America Addiction Technology Transfer Center.

Hintz, T. & Mann, K. S. (2006). Co-occurring disorders: policy and practice in Germany. American Journal on Addictions, 15(4), 261-267.

Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y. & Adams, N. (2007). An Action Plan for Behavioral Health Workforce Development: Executive Summary. Washington, DC: Substance Abuse and Mental Health Services Administration (SAMHSA).

Hurd, H. N. (1916). The institutional care fo the insane in the United States and Canada. Baltimore: Hopkins Press.

ISCA. (2002). Stright, Inc. Tax Report. Bealeton, VA: International Survivors Action Committee.

Janzen, R. (2001). The Rise and Fall of Synanon: A California Utopia. Baltimore, MD: The John Hopkins University Press.

Kaplan, C., & Broekaert, E. (2003). An introduction to research on the social impact of the therapeutic community for addiction. International Journal of Social Welfare, 12(3), 204-210.

Kataoka, S., Zhang, L, & Wells, K. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159,* 1548-1555.

Kessler, R., Beglund, P., Demler, O., Jin, R., & Walters, E. (2005). Lifetime prevalence and the age-of-onset distribution of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593-602.

Kessler, R., McGonagle, K., Zhao, S., Nelson, C., Hughes, M., Eshelman, S., Wittchen, H., & Kendler, K. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Study. Archives of General Psychiatry, 51, 8-19.

Kessler, R., Nelson, C., McGonagle, K. A., Edlund, M. J., Frank, R. G. & Leaf, P. J. (1996). The epidemiology of co-occurring addictive and mental disorders. *American Journal of Orthopsychiatry*, 66, 17–31.

Kuhn, T. S. (1962). The structure of scientific revolutions.: University of Chicago Press: Chicago.

Lamb, H. R., & Oliphant, E. (1978). Schizophrenia through the eyes of families. *Hospital & Community Psychiatry, 29*(12), 803-806.

Landry, M. J., Smith, D. E., McDuff, D. R., & Baughman, O. L. (1991). Anxiety and substance use disorders: the treatment of high-risk patients. Journal of the American Board of Family Practice, 4: 447-456.

Lefley, H. P. (1998). Families, culture, and mental illness: Constructing new realities. *Psychiatry: Interpersonal and Biological Processes, 61*(4), 335-355.

Lehman, A. F., & Dixon, L. B. (1995). Double jeopardy: Chronic mental illness and substance use disorders.: Harwood Academic Publishers/Gordon.

Lehman, A. F., Myers, C. P., & Corty, E. (1989). Assessment and classification of patients with psychiatric and substance abuse syndromes. Hospital and Community Psychiatry, 40(10): 1019-1030.

Libby, A., Orton, H., Stover, S., & Riggs, P. (2005). What came first, major depression or substance use disorder? Clinical characteristics and substance use comparing teens in a treatment cohort. *Addictive Behaviors, 30,* 1649-1662.

Lunt, A. (2004). The implications for the clinician of adopting a recovery model: The role of choice in assertive treatment. *Psychiatric Rehabilitation Journal, 28*(1), 93-97.

Mathew, T., Shields, A., Yanov, S., Golubchikova, V., Strelis, A., Yanova, G., Mishustin, S., Fitzmaurice, G., Connery, H., Shin, S. &. Greenfield, S. F. (2010). Performance of the Alcohol Use Disorders Identification Test Among Tuberculosis Patients in Russia. Substance Use and Misuse, 45(4), 598-612.

McGovern, M. (2008). *Clinical administrator's guidebook: Integrated services for substance use and mental health problems.* Center City, MN: Hazelden.

McGovern, M. P., Xie, H., Segal, S. R., Siembab, L., & Drake, R. E. (2006). Addiction treatment services and co-occurring disorders: Prevalence estimates, treatment practices, and barriers. *Journal of Substance Abuse Treatment, 31*(3), 267-275

McLellan, A. T., & Druley, K. A. (1977). Non-random relation between drugs of abuse and psychiatric diagnosis. Journal Of Psychiatric Research, 13(3 (Print)), 179-184.

Menezes, P., Johnson, S., Thornicroft, G., Marshall, J. (1996). Drug and alcohol problems among individuals with severe mental illness in South London. British Journal of Psychiatry, 168(5), 612-619.

Meyer, R. E. (1986). How to understand the relationship between psychopathology and addictive disorders: another example of the chicken and the egg. In: Meyer, R. E., ed. Psychopathology and Addictive Disorders. New York: Guilford Press.

