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Evidence-Based Resources for Behavioral Health

Integrated Dual Disorders Treatment

Best Practices, Skills, and Resources for Successful Client Care

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The names, details, and circumstances may have been changed to protect the privacy of those mentioned in this publication.

The poem "Once Again" that opens chapter 15 has been reprinted with permission from the author.

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Evidence-Based Resources for Behavioral Health

The Dartmouth PRC-Hazelden imprint was formed as a partnership between the Dartmouth Psychiatric Research Center (PRC) and Hazelden Publishing, a division of the Hazelden Betty Ford Foundation—nonprofit leaders in the research and development of evidence-based resources for behavioral health.

Our mission is to create and publish a comprehensive, state-of-the-art line of professional resources—including curricula, books, multimedia tools, and staff-development training materials—to serve professionals treating people with mental health, addiction, and co-occurring disorders at every point along the continuum of care.

For more information about Dartmouth PRC-Hazelden and our collection of professional products, visit the Hazelden Behavioral Health Evolution website at www.bhevolution.org.

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HOW TO USE THE CD-ROM

Included with this program is a CD-ROM that contains the participant handouts and additional facilitator materials. All the documents on the CD-ROM are in PDF format and can be printed and copied for your personal use.

To open the documents on the CD-ROM, you will need Adobe Reader. If you don't have Adobe Reader, this software can be downloaded for free at www.adobe.com.

For a list of what is contained on the CD-ROM and for further instructions, please see the Read Me First document on the CD-ROM. Thumbnail views of the first page of each CD-ROM document are shown at the end of this manual.

PREFACE

by Lindy Fox Smith

In addiction treatment settings, most clinicians are open and transparent with their colleagues and, when appropriate, with their patients about their own personal recovery. They tend to believe that their past experience of addiction is a resource rather than a detriment in their work with their clients. In fact, during the early history of addiction treatment, it was believed that only clinicians in recovery could help patients who have substance use disorders. In mental health centers, however, as you'll read in chapter 2 of this new and revised version of *Integrated Dual Disorders Treatment,* "Mental health has traditionally *not* valued the experience of recovery in the workforce. Hence, mental health professionals tended not to disclose their personal histories of recovery." They simply were not as likely to have their experience of mental health disorders valued.

Many of the chapters in this book flow from my lived experience, both personal and professional. I've always hoped that I am reducing stigma about mental health disorders by openly sharing my life and history of my own co-occurring disorders. I have never felt rejected by an audience because of my disclosure and transparency. In addition, I have been very fortunate to have worked for an organization that values such personal experience. Being a past recipient of the very services that I have trained clinicians to deliver has been an enormous help in my own work. My personal experience and professional understanding of co-occurring disorders have allowed me, among other more renowned researchers and clinicians, to contribute in a unique way to the creation of this book.

I finished a master's degree in counseling psychology with a concentration in substance use disorder treatment in 1989. In the years before my formal degree, I had "specialized" in co-occurring mental health disorders and substance use in my personal life. For generations my family had struggled with alcoholism and mental health disorders. Both of my grandfathers were alcoholics; my paternal grandmother suffered with a mental health disorder and died in Vermont's State Psychiatric Hospital after years of hospitalization; and my father was also an alcoholic. I grew up avoiding him by hiding in closets in our house, which seemed perfectly normal to me.

In high school, I joined the cheerleading squad, had a boyfriend, and was valedictorian of my senior class, but none of these accomplishments could fill the empty hole inside me. If people really saw who I was, I thought, they would know I was a fraud. Scared, lonely, and always sad, I started drinking to obliterate those feelings—and to a certain degree it worked.

In college, my drinking escalated and I married a drinking buddy I'd met at a bar. Things quickly got worse. My husband and I thought we could deal with my depression ourselves. Although I graduated from college summa cum laude, I continued to stumble through alcohol binges and depression.

At twenty-three, I had a child, a beautiful daughter, and thirteen months later another daughter. I stopped drinking when I got pregnant with my first daughter, and perhaps because of that my mood was fairly stable. After giving birth to my third daughter, I experienced a terrible postpartum depression and never recovered before getting pregnant a fourth time. I was unable to get out of bed to care for my three young daughters or for myself. I went into therapy for the first time, and the therapist kept me alive through my pregnancy.

