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The Redesignment of an Acute Inpatient Dual Diagnosis Unit

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THE REDESIGNMENT OF AN ACUTE INPATIENT DUAL DIAGNOSIS UNIT

Irene Harris Griggs, B.S.N.

An Abstract Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Science in Health Care

2000

ABSTRACT

This project will focus on the study of mental illness and chemical abuse/dependence as it has progressed into the entity of dual diagnosis or what experts consider co-existing or co-occurring disorders.

Research has revealed the increase in the number of individuals suffering from co-occurring illnesses since the early 1980's. Because this condition has become the norm rather than the exception, it becomes necessary to focus more clearly on individuals that are diagnosed with this illness and on the most effective treatment in order to assist the individual in recovery.

Individuals have had co-existing or co-occurring disorders prior to the early 1980's. Beth Israel Hospital developed and began a distinct DD unit in 1979. However, the focus on this population garnered support in the 1980's and continued to grow. Some clinicians believe this population is one of the most difficult to treat and have sought ways to develop appropriate treatment.

The purpose of the present study is to examine the operations of an acute dual diagnosis unit in an effort to determine the strategies necessary to enhance its operations resulting in improved treatment for the DD population. Specifically, it will review the treatment practices and special needs of the DD patient.

The study of the acute dual diagnosis unit was reviewed in comparison to the latest research findings of the best practices for

treatment of the dual diagnosis patient. There is no single way to develop a dual diagnosis unit; however, there are principles in place to guide program developers toward appropriate treatment.

Results of this study suggest that the DD unit needs to have a conceptual framework to build on, principles to guide treatment and staff educated in the knowledge of addictions.

THE REDESIGMENT OF AN ACUTE INPATIENT DUAL DIAGNOSIS UNIT

Irene Harris Griggs, B.S.N.

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A Culminating Project Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Science in Health Care Management

2000

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Chapter 1

INTRODUCTION

Preface

Over the last four decades health care in the United States has changed dramatically. The spiraling cost of the delivery of health care has influenced this rapid change. According to Harry A. Sultz and Kristina M. Young, authors of Health Care USA:

> the cost of health care in 1994 totaled $949.4 billion or 13.7 percent of the gross domestic product (GDP)...The rise in health care spending has consistently outstripped the rate of general inflation, and the U.S. Department of Commerce predicts it will continue doing so. (106)

This dramatic increase in cost is one of the major causes for the focus on health care today (See Appendix B). Also, access to health care, rapid advancements in technology, and recent discoveries in the medical arena have fueled the changes in the health care environment. Furthermore the 1983 advent of Diagnostic Related Groups (DRGs), and the Perspective Payment System (PPS) have been instrumental in these changes. Health care finance has gone from a retrospective payment system to a perspective payment system. In essence, health care providers are no longer afforded the opportunity to be reimbursed for services rendered at

the fee charged by the healthcare providers because of changes in government regulations. The PPS is based on the DRGs and thus, the health care providers are to be reimbursed according to a predetermined amount, based on the diagnosis.

Furthermore, individuals across the economic strata are impacted by the changing tides of health care. In the early part of the century healthcare was a benefit that many individuals took for granted. Today, healthcare cost appears to be an issue at the forefront of many conversations.

The managed care concept is one of the major components used today in streamlining the cost of health care. Exactly what is managed care? According to Karen Zander of the New England Medical Center Hospitals (NEMCH), a forerunner in the development of the managed care concept, this definition is given:

> It is unit based care that is organized to achieve specific patient outcomes within fiscally responsible time frames (length of stay) utilizing resources that are appropriate in amount and sequence to the specific case type and to the individual patient. Care is structured by case management plans and critical paths which are based on knowledge by case type regarding usual length of stay, critical events and their timing, anticipated outcomes, and resource utilization. (516)

Many state government agencies are using managed care concepts to provide cost effective care for patients suffering from mental illnesses and substance abuse/dependency.

The key players in today's health care setting are the insurance companies who encompass many health maintenance organizations (HMO's), the hospitals, physician practice groups, public health providers, and other entities that provide health care. Understanding Health Policy A Clinical Approach (47-60).

The author feels that it is important to review the historical changes in health care in order that the reader has a clear understanding of the changes in the health care arena today. In the past, the cost of the care provided was not consistent throughout the health care industry. Therefore health care delivery systems have developed to incorporate and to balance the needs of the patient with the provider of the delivery of care, and the third party payer, the insurance companies. Nevertheless, it should be kept in mind that the primary objective is to explore the health care systems in terms of their ability to provide quality care in the most cost-effective manner.

Previously the health care providers did not always link the quality of care to the cost of care. Although DRGs and the PPS have had a great influence on the financial patterns of health care, it is not the only major influence. There have been many changes in the health care system in regard to mental illness and substance abuse. As a result, many of the

health care delivery systems are taking the initiative to redesign their treatment for this segment of the population. Federal and state governments are beginning to change their patterns of funding to address the needs of the client who has a mental illness and a substance abuse problem.

Historically, mental illness was closely linked with the mystical realm...and people with these problems were considered to have been demonically possessed and to have fallen from the grace of God ("Mental Disorder" Encyclopedia Britannica Online 1). Today, mental illness is defined as a disease that affects the thought processes and behavior of individuals. It is thought to be an alteration of the brain and it has been scientifically linked to changes in the chemistry of the brain. Substance abuse, on the other hand, is defined according R.B. Murray & M.M.W. Huelskoetter 's Psychiatric/Mental Health Nursing as: "Excessive or unhealthy use of harmful substances, such as alcohol, tobacco, or drugs, or use of products, such as food, that becomes unhealthy when excessive amounts are ingested" (406). Dependence on a substance or drug is defined according to Fortinash & Holoday-Worret in their book Psychiatric Mental Health Nursing as: "A physiologic state of adaptation to a drug or alcohol, usually characterized by the development of tolerance to drug effects and the emergence of a withdrawal syndrome during prolonged abstinence" (342).

According to the director of the National Institute on Drug Abuse (NIDA), Alan I. Leshner, Ph.D., and Leslie Knowlton both reported their findings in the Public and Research Views of Dual-Diagnosis Explored. "The public's perception, is that such disorders (as cocaine addiction) represent social problems involving failure of will, while in reality they are brain dysfunctions displayed as behavioral dysfunctions that often occur together" (1).

Many in the field of addiction have attributed substance abuse/dependency as a link to altered brain chemistry and even to heredity. Whether this will be the definitive answer is still debatable. However, it is a known fact that the continued use of illicit drugs does have an affect on the brain because "chronic cocaine use alters the brain" (1).

Changes in society have led to an emphasis being placed on the need for everyone to have access to health care services. The technological explosion of the twentieth century has left its mark on health care technology because it has provided many with the opportunities to utilize techniques and to pursue early detection and treatment for many past incurable diseases, as well as for mental illnesses and substance abuse. It has thereby increased the quality of life and the life span of the general population.

In addition, sites for treatment have also undergone many changes. The healthcare delivery system for substance abuse and mental illness is no exception to this trend. It has gone from a parallel model of treatment

to a sequential model of treatment, to what is now considered the best approach, that of the integrative model. The parallel model has consisted of the client being treated by both the mental health clinician and the addiction counselor at the same time, although in different settings with separate philosophies. Usually, if there is not an observable pattern of problematic behavior that reflects a clear connection between both illnesses, the result has been a lack of coordination between both treatment services. Subsequently, the sequential treatment model allows the client to be treated for either the mental illness or the substance abuse problem first, and then seek treatment for the other illness afterwards. Coordination of care has been problematic with this model and this model continues to foster separate delivery systems with separate philosophies. However, the integrative approach bridges the gap between the separateness of both the parallel and sequential models. Many people are treated in their homes or in outpatient settings rather than in the traditional hospital setting due in part to technological advances. Consequently by examining some of the historical aspects of mental illness and substance abuse, the author feels that one should be able to design a model that would be more beneficial in the treatment of individuals who are diagnosed with co-existing or DD disorders. To clarify, dual diagnosis is defined as a disorder consisting of both a mental illness and a substance abuse/dependence problem. This disorder affects a large percentage of our population. Thus it will be meaningful to examine

historical aspects as well as current practice so that the future outlook will lead to a better understanding of the health care delivery systems for the dually diagnosed patients.

History of Medicine

History has always played an important role in how people view the various elements of their culture. With this in mind, the author would like to see the history of medicine examined in relation to our current system and the process by which medicine has evolved. Presently the focus on medicine and health care is on providing quality, cost-effective services. This perspective crosses all strata of the health care arena and applies to mental illness and its impact on society and the various methods that have been used to treat the sick and infirm. Changes in the health care field have led to the redesignment of numerous systems in order to be more responsive to the needs of the consumer. This paper will attempt to delineate a clear link from the past to the current healthcare systems. It will look at mental illness and its various changes and will culminate in the redesigning of a dual diagnosis unit.

Historically, man has attempted to use remedies to cure himself and others from sickness and illness dating back to primitive and prehistoric time. Stanhope and Lancaster, authors of Community Health Nursing Process and Practice for Promoting Health wrote:

> Primitive people have always been concerned with the events surrounding birth, death and illness. With few

> exceptions primitive tribes had a certain amount of group spirit and a sense of hygiene...In their struggle to exist, early people tried to understand disease to devise ways to cope with disease-producing agents. They based health practices on magic and superstition rather than on facts about the cause and effect of certain events and actions on health. Shamans, or medicine men, cared for both health and religious needs and were highly esteemed (4).

Michael Woods, author of "Ancient Medicine" wrote:

> Ancient physicians had no miracle drugs to treat diseases... But they did an amazingly competent job of treating the sick and injured...Some of the medical technology developed in ancient times surpassed anything available in the modern world until the eighteenth or nineteenth century (1).

According to the "History of Medicine" taken from Encyclopedia Britannica, Volume 11, minor problems such as the common cold and constipation were considered to be a normal part of living. More serious illnesses were attributed to the, "supernatural, the work of a malevolent demon or of an offended god who entered the body" (823).

In this early era, folklore and domestic medicine were used to remove the demons. Domestic medicine, which was made from vegetables and herbs was made into potions. This was viewed as the beginning of the pharmacological impact on medicine. According to C.D. O'Malley's works, "Medicine," Microsoft (R) Encarta ® 98 Encyclopedia, many of the potions that were developed in this era are being used even today to treat various conditions...Cathartics, diuretics, emetics, and enemas were used by

many (1). One of the most prominent practices of ridding the body of demons and disease was trepanning; this practice involved boring holes into the skull to release/remove the demon or disease from the body. Conditions such as epilepsy, mental illnesses and severe headache were also likely to be treated with this practice (1). During this era, surgeries and therapies for certain conditions were successful. Wound care and care of fractures and dislocations were among the successful therapies. In contrast to today's medical practices, the temples were used as the seat of medical care. Thus many times the sick or afflicted were left outside the temples where people could offer advice to the sick according to "History of Medicine" (823). The temple was a common place for the population to gather and it was the religious orders that initially took care of the sick. During this period, there is evidence that individuals with illnesses and sickness were viewed as unclean. The belief during this time was that people with unclean, demon possessed spirits were the ones who would be afflicted by sickness and disease. It was felt that they had fallen out of favor with God. Some of the problematic behavior that individuals exhibited had been attributed to unclean spirits or demon possessed spirits and now likely are what many today would call mental illness. The Encyclopedia Britannica Vol. 1 on "Alcohol Consumption", has listed "alcohol as the oldest and most widely used drug" (441). Evidence of the abuse of alcohol dates back to biblical times. Proverbs 23:20- warns, "Be not among winebibbers"; and Proverbs 23:21 remarks

about "the drunkard and the glutton shall come to poverty: and drowsiness shall clothe a man with rags". Also, there is a story in Genesis about Noah "planting a vineyard and drinking the wine until he was drunk" (10:21).

> That alcoholic beverages should have displaced other fluids in early religions, both as offerings and drink, is not surprising, its capacity to help the shaman or priest and others to a desired state of ecstasy or frenzy could not long have escaped observation, and its appreciation was naturally attributed to the supernatural spirits and gods. (Encyclopedia Britannica Vol. 1,"Alcohol Consumption"441).

ANCIENT TIMES

Egyptians

C.D. O'Malley, author of Medicine has written about two schools of thought in regard to medicine associated with this culture. One is magico-religious, embodying primitive elements, and the other is empirico-rational, which is based on experience and observation and lacking in mystical features. Diseases of the skin and eyes were treated more rationally because of their accessibility. According to O'Malley, diseases of areas that were not as accessible continued to be treated with spells and incantations by the priest-magician. Research reveals that the Egyptians were very adept at setting fractures and used methods very similar to those used today. Stanhope and Lancaster have also written that; "Egyptians of about 1000 BC were the healthiest of all early civilization,

and used principles based on observation and empirical knowledge rather than magic", which also supports the finding of O'Malley (4). The suggestive practice of gathering information by questioning the patient along with the practice of observation led to the present way that illnesses and sickness are being diagnosed. According to Encyclopedia Britannica's "History of the use of Alcohol", the Egyptians and Mesopotamians made references to the ill effects of the consumption of alcohol. "There are ample indications that some people so loved drink and were so abandoned to drunkenness that they must be presumed to have been alcoholics" (441).

Babylonians

The Babylonians' contribution to medicine was made apparent with the findings of the Code of Hammurabi. Allen D. Spiegel's, Hammurabi's Managed Health Care-Circa BC suggests that the foundation for managed health care was at the dawn of civilization, about 4,000 years ago. The Code was established between the seventeenth and twenty-first centuries BC (1). It was a compilation of legal guidelines and fees for the practice of medicine. Also, according to "History Of The Use Of Alcohol" Encyclopedia Britannica, "it was the earliest known code of laws used to regulate drinking houses" (441). Beer and other types of alcohol were prescribed by many of the Sumarian physicians for many ailments (441). Leo D. Bores, author of The Babylonians suggests, "these legal regulations of medical and surgical practice toward the beginning of the

second millennium BCE would indicate that medicine in ancient Babylon was already centuries old at that time, and that the beginning of medical knowledge must therefore reach back well toward 3000 BCE, perhaps into the Sumerian civilization" (1). However, Bores comments; "Although there is an indication that medicine was practiced in Ancient Babylon, it is documented that primitive folk medicine, with all its superstitions, completely dominated the medical teaching of the time" (2).

Mesopotamian Culture

Mesopotamia was home to many civilizations over a period of time. Many of the earlier civilizations believed in magical practices and demons. There are indications from surviving cuneiform tablets that medicine was viewed rationally. Of importance is the Treatise of Medical Diagnosis and Prognoses, 1600 BCE, which is a collection of Mesopotamian medical knowledge. This treatise is a well-organized list of medical findings that spans many centuries. Research of the Mesopotamian period indicates that there were two different approaches to medical illness. There was the ashipu, a sorcerer who diagnosed illnesses and the asu who prescribed herbal remedies. The asu was thought to use empirical application of medicine. People of wealth would likely seek out both the ashipu and the asu in the treatment of their illnesses. Allen D. Spiegel has written about the credentials of the providers of that period. He suggests that there were three types of healers: Baru (deviner), Ashipu (exorcist) and Azu (physician). . . A Baru, essentially an internal medicine specialist,

practiced hepatoscopy, believing that the liver was the seat of the soul and center of vitality (1). According to Spiegal, "a patient could consult any willing provider, however, some providers risked the penalty of death or dismemberment ...The Azu were educated and learned from practical experience. They were adept at diagnosing ailments by listening to the patient's accounts, not by physical examination" (1). The research did not reveal if either of these healers restricted their practices to individuals who exhibited behaviors that were indicative of mental illness or addiction. It is, however, during this time that "Sumerian records from the time of Mesopotamia (5000 to 4000 BC) refer to the use of the poppy and medicinal reference to opium is contained in the Assyrian medical tablets" ("Drug Use" Encyclopedia Britannica Online 1). Undoubtedly people with genetic traits would be predisposed to them and to mental illness and addictions, and thus were likely to succumb to either illness or have a co-occurring illness. Since many substances were available, it can be speculated that these substances were also abused. However, "there is no adequate comprehensive history of the addictive aspects of opium use in spite of the fact that it has been known since antiquity" ("Drug Use" Encyclopedia Britannica Online 1).

India

In ancient India, the people thought that sickness and disease were caused by demons. Therefore magical practices were common for the treatment of diseases and the expulsion of the demons. However, in the

seventh century, "Islam prohibited the use of alcohol...The Hindu Ayurveda (c.1000BC) skillfully described both the beneficent uses of alcohol as well as the consequences of intoxication and the disease of alcoholism" ("History Of The Use Of Alcohol" Encyclopedia Britannica 1 442). This was most prominent in the early centuries. During the Brahmanistic Period or the Golden Age of Indian Medicine (800BC-1000AD), there was a rational and empirical view of medicine. The Hindu physicians assessed patients by using all five senses. There is data that supports good clinical assessment and accurate prognosis; for example, diet and hydration were used in the past as a form of therapy as it is used today in the treatment of substance abuse. Good hygiene was essential then, as today, in the treatment of diseases and sicknesses. People who exhibited poor hygiene were thought to display signs of mental illness and/or substance abuse (O'Malley 2-3).

