

# Models of Service for Persons with Co-occurring Mental Health and Substance Use Disorders: **A Review of the Literature**

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## Introduction

The purpose of this paper is to present a cursory review of current literature on how mental health and addiction services can best be organized and delivered to meet the needs of persons with combined mental health (MH) and substance abuse (SA) disorders. It is well known that this target group is not well served under the current configuration of separate mental health and addiction services. The literature review will focus on addressing this problem from a service system planning perspective. The context of this literature review is that it is part of a multi-agency community initiative committed to improving services (including removing services barriers ) for persons with dual disorders.

Much of the literature pertaining to this issue is relatively recent, dating back a mere 15 –20 years. It will be apparent to the reader that universal terminology is lacking and that the terms used to refer to the condition will vary depending on the author. The author of this paper has taken liberty to try to refer to the focal problem condition as “dual disorder”, although it is also referred to variously as dual diagnosis, co-existing disorder, co-occurring disorder, co-morbidity and concurrent disorder.

## Prevalence of Dual Disorder

In a recent study of all persons seeking alcohol or other drug treatment in Ontario, it was found that 65% had also had a psychiatric disorder (Ross et al, 1998). Drake and Mueser (2000) estimate that approximately 50% of clients with severe mental illnesses who are in community mental health programs develop substance use disorders (SUD) at some time in their life; between a 1/4 and 1/3 experience active SUD. Such co-occurring disorders, they say, are associated with a multitude of problems including high rates of suicide, homelessness, hospitalization and incarceration.

## Classifying Dual Disorder Subtypes (Differential Diagnosis)

As Robert Drake and Michael Wallach (2000) point out...

*In many ways dual diagnosis is an unfortunate misnomer... The population of persons with co-occurring mental health and substance use disorders is itself quite heterogeneous. It includes individuals with less disabling mental illnesses such as anxiety disorders, those with different severe illnesses such as schizophrenia and bipolar disorder, and those with either substance abuse or substance dependence.*

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Ries R.K. and Miller, N.S. (1993) developed a four-cell table as a heuristic tool for identifying diagnostic subtypes. The identification of subtypes is helpful for determining what service specializations need to be involved and when, and what level of care is appropriate. The Ries and Miller four-cell table invites classification of clients on the basis of an independent assessment of severity in each of the MH and SA domains. When combined, clients may fall into high-high, high-low, low-high, or low-low categories.

	Substance Abuse High Severity	Substance Abuse Low Severity
Psychiatric Disorder High Severity	<b><i>High/ High</i></b>	<b><i>High/ Low</i></b>
Psychiatric Disorder Low Severity	<b><i>Low/High</i></b>	<b><i>Low/Low</i></b>

Another dual disorder typology is offered by Sheldon Zimberg (1999). His model identifies 3 subtypes:

- Type I      Primary psychiatric disorder
- Type II     Primary substance abuse disorder
- Type III    Dual primary disorders

Such classification systems are important for assisting in assessment and triage in integrated service systems where access to fully integrated programs will likely always be limited in terms of the number of cases that can be accommodated within long-term intensive case management programs.

## Barriers to Service

The co-morbidity literature indicates that people with combined mental illness and substance use issues tend to be viewed by both mental health and substance abuse clinicians as difficult to serve. They are viewed as highly emotional and difficult to manage, poor treatment compliers, time consuming, lacking social supports, more likely to quit treatment and more likely to experience relapses. Traditionally specialized mental health (MH) and substance abuse (SA) have tended to operate separately and clients with dual disorders often find themselves falling into gaps between these two services systems. Several related service system barriers are identified in the literature. They include, among others:

- Difficulty in diagnosing a dual disorder

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- Most traditional mental health and substance abuse programs typically are not designed to accommodate dual disorder clients
- Propensity for clinicians to view dual disorder clients as the responsibility of the alternate service field
- Lack of specialized services and cross-trained clinicians
- Lack of shared case management, shared tools, and assessment language between the fields
- Fundamentally different perspectives on the nature and origin of the problems experienced by the client and different perspectives on what constitutes appropriate treatment responses
- Organizational funding and governance barriers to cooperative and collaborative program development.

[A more extensive look at the potential for conflicting approaches in MH and SA can be found in the 1994 paper by Richard Ries, entitled, “*Assessment and Treatment of Patients with Coexisting mental Illness and Alcohol or Drug Abuse*”.]

A discussion of these issues from a Canadian perspective can be found in the 1995 Discussion Paper from Health Canada entitled, *Exploring the Links Between Substance Use and Mental Health*.

### An Evolution in Service Approaches

Over the past fifteen years, there has been considerable movement towards seeking greater integration of services in an attempt to better meet the needs of the vast numbers of dual disorder clients. Attempts to integrate services have resulted in the incorporation of intensive case management approaches, assertive outreach components, and longitudinal stage-wise programming which are designed to match program effort with client motivation (Drake et al., 1998). Inter-system consultation, collaboration and integration of services are now becoming the treatment standard for persons with dual disorder.