Minkoff, K. (1991). Program components of a comprehensive integrated care system for serious mentally ill patients with substance disorders. In New Directions for Mental Health Services (Vol. 50, pp. 13-27): Jossey-Bass Publishers, Inc.

Minkoff, K. (1993). An integrated treatment model for dual diagnosis of psychosis and addiction. In Dual diagnosis of mental illness and substance abuse: Collected articles from H&CP. (pp. 17-22): American Psychiatric Publishing, Inc.

NASMHPD--NASADAD. (1999). NASMHPD, NASADAD reach agreement on federal dual-diagnosis policy. Mental Health Weekly, 9(27), 1.

Osher, F. C., & Drake, R. E. (1996). Reversing a history of unmet needs: Approaches to care for persons with co-occurring addictive and mental disorders. American Journal of Orthopsychiatry, 66(1), 4-11.

Quinn, J. F., Bodenhamer-Davis, E., & Koch, D. S. (2004). Ideology and the stagnation of AODA treatment modalities in America. *Deviant Behavior, 25*(2), 109-131.

Peters, R. H., Bartoi, M. G., & Sherman, P. B. (2008). *Screening and assessment of co-occurring disorders in the justice system.* Delmar, NY: CMHS National GAINS Center.

Plant, R. (1999). Hegel: NY: Routledge.

Putnam, C. (2000). Integration of behavioral health care with child protection services: Weaving together practices for improved outcomes. Lansing, MI: Health Management Associates.

Reebye, P., Moretti, M., & Lessard, J. (1995). Conduct disorder and substance use disorders: Comorbidity in a clinical sample of preadolescents and adolescents. *Canadian Journal of Psychiatry, 40,* 313-319.

Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, B. J., Judd, L. L. & Godwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) study. *Journal of the American Medical Association*, 264, 2511–2518.

Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto US mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry, 50*, 85–94.

Ritzler, B. A., Strauss, J. S., Vanord, A., & Kokes, R. F. (1977). Prognostic implications of various drinking patterns in psychiatric patients. The American Journal Of Psychiatry, 134(5 (Print)), 546-549.

Roberts, A., Corcoran, K. (2005). Adolescents growing up in stressful environments, dual diagnosis, and sources of success. *Brief Treatment and Crisis Intervention, 5*, 1-8.

Robins, R., & Regier, D. (1991). Psychiatric disorders in America: The epidemiologic catchment area study. New York: Free Press.

Rowe, C., Liddle, E., Greenbaum., P., & Henderson, C. (2004). Impact of psychiatric comorbidity on treatment of adolescent drug abusers. *Journal of Substance Abuse Treatment, 26,* 129-140.

Sacks, S., Sacks, J., De Leon, G., Bernhardt, A. I., & Staines, G. L. (1997). Modified therapeutic community for mentally ill chemical 'abusers': Background; influences; program description; preliminary findings. Substance Use & Misuse, 32(9), 1217-1259.

SAMHSA (1995). Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse Treatment Improvement Protocol (TIP) Series no. 9. Rockville, MD: Center for Substance Abuse Treatment.

SAMHSA (2005). Substance abuse treatment for persons with co-occurring disorders. Treatment Improvement Protocol (TIP) Series no. 42. Rockville, MD: Center for Substance Abuse Treatment.

SAMHSA Office of Applied Studies. (2005). *Results from the 2004 National Survey on Drug Use and Health: National Findings.* (www.drugabusestatistics.samhsa.gov/nsduh.htm#NSDUHinfo)

SAMHSA. (2002). Report to Congress on the Treatment and Prevention of Co-Occurring Substance Abuse and Mental Disorders. Rockville, MD: Substance Abuse and Mental Health Services Administration.

SAMHSA. (2003a). Co-Occurring Disorders: Integrated Dual Disorders Treatment: Implementation Resource Kit. Rockville, MD: Substance Abuse and Mental Health Services Administration.

SAMHSA. (2003b). President's New Freedom Commission on Mental Health--Achieving the promise: Transforming mental health care in America. Rockville, MD: Substance Abuse and Mental Health Services Administration.

SAMHSA, (2003c). Strategies for developing treatment programs for people with co-occurring substance abuse and mental disorders. Washington, D.C.: US Department of Health and Human Services. (www. samhsa.gov).

SAMHSA. (2005). Substance abuse treatment for persons with co-occurring disorders. Treatment Improvement Protocol (TIP) series no. 42. Rockville, MD: Center for Substance Abuse Treatment.