China

China's major contribution to medicine was mainly through external treatment. Massage and cupping, a procedure that created counter irritation to bring blood to the body surface was used in the treatment of the sick. Acupuncture was also used in the treatment of the sick (O'Malley 3). Today, western societies have adapted the use of acupuncture to curtail tobacco addiction.

Greek

Early Greek medicine was endowed with magical traits and folklore. The evolution of medicine being separated from folklore and magical traits came about through the works of Hippocrates (c400BC). Hippocrates regarded, "mental disorders as diseases to be understood in terms of disturbed physiology" ("Mental Disorder" Encyclopedia Britannica Online 1). "He and his followers emphasized natural causes, clinical observation, and brain pathology in the study of mental disorders" (1). He was undoubtedly one of the most famous physicians. He is credited with "separating philosophy from medicine...The Hippocratic oath that is used today was based on his works of ethical behavior for physicians ("Homer to Hippocrates" Antiqua Medicina Online 1). Medicine entailed the clinical observation and the experience of the patient. The Greeks gave us expected outcomes for certain diagnoses along with the prognosis. "Homer's writings indicate Greek usage of the substance poppy at least by 900BC" ("Drug Use" Encyclopedia Britannica Online 1).

Medical officers and public physicians were appointed to care for the sick. Although hospitals were developed for the sick, most physicians went from city to city to treat the sick. It was during this period that women began to be associated with healing. Documentation reveals that the women were the caregivers in the homes. Although the individual was not given the title of nurse at this time, she was given the responsibility to care for the sick (Stanhope and Lancaster 5).

Roman

According to "Etruscan and Roman Medicine" Antiqua Medicina, Roman medicine was divided into three distinct areas: (1) the "practical" medicine of the pater familias, that is, home remedies based upon an agricultural context; (2) the state religion as handed down from the Etruscans; and (3) the private practitioner using Greek medical principles. The Roman culture did not contribute significantly to the medical body of knowledge; its major influence was in public health. C.D. O'Malley stated that, "original Roman contributions were made in the fields of public health and hygiene. . .In the organization of street sanitation, water supply, and public hospitals, the methods of the Romans were not surpassed until modern times" (5).

Stanhope and Lancaster reported:

> The Romans viewed medicine from a community health and social medicine perspective... They emphasized regulation of medical practices, punishment for negligence, drainage of swamps, provision of pure water, establishment of sewage systems, supervision of street cleaning and public food preparation (5).

Even though Asclepiades of Bithynia (124BC) offered opposing views to Hippocrates' belief in the healing power of nature, he gave special attention to mental disease, by clearly distinguishing hallucinations from delusion. He released the insane from confinement in dark cellars and prescribed a regiment of occupational therapy, smoothing music,

soporifics (especially wines), and exercises to improve the attention and memory ("Medicine, History Of" Encyclopedia Britannica 1). Galen, a prominent Greek physician (AD 130-200) in Ancient Rome, studied under Hippocrates. According to the article "Galen", "Galen crystallized all the best work of the Greek medical schools which had preceded his own time. It is essentially in the form of Galenism that Greek medicine was transmitted to the Renaissance scholars" (1). This transition of knowledge is a very important link in the progression of medicine.

MIDDLE AGES' MEDICINE

Arabic

O'Malley's research indicates that medical progress stopped in Rome as the barbarian tribes grew. The moral fabric of that culture began to unravel and this created a backward shift in medicine. Thus folklore, mysticism, and superstition regained popularity and disease was again thought to be a punishment for sin ("Medicine in the Middle Ages" 5). The Arabic culture continued to be influential on traditional Greek medicine. During this period drugs were used extensively. According to DuVal, "Rhazes expounded on the need for sanitation in hospitals" (13). This culture is also credited with discerning that through blood, infectious diseases were spread ("Arabian Medicine" 13).

A physician called Avicenna, produced the Canon of Medicine which synthesized the works of Hippocrates, Aristotle, and Galen. The practice

of licensure of the physicians after successfully completing an examination was introduced in this culture (O'Malley, "Medicine in the Middle Ages" 5).

Europe

At this time, Europe was leaning toward medicine that reflected an ecclesiastical framework. The care of the sick was being delivered in the monastic infirmaries. During this time, it became apparent that many of the charitable organizations and institutions were being developed to care for the sick. The Europeans focused on the need for a scientific basis for medical knowledge (O'Malley 6).

THE RENAISSANCE PERIOD

This time period spans the fourteenth, fifteenth, and sixteenth, centuries. During this period there was an eagerness to transcend the traditional way of thinking and its limitations. There was a desire and eagerness for discovery and for creativity. Revitalization in the Greek and Roman cultures was present. Although few major changes were made in medical thought, the works of Galen and the Arabists were scrutinized and there was a renewed interest in the works of Hippocrates (Encyclopedia Britannica 11, "History of Medicine" 828-829).

The Renaissance introduced a new period of history during which community health as it is currently known was begun (Stanhope and Lancaster 6).

Seventeenth and Eighteenth Centuries

There were numerous discoveries that advanced the practice of medicine during this period. Although the seventeenth century began with a focus on ways to simplify medicine, it ended with a need to look toward clinical observation as a determining factor in the treatment of the sick.

Others also made lasting contributions in the field of medicine. Anton van Leeuenhoek's invention of the microscope was instrumental in looking at bacteria and how it spread, while Thomas Willis was credited with the discovery of diabetes mellitus, hysteria, the anatomy of the brain, and the nervous system. The discovery of the anatomy of the liver has been attributed to Francis Glisson. In addition homeopathy, which involved treating the patient with small doses of medication, was developed during this period (Stanhope and Lancaster 6; DuVal 14).

The controversy as to whether the body was machinelike (iatrophysics) or functions as a chemical process (iatrochemistry) was highly debated in the past as it is now. Rene Descartes, a seventeenth century philosopher, was the father of iatrophysics. Sanctorius, a physician out of Padua, was a forerunner in iatrochemistry during the seventeenth century. This was a period when physicians were looking for a quick and logical way to define how the human body worked. During the eighteenth century, the works of Phillippe Pinel influenced the medical community in regard to the treatment of mental illness (Encyclopedia Britannica 11 "History of Medicine" 830).

According to "Pinel, Philippe" Encyclopedia Britannica Online,

> In 1792 he became the chief physician at the Paris asylum for men, Bicetre, and made his first bold reform by unchaining patients, many of who had been restrained for 30 to 40 years. Pinel discarded the long-popular equation of mental illness with demoniacal possession. He regarded mental illness as the result of excessive exposure to social and psychological stresses and, in some measure, of heredity and physiological damage. In Nosographie Philosophique (1798; "Philosophical Classification of Diseases") he distinguished various psychoses and described, among other phenomena, hallucinations, withdrawal, and a variety of other symptoms (1).

Stanhope and Lancaster reported, between 1750 and 1830, the concept of community health was cemented. It was during this time that American medicine began to focus on public health functions and many authors felt that the beginning of American medicine came in 1765, when John Morgan established the first medical school (M.K. DuVal). Sultz and Young, authors of Health Care USA wrote:

> Throughout history, public health activities have reflected the state of knowledge of the time regarding the nature and cause of the diseases that affect mankind, the practices employed for their control or treatment and the dominant social ideologies of the various political jurisdictions. From a historical perspective, the interaction of disease, state of knowledge at the time, and societal values have resulted in a dynamic and continuous process of public health activity (253).

In America the quest for medical knowledge was present with the early settlers. However during the eighteenth century, as more people entered the country and the cities became more congested, the need grew. Diseases spread through the populated areas very quickly and many were deadly. As a result, sanitariums and almshouses were established near harbor cities to house the immigrants who were physically sick or who suffered from a severe form of mental illness ("Mental Health and Hygiene" Encyclopedia Britannica 2 911).

MODERN MEDICINE

Nineteenth Century

The nineteenth century brought about its unique impact on medicine which some authors describe as the Golden Age of Medicine. Numerous discoveries and inventions had a profound effect on medicine. Although surgery had been advancing during the eighteen century, it was Joseph Lister's knowledge and foresight to apply the principles of bacteriology in the operating room that made a great difference. He discovered and used antiseptics. Although nursing had been in place for many centuries, Florence Nightengale's approach to nursing care set the stage for the nursing profession to advance the principles of quality nursing care. "Evelyn Wilkerson " The History of Nursing Online (1).

The various discoveries and inventions that aided the physicians in promoting/providing optimal care were many. The x-ray was discovered and has been vital in assisting with the diagnosis and treatment of

numerous diseases and conditions. The discovery of ultraviolet ray and its benefits/treatments in various disease processes proved to be very beneficial to the medical field. The discovery of radium and its effects on specific types of cancer was also very beneficial.

According to "Drug Use" it was during this period of expansive medical learning that concern grew over the excessive use of opium. (Britannica Online "History of Drug Use" 1) Also, "Drug Use" referenced a London physician by the name of Jones, as describing the "excessive use of opium as a problem" (1). However, as previously stated, there is no real trail that indicates signs of addiction were a major concern to society at that time, especially in the West (1). However opium had many applications in the medical arena. "At one time, the extensive use of these medicines for various gynecological difficulties probably accounted for the high addiction rate among women (three times the rate among men)"(1). Opium and its derivatives could be purchased without a prescription and were available and used by most individuals for one ailment or another. This set of circumstances created an environment that was susceptible to drugs being abused. Along with the availability of the drugs was the lack of knowledge about the addictive disease processes which also fostered abuse. "The hypodermic needle which was invented in the mid nineteenth century, and its subsequent use to administer opiates during wartime produced large numbers of addicted soldiers...it was thought mistakenly that if opiates were administered by vein, no hunger or addiction would

develop, since the narcotic did not reach the stomach" (1). This is a clear indication of the lack of understanding and knowledge that the medical field had at that time regarding the science of addiction and addictive drugs.

Twentieth Century

The twentieth century saw the development in rapid succession of serums, vaccines, antitoxins, and toxoids to combat many deadly infectious diseases (M.K. Duval 16). With the advent of these developments and better living conditions came a longer life expectancy. Diseases that once eradicated a whole population of people were being controlled. Immunizations and vaccines against typhoid, tetanus, diphteria, yellow fever and other diseases decreased the population's mortality. The focus of medicine went from mortality to morbidity, with the emphasis changing from keeping people alive to keeping them healthy...Drugs such as penicillin, streptomycin, and sulfa drugs played an important part in controlling various diseases and infections. Antispasmodics and antihistamines were also discovered and played an important role in the treatment and elimination of various diseases. Major tranquilizers were discovered which made it possible for individuals who had been hospitalized for long periods of time to be treated in a less restrictive environment. O'Malley has written that "a major advance in treatment of these disorders was the introduction of drugs...the first of

these, the phenothiazines, were used in the early 1950's" (Medicine, Mental Illness 15).

It was during the early part of the twentieth century that diet and its role on the health of the individual was studied. Also the organization of community health efforts improved simultaneously with changes in medical care and the development of hospitals as treatment facilities for all people (Stanhope & Lancaster 17).

Changing technology has altered the health care system. Innovations have been introduced at an increasing rate over the last ten years and the rate of technological innovation continues to accelerate. Changes in technology not only include aspects such as computer hardware and software, instruments, and drugs, but also, new ways of thinking about and performing diagnostic techniques and surgical procedures (Stanhope and Lancaster, 32). Technological advances such as the use of renal dialysis in the treatment of end stage and acute renal failure have helped prolong life until a viable kidney transplant could be performed. X-rays have played a vital role in the advancement of medicine. Computerized tomography (CT) scans, magnetic resonance imagery (MRI), position emisson tomography (PET), computer ultra sound all have had a tremendous impact on the diagnosis of physical and mental diseases. (DuVal, 17 and O'Malley, 15)

Medicine has changed drastically during the twentieth century, and many factors have influenced this change. As previously stated, the

organization of community health efforts have played a major role in improving the health of individuals. According to Stanhope and Lancaster, "the early twentieth century witnessed multiple improvements that both directly and indirectly affected health status... Organized community health efforts improved simultaneously with changes in medical care and the development of hospitals as treatment facilities for all people" (17). In 1902 Congress renamed the Marine Hospital Service and gave it an established organizational format under the direction of the surgeon general...The title was broadened in 1912 to become the United States Public Health Service (USPHS). This government influence has led to many developments that have impacted the healthcare of individuals. Hospitals and sanitariums were set up to treat individuals with diseases such as tuberculosis and leprosy and for individuals who had severe mental illness. Individuals with mild forms of mental illness were usually kept at home. O'Malley reported that "even in the early part of the twentieth century, mental illness was almost a sentence of doom, and mentally ill persons were handled with cruel confinement and little help...Successful therapy for some mental illnesses had greatly improved the prognosis for these diseases and has partly removed their stigma" (15). Monies were allocated for research and treatment of various diseases. All immigrants were required to have health screenings. One major development was the Federal Social Security Act of 1935, which in

part supported states and communities in their endeavors to provide optimal health services to their people (Stanhope and Lancaster 18).

The influence of the government has contributed greatly to the improved health status of individuals. The twentieth century had brought about numerous advances in the medicine which have been extremely beneficial. However: "By the turn of the century, narcotic use had become a worldwide problem, and various national and international regulatory bodies sought to control traffic in opium from the Near and Far East" "Drug Problems" Encyclopedia Britannica 5 (1051). According to Britannica Online "narcotic use was largely associated with metropolitan slums and principally among poor and culturally deprived" (1). However it has crossed cultural barriers and it is now being viewed as a mental illness by the middle and upper classes. It seemed as though many of the social problems that affected the lower class citizens were not addressed until those problems began to have an impact on the middle and upper classes of citizens. It was easier then for some to have a mental illness versus a substance abuse/dependency problem. So one stigma is traded for another one. Research verifies how different cultures have viewed the mentally ill.

> Throughout the ages the mentally disturbed have been viewed with a mixture of fear and revulsion. Their fate generally has been one of rejection, neglect, and ill treatment. Though in ancient medical writings there are references to mental disturbance that display views very similar to modern humane attitudes, interspersed in the

> same literature are instances of socially sanctioned cruelty based upon the belief that mental disorders have supernatural origins such as demonic possession ("Mental Health and Hygiene" Encyclopedia Britannica 11, 910).

There continues to be fear and trepidation for the mentally disturbed. This is apparent not only in the population that is not afflicted by mental illness but is expressed in the population of people who have addictions. Many do not wish to be associated with or diagnosed with mental illness. Regarding the stigma that addicts have toward each other, in "Mentally Ill Alcohol and Substance Abusers" The Journal Online 1995, Dr. Burt Pepper wrote,

> Before the 1970's alcoholics tended to despise drug addicts and viewed them as deviant because they used an illegal substance. (He continued,) Substance abusers/addicts, on the other hand, felt that their intoxication with heroin, marijuana or high-class and expensive cocaine, put them a distinct cut above the lowly alcoholic. Both alcoholics and substance abusers tended to look down on those who suffered from a serious psychiatric disorder (1).

The stigma remains today and it is the responsibility of clinicians and other mental health and substance abuse professionals to become advocates for those with a mental illness and/or substance abuse/dependency. The public and other clinicians must be educated as to the effects that these illnesses have on family systems and society as a whole. Both the mental health and the addiction delivery systems must be

educated about the client with a dual diagnosis. Treatment facilities must continue their research toward developing a treatment modality that is cost effective yet provides quality care.

Chapter 2

This chapter will examine the history of dual diagnosis along with various treatment models. Some of the pertinent literary resources also will be reviewed. The concept of dual diagnosis can better be understood when looking at the history of Psychiatric/Mental Illness services and services for Addiction. Fred C. Osher and Robert E. Drake wrote:

> The treatment of Addictive disorders has been alternatively embraced and shunned by the health care system in general and the mental health providers in particular. Addictive disorders were first treated in medical settings in the early nineteenth century, after Benjamin Rush advocated a "disease theory" of addiction and Samuel Woodward successfully argued for involuntary treatment in the asylum. Subsequently, the inability of physicians to produce a medical "cure" for addictions and the mounting cost associated with these institutions eroded public support and asylums began to vanish. These events occurred at the start of the twentieth century, just as a budding mental hygiene movement posited that inexpensive, community-based care could engage patients in early stages of addiction and arrest the development of addictive conditions. (5-6)

There tends to be little supportive data that lends itself to the history of addictions in the United States prior to the nineteenth century. "Thus ideology has led to the development and growth of community-based care during the 1920's and 1930's" (6). "Organizations such as Alcoholics Anonymous (AA) and Narcotic Anonymous have been instrumental in the

transition of treatment from an inpatient hospital setting to a non-medical community setting" (6).