Following the delivery of my fourth daughter, I was hospitalized and diagnosed with bipolar disorder. I could not cope with my bipolar disorder, marriage, and four children. After returning home, I attempted suicide and had to return to the hospital. When I left the hospital, I moved into my parents' basement, so that was the last time I ever lived full time with my children.

Over the next four years, I was in and out of the psychiatric unit of a local hospital thirty times. I would start drinking, get depressed, become suicidal, and go into the hospital, where I would stabilize on medications, go home, and start the cycle all over again. My psychiatrist didn't know that I was drinking until one night at 2 a.m. when I called him drunk. During the next two years he referred me to Alcoholics Anonymous and a local addiction treatment agency, but I never took the referral seriously, because my psychiatrist never bothered to talk to my substance use counselor.

Finally, after four years, my psychiatrist referred me to Dartmouth Hitchcock Hospital in Hanover, New Hampshire, for shock treatments for treatment-resistant bipolar depression. Fortunately for me, a young resident doctor recognized that I needed treatment for my alcoholism rather than shock treatments and instead sent me to an alcohol and drug rehabilitation program. While I was there, my ex-husband brought my four little girls to visit me, took pictures of us together, and later mailed the photos to me. I stared at them every hour and decided

then to turn my life around. I didn't want my daughters visiting me in hospitals and rehabs all my life. I remember distinctly choosing to be a well person instead of a sick person, not to drink or use drugs anymore. It was a kind of spiritual awakening.

My whole life began to change. At the urging of one of the psychiatric nurses, who had never been willing to view me as a sick person, I applied to and was accepted into a graduate program for counseling psychology. I participated in a Twelve Step program to support my recovery from my alcoholism, and medication helped stabilize my bipolar disorder. I wasn't admitted to a hospital again. My relationship with my daughters improved because I was now consistently sober. I also married a wonderful and supportive man, a psychiatrist named Dr. Tom Fox, whom I had met during my last internship in graduate school.

We moved to New Hampshire so that Tom could take a job as the medical director for the New Hampshire Department of Mental Health. Tom had been associated with Dartmouth's Department of Psychiatry for several years and was a friend of Dr. Bob Drake, who was starting a research center where a job might be available for me. As a favor to Tom, Bob interviewed me, though perhaps fearing what I might be like. He was pleasantly surprised that I seemed qualified for the job.

In 1989, I became one of the first employees at the Dartmouth Psychiatric Research Center and engaged in research to develop a model of integrated treatment for people who have a co-occurring severe mental health disorder and a substance use disorder. It made perfect sense to me then because I had experienced its opposite—nonintegrated treatment—for years.

I began as an interviewer in a dual diagnosis study in New Hampshire. Over time I did diagnostic interviews, ran treatment groups, and supervised other clinicians who were running groups. As requests increased from other states for information on the new model of integrated treatment, Bob asked Tom and me to consider doing some training. We traveled around the country and eventually around the world doing presentations on the integrated treatment model of care for people with co-occurring disorders.

At the research center, I continued to expand into new areas. The original dual diagnosis study in New Hampshire was continued for eighteen years. I helped to write the highly successful book *Integrated Treatment for Dual Diagnosis* and numerous articles based on our experiences in New Hampshire. I joined another renowned researcher and clinician, Kim Mueser, to pilot a model of family treatment for clients with co-occurring disorders in New Hampshire. After the pilot,

we conducted a randomized controlled trial of our family model in Los Angeles and Boston and revised the model into another pilot. I also helped in the development of the *Illness Management and Recovery* and the original *Integrated Dual Diagnosis Treatment* tool kits for the Substance Abuse and Mental Health Services Administration (SAMHSA).

One chapter in this manual that I did not write deals with a very important issue in my life: supported employment. I have always maintained a job throughout the ups and downs of my recovery. Work and the support of family and friends are the cornerstones of my recovery, as they are for many with co-occurring disorders. This experience taught me in no uncertain terms the importance of supported employment for people with severe mental health disorders.