SAMHSA. (2006a). Overview Paper 3: Overarching Principles To Address the Needs of Persons With Co-Occurring Disorders. Rockville, MD: Substance Abuse and Mental Health Services Administration.

SAMHSA. (2006b). Therapeutic Community Curriculum: Trainer's Manual (No. DHHS

Sciacca, K. (1991). An integrated treatment approach for severely mentally ill individuals with substance disorders. New Directions for Mental Health Services, 50, 69-84.

Sciacca, K., & Thompson, C. M. (1996). Program development and integrated treatment across systems for dual diagnosis: mental illness, drug addiction, and alcoholism (MIDAA). Journal of mental health administration., 23(3), 288-297.

Scott, K., McGee, M. A., Schaaf, D., & Baxter, J. (2008). Mental-physical comorbidity in an ethnically diverse population. *Social Science & Medicine*, *66*, 1165-1173. doi: 10.1016/j.socscimed.2007.11.022

Shaffer, D., Fisher, P., Dulcan, M. K., Davies, M., Piacentini, J., Schwab-Stone, M. E., Lahey, B. B., Bourdon, K., Jensen, P. S., Bird, H. R., Canino, G., & Regier, D. A. (1996). The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and performance in the MECA Study. Methods for the Epidemiology of Child and Adolescent Mental Disorders Study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 865–877.

Skinner, D. C. (2005). A Modified Therapeutic Community for Homeless Persons with Co-Occurring Disorders of Substance Abuse and Mental Illness in a Shelter: An Outcome Study, 40(4), 483-497.

Solomon, J., Zimberg, S., & Shollar, E. (1993). Dual diagnosis: Evaluation, treatment, training, and program development.: Plenum Medical Book Co/Plenum Publishing Corp.

Sowers, W. (2005). Transforming Systems of Care: The American Association of Community Psychiatrists Guidelines for Recovery Oriented Services. Community Mental Health Journal, 41(6), 757-774.

Tjaden, P. & Thoennes, N. (2000). Extent, Nature, and Consequences of Intimate Partner Violence, Authors. Washington, D.C.: The Centers for Disease Control and Prevention and The National Institute of Justice, the U.S. Department of Justice, Office of Justice Programs. Retrieved from: https://www.ncjrs.gov/pdffiles1/nij/181867.pdf

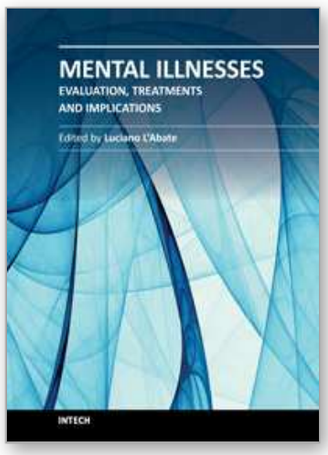
Thomas, G. and Pring, R. (Eds.) (2004). Evidence-based Practice in Education. Open University Press.

Virgo, N., Bennett, G., Higgins, D., Bennett, L & Thomas, P. (2001). The prevalence and characteristics of co-occurring serious mental illness (SMI) and substance abuse or dependence in the patients of Adult Mental Health and Addictions Services in eastern Dorset. Journal of Mental Health (2001) 10, 2, 175–188, doi: 10.1080/09638230020023732.

Wing, D. M. (1995). Transcending alcoholic denial. IMAGE: Journal of Nursing Scholarship, 2(2), 121-126.

Wise, B., Cuffe, S., & Fischer, D. (2001). Dual Diagnosis and successful participation of adolescents in substance abuse treatment. *Journal of Substance Abuse Treatment, 21*, 161-165.

Yates, R. (2003). A brief moment of glory: The impact of the therapeutic community movement on the drug treatment systems in the UK. International Journal of Social Welfare, 12(3), 239-243.



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In the book "Mental Illnesses - Evaluation, Treatments and Implications" attention is focused on background factors underlying mental illness. It is crucial that mental illness be evaluated thoroughly if we want to understand its nature, predict its long-term outcome, and treat it with specific rather than generic treatment, such as pharmacotherapy for instance. Additionally, community-wide and cognitive-behavioral approaches need to be combined to decrease the severity of symptoms of mental illness. Unfortunately, those who should profit the most by combination of treatments, often times refuse treatment or show poor adherence to treatment maintenance. Most importantly, what are the implications of the above for the mental health community? Mental illness cannot be treated with one single form of treatment. Combined individual, community, and socially-oriented treatments, including recent distance-writing technologies will hopefully allow a more integrated approach to decrease mental illness world-wide.

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