This transition has led to parallel care, which is now known as an early treatment modality. However, the sequential model of treatment is more than likely the first modality to be used with the dual diagnosis population according to Richard Ries, author of Assessment and Treatment of Patients with coexisting Mental Illness and Alcohol and Other Drug Abuse (12). As a result, individuals who suffer from both a mental illness and an addictive disorder are usually treated by two separate delivery services with different philosophies.

Frank Baker, Ph.D., author of Coordination of Alcohol, Drug Abuse, and Mental Health Services has stated, "Beginning in the late 1960's and flourishing in the late 1970's, alcohol and drug abuse services moved toward distinct community-based services" (6). This trend also leads patients away from the traditional hospital setting to community based settings. According to Osher & Drake, "Not until new theoretical models posited biologic underpinning to addictions did the traditional health system grudgingly reconsider its role in providing addiction treatment" (6). In essence El-Mallakh has written, "clients who abused substances existed before the 1980's, however, this population became increasingly visible in treatment settings when the American Psychiatric Association's Diagnostic and Statistical Manual of Mental disorders and Addictive

Disorders (DSM-IV) specified the identification of Multiple Axis I disorders" (71-72). Multiple Axis disorder describes the methodical order of assessing two or more elements (axes) to obtain different information to help clarify and determine treatment for the client and to predict outcome (DSM-IV-25).

> Axis I Refers to clinical disorders. Other conditions that may be a focus of clinical attention.
> Axis II Personality disorders and mental retardation
> Axis III General medical conditions
> Axis IV Psychosocial and environment problems
> Axis V Global assessment of how the patient is functioning. (DSM-IV-25)

El-Mallakh has gone on to say, "The specification of multiple diagnoses legitimized the notion of simultaneous disorders of mental illness and substance abuse" (72). Nevertheless, there have been numerous barriers and obstacles to program development for the dual diagnosis patient. Historically, since the beginning of the addiction treatment model and recovery model, there has been a rivalry between the mental health professionals and the addiction professionals (Osher and Drake 6). The contrasting philosophies of the two systems have led to conflict and confusion for the patient. Minkoff has reported in "Models for Addictions Treatment in Psychiatric Populations", "one of the most important barriers to developing additional treatment models in the psychiatric population has been irreconcilable philosophic differences and pervasive mistrust that

exist between additional counselors and psychiatric care providers" (412). He goes on to say, "those differences concern the nature of treatment offered (medication versus 12-step programs; science versus spirituality: professional help versus peer help)" (412). El-Mallakh acknowledges, "many mental health professionals dismiss the usefulness of 12-step AA programs because they seem to view it as lacking a scientific basis" (73). Appendix C illustrates similarities and differences of the different treatment systems. Other barriers include the lack of appropriate assessment and diagnostic tools for this population and the lack of staff education and training. Ralph Swindle et. al. have noted in "Patient Treatment for Substance Abuse", "the knowledge base concerning treatment approaches for this population consist largely of clinical descriptions and program case studies" (80). Minkoff in "Models for Addiction Treatment in Psychiatric Populations" has further stated, "there is virtually no empirical information about effective program characteristics for these patients" (412). Also, a lack of funding at the federal, state and local levels continues to further divide the service delivery systems.

Two decades ago, mental health clinicians saw an increase in the number of patients that had been admitted to psychiatric hospitals and psychiatric facilities suffering from a mental illness as well as from some type of substance abuse or dependency. These patients have been identified as individuals with a dual diagnosis (DD) or co-occurring

disorder (COD) or co-existing disorder (CED). Consequently, this diagnosis identifies the patient as having a mental illness and a substance abuse/dependency disorder. The dually diagnosed patient has presented both the mental health delivery service and the addiction delivery service with many thought provoking questions as to the most effective model of treatment. Kenneth Minkoff, author of "Integrated Treatment Model for Dual Diagnosis of Psychosis and Addiction" has written "Despite the powerful impact of this population on the service delivery systems, advances in treatment and training have been surprisingly slow" (1031). Many hybrid treatment models have been developed to treat this population; however, there is no ***ideal*** model of treatment for the various settings that treat this population. Many organizations have developed and tailored models to their facilities. Sheldon Zimberg, author of "A Dual Diagnosis Typology to Improve Diagnosis and Treatment of Dual Disorder Patients" has said, "the lack of a reliable and valid approach to diagnosis was a major roadblock to effective integration of psychiatric and substance abuse treatment" (47).

In examining patients who suffered not only from mental illness but also from substance abuse, it is noteworthy to point out that this rate of dual disorders has been steadily increasing. Much of today's research indicates the rate could be as high as 70-75%. According to Miller's article "Prevalence and Treatment Models for Addiction in Psychiatric

Populations', the prevalence rate from co-morbidity of addictive disorders range from between 25% and 80% in the psychiatric population" (Norman Miller 399). Appendix D reveals selected studies of the rate of substance abuse among treatment samples of psychiatric patients. This increase has been attributed to numerous factors. Mental health advocates have been working towards placing more consumers (patients) in the community. As a result, there are fewer people who are institutionalized. The advent of medications that has enabled the patient to be treated in the community is also a factor. With these changes there has been an increased accessibility to alcohol and illicit drugs. Many patients with mental illness have begun to use drugs to self medicate and, as a result, have become dependent on them. This theory has been challenged by many in the field of DD. Minkoff suggested that many patients drink and take drugs due to loneliness and isolation rather than for self-medication (Integrative Model for Dual Patients Video 1997). During the last two decades, deinstitutionalization has been increasingly associated with the emergence of large numbers of individuals with concomitant substance disorders and severe, chronic psychiatric disorders (Minkoff 13). Kathleen Sciacca and Christina K. Thompson, authors of "Program Development and Integrated Treatment Across Systems for Dual Diagnosis: Mental Illness, Drug Addiction and Alcoholism (MIDAA)", have written "that in 1986, the New York State Commission on the Quality of Care for the

mentally disabled found that 50% of the patients admitted for psychiatric care across New York State also had alcohol and substance abuse problems that required treatment" (288). Other studies in 1993 showed that 90% of prisoners with mental disorders have co-occuring substance disorders and that half of the homeless population with mental illnesses also suffered from substance disorders. (288). With the rapid rise in the number of patients who are diagnosed with co-occurring disorders, it is imperative that the service communities re-examine ways to provide the most effective level of treatment for patients who are dually diagnosed. Jan Fawcett, author of co-morbidity, "Dual Diagnosis and Addictions—We Can't Ignore Them", has stated, "Co-morbidity of one type is the rule and not the exception in the real world of practice" (397). As previously mentioned, in the last twenty years, there has been documented studies of the enormous increase in the number of individuals who have been diagnosed with a DD.

For the purpose of this paper, both dual diagnosis and co-occurring disorders will be representative of patients who are diagnosed with a mental illness and a substance abuse/dependency disorder. D. Daley et. al., authors of Dual Disorders, refer to "DD cases in which the individual has both a chemical dependency disorder and another serious psychiatric illness, such as depression" (1). Since the term DD can be related to other entities such as an individual who has diabetes and a mental illness

or someone who is diagnosed with a mental illness and mental retardation, this clarification is needed. Because DD can also be linked with other diagnoses, it is necessary that a common language be developed for this population of people who are diagnosed with a mental illness and a substance abuse/dependency disorder. Kathleen Sciacca and many other authorities on DD have expressed the need for a common language. This common language would assist both the addiction and the mental health delivery systems with a reference point in understanding the clients which they serve.

Presently, there are numerous phrases and buzzwords to describe this population. The mentally ill chemical abuser is called MICA. The chemical abuser with mental illness is called CAMI. Another name that describes this population is MISA, which refers to the mentally ill substance abuser. Although there are a variety of names to identify this population, Sacks et al., have reported, "the most popular and general term used is 'MICA', an acronym for the mentally ill chemical abuser (which) identifies persons who have a serious diagnosable mental disorder" (1223). Even though this phrase is becoming familiar among both the mental illness and addiction service delivery systems, there is no consensus about what terminology to use. Sheldom Zimberg, author of "A Dual Diagnosis Typology to Improve Diagnosis and Treatment of Dual Disorder Patients" has come up with a typology to address the issue of a

common language. He does not think that phrases like MICA, MISA, CAMI and others are useful as a common language to define the DD patient (47). This typology consists of three categories or types for the DD patient. Category or Type I is used for the patient who has a "primary psychiatric disorder" and Category or Type II is for the patient who has a "primary substance use disorder" and Category or Type III is for the patient who has "dual primary disorders" (48). See Appendix E, which shows a detailed description of all three types.

Sacks et. al., have acknowledged, "a need to synthesize current information on diagnosis and classifications toward the development of a uniform classificatory system that addresses the issues of type, severity and primacy of disorders" (1224). In working with the DD population for the past two and a half years, it is apparent that this classifications system is much needed. There tends to be confusion between treatment team members because of the lack of clarity in defining or classifying the broad range of patients who are DD. "The DSM-IV does distinguish between primary and secondary disorders but does not provide a reliable and valid way to differentially diagnose co-occurring psychiatric and substance use disorders" (Zimberg 1999). Also, there is confusion between the addiction and the mental health delivery services, in regard to treatment approaches for the various types of DD patients. Many of the patients with an exacerbation of their mental illness, regardless of the cause, will be

mental illness, regardless of the cause, will be treated in the mental health service delivery system. Many of the patients who exhibit primary substance abuse with an Axis II diagnosis will be treated in the addiction service delivery. When speaking of the Axis II patients, the implication is that patients with personality disorders are more likely to be treated in the addiction delivery service. Although this was quite frequently the case in the past, it is changing. Many of these patients are now being treated in the mental health delivery service. Since both systems have different treatment approaches based on the classification or diagnosis of the DD patient, these different approaches will only serve to further enhance the confusion that may result from both settings for the patient and for the treatment team members.

Another primary issue is the cost of healthcare, which has been at the forefront in this country for at least two decades. The managed care concept was ushered in as the premier tool to decrease excessive healthcare expenditures and has been applied to many mental health and addiction service delivery systems in an effort to control cost without compromising the quality of care. However insurance companies nationwide have limited the amount of monies that is spent on mental illness and on substance abuse and in essence have impacted the treatment of DD patients. Many companies allow up to $25,000 a year to be spent on mental illness or substance abuse/dependency.

The mere fact that the typical DD patient accesses emergency services and inpatient hospitalization frequently shows the increased cost of the DD patient. Drake reported:

> The economic cost of dual disorders have also become apparent...Research has demonstrated that even though patients with DD are prone to drop out of traditional outpatient treatments, their total treatment costs are higher than treatment cost of patients with single disorders because they are high users of expensive hospital and emergency services...(590)

RachBeisel et. al., concurred with this in their article 'Co-Occurring Severe Mental Illness and Substance Use Disorders: A Review of Recent Research", citing a study by Dickey and Azeri in which three groups of patients were documented in regard to the cost of services.

"One group of patients had severe mental illness and a substance abuse disorder, and received treatment for both disorders. Another group with severe mental illness and substance abuse disorder was treated for the severe mental illness and a third group, who had only severe mental illness received treatment for that illness." (1432). The results indicate that patients with DD were four times more likely to seek treatment in an acute care setting, and spend more days hospitalized. "Comparisons of the annual costs of treatment across the three groups showed significant differences between those with no substance use disorder, for whom the annual cost of care was $13,930, and those with either a treated or an

untreated substance use disorder for whom annual cost were $22.917 and $20, 049 respectively" (1432). Not only does the DD population seek the more expensive treatment setting, but many have compromised themselves medically and thus require increased diagnostic testing and treatment for physical ailments. Also, according to Drake, the recidivism rate is higher among the DD population, which attributes to the increased cost (43, 48, 49).

It is difficult to separate the DD population from the substance abuse/dependency population when it comes to funding for treatment. Both populations have to compete for funding for treatment. This is seen on the local level, the state level and the federal level. According to a "Nightline" commentary, "there is more money allocated to curtail the supply of drugs at the source (Columbia) than is allocated for the treatment of individuals with substance abuse/dependency disorders...For every dollar allocated for treatment, the return would be a four dollar savings". According to Michael Massing, a guest on "Nightline" and the author of The Fix, "We are never going to be able to stop the flow of drugs into this country" (June 29, 2000)...However, treatment for substance abuse/dependency is twenty-three times more effective than fighting drugs at the source (Michael Massing). From a simple economic perspective, both the mental health delivery service and the addiction delivery service should seek funding for treatment of the DD population.

Not only do the clinicians in this field need to develop a more effective classification system and cost efficient system, they also need to review the assessment tools that are being used to determine their reliability. Research indicates that the importance of a thorough assessment and diagnosis is critical to guiding the appropriate treatment and outcomes for this population. One of the first steps in treating the DD patient is a good assessment and as Kathleen Sciacca reflects in "An Integrated Treatment Approach", "diagnostic clarity is the first step in planning successful treatment" (1).

According to Onken et. al. in the book, "Treatment of Drug Dependent Individual With Comorbid Mental Disorders", comments where made about some of the problems and concerns in "assessing substance disorders among persons with severe mental illness". One of the main problems is "the ability to obtain a thorough history of substances"...This has been a shortcoming for the mental health clinician (87). The fact that self-reporting is one aspect of gathering data about substance use can be misrepresented by the DD population because they can minimize the use of their drug of choice. Also, the patient with acute symptoms of mental illness may not be able to give a valid history of drug use (87).

There are many instruments used for the assessment of substance abuse/dependency. The Chemical Abuse and Dependence Scale (CAGE), the Michigan Alcoholism Screening Test (MAST) the Alcohol

Severity Index (ASI) are some of the most commonly used. Along with these there are other instruments and modified versions available. The ASI has been used extensively in the addiction delivery system. It is being considered for use with DD patients in the state of Missouri. "Although researchers have found a strong correlation between the ASI and other instruments, new research has revealed concern about the validity of the ASI" (RachBeisel (1428)...They suggest that results from Lehman and colleagues, and others indicate that the ASI should not be used alone in the assessment of DD patients" (1428). These are the reasons given:

> The ASI appears to underestimate subject's substance abuse problems for three reasons: 1. "Regular use" used in the assessing of substance use imposed a cutoff at least three times a week. This is not a problem for the general population; however, DD patients can use less alcohol and drugs and have greater negative outcomes...This may not be picked up. 2. It lacks questions that explore the interactive effects of severe mental illness and substance abuse use. 3. The drug and alcohol treatment history elicited by the instrument assumes that treatment is delivered through the addiction treatment delivery service. In actuality, patients with severe mental illness are treated in the mental health delivery system (1428).

Onken et. al., have reported that "standard instruments such as the ASI are relatively insensitive to clinically important levels of abuse among persons with psychiatric disorders" (88). The DD patient can use smaller amounts of a drug of choice yet have severe complications whereas the

patient who has only a substance abuse problem can and usually will consume more drugs or alcohol before he is faced with severe complications (88). Another issue that Onken et. al., have addressed is the "need for assessment instruments that are able to capture the motivation levels of the patients" (88).

Thus far the issues of a common language, cost factors, and assessment tools have been reviewed. Other areas of concern are staff education, staffing patterns, admission criteria and program structure along with programming issues. These areas of concern will be addressed in this chapter and in following chapters. However before these concerns are addressed, the various treatment models for the DD patient will be presented.

The literature review indicates that there are three dominant delivery models for the DD patients: the sequential model, the parallel model, and the integrated model. The sequential model involves the DD patient being treated for one disorder, then the other. The "Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse" of the Treatment Improvement Protocol Series (TIP 9), it was written, "with this model, addiction clinicians felt that the addiction should be treated first, and the individual must be in a stage of abstinence recovery from addiction before treatment for the psychiatric disorder could begin" (Ries 12). The clinician from the addiction system

has had little, if any, knowledge of the disease concepts for mental illnesses. Likewise, the mental health clinician has also had little or no knowledge about the effects of substance abuse/dependency. This lack of knowledge has compromised the care of the DD patient (El-Mallakh 74). Care has been fragmented at best and subverted or not provided at all in the worst case scenario (74).

Historically, when the separation began with the treatment of mental illness and substance abuse/dependency, a parallel system was created. However, it was the standard practice at that time to treat one disorder, then the other. Based on the report by Drake et. al. "The Course, Treatment, and Outcome of Substance Abuse", the argument can be made that "With conceptualization of the DD problem came a clearer picture of the poor fit between DD patients and the existing treatment system" (45). This observation has led to the movement towards an integrated system.

The parallel model of treatment will provide the DD patient with treatment for both the mental illness and substance abuse disorder at the same time. However each system has had its own specialized clinicians and thus, in the past, they were not cross-trained. Therefore each system's clinicians have had little, if any, knowledge about the disease process of the other system. El-Mallakh has commented that "the parallel model, which is defined as the provision of concurrent but

separate treatment of mental illness and addictive disorders, retains some of the limitations of the sequential model...Adherence to incompatible interventions sends conflicting messages to clients and may result in poor compliance with both treatment systems" (74). Drake et. al., have written that "patients were typically extruded from one type of program (and often from both) and rarely engaged in concurrent mental health and substance abuse treatments" (The Course Treatment and Outcome of Substance Abuse 45).