Since 2005, I have undertaken new projects professionally. I train and supervise interviewers and do consultation and training for different states and agencies. As a consultant, I enjoy the exciting challenge of helping programs overcome barriers. Writing—including helping to author this manual—is now part of my life. Many chapters in the manual represent my work in the field of co-occurring disorders treatment for more than twenty years and the culmination of my living with mental health and substance use disorders. Although I retired from Dartmouth Psychiatric Research Center in 2012, I continue to enjoy the support of many colleagues at Dartmouth who have devoted their lives to helping people with co-occurring disorders.

The chapters on family are obviously ones that are near and dear to my heart. For a variety of reasons, families are often ignored by clinicians. My own husband and children were often left out of my treatment. It had a devastating effect on all of our lives when I was so ill. After years in recovery, my relationship with my daughters has grown stronger. My girls were never angry with me or saw me as a bad mother, although my own guilt got in my way. Now I have two beautiful granddaughters who see me as their "Nana" and not as someone with a co-occurring disorder. In 2001, my husband, Tom, was diagnosed with pancreatic cancer. After one very painful year, he died. This loss devastated me, personally and professionally.

I have since found a wonderful man to share my life. We travel around in our RV with two big dogs and a great deal of laughter and love. My personal life is intertwined with my professional life. I can't and won't separate the two.

Much of my knowledge of Twelve Step groups and peer recovery supports comes from my own personal experience and from peers in the program. At first,

I didn't take Twelve Step meetings seriously. I wasn't at that point or stage. When I write about stagewise treatment in this manual, I often think about the many practitioners who treated me who had no knowledge of stagewise interventions. I continued to drink and to cycle in and out of the hospital; requiring me to go to AA didn't work because I had no desire to stop drinking. Attending AA then was just something to do to pass the time while I was in the hospital. I needed a therapist who understood what stage I might have been in and who would have given me the help and motivation to change. In this manual's chapter on motivational interviewing, I describe how to identify the client's goal and how to reveal a discrepancy between the client's substance use and achievement of the goal. I base that description on my own life. When I finally realized my substance use was interfering with my relationship with my daughters, I stopped drinking. I have long felt that if someone had identified that goal for me much earlier, my recovery might have happened sooner.

Only when I decided to get sober did meetings become a necessity. I got a sponsor and attended a meeting every day. When I had my four little girls with me, they came to meetings too. They were very well behaved and everyone enjoyed seeing them. My daughters thought that everyone's mother went to AA on Saturday mornings.

During the most devastating years of my suffering from mental health disorder and addiction, this is the manual I would have handed to every clinician and psychiatrist who treated me. Each page now speaks to me as a professional in the field of mental health. Back then, there was no chance for me to receive integrated treatment, but now I have the chance to help others receive this evidence-based practice. This manual was co-written by some of the leading authorities in the country. Without their research and work, it would not have seen the light of day.

• • •

INTRODUCTION

This expanded and updated *Integrated Dual Disorders Treatment (IDDT)* can assist mental health practitioners in their work with clients with severe mental health and substance use disorders in important ways. It aims to improve clinicians' skills, encourage clinicians in various tasks, and provide resources for the successful practice of those skills and tasks.

This updated edition of the original widely disseminated IDDT contains nearly a decade of new research since the first version appeared on the SAMHSA website in 2002. This edition brings the most comprehensive research and information available today to the mental health field. It teaches clinicians about addictive substances and the basic skills needed to help people with a substance use disorder and a mental health disorder (dual disorders) recover from both disorders.

This new version of *IDDT* differs significantly from the original website version. It comes packaged with a CD-ROM, which contains handouts and worksheets for clients and clinicians. The CD-ROM creates a more permanent record for photocopying. Other major differences between this updated version and the 2002 version include the following:

- This version is written in everyday language as opposed to academic, journal language. It is our expectation that practitioners, supervisors, clinical leadership, and clients will find the curriculum to be approachable and much easier to use.
- This version clearly sets out tasks and skills for administrators, senior organizational leaders, clinical leaders, and practitioners to facilitate the best possible implementation.
- It deals with how to conduct group treatment, and the material in the chapter on group treatment has been updated based on recent research.
- Supported housing is incorporated in this manual as a component of integrated treatment. Material in this chapter has also been updated based on recent research.