The crusade toward the integrated model began as a way to provide the optimal level of treatment for the DD patients. With this treatment model, mental health and substance abuse treatment are provided by the same individual or team simultaneously. El-Mallakh defines the integrative treatment as "the combination of mental health and substance abuse interventions in a concurrent and coordinated manner" (75). She goes on to say "adequate treatment within the integrated model requires 'on-going attention to both disorders and synthesis of treatment principles'" (75).

The integrative model has been held in high esteem by many clinicians. Kenneth Minkoff, one of the forerunners in developing and describing the need for integrative treatment, has written extensively about the subject. Minkoff, co-editor with Robert E. Drake, of Dual Diagnosis of Major Mental Illness and Substance Disorder, has laid the

foundation for a conceptual model of integrative treatment for the DD patient. Kenneth Minkoff, M.D. is Chief of psychiatric services at Choate Health Systems in Woburn, Massachusetts and medical director of Caulfield Center, an integrated psychiatry and addiction hospital. He is one of the clinical faculty of the Cambridge Hospital Department of Psychiatry of Harvard Medical School. Robert E. Drake, MD, Ph.D. is associate professor of Psychiatry and Community and Family Medicine at Dartmouth Medical School and director of the New Hampshire Dartmouth Psychiatric Research Center (108).

Minkoff's conceptual model is based on the application of both the disease and recovery models ("Models for Addictions" 413). Minkoff has discussed the increase in the number of patients with dual diagnosis and the challenges that it has created for both the mental health and the addiction delivery systems in Dual Diagnosis of Major Mental Illness and Substance Disorder (13). He has described certain issues that must be examined to ensure a comprehensive care system (14). These issues and the their impact on the an integrative system will be discussed. The integrative model that Minkoff has developed was founded on hybrid models of treatments. However, his model views both disorders, (mental illness and substance use disorder) as a primary and as a biological mental illness ("Models for Addiction" 413). Minkoff has built upon these guiding principles for treatment.

Minkoff has described the Models for Addiction Treatment in Psychiatric Populations as follows:

> Principle 1
>
> The treatment of addiction in psychiatric populations is basically the same as the nonpsychiatric populations, incorporating the elements of intervention, education empathic confrontation of denial, training in relapse prevention skills, and developing an intensive, ongoing program of recovery based on use of both self-help and professionally led groups. Most models rely on 12-step programs as a cornerstone of recovery support, due to the extensive availability and accessibility of these programs. Pharmacotherapy for addiction remains an adjunctive rather than primary method of intervention.
>
> Principle 2
>
> Standard addiction treatment requires modification in order to be applied in psychiatric populations. Modifications include special preparation and training for the use of 12-step programs, simplification of traditional addiction interventions like step assignments to accommodate cognitive limitations, modification of group work or step work to incorporate dual diagnosis questions; and specific social skills training to ask for help, use phone numbers, or resist peer pressure. The most significant modification of traditional addiction treatment has emerged recently in the development of a new 12-step program called Dual Recovery Anonymous (DRA). The DRA Big Book incorporates stories of recovery by addicted individuals with a wide variety of psychiatric disorders, and is structured similarly to the AA or NA Big Book...(10-12)

Minkoff has also described these as components of his Integrative Model:

1. A program must provide for differentiation in patient's diagnosis, activity, disability and degree of motivation. Can the integrated model provide this?

2. A program must decide on whether it will be abstinence-oriented versus Abstinence-mandated. Should abstinence be a prerequisite for the program? Should the focus be on abstinence as a goal? Most dual diagnosis programs require a combination of abstinence-mandated and abstinence-oriented programs, with clear guidelines defining the respective roles of each.

3. Locus of care – The recovery model encourages patients to seek treatment that will be congruent with their long-term outcome goals of persistent sobriety. Therefore, patients may seek help in more restrictive treatment settings initially to accomplish their goal. In designing a system of care for dual diagnosis patients, the goal of maximizing recovery must be primary and must also be integrated with the goal of minimizing reliance on the restrictive institution. (15-17)

It cannot be expected or assumed, however, that pushing the client into less restrictive settings with more freedom will always enhance the recovery process (17).

In continuing the review of Minkoff's Integrative Model, there are specific elements that also should not be overlooked.

1. Element of conceptual Framework:
   a) Chronic mental illness and substance abuse disorders are both examples of chronic mental illness.
   b) Each illness fits into a disease and recovery model for assessment and treatment. (Stabilize acute symptoms).
   c) Each illness is considered primary regardless of order of onset.
   d) Both illnesses can be regarded as having parallel phases of treatment. Acute stabilization, engagement

in treatment, prolonged stabilization/maintenance and rehabilitation/recovery.

e) The progress in recovery for the DD patient can be different for each illness. Therefore, the recovery process commonly proceeds independently.

2. Program elements must have:
   a) Ways to address each phase of recovery for each illness.
   b) Ways to address various levels of severity and disability in each phase for each illness.
   c) Must consider the various motivational levels of client's adequate levels of care for those who is disabled but unmotivated, while creating systemwide incentives for clients to progress to programs that are more desirable but also more demanding.
   d) Continuity and consistency of care.
   e) Comprehensive – programs must address different phase of treatment.
3. Define level of substance-related problem behavior that cannot be tolerated with the program.
4. Develop a clear set of policies that determine the behavioral consequences for violation because policies are not punitive. (17-24)

Many clinicians have built on Minkoff's conceptual model. Osher and Kofoed, pioneers in the field of DD have categorized his model into engagement, persuasion, and active treatment. The intended outcome of active treatment is prolonged stabilization (18). El Mallakh addresses these elements as well as relapse prevention as being essential in DD programs. The definitions that she has given to each element are as follows:

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Engagement – convincing the patient that an agency or provider has something desirable to offer.
Persuasion – Assisting the patient with his determination that long-term treatment is necessary.
Active Treatment – helping patient develop attitudes and skills that are necessary to maintain sobriety.
Relapse Prevention – Help clients recognize typical patterns of decompression and relapse. (75)

Robert E. Drake, a colleague of Minkoff' is also a proponent of the integrated model. He integrated the elements of engagement, persuasion, and active treatment and relapse prevention into a case management model for DD patients. Drake et. al., in "Review of Integrated Mental Health and Substance Abuse" expounded on "one of the earliest approaches to integrated treatment for patients with DD involved adding a substance abuse treatment group to the usual mental health programs" (590). These groups were developed for educating the DD patient in the DD process, providing support and decreasing substance use leading to abstinence (590).

Collins E. Lewis, MD, author of "Treatment of the Dual Diagnosis Patient" has reported that Drake and coworkers reviewed 13 dual diagnosis papers and found that eight overall principles emerged and four major principles:

1. Integrated treatment - "Both mental health and substance abuse treatment should take place within one system with one supervisory authority". There should be a coordinated effort for the treatment of substance abuse and mental health.

2. Intensive case management (CM) - Care should be coordinated by clinicians with small caseloads and assertive outreach. CM should guide the patient through the necessary levels of treatment and monitor the patient's progress and expectations.
3. Group therapy - Groups that deal with dual diagnosis are essential components of treatment. Peer oriented, educational, interactive, behavioral skill training, and community support groups such as AA, NA, and Double Trouble. All group participants should be screened for verbal, social and cognitive skills to better assimilate patient into groups where peers exhibit similar levels of functioning
4. Phases of treatment - The conceptualization of treatment as a process of different phases eliminates the controversy about the time when to insist on abstinence. Dr. Lewis elaborates on the different phases that have been proposed by Drake and colleagues. Engagement, persuasion, active treatment and relapse prevention. (1-2)

The other principles that were addressed are:

1. Substitute activities-Focused activities on skill building, group identity formation, improving self-esteem, and abstinent lifestyle.
2. Cultural relevance-Aimed at synthesizing values, styles, language and characteristics of certain populations into the program.
3. Training-Should be ongoing and longitudinal.
4) Families of the client Education them about support groups as well as mental illness and substance abuse. Families may also reluctant to participate in treatment and may need considerable outreach. (3-4)

Dennis Daley, Ph.D., one of the authors of Dual disorders, is also one of the leading consultants on DD patients. He has had extensive

experience in program development and management, treatment, teaching, research and publishing. He has presented nationally and internationally on the subject. Currently he is Director of the Center for Psychiatric and Chemical Dependency Services at Western Psychiatric Institute and Clinic/University of Presbyterian Medical Center in Pittsburgh, PA. Also, he is Associate Professor of Psychiatry at the University of Pittsburgh School of Medicine. The treatment services that he promotes/advocates are integrative. The programs aim at a balance between the psychiatric disorder and the chemical dependency disorder. Focus is on the interrelationship between the disorders (204). Daley and _?_ does not speak of a conceptual model in the context of Minkoff, Drake, and others. However, they have addressed the need to provide information and education to increase the patients awareness of both disorders. Also, they have addressed the need for assisting the patient in developing the motivation to change and assisting with the change process skill development. They are advocates of looking at both the process and the content, (282). In their book, Celebrating Small Victories, Montrose and Daley, stated, "We believe the integrated treatment is usually the best approach because it focuses on both psychiatric and substance use recovery issues" (82). Dennis C. Daley et. al, "Integrating a Dual-Disorders Program in an Acute-Care Psychiatric Hospital" has addressed the development of an inpatient acute-care dual-disorder unit

that treated patients with mood disorders. One of the areas of concentration for this unit was to "develop a more systematic and structured program"(47). Daley has also written about the resistance that was encountered with the initial development of the unit.

Kathleen Sciacca, MA is the founder of Sciacca Comprehensive Service Development for Mental Illness, Drug Addiction and Alcoholism (MIDAA) in New York City. She is a Mental Health Program specialist for the State of New York's Office of Mental Health and has lectured and developed programs throughout the country for the DD population ("Sciacca Comprehensive Service Development for Mental Illness, Drug Addiction and Alcoholism" 1-3).

Sciacca's contribution to the field of DD has been great. She developed the MIDAA Service Manual for the DD patient. It is a step by step approach to integrated treatment. She brought to the forefront the need for a common language and the need for clear and accurate assessments and diagnoses in "An Integrated Treatment Approach for Severely Mentally Ill Individuals with Substance Disorders" (2). She supported the New York State Commission on Quality of Care for the mentally Disabled use of terminology such as Mentally Ill Chemically Abusing, (MICA), Mentally Ill Chemical Abuse and Addiction (MICCA) and Chemical Abusing Mentally Ill (CAMI). She defined the differences and explained what MICCA and CAMI entailed:

1. Severe mental illness exists independently of substance abuse; persons would meet the diagnostic criteria of a major mental illness even if there were not a substance abuse problem present.
2. MICAA persons have a DSM-III-R, Axis I (American Psychiatric Association, 1987) diagnosis of a major psychiatric disorder, such as schizophrenia or major affective disorder.
3. MICAA persons usually require medication to control their psychiatric illness; if medication is stopped, specific symptoms are likely to emerge or worsen.
4. Substance abuse may exacerbate acute psychiatric symptoms, but these symptoms generally persist beyond the withdrawal of the precipitating substances.
5. MICAA persons, even when in remission, frequently display the residual effects of major psychiatric disorders (for example, schizophrenia), such as marked social isolation or withdrawal, blunted or inappropriate affect, and marked lack of initiative, interest, or energy. Evidence of these residual effects often differentiates MICCA from reputations of substance abusers that are not severely mentally ill. (1-2)

To differentiate persons who have severe alcohol and/or drug addiction with associated symptoms of mental illness, but who are not severely mentally ill, the term *chemical abusing mentally ill* or CAMI has emerged. These persons can be described as follows:

1. CAMI patients have severe substance dependence (alcoholism; heroin, cocaine, amphetamine, or other addictions), and frequently have multiple substance abuse and/or polysubstance abuse or addiction.
2. CAMI persons usually require treatment in alcohol or drug treatment programs.
3. CAMI persons often have coexistent personality or character disorders 9DSM-III-R, Axis II) (Solomon, 1982).

4. CAMI patients may appear in the mental health system due to "toxic" or "substance-induced" acute psychotic symptoms that resemble the acute symptoms of a major psychiatric disorder. In this instance, the acute symptoms are always precipitated by substance abuse, and the patient does not have a primary Axis I major psychiatric disorder.
5. CAMI patients' acute symptoms remit completely after a period of abstinence or detoxification. This period is usually a few days or weeks, but occasionally may require months.
6. CAMI patients do not exhibit the residual effects of a major mental illness when acute symptoms are in remission. (3-4)

Sciacca first developed the MICAA/MIDAA treatment model in 1984 (See Appendix F). Sciacca was a pioneer in the use of "programming based on the nonjudgmental acceptance of all symptoms and experiences" of both disorders (Dual Diagnosis of Major Mental Illness and Substance Disorder 73). The correlation between her nonjudgmental acceptance philosophy and the widely publicized motivational interviewing technique (MIT) is illustrated in the Chart in Appendix G.

MICAA treatment groups were implemented as a component of existing mental health treatment or as an integrated program exclusively for MICAA.

The MICAA process began by engaging the patient in a nonconfrontational manner in order to build a therapeutic trusting relationship (73). There are many advocates of this approach. Also, there are documented findings that this approach is more beneficial when

working with the DD patient. See Appendix H for examples of the change process and motivational interviewing techniques.

CHANGE

In looking at the various treatment models and systems one can see the need for delivery systems to make changes in their current treatment practices to provide better services for the DD patient. These changes cross the entire system of organizations. They include issues such as staffing, education, effective patient assessment tools, and specifically, change in resistance issues.

In looking at the DD population and the various challenges that this population presents for the treatment team and the trend toward the integrated models, it is vital to address these issues. The treatment philosophy is changing and there is blending of two separate entities, that of the mentally ill and the addiction entity. These changes have made it necessary to address the change process and resistance to change. On the federal, state, and local levels there has been a need to integrate services for the DD population. As reported earlier, there has been conflict between the mentally ill delivery service and the addiction delivery service. Although this conflict was due to different philosophies, the need to change also impacted this conflict, specifically the resistance to change.

People and organizations do not change simply for the sake of doing things differently. Usually there is some type of cause or force for the

change. Stephen P. Robbins, author of Management has written that there are external forces and internal forces that necessitate change (530). The external forces are: The Marketplace, Laws & Regulations, Technology, the Labor Market, and Economic Changes...Internal forces are: Organizational strategy, The Workforce, and Employee Attitudes (531). Many of the changes toward integrated treatment for the DD patient are a result of external and internal forces. Externally, the service delivery systems saw an increase in the number DD patients (the Marketplace), which were not being serviced effectively. Both the mental health delivery system and addiction delivery system fell short in this area. Also, due to economic changes (an external force), funding for the DD patient was limited. Many patients had their funding for housing and treatment for mental illness canceled when they sought treatment in the addiction's delivery system (RachBeisel 1432). Internal forces that have effected change in treatment with this population have been the strategies used for treatment, the different philosophies of the workforce, and attitudes that employees have toward this population. According to Robbins, "implementing change in an organization should be seen as a response to the status quo and needed only in occasional situations...Change is a natural state and managing change is a continual process" (Management 532).

Reasons for resistance to change can be many. They may also have individual meanings. Robbins cited three reasons for change resistance: "uncertainty, concern over personal loss and the belief that the change is not in the organizations best interest" (534). The Change Book A Blueprint for Technology Transfer, by addiction technology transfer centers (ATTC), reported, "staff can be resistant to change due to many factors including: lack of understanding new information, lack of incentive for change, competing priorities, funding limitations, fear of failure and a general fear of change" (19). Robbins further stated that;

> Changes substitute ambiguity and uncertainty for the known. Change threatens the investment one has already made in the status quo. The more they have invested in the current system, the more they resist change, due to fear of the loss of status, money, authority, friendships, personal conveniences or other benefits they value. (534)

Techniques that can be used to reduce resistance and bring about effective change proposed by Robbins:

- Education and communication
- Participation
- Facilitation and Support
- Negotiation (535-536).

Techniques that can be used to reduce resistance and bring about effective change proposed by ATTC.

- Directly address resistance
- Discuss the pros and cons openly
- Provide incentives and rewards
- Celebrate small victories
- Actively involve as many people as possible from the beginning
- Emphasize that feedback will shape the change process
- Use opinion leaders and early adopters for training and promotion
- Listen to fears and concerns
- Educate and communicate
- Develop realistic goals (21).

EDUCATION

One of the most effective ways to deal with change resistance is education and effective communication. The educational needs of staff working with the DD population are many. Also, education goes hand in hand with communication. The staff working with this population are faced with many issues, not only in regards to resistance to change, but also with the immediate needs of the patient. The literature supports the severity of the patients admitted to public hospitals. Mark S. Gold and Andrew E. Slaby, editors of Dual Diagnosis in Substance Abuse have written, "public psychiatric hospitals typically admit patients whose mental illnesses are acutely disruptive, severely, debilitating, or life threatening" (145). A patient presenting with this magnitude of care needs a staff that is knowledgeable and competent to address their needs. Also, staffing

must be available to respond to their physical, emotional, and spiritual needs in regard to their mental illness and substance abuse problems. Edward L. Hendrickson, et al. authors of "Supervising Staff Treating the Dually Diagnosed" have stated, "usually a clinician will bring to this work a proficiency in treating either substance use or mental disorders but not both" (1). Recommendations were made as follows:

> The need to cross-train staff providing dual diagnosis treatment. Trained substance abuse clinicians increase their knowledge and skills in the areas of mental disorders: medication used to treat mental disorders; how these disorders can affect functioning levels; how to be more flexible and less directive in the treatment approach; and reducing the level of self disclosure. Trained mental health clinicians should increase their knowledge and skills in the areas of psychoactive drugs and their effects; the nature and treatment of addictions; the importance of abstinence; the importance of self-help groups; how to deal effectively with court-ordered individuals; how to be more concrete, directive, and confrontive in their treatment interventions; and increasing the level of self-disclosure. (1-2)

The literature reflects the need for cross-training staff to enable them to better address and respond to the needs of the DD patient. This had been seen as a concern on the DD unit that will be examined. There is a need not only to educate all levels of staff in the context of what DD is, but also what are the most effective ways of treatment. Education on the subtle and not so subtle mechanics of manipulation, transference and countertransference must be reviewed. Dennis Daley et al has written, "before staff can feel competent to deal with the DD patient, staff members

will likely need thorough training" (201). Ken Montrose and Dennis Daley have written in Celebrating Small Victories that "Too many professionals do not want to treat both mental illness and substance abuse because they do not think they are competent to do so" (59). According to Joan E Zweben, author of "Dual Diagnosis Key Issues for the 1990's", "cross training is a key factor to determining the effectiveness of treatment efforts in the long run" (4). Zweben advocates that "training in the integrated assessment and treatment of the DD patient be a required component in the curriculum of professional" (4). Solomon et al in their book Dual Diagnosis suggest that "education and the 'sharing of knowledge' between mental health and the addiction field 'will help' bridge the gap and lead to specialized program development" (17). These are just a few of the individuals who are proponents for education of staff. This training should include the requirement of mental health staff to attend AA/NA meetings along with Alanon meetings to gain an understanding of addiction and learn about the recovery process. This is supported by Montrose and Daley who also believe that training should include workshops, lectures, seminars, and case discussions and readings (59).

Research in the field indicates that communication is the most powerful tool that the treatment team and its members have to use in assisting the patient toward recovery. Therefore it is vital for team members to understand the impact that communication plays in the therapeutic

environment along with the frequent causes of miscommunication that can create havoc in a therapeutic milieu. Since the DD patient has been considered by most authorities as one of the most challenging and difficult patient populations, it is necessary for all individuals working with this population to be aware of communication patterns and psychological issues that may impede the progress of treatment (Drake et al, The Course, Treatment, and Outcome...45).

Two of the most common occurrences in working with all patients are transference and counter-transference. Both are intensified when working with DD patients. According to Katherine Fortinash and Patricia A. Holoday, authors of Psychiatric Mental Health Nursing, transference has been defined as an unconscious response whereby a client / patient associates the staff member with someone significant in his or her life and acts on those feelings (194). R. Beckmann Murray and Huelskoetter defined transference as;

> A process whereby the client inappropriately, unrealistically, but unconsciously displaces onto you or invests in you the patterns of behavior and emotional reactions that originated with authority figures in childhood, usually parents...Transference is not simply positive or negative, and it is not age or sex related. It is a recreation of the various stages of emotional development or a reference. Negative transference may have been viewed as acting out (165).

Solomon et al view transference as "the displacement of patterns of feelings, thoughts, and behavior originally experienced in relation to significant figures during childhood onto a current interpersonal relationship" (131). Countertransference on the other hand is the caregiver experiencing the phenomenon of an unconscious, inappropriate emotional response to the client as if he/she were an important figure in their life or unconsciously based in past unresolved experiences with key people in their life. The staff relates to the client in much the same way that the patient does in transference.

Solomon et. al. reported that, "feelings of frustration, anger, incompetence, and powerlessness are common among mental health professionals who encounter and/or work with people who are dually diagnosed" (127). Studies of the attitudes of mental health and addiction clinicians toward alcoholism and mental illness indicate the existence of negative moralistic attitudes, and insufficient knowledge in relation to those who have DD. ("Countertransference and attitudes in the context of clinical work with Dually Diagnosed Patients", 127).

The author has worked with this population for the past several years, in my view educating the staff in regard to this concept of countertransference is much needed throughout all levels of the treatment team. There have been psychiatrists as well as psychiatric aides caught in the crossfire of transference and countertransference. Although most

staff members have good intentions, they are not always aware of these concepts and the impact that it could have on the patient and themselves. I have observed patients getting into power struggles with staff and vice versa, with some team members taking sides. This is a classic example of the interactions often encountered in working with DD individuals. Often the staff does not view the patient as having an illness, just an addiction, and the patient has been seen as being manipulative and prone to game playing.

Solomon et. al. lists some clear-cut examples of statements that were made by professionals indicative of the attitude they have toward this population of patients.

> "I didn't become a psychiatrist to treat drug addicts."
> "He's manipulative and sociopathic. So what if he's hearing voices, he's an addict."
> "These patients sabotage themselves and us. They've alienated everyone in their lives...All they care about is getting the drug". (128)

As for the last statement, when asked how her experience with the patient population affected her feelings about her job, this individual replied, "I dread coming here in the morning". Attitudes such as this are common within this population. The DD unit that is being examined by the author unfortunately includes staff members with this attitude. Nursing staff that had to be reassigned to this unit at times voiced their displeasure at

having to work with this population of patients, and exhibited many hostile, non-caring attitudes. Many of the professionals, administrative staff, and other disciplines view this population as alcoholics, drunks, or addicts who manipulate everyone. Staff from other units has confronted the DD staff with statements such as, "you all let these patients get way with whatever they want", and "they're just manipulating you". Many individuals do not want to work with the DD patients. For this reason, "the degree to which learned negative attitudes contribute to an increase in the clinician's vulnerability to negative countertransference must be considered" (Solomon et al 133). In light of this and because "Countertransference is always an active element of therapeutic work", it is part of all types of therapeutic environments. Also, "Countertransference, like transference, can function as one of the most valuable tools available to the therapeutic relationship or the opposite, a danger to the therapeutic relationship" (Solomon et al 143).

This chapter has given a review of the literature and has defined the various types of treatment models. Some of the obstacles and challenges that the DD population face have been examined. In the following pages the author will examine and present a case study of an the operations within an acute DD unit. The review of this case study is intended to illustrate the need for the redesign of the DD unit.

Chapter 3

A Case Study of An Acute Inpatient Dual Diagnosis Unit

The administration at Metropolitan St. Louis Psychiatric Center began to look at the need for a dual diagnosis unit in 1996. Dr. Collins E. Lewis developed a proposal for a Dual Diagnosis Unit (DDU) in January of 1996. At that time he wrote, "statistics indicate approximately one-third of the patients treated at the facility had a primary or secondary chemical dependency diagnosis" (Jan., 1996)...He also said, "when the chemical dependency diagnosis is primary, there is almost always a secondary psychiatric diagnosis" (1996). A review of the Program Description written by Dr. John Csernansky, Medical Director stated:

"The primary rationale for forming the DDU was the realization in 1995 and 1996 that a significant subgroup of psychiatric clients treated at MPC had a primary or secondary diagnosis related to chemical dependency or abuse on admission (1, 1999)." Dr. Csernansky went on to explain:

> January through June of 1995, an average of 15 percent of clients had diagnosis related to chemical dependency or abuse on admission. However, by the time of discharge, a much larger percentage of clients, (40%), had a chemical dependency or abuse diagnosis, suggesting that such problems are not always apparent upon initial evaluation of the client. Finally, when the chemical dependency diagnosis was primary, there was almost always a secondary psychiatric diagnosis...(1999)

The proposal addressed personnel need, space allocation, and criteria for admission to the program, and anticipated length of stay as well as programming. This proposal indicated the essential components of an inpatient treatment program as well as a day hospital and evening aftercare programs with Alcohol Anonymous (AA) and Narcotic Anonymous (NA) support.

With this data in mind and with research indicating a growing number of patients who would be diagnosed as DD, the administration at MPC went forward with a separate, distinct DD unit. This change process was driven by MPC's internal and external environment. As previously stated, there was an increase in the number of patients diagnosed with co-occurring disorders admitted to MPC. The external influence can be seen in a nationwide study by Charles Maynard, Ph.D. and Gary B. Cox, Ph.D., authors of "Psychiatric Hospitalization of Persons With Dual Diagnoses: Estimates From Two National Surveys" report. Their study looked at the number of clients discharged with a DD from community hospitals nationwide with a dual diagnosis. They chose to exclude state and federal psychiatric hospitals. Their results reflect that patients with dual diagnoses accounted for 17 percent to 19 percent of psychiatric hospitalizations in the National Hospital Discharge Survey (NHDS) in 1990 and 1994. In another survey, the Nationwide Inpatient Sample (NIS) which had more secondary diagnosis codes, the DD patient constituted 25 percent of hospitalizations for mental disorders (1616) (See Appendix I).

PLANNING

The administrative team continued to gather data to support having a distinct unit. Planning initiatives continued and it was decided that 2 East would be converted to the DD Unit effective October 1997. The conversion was successfully implemented as scheduled.

There was little knowledge to draw on in regards to integrative acute inpatient DD models. Much of the research focused on "hybrid" models. These models encompassed building or developing integrated programs within existing systems.

The administrative team sought out experts in the field of dual diagnosis and addictions to assist them with education, training and program development. Kenneth Minkoff, M.D., an expert on dual diagnosis was brought in to educate staff and assist with the development of a program model. His conceptual model was considered for the unit. Dr. Minkoff presented to the administrative team and senior staff members. Dennis Higsbee, another expert in the field was brought in to educate and train the front line staff.

In looking at the planning process for the unit several questions came to mind. Was there a written description of how the unit was to function? What were the objectives of the unit? What was the mission and vision?

After reviewing several pieces of correspondence, it appeared that the administrative team met consistently for planning and development. However, the author could not determine if they focused on all aspects of

planning and whether the planning was formal or informal? Although the objective was to develop the DD unit, little to no written data was found to support this. No detailed plans where found to see what specific objectives would be used in the development of a comprehensive, prioritized list of plans for coordination, development, integration and implementation of activities. With this planning background, the author concluded that in essence there was no formal planning for the unit. Robbins, author of Management defined formal planning as a sharing of specific objective among others in the organization. These objectives are developed over a period of years and committed to writing. Detailed guidelines are given for the accomplishments of the objective (192). One of the goals of this paper is to document detailed guidelines to assist the unit in functioning and establishing precise objectives.

In regard to the unit under study, it appears that informal planning was used frequently. Informal planning consists of verbally communicating the objectives. There is little to no documentation of the objectives or the action plans needed to bring the project to light. "The planning is general and lacks continuity" (192). Indeed, the author could find no operational plans. These plans would have shown how the overall objectives would have been met. Also, there was a lack of specific plans which would have "clearly defined objectives, leaving no room for interpretation"(194). However there were some directional or flexible plans that provided general guidelines (Robbins 194).

No evidence was found in reference to the administrative team developing strategic plans. Neither long nor short-term documented plans could be found. There was no mission or vision statement for the unit. No written objectives could be found either.

There was an outline of the admission criteria and discharge planning along with a detailed plan for programming that involved the various groups and therapies. Unit rules and guidelines were developed but the author feels they left room for inconsistency when applied. Also they were interpreted differently by several of the treatment team clinicians.

Staffing

When the writer began managing the unit several concerns were at the forefront, of immediate concern was a staffing crisis. There was a shortage of day and evening shift Registered Nurses (RNs) in addition to a shortage of psychiatric aides on the evening and night shift. Not only was the unit understaffed, the staff was being pulled to cover other units. Similarly staff from other units were being pulled to 2 East when needed. This shifting of staff led to inconsistent and inadequate coverage, which fueled inconsistency among staff. These actions could predispose the patient to less than favorable outcomes, making treatment more difficult for them. A lot has been written about the poor outcomes of the dually diagnosed patient. In the Integrative treatment model Video, Part (1) Minkoff reported that this population was difficult, exhibited self-destructive behavior and had poorer outcomes (1997). Literature would appear to

support the fact of DD patients being more difficult to treat. Although this is a commonality, there was no adjustment for staffing the DDU. Mark S. Gold and Andrew E. Slaby, editors of Dual Diagnosis in Substance Abuse wrote; "Public psychiatric hospitals typically admit patients whose mental illnesses are acutely disruptive, severely, debilitating, or life threatening" (145). This level of acuity requires not only a staff with the knowledge base and competency to assess and provide treatment for these patients, but adequate staffing to respond to their needs. Their physical and emotional needs as well as substance disorder concerns need to be treated. Quality treatment can be lacking when there is inadequate staffing patterns and staff that are not trained in DD or addiction. It has an impact on patient outcomes and a safe therapeutic milieu.

When staff are inadequately trained or have no interest in working with this client population, other issues come to the forefront. Unfortunately, this unit had staff that would sabotage various aspects of the program. Some did this intentionally while others were unaware of their actions due to the lack of training. Many of the staff were comfortable being pulled to other psychiatric units, however, they were afraid and exhibited resentment when they were pulled to the DDU. This added to the confusion and inconsistency of the staff. Although most of the staff was knowledgeable about mental illness/psychiatry, many were lacking in knowledge about dual diagnosis and addiction.

Education and Training

According to a memo from Doug Grob, the administrative team chose Kenneth Minkoff, MD as trainer for the "senior staff". Dennis Higsbee, another expert in the field, provided training for the direct care staff. The author feels that more education and training should have been provided prior to the dedication of the DDU, however this did not happen. The staff that agreed to work this unit should have been given clear directives on how the unit was to function and what was expected of them. When this writer took over the unit, the direct care staff (some nurses and psychiatric aides) felt that the clinician staff, physicians, psychologist, and social worker were not supportive of them. They perceived that when patients acted out, they had to be in the forefront in controlling the patient and the latter group was there only to watch. This environment led to the need for team building, which began with the clinical treatment first and encompassed team building with all staff. Like education, team building is an ongoing process. Both are major components in developing a therapeutic milieu (program).

The education and training that was provided was a good point of reference for the staff. It provided a general knowledge of the concepts of dual diagnosis: Barriers to treatment, what type of treatment would be provided and what community resources were available for the clinical staff. Issues that would affect the staff personally, such as manipulation, transference and counter-transference issues went lacking. Minkoff talked of this briefly in the video "An Integrative Model". He spoke of the difficulty

that the DD population evokes for clinicians due to their ability to "stir-up" feelings in staff...staff needs to be able to deal with these feelings (1997).

In looking at the educational and training component, it was interesting to note the staff development team did not become involved in assisting with education and training until August, 1997. Since this department is charged with the task of developing and overseeing issues pertaining to staff education and training, they should have been involved in the process much earlier.

Another educational process that was lacking was a formal orientation program for new employees. Along with this should come DD addiction competencies for all staff. A formal orientation program would have been very beneficial since there was a high staff turnover rate. Also, it would have educated new employees in the concept of dual diagnosis. Again, the lack of education can limit the clinician rendering quality treatment and has an impact on the safety of the milieu.

Educating, not only the DDU staff but also the hospital as a whole in the concepts of dual diagnosis is essential in order to decrease the stigma associated with this disease. Actually the effort to integrate a system should be "organization wide", providing education for all levels of staff. Managers and other clinicians also need to be advocates for these patients. Many will need to change their mindset about patients who are afflicted with addictions. They are not to be viewed as "system misfits" who do not fit into the general program; they are rapidly becoming the

norm in psychiatry rather than the exception. Therefore it would behoove staff and clinicians to embrace this change.

Program Development Issues

Currently programming has limited motivational structure built into it. The DDU consist of a two-tier program. The first is the Acute Detoxification and Psychiatric Treatment (ADAPT) program that patients are admitted to, and the second is the Active Recovery and Treatment (ART). Detoxification and acute stabilization of psychiatric symptoms are treated in the first phase. However, there are many patients who stay in the ADAPT program due to their functional status. Others progress to the second tier. However there are no written guidelines to assist the clinical staff in determining when to progress a patient from one level to the next. After detox and stabilization, the unit psychologist and the rehabilitation staff discuss whether the patient is ready to be moved to the next level. They will often collaborate with other members of the treatment team for input into the decision.