- Issues regarding criminal justice and dual disorders are discussed in this manual.
- Physical and medical health care issues are discussed in this manual, as well as trauma treatment and recovery.
- The topics of training and consultation are also discussed and appear in a unique chapter, not found in other publications.
- This manual includes many clinical vignettes that illustrate aspects of treatment and serve to motivate readers.

In this manual, the word *recovery* means that the client is learning to master both illnesses—substance use and mental health disorders—in order to pursue personally meaningful life goals. A primary purpose of *Integrated Dual Disorders Treatment* is to educate, train, and assist mental health clinicians to motivate and inspire their clients to strive for and attain *recovery* goals as listed in chapter 2, Recovery-oriented Treatment.

This manual also assumes that because co-occurring disorders are so common, all clinicians need to learn basic skills to foster recovery. We also assume that clinicians, like others, learn in different ways. Some read textbooks, some prefer training videotapes or online webinars, some rely on supervision, and some like practical manuals such as this one with worksheets and handouts included on a CD-ROM.

The curriculum covers the basic information needed to treat people with co-occurring disorders. Most mental health clinicians will need to acquire basic skills to address co-occurring substance use disorders. If mental health clients are not treated for their addictions at the same time they are receiving mental health treatment, they are not likely to sustain and stabilize themselves in recovery. This manual will help clinicians learn practical substance use treatment skills, as well as provide guidance in how clinicians can get additional training.

For this purpose, we assume that every clinician needs four basic skills:

1. Working knowledge of common addictive substances and how they affect mental health disorders
2. Ability to assess substance use disorders
3. Skills to provide motivational counseling for clients who are not ready to acknowledge a substance use disorder and pursue recovery

4. Skills to provide integrated addiction counseling for clients who are motivated to address their problems with substance use

Integrated treatment for people with dual disorders is more effective if the same clinician or clinical team helps the client with both substance use and mental health disorders. That way the client gets one consistent, integrated message about treatment and recovery. This manual will help you learn the skills to provide effective integrated dual disorders treatment.

How to Use This Curriculum

Use this curriculum in any way that fits your learning style! Supervisors may want to use the manual and CD-ROM materials to teach skills to clinicians or to review the basic skills for themselves and then teach them without using the manual. Organizational leaders wanting to provide integrated treatment will find direction and resources in this manual. Some clinicians may want to read the entire manual at once, but most prefer to read one chapter at a time and discuss it with their treatment team members or colleagues. Some will seek out the worksheets and handouts on the CD-ROM for use with clients. Most of the handouts are for clients, but clinicians will find handouts, such as screening and assessment tools, for themselves.

All handouts and worksheets are PDFs located on the CD-ROM and can be reproduced or copied without worry of copyright infringement. The handouts are organized by the chapter or appendix where they are first identified. Other materials on the CD-ROM are organized in folders that contain alcohol and drug fact sheets, mental health disorders fact sheets, and screening and assessment tools.

Nearly every chapter in the manual begins with a vignette, or case study, that illustrates the chapter's topic. These are offered to stimulate thinking about the many special issues and unique situations that arise in doing this work.

One way to use the manual is to read the vignette and discuss it before you read the chapter. Information in each chapter comes from experts in the field who have been providing integrated dual disorders treatment for years, so you can examine your own ideas in relation to theirs.

A vignette entitled "Susan" appears at the end of this introduction. It is longer than the vignettes in the chapters to provide the clinician with a more complete case example of a "patient" with co-occurring disorders who successfully undergoes integrated treatment. Susan travels from addiction, depression, and hallucinations to sobriety and recovery, and from a relapse to meaningful employment

and hopefulness. In this scenario, the clinician sees many facets of recovery, including persuasion groups, family therapy, case management, peer recovery support groups, and relapse prevention.

The preface to the manual by clinician and researcher Lindy Fox Smith raises an important issue and challenge for today's mental health practitioners. Ms. Fox Smith reminds the reader that, unlike the addiction profession, "mental health has traditionally *not* valued the experience of recovery in the workforce. Hence, mental health professionals tended not to disclose their personal histories of recovery." She encourages all clinicians to consider their personal experiences with mental health disorders or addiction as valuable to their work and their clients, as well as to their colleagues.