With the exception of one group, patients from the ADAPT and ART programs attend most of the same groups and classes. The group leaders can decide if a patient is appropriate or not appropriate for a group or class. Again, there is no documentation as to what type of behavior is acceptable and what is not. It is mainly subjective rather than objective. However, patients who are disruptive are not allowed in groups/classes. Neither of these tiers fully addresses the negative, disruptive, and

destructive behaviors of the patients. Also this was subjective and many times the treatment team members were at odds with the physician and vice versa about the consequences applied to patients who were threatening, manipulative and destructive toward others (patients and staff) staff members and property. A program needs to be developed to eliminate as much subjective decision making as possible and incorporate a conceptual framework that can move the patient along a treatment continuum.

Another program issue is that the clinical staff has had minimal training in motivational interviewing skills. This approach is becoming a standard practice in servicing the dual diagnosis client. According to William R. Miller, Consensus Panel Chair for Enhancing Motivation for Change in Substance Abuse Treatment:

> Motivational interviewing is a therapeutic style intended to help clinicians work with clients to address their ambivalence. Also, during this interview the clinician's approach is directive yet patient focused, with clear goals of eliciting self-motivational statements and behavioral change from the client and seeking to create client discrepancy to enhance motivation for positive change...(xix 2000)

These skills will help the treatment team and the program become more responsive in meeting the needs of the patient. It will assist the clinician in meeting the patient at whatever phase/level they are.

Admissions

Currently the DDU admits all patients through the emergency room. A small number of patients are transferred from other units after being evaluated by a DDU psychiatrist. This unit has five designated beds for involuntary court committed alcohol and drug addiction (ADA) patients. The current criteria for admission to the unit is as follows: The patient has a severe axis I diagnosis coupled with a substance use disorder. This can include intoxication, impending delirium tremors and psychosis. Initially patients who were medically unstable or who have severe mental retardation, severe organic brain syndrome or severe physical problems were not to be admitted to the unit because of their inability to participate in programming. Also, patients diagnosed with only an axis II diagnosis did not meet criteria for admission to the DDU initially. Although this criterion was adopted and used when the unit opened, it is no longer followed as stringently. The DDU accepts most if not all patients with these diagnoses for treatment. This creates a unit atmosphere of confusion many times, because staff are not only faced with disruptive behaviors but they also may be faced with medical and psychiatric crisis. With limited staff having limited knowledge of addictions/DD it can be difficult to be all things to everyone. Indications would appear to lead to the need to clarify what the unit wants to be and on which patients they want to focus.

The ADAPT program allows for continued assessment and clarification of the diagnosis through interviewing and some testing. Originally, there was consideration of conducting further tests such as the CAGE, MAST, and ASI tests for substance use clarification. However a modified MAST assessment tool was developed and is being used for Emergency Rooms and the DDU. It has two sections. The first section of the assessment is to be completed by the emergency room physician, and the attending physician is to complete the second section of the assessment after interviewing the patient on the unit. This assessment tool is not as comprehensive as other tools in assessing for substance use disorders. It does allow for some self-reporting by allowing patients to answer specific questions related to substance use disorder. However there is objective data solicitation too. It is the responsibility of the admitting physician to assess the patient and determine whether the patient has a dual diagnosis and is to be admitted to the DDU. However there are concerns with this process. Many of the physicians who worked in the emergency room are not well versed on what signs and symptoms they need to look for in DD patients. Also, many do not take into account the importance of good historical data in assessing the patient. This can lead to patients being misdiagnosed or not treated at all for their substance abuse. Although many have had some training in the addiction field, it is limited. Goldsmith and Miller reported,

> Several reports have recommended content for model curriculum in alcoholism and the addictions...Yet the adoption of model curricula is constricted by inconsistent and superficial training in the addictions provided by medical schools. Because addictions are covered only superficially in their training, many residents do not know the basic information about neuropsychopharmacology, medical and surgical pathology associated with drinking and the addictions, the DSM-III-R diagnostic criteria for alcohol/drug related diagnoses, or that effective treatment is available. (433)

Most literature on dual diagnosis emphasizes the need for an accurate assessment and diagnosis because an accurate diagnosis leads to the most appropriate and beneficial treatment for the patient. Appropriate assessment and diagnosis will have a bearing on the length of treatment in the ADAPT phase. The length of treatment in the ADAPT program is between five and seven days. After detoxification and/or acute stabilization of the symptoms, the patient may be ready for another phase of treatment, in which the patient is advanced to the ART program or the patient can be discharged. Many times the patient has not taken ownership of their addiction and demands discharge after completing the ADAPT phase which indicates that the patient is not fully engaged in their treatment.

If the patient is vested in his treatment, cognitively functional, and follows the guidelines that have been set, he/she is advanced to the ART program wherein the patient continues to work toward discharge. There is no set time frame for completion of this phase and the patient may be

discharged at any point during this phase. It is hoped that patients in this phase show a willingness to participate actively in their treatment. The original plan for the ART phase had the following criteria: It would receive patients from the ADAPT phase, other units, or 21 day court committed transfers from other facilities. In general, the patients were not to have any signs of active self-harm or assaultive behavior and were to participate in the program without disruptive behavior. The initial anticipated Length Of Stay (LOS) for the ART phase was twenty-one days.

Actually, the patients' LOS could range from 1day for some to seven or eight months for others. This depended on the patient's response to treatment as well placement issues. This broad treatment range created many concerns within the program. There have been differences between treatment disciplines due to the rationale for keeping patients longer than many deemed necessary or discharging them too soon. The author feels that the criteria need to be developed for both phases of treatment.

Discharge planning begins at the time of admission. Family members and significant others are to be involved with discharge plans with the agreement of the patient. The patients are to attend a discharge-planning group to prepare for discharge. These groups are held weekly and are facilitated by a social worker. In accordance with the social worker, the Substance Abuse Counselor assists patients who are being discharged to treatment facilities with discharge plans.

Self Help Groups

Currently the unit has AA and NA groups twice weekly. Someone from the community usually leads the groups. When community facilitators are not available, one of the staff members steps in. However, when this staff member is not available the group may or may not convene. Again, everyone who works the DDU should be knowledgeable of 12 step self-help groups in order to function satisfactorily in this role.

Overall, the fact that the DD unit is a separate and distinct unit is an asset or strength. It allows for the concentrated efforts to be focused on one unit rather than on every unit in the hospital. This allows for the development of a concentrated workforce to gain expertise in working with the DD population through repetitive hands on experience. Along with this is the staff's willingness and flexibility in working with this population. Also, although the staff lacks knowledge of addiction and dual diagnosis most are eager to learn. Another strength is the fact that the administration supports the development of the unit.

Lack of a strong conceptual underpinning has led to inconsistency in the program. There is no clear direction as to what sub-group of the DD population, if any the unit wants to focus on. Clear and adequate assessment tools need to be put into place to optimize the admission and treatment process. Lack of team cohesiveness is a weakness. This is due in part to the rapid turnover of staff and resistance to change. The timeframe that it takes to get approval from administration for things such

as the unit guidelines, the level system, and dietary needs is too long. Decisions that are made above the program level by individuals that are not always familiar with the functioning of the DD unit or with the dynamics of serving this population.

Chapter 4

The purpose of this chapter is to suggest changes that need to be implemented in order to make the DDU operate more effectively. It will serve as a formal plan and proposal for change.

Planning – Organizational Change

Planning is a vital part of program development. It is essential for formal planning to be conducted and the results implemented as needed and according to plans. However those plans need to be well grounded and thought out. Solomon et al. cited Eugene Bardach for an introduction to their chapter on "Program Development", which I feel is quite appropriate: "First things first. It is impossible to implement well a policy or program that is defective in its basic theoretical conception" (239). With this in mind, the author feels it essential in redesigning the DD unit to have well grounded formal plans that have a strong theoretical base on which to build. Not only is it important to have a strong base, it is necessary to have a well-documented plan of action to follow when implementing change. It is critical that you have a leader who understands the planning process and will be able to monitor the implementation of change.

In Dual Diagnosis, the following concerns are addressed in regard to DD programs. "Programs often lack well-organized systems for assessing, diagnosing, and planning treatment for a number of patients, in the context of resource limitations...Although there is no 'one best day' to

the context of resource limitations...Although there is no 'one best day' to treat all patients, individual programs need a unified and coherent clinical vision" (Program Development 240).

Lacking an well-organized system may reinforce the clinical uncertainty that is likely to exist regarding the DD patient. It is important for the program leader to set priorities and complete them no matter how difficult and hectic the task may be. Clinicians who have the responsibility of developing and managing DDU or other programs have a tendency to lean toward clinical issues rather than toward organizational planning and management processes (241). Failure to focus on planning and implementation of priorities can lead to a standstill within a program. This standstill can create confusion among the staff and patients and lead to a deterioration of the program. Without plans and priorities a program can unravel quickly.

The DD unit had several incidents from its inception, which brought to light the need to carefully assess the way the unit was developed and functioning. Some of these incidents involved patient and staff safety. Others involved the inconsistency of treatment and conflicts between members of the treatment team. There was no adequate structure or consequences in place to address the patient's sometimes aggressive or assaultive behavior and occasionally patients when they felt or knew there would be no consequences would verbally abuse the staff. One team member felt this was to be expected from the DD patient and the staff

should be able to handle the abuse. Lack of understanding of such basics as transference and countertransference issues made the author realize the lack of education the team had in working with this population.

At this point the author felt the need to put into place some structure that would assist patients with controlling their behavior. Based on that need, a level system was discussed. However several team members did not believe a level system was feasible. Due to the fact that the team was not as cohesive as it needed to be and that there was a lot of conflict between individuals, the author began team building exercises to foster good communication and to develop a more cohesive group.

Upon review of these issues with the administration became apparent that there were no mission or vision statements, therefore, no clear direction as to how the unit was to function. When the team did agree on a resolution to a problem, it had to be submitted to the administrative team for approval before it could be implemented. This led to long delays and staff frustration.

Rather than continuing to meet with the administrative team in regard to the concerns of the unit, I asked the administrative team to meet with the treatment team collectively to discuss their concerns. There were several meetings held between the treatment team and administration. The meetings resulted in some positive outcomes. One of the requests was additional staff as there were five vacancies on the unit at the time. Although the author had repeatedly asked for resources for a retreat away

it initially was denied. However they did have a consultant come and work with the staff on a level system. Although the team worked with the consultant for a period of time they were not in agreement with his proposals and ideas. Another meeting was held and permission was granted for the retreat to be held away from the facility with an independent facilitator. A Mission and Vision statement was agreed upon.

Most of the planning has come about through monitoring and observing the functioning of the unit and the team members. Although many plans were developed, the author feels that it was difficult to implement them effectively due to the nature of a mechanistic/bureaucratic organization. In essence the decision making body is not at the program level and proposals have to be sent up to other committees for approval. It took over one year to get approval to stock more food on the unit for the DD patient although documentation giving support as to the nutritional needs of DD patients was provided to administration.

Planning has been an ongoing process on the DD unit. The current plan is to implement the level system that the team developed to add structure to the program for the patients. We also look at additional ways to improve staff and patient safety. The treatment team will review and incorporate the special needs of the patient population. Programming will focus more on the DD patient and their treatment of the DD patients will be guided by the best practices. A formal orientation program is being

be guided by the best practices. A formal orientation program is being developed specifically for new DD staff. Unit based competencies are also being developed and will be implemented

Staffing Needs

Chapter three discussed the staffing shortage this author encountered when initially assuming responsibility for the DDU. Although there has been slight improvements concerning the staffing situation, there remain vacancies for licensed staff on the evening shift and for direct care staff on all three shifts. Additionally there is a high turnover rate on this unit and throughout the hospital; this may be indicative of staff burnout. The DD population is known to be far more challenging and problematic which can lead to a "high staff burnout rate" (Solomon et. al. 241). Knowing this has led to continuous assessment and planning of staffing patterns with recruitment and retention as a priority. As Ginger Shullanberger, author of "Nurse Staffing Decisions: An Integrative Review of the Literature" reported:

> Protecting patients and providing them with the best possible care in order to promote healing with a return to their optimal level of functioning is central to nursing...Having an adequate number of knowledgeable trained nurses is imperative to meet these outcomes. (125)

The normal staffing pattern for the DDU is to two licensed staff and three direct care staff. This pattern has been applied to both the day and the evening shift. The night shift's normal pattern is one licensed staff and

three direct care staff. Most the time the unit functions with the normal pattern and on occasion with more staff. However there are times when the unit functions with less than the normal pattern. This occurs more on the evening and night shifts than on the day shift. There is an acuity system that is used to determine the needs of each unit. However it does not delineate the difference in the treatment of DD patients from the general population, it treats all units the same.

The current staffing system does not take into account the vast number of admissions and discharges to the unit. Admissions and discharges are the sole responsibility of the RN who must complete the admission assessment and document an admission note. Also on discharges they must review the discharge medications with the patients, have them sign they have provided this education, and document pertinent information about discharge.

The author feels the process places too large a share of the workload on the RN. The DDU has one-third to one-half more admissions and discharges per month as compared to the other units. There have been times when there was an RN and LPN assigned to the unit as the only licensed staff. The RN assumes the charge position and the LPN is responsible for medications. Although there are times when there are no admissions and discharges however there can be a many as seven to eight admissions a day and four to six discharges a day. This additional work remains the responsibilities of the charge nurse. Not only is the RN

responsible for the aforementioned task, she is responsible for the unit as a whole. The RN will oversee medication dispensement, co-sign physician orders and maintain a safe therapeutic environment. For the most part the charge nurse will intervene in any and all concerns of the patients. This covers a gamut of situations from defusing volatile patients to leading groups or making sure that patients get their valuables from the cashier when needed.

The lack of another licensed person on the DDU can have an impact on the quality of care that is provided. Also, Shullanberger commented on studies that focused on patient outcomes and skill mix citing the:

> need for an optimal skill mix: their findings suggest that a RN to non-RN ration of 85% to 87% yield this result. At this level, there were the fewest number of patient and family complaints, patient falls, medication administration errors and observable decubiti. (147)

For this reason a recommendation has been made to increase the licensed staff to three on the day and evening shifts. Also it is being recommended that a RN position for 1PM-9PM be added to the budget to assist with admissions and discharges. This time frame has been cited as the high volume time for admissions and discharges to the unit.

In addition a recommendation is being made for a head nurse or nurses supervisor position to supervise the nursing staff on all three shifts. This position would be an assistant to the unit manager although the unit manager will retain responsibility for the unit and oversee all facets of

program development. The new position will play a major role in the orientation process of new nursing employees and in monitoring nursing staff competencies. This will help maintain a quality orientation process along with the assistance of staff development.

The unit manager will then take on the responsibility of program development and marketing and will continue to be responsible for designated tasks as well as monitoring the change process. This position will collaborate with individuals on the state level to ensure that the program's goals and functioning is in alignment with the state and federal guidelines.

The author also wishes to recommend that another Substance Abuse Counselor (SAC) be added to staff to provide consistent 12-step programming as well as groups and educational classes for DD in the evening and on the weekends. This position along with the current SAC position will play a major role in the orientation process and in educating the unit staff as well as the hospital staff in the field of addictions and dual diagnosis.

The author's first order of business is to recruit and retain adequate staffing. When this has been completed, the next step will be to move toward a self-contained unit where the staff covers for themselves for off time, providing the DD unit more consistently with knowledgeable and competent staff. They are not to be pulled to other units and other staff members will not be pulled the DDU unless a dire emergency exists. This

will assist in providing more consistent treatment for the patients and is an opportunity to train designated staff from other units to work on the DDU when needed.

In the event that a case management delivery system is adopted there will need to be additional social work positions allocated. The literature does support the use of the case management model in working with the DD patient. Due to the DD patient's inability to become active with outpatient treatment and services, it is reasonable to expect that a case management model would be an option (Organizational Guidelines for DD Programs 154). Mercer et al, authors of "Organizational Guidelines for DD Programs" expressed:

> Case management for these clients must be intensified and reoriented from the usual linkage approach to incorporate individual substance abuse counseling, assertive outreach, and in vivo interventions. Clinical case management for clients with dual disorders includes the traditional clinical case management functions of assessing symptoms, intervening in crises, and coordinating and monitoring medications" (154).

Currently, there are two social workers for twenty-five patients. The workload can be overwhelming at the current staff to patient ratio. To add the responsibility of intensive case management to current staffing would require administration to evaluate the feasibility of such endeavor. However this approach would more than likely decrease the recidivism rate of the DD patient. Patients would be seen more frequently and signs and symptoms of relapse or acute psychiatric episodes could be detected sooner and handled on an outpatient basis.

EDUCATION AND TRAINING

Many experts have identified some of the educational needs for clinicians that work with the DD patient. It has been addressed from the addiction perspective as well as the mental illness/psychiatry perspective. Many entities are cross-training their staff as a prelude to integrative treatment and as a result staff that are expert in the addiction field are learning about mental illness/psychiatry and staff with mental illness/psychiatry expertise are learning about addiction. Since the DD unit that is being redesigned is built on the foundation of mental health/psychiatry, I will be presenting the educational needs for staff working in this area. The authors of "Integrating a Dual-Disorders Program in a Acute-Care Psychiatric Hospital" summed up most of what the author thinks is necessary for staff to know in order to provide quality patient care for the DD patient. These areas are:

> Symptoms of addictions, the relationships between psychiatric illness and substance abuse, etiology of addiction, consequences of addiction, the continuum of care, typical recovery issues or themes, the importance of self-help programs, addiction and the family, and relapse prevention. Understanding denial, ambivalence toward recovery, and the meaning of craving and desires to use substances are especially critical areas since it is common for staff members inexperienced with alcoholics and drug addicts to interpret a patient's denial or ambivalence toward recovery as lack of motivation or indicative of a poor prognosis. (49)

All clinical staff will be expected to attend training and become competent in these areas. Training will be provided through unit inservices using didactical methods, conferences, lectures, case presentations, cross-training efforts, and the review of periodical and journal articles that focus on DD.

Other critical areas of education that will be addressed will be transference and countertransference and the effects on staff's attitudes toward this population. Team building also is a vital element in the development of this program.

PROGRAM ISSUES

A theoretical model based on an integrative approach will be implemented. This will serve as a foundation for the DD unit. This model will allow staff to meet the patient at whatever level that may be, in their effort to provide treatment. It is a stage-wise model that encompasses the Engagement stage, the Persuasion stage, the Active Treatment stage, and the Relapse Prevention stage. The model will define and give goals for each stage. Relevant clinical interventions will be given for each stage. Kim T. Mueser et al, authors of "Integrated Mental Health and Substance Abuse Treatment for Severe Psychiatric Disorders" have succinctly explained this model as shown in Appendix J

A level or stage system has been developed and is in the process of being approved for implementation. This level system is aimed at providing more structure in the program for patients and to assist with

motivation. After implementation it will be evaluated to ascertain its effectiveness after a six-month and a twelve-month period. In addition this system will be analyzed to see if it can be incorporated effectively into the theoretical model that the unit implements. The treatment team hopes that this level system will foster positive behavioral responses.

The two tier system of ADAPT and ART will be integrated into the theoretical stage-wise model. With this integration should come a clearer perspective of the level of treatment needed by the patient. A concise set of criteria will be used to determine the patient's level of functioning. Hopefully, this will also move the patient along in treatment.

ADMISSIONS

One of the goals for the treatment team will be to evaluate and decide on the type of assessment tools to use for the initial assessment for substance use. It will be necessary to make this determination as soon as possible and implement the selected tool. It may be necessary for two or more tools to be used to gain a clearer perspective of the substance use of the patient.

After determining the tool or tools that will be used, the unit physicians, clinical executive committee and the unit manager will need to review the criteria for admissions and determine if the patients that are being serviced on the unit are indeed the ones they are equipped to treat. Thought should be given as to whether the unit should be set-up separately for DD patients with mood disorders versus DD patients with

schizophrenia. Perhaps the unit should not admit patient with Axis II diagnosis or if the unit should continue accepting all DD patients as in the past. Either way, the treatment team will have to develop more flexible approaches to treatment for these patients.

One of the areas that is lacking in the current system is a tool to objectively evaluate the withdrawal symptoms of the patients. This would be a valuable asset to the nurse. Currently patients come to the nurse requesting medications for withdrawal. At times they may or may not need them. The Withdrawal Assessment Scale (WAS) and the Clinical Institute Withdrawal Assessment for Alcohol–revised (CIWA-Ar), are objective measures of withdrawal for alcohol. The WAS and the CIWA-Ar can be administered in a brief time. Both can be beneficial in guiding the nurse with symptom triggered pharmacological management of withdrawals. Joseph P. Reoux and Kristin Miller, authors of "Routine Hospital Alcohol Detoxification Practice Compared to Symptom Triggered Management with an Objective Withdrawal Scale (CIWA-Ar)" reported on the use of this instrument in monitoring the symptoms of withdrawal and administering medications when the symptoms were present rather than medicating the patient routinely, or whenever the patient felt that it was needed (136). An example of this tool is in Appendix K. The author thinks a tool like this should be used by the DD unit when a patient is going through detoxification. Also tools of this nature that can assess symptomatology of withdrawals from other drugs should be used.

DISCHARGE

The discharge process for each patient should be planned whenever possible. It is difficult for all staff that is involved in discharge to complete last minute preparations. This problem is compounded when there are three to four discharges a day. The physicians need to make all treatment members aware of discharge plans at least one-two days prior to the date. Many times the social worker cannot resolve placement issues or housing issues on short notice.

Another avenue that needs to be addressed is the linkage process between MPC and the community agencies. The linkage process involves connecting DD patients with substance abuse and psychiatric treatment after discharge from MPC. Many times the patient may be discharged to an outpatient treatment facility or an inpatient treatment facility for substance use. There needs to be a dedicated staff that serves as liaison between the MPC and these facilities. This could fall under the responsibility of the unit manager if that position is allocated the time. This would be time well spent in an effort to build positive relationships in the community.

This is a summary of the most urgent changes that are being proposed In order to provide continued growth and development of the DD unit. These changes are part of the larger organizational change toward integrative treatment. The DD patient is no longer the exception, he or she is the norm.

Chapter 5

People have been suffering from mental illness and or substance abuse/dependency since the beginning of time. Unfortunately they will continue to suffer. The one saving Grace is there is treatment available that can alleviate the pain and suffering of these individuals. The reality is DD is treatable. Since the mid-1980's, clinicians have identified the rapidly increasing segment of the population that is afflicted with this illness. There have been numerous studies on practically every facet that may affect a patient with DD.

This paper presented an overview of the long history of mental illness and substance use as separate yet entwined to the current time when the are treated side by side. This integrative approach to treatment of both the patient's mental illness and substance abuse disorder side by side is rapidly changing the landscape of mental health and substance abuse treatment. Also it discussed research findings on DD and explored the functioning of an acute care DD unit. Some of the significant findings and trends toward further program development have been addressed. Issues pertaining to quality treatment also have been explored.

There are several pertinent issues that the author would like to leave with the reader that will help to provide safe quality care for the DD

patient. First, when developing any program and especially a program for the DD population, a well documented plan of action should be developed. This action plan should guide management through the entire process of planning, developing, implementing and evaluating the effectiveness of a program. There must be a vision and mission statement to follow. To build a solid program foundation, there must be a conceptual framework to build on and it must be made functional. We live in an ever changing world and without change there would be no growth. Being mindful of this, organizations that want to develop programs must be willing to foster the needed change. Since program development and implementation will require the support of the entire organization, it is necessary to look at the impact it will have on the entire organization. Currently there is not a right or wrong way to develop a DD program. However the program should be tailored to meet the needs of this population. Since the DD population is so varied, the organization will need to determine what portion of this population they wish to focus.

Administratively when planning any program, careful thought should be given to whether the resources are available to implement the program successfully. This should include funding for hiring a program developer with the expertise in the desired area, if necessary, or consultants. Educational resources for staff development should considered during the planning stage. It should cover staff development needs over a period of time. Resources should be allotted for adequate staffing. Initially, it would

be better to increase staffing when opening a program and backing off staff as needed rather than to begin with minimal staff.

Many of the DD programs operating today are hybrid programs developed within existing psychiatric or addiction programs. From this mode of development have come many advances in the care and treatment of the DD patient. Certainly there are many resources and research findings to aid in the development of quality program. These resources exist on the federal, state and many local levels. Several clinicians have developed principles that guide the treatment of the DD population. A list of the principles taken from "Organizational Guidelines for Dual Disorders Programs" by Carolyn C. Mercer et al are listed in Appendix L.

The second area that will be addressed is the fact of the DD patient being one of the most challenging and difficult populations with which to work. They have an increased tendency for violence toward self and others, coupled with poor impulse control. DD patients can be very manipulating and demanding and they are experts at projecting their feelings onto others and watching for a response.

Staff who work with this population are often pulled into all types of power struggles without being aware of what the patient is doing. Splitting or dividing staff takes on new meaning with this population. For this reason, the author thinks it is extremely important to educate all staff on the various aspects of transference and countertransference. Staff needs

to be aware of their own feelings and what "pushes their buttons". The staff must work through their own issues in order not to impede in the treatment process.

Certainly, the reality is that some staff will not work effectively with this population. Therefore it is crucial that the program leader assess the suitability of the staff members, as a cohesive team is extremely important in the delivery of care for this population.

Finally this paper discussed the increased number of patients with dual diagnosis which has fostered the merging of two distinct treatment philosophies for the good of the patient. In the author's view, an integrative approach to treatment is effective and promising, however there is no one best treatment model. This approach allows the clinician to meet the patient on whatever level they may be, in order to provide appropriate treatment. Also, the patient can be guided through different stages of treatment from denial to recovery. Because this population greatly impacts society in various ways, clinicians need a valid form of treatment to stabilize and engage the patient is treatment. Also, federal, state and local agencies need to combine their resources to better assist the DD patient.

The author would like to leave the reader with food for thought in relation to change and direction. Both the mental illness sector and the addiction sector must bridge the gap between their philosophical views in order to bring about the needed changes that will have a positive impact

on the treatment of DD patients. Mindfully, both should consider the following by Iyanla Vanzant in Acts of Faith:

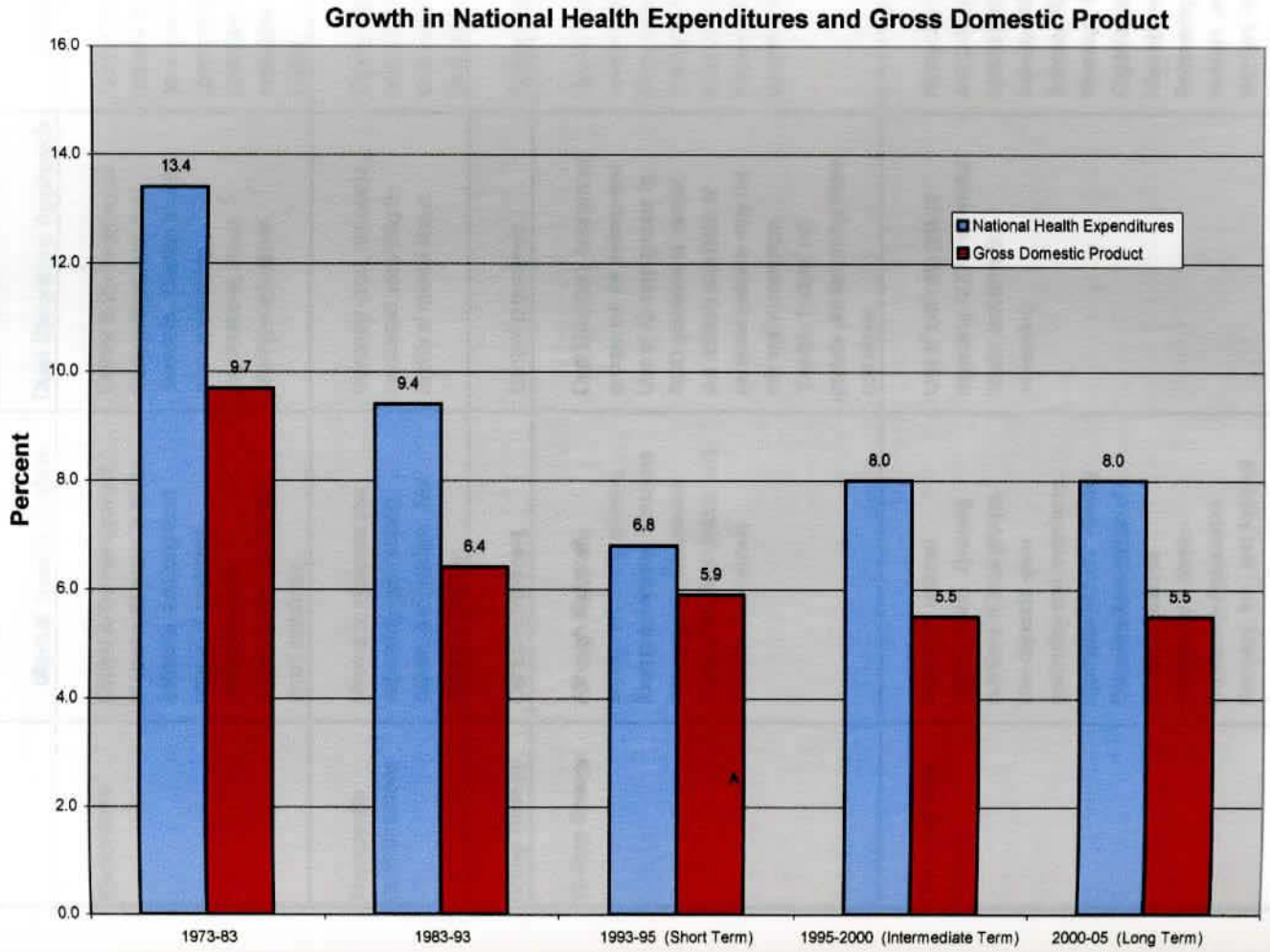
> When we are following the wrong teachings or philosophy, we get stuck. We do not evolve. Life just does not seem to come together. We see the same people doing the same thing. We may all be in agreement, but we still are not growing. We may know there is something better, somewhere. We may want or need more. But because we do not know exactly what "it" is, we stay stuck in what is familiar. Could it possibly be that it is time to move on? Shift gears? Get back to basics? Open our minds? Try something new? Well, we will never know until we try. The only way to really be sure we are on the right track is to derail ourselves for just a moment and see what new direction beckons. (6/7)

Appendix A

Five Primary Questions for Examining the Redesignment of the Dual Diagnosis Unit

1. What is the definition of mental illness/disorder?
2. What is the definition of substance abuse/addiction?
3. Historically, what impact does the relationship between the past and present views about mental illnesses and drug addictions have on current treatment procedures?
4. Why is there a need to modify the parallel and sequential treatment models?
5. What are the key benefits of an integrated treatment model for the dual diagnosis client?

Appendix B



Taken from Health Care USA p. 167

Apendix C

Treatment Approach Similarities and Differences			
	Mental Health System	**Dual Disorders Approach**	**Addiction System**
Medications	Central to the management of severe disorders in acute, subacute, and long-term phases of treatment: antidepressants, antipsychotics, anxiolytics, mood stabilizers.	Central to the treatment of many patients with dual disorders. Caution is used whrn prescribing psychoactive, mood-altering medications.	Central for acute detoxification; less common for subacute phase. Few used during long-term treatment: disulfiram, naltrexone, methadone, and LAAM.
Therapeutic Confrontations	Minimal to moderate use, depending upon setting, patient, and problem. Not central to therapy.	Generally used, but use is modulated according to fagility of mental status.	Use by staff and peers is one of the central techniques in AOD treatment.
Group Therepy	Central to treatment.	Central to treatment.	Central to treatment.
12-Step Groups	Although historically underused, use is growing. Examples include: Emotions Anonympous, Obsessive-Compulsive Anonymous, and Phobics Anonymous.	Dual Disorders Anonymous groups not yet widespread. Use of 12-step groups for AOD problems is central, but actively psychotic or paranoid patients may not mix well in meetings. "Double Touble" AA groups are becoming more numerous.	Use of 12-step groups is central to AOD treatment. Great availability. Examples indlude: Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous.
Other Self-Help Groups	Numerous national organizations. Growing numbers of local groups. Use depends upon availability and awareness. Examples include: Anxiety Disorders Association of America, National Depressive & Manic-Depressive Association, Recovery, Inc., and National Association of Psychiatric Survivors.	Use of self-help groups regarding AOD and mental health problems is increasing.	Numerous organizations and groups, often specialized. Examples include: Women for Sobriety, Rational Recovery, Secular Organizations for Sobriety, International Doctors in AA, Recovering Counselors Network, and Social Workers Helping Social Workers.