Chapters 1 and 2 provide a short introduction to integrated treatment and dual or co-occurring disorders. Chapters 3 and 4 identify tasks for senior organizational leadership and the clinical leader in establishing an IDDT program. Chapters 5 through 10 present tasks and skills for direct treatment, whether individually or in groups, as well as important issues for screening, assessment, and stagewise treatment. Chapter 11 addresses the effects of addictive substances and how they impact a person with a mental health disorder. Chapters 12 and 13 focus on new research in housing, supported employment, and education for people with severe mental health disorders. Chapter 14 addresses one of the most critical factors in a client's recovery: the family. Readers will also find a curriculum and a wealth of resources for conducting family psychoeducation. Chapters 15 through 20 address special issues, such as criminal justice, physical and medical health care, medications, elders with co-occurring disorders, and trauma treatment and recovery. In the unique chapter 21, readers can learn more about specific training and consultation. Finally, in the appendices, readers will find abundant information and resources, such as the IDDT Fidelity Scale and the General Organizational Index (GOI).

Explanation of Terms

The *IDDT* materials were developed by people from a variety of backgrounds and perspectives. During the writing of this manual, it became evident that many different terms are used to describe the key stakeholders. For the sake of clarity and consistency, in most instances common terms are used to identify these groups throughout the manual. In some situations more precise, or alternative, terminology is used. For instance, in the supported employment chapter, the term *employment specialist* is used rather than *practitioner.*

Many terms can be used to describe people giving or receiving treatment. For this manual, we chose the word *client* to describe a person working with treatment providers. We use *case manager, clinician,* and *counselor* to describe the people providing services. We use *family* to describe a relative, spouse, or even a friend.

Terms common to the mental health field often have very different meanings in the addiction field. For example, in the addiction field, recovery is equated with "abstinence." In this manual, as stated earlier, recovery means that the client is learning to master both illnesses—substance use and mental health disorders—in order to pursue personally meaningful life goals.

For some clinicians, terms may hold different meanings from the way they're used in this manual. We tried to keep the terms general enough to apply for most clinicians in the field of mental health. A few terms frequently used in this manual are defined here.

Client primarily refers to a person who has a severe and persistent mental health disorder. However, this term is not intended to exclude clients with milder and less severe mental health problems. Clients in IDDT include people with mental health and substance use disorders. The IDDT client is essentially a person with dual or co-occurring disorders.

Clinic refers to any center where the client with co-occurring disorders is treated. However, the term is intended to be interpreted broadly. It can be the hospital, a community or mental health center, or even the clinic in a prison or community correction center.

Clinical leader is a director who champions the co-occurring disorders program and makes it a success. The clinical leader's role is to oversee all co-occurring disorders services, including development, operations, quality improvement, and maintenance. The ideal candidate for this role is someone who knows the organization well and who has the trust of senior leadership, frontline clinicians, and other staff.

Clinician encompasses a variety of practitioners in different fields. The term includes counselors to directors, social workers, addiction specialists, and those who deliver mental health services to clients with co-occurring addiction psychiatric issues.

Co-occurring disorder generally refers to a co-existing mental health disorder and a substance use disorder, though originally the term included a physical dis-

order as well. *Co-occurring disorders* is more often used today instead of the term *dual disorders,* which is restricted by the use of "dual," meaning two. Co-occurring disorders may refer to clients who have one or more mental health disorders coupled with one or more addictions.

Dual disorders also refers to co-occurring disorders. See the previous definition.

Family refers to all members of the immediate and extended family. It also includes significant others, friends, and others who are key supporters but not family members by blood or marriage.

Mental health program leader describes the person at the mental health provider organization who is trying to put IDDT into effect. This term is used instead of *program supervisor, operations director, program manager,* or *program administrator* because it makes clear that this person's job is to lead with the support of the agency's administration.

Peer recovery support group encompasses any group led and run by peers for the purpose of promoting health and recovery from mental health disorders and addiction. Traditional Twelve Step peer recovery support groups include Alcoholics Anonymous, Narcotics Anonymous, Double Trouble in Recovery, Dual Diagnosis Anonymous, Dual Recovery Anonymous, or Emotions Anonymous.

Practitioners refers to the people who deliver the evidence-based practice. It is often equated to the term *clinician,* which is used more frequently in the new manual.

Senior organizational leader may be a member of the board of directors, CEO, research or other director, medical doctor, and/or administrator whose tasks are to define the mission and set the agenda, integrate programs, secure financing, set up the structure, designate a program director, create a quality improvement committee, establish an effective records system, and monitor reports.

Substance is not simply an illicit drug, but may include "legal" drugs such as tobacco, alcohol, inhalants, or prescription medications. The fact sheets included on the CD-ROM provide information on alcohol, amphetamines, club drugs, heroin, inhalants, marijuana, cocaine, and tobacco.

Substance use and ***substance use disorder,*** or addiction, require clear, distinguishing definitions. They are often used interchangeably. However, in general, the term *substance use* implies that psychological and physiological addiction may not yet have taken over the client's life. A person makes poor choices

around substance use, but he or she is still more or less in control of those choices. *Substance use disorder, or addiction,* however, is a more serious disorder when a person may take larger amounts of the substance for longer periods, want to reduce or control use but be unsuccessful, and crave intoxication despite negative consequences such as failing to fulfill obligations, damaging interpersonal relationships, and risking physical hazards. Clinicians need to use current *DSM-5* criteria to make an accurate diagnosis of substance use disorder for any of the ten classes of substances included. Information about *DSM-5* criteria appears as a chapter 11 handout on the CD-ROM.

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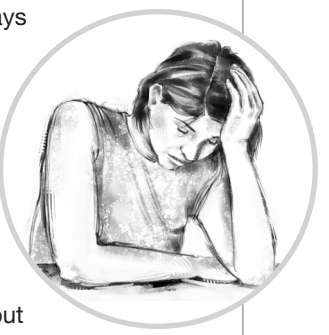
Susan

Susan began drinking heavily in college. She also suffered from periods of depression that kept her in bed for days at a time. Her friends worried about her, but then she would snap out of her depression, laugh it off, and seem her normal self. After college, Susan's drinking escalated and she also began using cocaine. She had several jobs, but her substance use usually interfered. She would miss work and eventually lose the job. Her bouts of depression also worsened. They no longer lasted just a few days, but went on for months at a time. During the depths of the depression, Susan heard voices that told her she was no good and that she would never amount to anything. Susan's family was very concerned and convinced Susan to go for help.



Susan went to the local mental health center, where she was evaluated by a co-occurring disorders team. Because Susan's family had persuaded her to come in, the team did not have to initiate contact with Susan. However, they still had to engage her in treatment. Susan's case manager asked Susan what she wanted help with. Susan said she really wanted a job, and she really wanted the voices to go away. The case manager said that the co-occurring disorders team could help her. As Susan progressed into the persuasion stage of treatment, her symptoms were improving, but she

was still using substances. She got involved in a persuasion group, where she met peers struggling with the same issues. By this point, Susan had a part-time job. The case manager asked Susan about having her family come in for family psychoeducation. She agreed.

After about a year, Susan began to recognize how her substance use was interfering with her job and how it increased her symptoms. She was ready to try a period of abstinence. Susan was moving into the active stage of treatment, and she joined the active treatment group. Here she again found peers who were struggling with issues similar to hers. She tried AA groups in her community and found a women's group that she really liked. Susan was doing fine. One night she went to a party with a friend and had a drink. It felt really good and Susan thought that it would be okay if she started having a few drinks now and then. She didn't tell her peers in the active treatment group what she was doing, and little by little she stopped going to her AA meetings. Susan's case manager noticed that Susan's mood was changing and that she was irritable a lot of the time. What started as a drink now and then turned into daily drinking that Susan could no longer hide. Her peers in the active treatment group confronted her. Susan felt so uncomfortable that she dropped out of the group. Finally, Susan returned to the persuasion group, where she was reminded of the effects that alcohol was having on her symptoms. The group talked about how she probably wasn't able to have just one or two drinks. After a period of time, Susan was able to return to the active treatment group. After eight months of staying substance free, Susan moved into relapse prevention. She developed strategies to avoid relapse and maintain an awareness of the relapsing nature of her co-occurring disorders. She focused on getting a job at a florist shop, which had been a dream of hers. She also focused on her goal of owning a home.