Appendix D

Selected Studies of Rates of Substance Use among Treatment Samples of Psychiatric Clients

Feature	Description
Author(s)/year:	Davis, 1984
Sample:	300 psychiatric patients (inpatients and out patients) at a moderately a moderately large, urban private university medical center
Data instruments:	Substance Use and Abuse Survey (SUAS)
Findings:	44% were "heavy" users of alcohol only, a single illicit drug only, or two or more drugs (including alcohol)
Author(s)/year:	Drake and Wallach, 1989
Sample:	187 chronically mentally ill patients living in the community after being discharged from an urban state hospital
Data instruments:	Clinicians' ratings
Findings:	32% of the sample misued alcohol, "street drugs," or both during the previous 6 months
Author(s)/year:	Hasin et al., 1985
Sample:	835 patients with (current) affective syndromes, recruited from inpatient and outpatient treatment units at 5 urban sites.
Data instruments:	Schedule for Affective disorders and Schizophrenia (SADS), Categorization by means of Research Diagnostic Criteria (RDC)
Findings:	Almost one-fourth of the patients had used alcohol or drugs at a clinically significant level during their current episode
Author(s)/year:	Regier et al., 1990
Sample:	20,291 epidemiological survey subjects in community and institutions settings in 5 cities
Data instruments:	Diagnostic Interview Schedule (DIS)
Findings:	Among patients with mental disorders seen in a specialty mental health setting, there was a 6-month prevalence rate of 20% of an alcohol or other drug use disorder
Author(s)/year:	Richard et al, 1985
Sample:	300 male patients admitted to an acute care psychiatric facility
Data instruments:	A structured drug use history interview and a psychiatric evaluation
Findings:	31% had used CNS stimulants at some time in the past, 11% in the last 6 months
Author(s)/year:	Safer, 1987
Sample:	68 chronic psychiatric outpatients seen at a community Mental health system
Data instruments:	Clinical review of case records
Findings:	43% were current substance users; 44% were current alcohol misusers

Appendix E

Descriptions and Examples of Dual Diagnosis Subtypes (Types I, II and III) From the Dual Diagnosis Subtypes Scale ---Lifetime Version

Type I. Primary psychiatric disorder

Psychiatric disorder clearly began before regular substance use such that the course of active substance abuse or dependence is contingent upon clear fluctuations in the psychiatric disorder (note: Substance use may have been present before onset of psychiatric disorder but cannot meet criteria for abuse or dependence.)

Example: Person binge drinks during clearly delineated episodes of major depression and does not drink when depression remits.

Type II. Primary substance use disorder

Substance use disorder clearly exists before onset of psychiatric disorder, and there is a distinct relationship between the course of substance abuse or dependence and episodes of psychiatric disorder such that psychiatric symptoms at present only during active phases of substance abuse or within three weeks of sobriety.

Example: Person meets criteria for major depressive episode while alcohol dependent, but does not have symptoms of major depression during periods of sobriety lasting more than three weeks.

Type III Dual primary disorders

A. Both psychiatric and substance use disorders are present and never Coincide with one another in onset and course.

Example: A person with a history of alcohol dependence who has maintained sobriety for ten years develops a delusion disorder, but never returns to drinking.

B. Both psychiatric and substance use disorders are chronic and severe, with indistinct onsets and overlapping course.

C. Psychiatric disorder clearly began before substance use disorder, but the two have independent courses such that neither one appears to consistently affect the course of the other.

D. Substance use disorder clearly began before psychiatric disorder, but the two have independent courses that neither one appears to consistently affect the course of the other

Example: A person with cocaine dependence for two years in early adulthood develops symptoms of schizophrenia that are chronic and persistent, even in periods of abstinence from any alcohol or drugs lasting for six months or more.

Reprinted from Hein, D.: Zimberg, S.: Weisman, S.: First, M. & Ackerman. S. 1997. Dual diagnosis subtypes in urban substance abuse mental health clinics. Psychiatric Services 48 (8): 1058-63, with permission of the American Psychiatric Association.

Appendix F

Sciacca Treatment Model for Dual Diagnosis (MIDAA)

PROGRAM FORM and/or INTERVENTION	PROCESS AND OUTCOME
1. Screening Mental health, DD CAGE. Substance abuse, MISF.	Identification of potential clients with dual diagnoses.
2. Pre-group interview and readiness scale. Engagement	a. Engagement into group treatment. b. Assessment of readiness level (1-5)
3. Continuation of engagement (when applicable).	Client requires engagement beyond pre-group interview.
4. Provide group treatment.	Phase 1: Client does not disclose personal situation, participates in discussions of educational materials/ topics, develops trust.
5. Complete monthly data form for each group.	
6. Administer comprehensive assessment (Phase 2). a. Integrate information into treatment plan. b. Make diagnosis.	Phase 2: a. Client discusses own substance abuse/ mental health.
7. Client progress review updated periodically.	Continuation of Phase 2: b. Client identifies adverse effects and/or interactions between dual disorders. c. Client recognizes impact of symptoms on well-being.
8. Client continues in treatment and/or relapse prevention. May include outside services	Phase 3: a. Client becomes motivated for treatment. b. Client actively engages in treatment and symptom management until stability and/or remission is achieved. c. Client participates in relapse prevention.

Source: Sciacca.

Note: MIDAA =Mental Illness, Drug Addiction, and Alcoholism; DD CAGE = Dual Diagnosis CAGE Questionnaire; MISF = Mental Illness Screening Form

Appendix I

Characteristics of mentally ill patients included in the 1990 and 1994 National Hospital Discharge Survey (NHDS) and the 1994 Nationwide Inpatient Sample (NIS) who did and did not have dual diagnoses

	1990 NHDS		1994 NHDS		1994 NIS	
Characteristic	Dual diagnosis	No dual diagnosis	Dual diagnosis	No dual diagnosis	Dual diagnosis	No dual diagnosis
Age (means+SD years	36+14	42+20	35+12	40+19	37+13	43+20
Women (%)	38	50	41	40	41	50
Nonwhite race (%)	21	20	25	24	29	28
Geographic region (%)						
Northeast	36	30	34	28	42	39
Midwest	34	36	36	37	30	30
South	19	24	21	25	15	19
West	12	10	9	10	13	12
Payer (%)						
Medicare	19	26	23	26	22	31
Medicaid	23	20	30	25	35	29
Private	30	33	27	33	26	27
Self	17	11	11	8	11	9
Other	10	10	9	8	6	4
Length of stay (means + SD days)	12+12	13+16	11+12	11+15	9+11	11+22
Principal diagnosis (%)						
Alcohol use disorder	23	23	13	18	20	17
Drug use disorder	11	9	8	12	13	12
Senility and organic disorders	2	7	2	3	3	8
Affective disorder	32	28	48	40	33	30
Schizophrenia	11	14	21	17	13	15
Other psychosis	2	4	0	0	3	4
Personality disorder	4	6	5	6	3	4
Preadult disorder	1	1	<1	1	1	1
Other mental disorder	14	9	3	3	11	8
Personal history of mental disorder	<1	<1	<1	0	<1	<1
N hospitalizations in sample	2,014	10,053	2,300	9,500	81,046	239,970
Weighted N for hospitalizations in all U.S. hospitals	252,797	1,289,235	291,801	1,258,305	429,558	1,281,841

Stages of Treatment		
Stage	Definition	Goal
Engagement	Patient does not have regular contact with dual diagnosis clinician	To establish a working alliance with the patient
Persuasion	Patient has regular contact with clinician, but does not want to work on reducing substance abuse	To develop the patient's awareness that substance use is a problem and create motivation to change
Active Treatment	Patient is motivated to reduce substance use as indicated by reduction in substance use for at least 1 month but less than 6 months	To help the patient further reduce substance use and, if possible, attain abstinence
Relapse Prevention	Patient has not experienced problems related to substance use for at least 6 months (or is abstinent)	To maintain awareness that relapse could happen and to extend recovery to other areas (e.g., social relationships, work)

Examples of Clinical Interventions for the Engagement Stage
a) Outreach
b) Practical assistance (e.g., housing, benefits, transportation, medical care)
c) Crisis intervention
d) Support and assistance to social networks
e) Stabilization of psychiatric symptoms

Examples of Clinical Interventions for the Persuasion Stage
a) Individual and family education
b) Motivational interviewing
c) Peer groups (e.g., "persuasion" groups)
d) Social Skills Training to address situations not related to substance abuse
e) Structured activity
f) Sampling contstructive social and recreational activities
g) Psychological preparation for lifestyle changes necessary to achieve remission
h) Safe "damp" housing (i.e., tolerant of some substance abuse)
i) Select medications to treat psychiatric illness that may have secondary effect on craving/addiction (e.g., selective serotonin reuptake inhibitors, tricyclic antidepressants, atypical antipsychotics, buspirone, buproprion)

Examples of Clinical Interventions for the Active Treatment Stage
a) Family problem solving
b) Peer groups (e.g., "active treatment" groups)
c) Social skills training to address substance-related situations
d) Self-help groups (e.g., Alcoholics Anonymous)
e) Individual cognitive-behavioral counseling
f) Substituting activities (e.g., work, sports)
g) Pharmacologic treatments to support abstinence (e.g., disulfiram, naltrexone).
h) Self housing
i) Out patient or inpatient detoxification
j) Contingency management

Examples of Clinical Interventions for the Relapse Prevention Stage
a) Supported or independent employment
b) Peer groups (e.g., "active treatment" groups)
c) Self-help groups
d) Social skills training to address other areas
e) Family problem solving
f) Lifestyle improvements (e.g., smoking cessation, healthy diet, regular exercise, stress management techniques)
g) Independent housing

APPENDIX K

Clinical Institute Withdrawal Assessment: Scale for Alcohol, revised (CTWA-AR)

NAUSEA AND VOMITING: Ask "do you feel sick to your stomach? Have you vomited?" Observation.
0 no nausea and no vomiting.
1 mild nausea with no vomiting.
2
3
4 intermittent nausea with dry heaves.
5
6
7 constant nausea, frequent dry heaves.

PAROXYSMAL SWEATS: Observation.
0 no sweat visible.
1 barely perceptible sweating, palms moist.
2
3
4 beads of sweat obvious on forehead.
5
6
7 drenching sweats.

AGITATION: Observation.
0 normal activity.
1 somewhat more than normal activity.
2
3
4 moderately fidgety and restless.
5
6
7 paces back and forth during most of the interview, or constantly thrashes about.

HEADACHE, FULLNESS IN HEAD: Ask "Does your head feel different? Does it feel like there's a band around your head?" Do not rate for dizziness or lightheadedness.
0 not present.
1 very mild.
2 mild.
3 moderate.
4 moderately severe.
5 severe.
6 very severe.
7 extremely severe.

ANXIETY: Ask "do you feel nervous" Observation.
0 no anxiety.
1 mildy anxious.
2
3
4 moderately anxious, or guarded, so anxiety is inferred.
5
6
7 equivalent to acute panic states as seen in acute delirium or acute schizophrenic reactions.

TREMOR: Arms extended and fingers spread apart. Observation.
0 no tremor
1 barely visible, but can be felt fingertip to fingertip.
2
3
4 moderate, with patient's arms extended.
5
6
7 severe, even with arms not extended.

VISUAL DISTURBANCES: Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there? Observation.
0 not present.
1 very mild sensitivity.
2 mild sensitivity.
3 moderate sensitivity.
4 moderately severe hallucinations.
5 severe hallucinations.
6 extremely severe hallucinations.
7 continuous hallucinations.

TACTILE DISTURBANCES: Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under you skin? Observation.
0 none.
1 very mild itching, pins and needles, burning or numbness.
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness.
4 moderately severe hallucinations.
5 severe hallucinations.
6 extremely severe hallucinations.
7 continuous hallucinations.

AUDITORY DISTURBANCES: Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
0 not present.
1 very mild harshness or ability to frighten.
2 mild harshness or ability to frighten.
3 moderate harshness or ability to frighten.
4 moderately severe hallucinations.
5 severe hallucinations.
6 extremely severe hallucinations.
7 continuous hallucinations.

ORIENTATION AND CLOUDING OF SENSORIUM: Ask "What day is today? What is this place?"
0 oriented and can do serial additions.
1 cannot do serial additions or is uncertain about date.
2 disoriented for date by no more than 2 calendar days.
3 disoriented for date by more than 2 calendar days.
4 disoriented for place and/or person.

TOTAL CIWA-Ar SCORE

Adapted from Sullivan ff: Sykora K. Schneiderman J. et al. Assessment of alcohol withdrawal; the revised clinical institute withdrawal assessment for alcohol scale (CIW-Ar. By J Addict. 1989;84:1353. (Scale is not copyrighted and may be used freely.)

PRINCIPLES OF TREATMENT

1. *Integration of substance abuse and mental health treatments* means combining substance abuse treatments with treatments that address the client's mental illness. The same clinicians provide substance abuse treatments along with mental health treatment within a single program or agency. Numerous models are available for integrating substance abuse treatment into existing mental health services. Successful integration entails organizing the specialized substance abuse treatments and educating and supporting the clinical staff while they develop skills for treating dual disorders.
2. *Flexibility and specialization of clinicians* means creating a specialized repertoire of techniques that uniquely address dual disorders and revising approaches in response to feedback from daily practice. Effective program leadership requires that clinicians learn to modify their perspectives and techniques, to deliver services in new ways, and to offer consultation with a wide range of providers and significant others outside the office walls. Assistance to clinicians for gathering data and evaluating their interventions can also help to support open and flexible attitudes. Agency policies need to allocate staff time to providing services to the population with dual disorders and protect the integrity of the team for working with this special population.
3. *Assertive outreach* means reaching out to meet and understand the client on her own terms, with vivo services in the community and with concrete assistance. Assertive outreach requires a different style of working with clients, changes in the setting for service delivery, a greater investment of staff time per client, and access to concrete resources. Clinicians will need training to understand the clinical basis for assertive outreach as well as the skills for using the strategies. Services and clinicians need to be reorganized for portability and mobility, and financing mechanisms need to support service delivery outside the office walls.
4. *Recognition of client preferences* means identifying the client's personal preferences and helping him creatively to express his preferences and to choose goals and treatments that are personally relevant and meaningful. Clinicians can be trained to develop collaborative working alliances that are built on the central mechanism of identifying and evaluating option with the client. The mental health agency should have available a range of effective dual disorder treatment options, so that family settings. Clinicians can learn to listen to clients, to educate them about options, to elicit their preferences, to encourage shared decision making, and to craft and deliver highly flexible, individualized treatments.

5. *Close monitoring* means cultivating external structures in the client's environment in order to help her achieve reliable control over substances. The interventions encompassed by the close monitoring principle span a range of clinical techniques and legal interventions. Close-monitoring techniques require extreme care, not only because of clients' rights, but also because of the need to support clients' self-motivation and self-control. Staff-development programs need to teach techniques to assure a balance between using external structures and cultivating self-motivation and self-control. Staff needs to know the details of available resources for supporting both the voluntary options and the involuntary option for close monitoring.
6. *Comprehensiveness of services* means providing treatment and services that address the full range of the client's rehabilitative needs and supporting his family members and significant others. Stable abstinence requires a stable life-style, and clients must make significant changes in their ways of handling stress and in their social networks, healthcare, and patterns of daily living. A well-developed community support program (CSP), closely affiliated with the medical back-up of a community mental health center (CMHC), will already have many of the comprehensive service elements that are necessary for clients with dual disorders. The array of CSP services includes client identification and outreach, mental health treatment, crisis response services, health and dental care, housing, income support and entitlements, peer support, family and community support, rehabilitation services, protection and advocacy, and case management. Other possible service foundations, such as the substance abuse treatment system, a medical center, or a general social service program, may prove to narrow such that administrators would need to create an extensive array of new services.
7. *Stability of living situations* means assuring that the client has a decent, safe, and stable place to live and that her living situation supports her substance abuse treatment goals. Research findings are modest in number but discouraging concerning intensive substance abuse treatments in a group home setting. Residential treatment programs are costly, appear effective for very few clients, and are ineffective when isolated from appropriate post-treatment residential support. Alternatively, substance abuse treatment supports can be organized for provision as needed in general housing programs for people with severe mental illnesses, and all housing support staff can be taught to support clients at different stages of substance abuse treatment.
8. *The long-term perspective* means anticipating a period of years rather than a period of months for the client to attain stable remission from substance use disorder. Since the short-term effects of interventions may involve increasing motivation rather than abstinence, administrators must guard against prematurely concluding that

substance abuse treatment services are ineffective or should be terminated.

9. *Stage-wise treatment* means anticipating that the client will respond to dual disorders treatment in stages and tailoring treatment to match these stages. Four stages of treatment are widely acknowledged by people working with clients who have dual disorders. Engagement refers to developing a trusting relationship with the client. Persuasion refers to fostering the client's motivation to reduce substance use, and involves helping him to appreciate the adverse consequences of using substances and the positive results of not using substances. Active treatment refers to helping the client to reduce substance use, and involves working with her to develop active strategies, skills, and relationships for achieving and maintaining abstinence. Relapse prevention refers to helping the client to prevent relapses and to cope with setbacks, and involves working with him to develop additional skills and strengths.
10. *Optimism* means sustaining hope for recovery over the long term. People with dual disorders are particularly likely to become discouraged about the future, and yet their hope for the future is a key to their motivation for controlling substance use. Designing models for organization and service delivery that are consciously intended to foster optimism and morale are key administrative challenges. Program evaluation and objective feedback on clients' progress can support a positive outlook among treatment partners. An optimistic attitude about clients and their potential helps greatly in representing the clients and the agency to the public and in fighting stigma.

Taken from "ORGANIZATIONAL GUIDELINES FOR DUAL DISORDERS PROGRAMS" by Carolyn C. Mercer, Ph.D., Kim T. Mueser, Ph.D., and Robert E. Drake, M.D., Ph.D.

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