In 1992, Richard Ries identified three basic service delivery patterns which appeared to apply to community-based treatment for persons with dual diagnosis. He called these patterns sequential/serial, parallel and integrated. This typology has been used extensively as a framework for discussing the desired directions in system change.

- **Sequential / Serial Services**  
Sequential patterns are the norm where traditional separate systems rules apply. With sequential treatment the patient is treated first in one system and then the other. These patterns are now seen as the most highly problematic for dual disorder clients.

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- **Parallel Services**  
Parallel treatment involves the client simultaneously in separate mental health and substance use treatment programs. It tends to place the responsibility for integration, continuity and coherency of services with the client and this can be problematic where the service systems do not share common philosophy, approaches or language and where few attempts are made to bridge the differences.
- **Integrated Services**  
Integrated approaches combine elements of both systems into a unified program. It involves cross-trained clinicians and unified case management. Each system of care within the integrated model must include program elements to meet the needs of clients at every phase of rehabilitation. This approach is posed as the ideal for clients with two or more primary disorders.

Drake and Mueser (2000) point out that integrated services are primarily focused on outpatient or community-based settings. The reasons for this, they say, are because...

- There is little evidence that hospital-based treatment is, by itself, effective in helping dual disorder clients to achieve stability; and
- Longitudinal evidence on recovery suggests that dual disorder clients attain stability over months and years while living in the community.

Mueser et al (1997), and Drake et al (1998), both provide excellent summaries of the current research supporting integrated service approaches. Whereas the Drake article speaks of the integration concept as a working hypothesis with only modest empirical support, Mueser et al (1997), state that “despite a lack of controlled studies, the weight of evidence on the effects of integrated treatment from some 30 studies is overwhelmingly positive”. These sentiments were echoed in the 1999 Report from the U.S Surgeon General. According to this report,

*Research amassed over the past 10 years supports a shift to treatment that combines interventions directed simultaneously to both conditions – that is, severe mental illness and substance abuse—by the same group of providers...*

*Combined treatment is effective at engaging people with both diagnoses in outpatient services, maintaining continuity and consistency of care, reducing hospitalization, and decreasing substance abuse, while at the same time improving social functioning.*

## Horizontal and Vertical Integration

Kenneth Minkoff (1999) distinguishes two facets of integration which provide a useful way of talking about different aspects of continuity in service. He refers to horizontal and vertical integration as two aspects of continuity... Horizontal integration refers to how well the services provided by different providers meld into a seamless service experience. Vertical integration refers to how well the client experiences continuity in their movement across the levels of care or stages of treatment regardless of who the providers are.

## Best Practice Service Principles and the Development of New Service Standards For Persons with Dual Disorders

Robert Drake identifies the following “Principles of Treatment” (Drake et al, 1993; also, Mercer-McFadden et al, 1998):

- **Assertive outreach**
  - Incorporating active interventions such as community outreach
- **Close monitoring**
  - Providing intensive supervision or intensive case management (voluntary or involuntary)
- **Integration**
  - Simultaneous and coordinated MH and SA service provision
- **Comprehensiveness**
  - Provision of a wide range of intervention and support services designed to meet basic needs of clients necessary for stable recovery. For example, depending on the client’s stage of rehabilitation, service components may need to address needs related to acute crisis stabilization, medication and psychiatric stabilization, detoxification and drug rehabilitation, physical health and nutrition, finances, housing, relationships, education and employment, recreation and social activity.
- **Stable living environment**
  - Providing access to a range of safe, supportive housing option
- **Flexibility and specialization**
  - Maintaining access to specialized service components for MH and SA but where the specialized programs have adopted the flexibility needed to address the additional challenges of dual disorder clients.
- **Stages of treatment**
  - Providing services to match the needs of clients at different stages of interest in change, where the movement from one stage to another is viewed as non-linear. Drake refers to the four stages of treatment developed by Osher and Kofoed (1989):

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- Engagement;
- Persuasion;
- Active Treatment; and
- Relapse Prevention
- **Longitudinal perspective**
  - Viewing both conditions as potentially chronic and usually relapsing, where programs are designed to expect and accommodate frequent failure, and where the focus should be on stabilizing small gains.
- **Optimism**
  - As demoralization is a common barrier to client progress, it is important that service providers work from an optimistic perspective and toward the enhancement of client optimism and self-efficacy.

After their review of 36 research studies on the effectiveness of integrated treatment for people with dual disorders, Drake et al (1998), affirmed that the program features that appeared to be most associated with effectiveness were: assertive outreach, case management, and longitudinal, stage-wise, motivational approaches.

In June of 1999, the Substance Abuse and Mental Health Services Administration (SAMHSA), in United States declared it's position on the treatment of individuals with co-occurring addictive and mental health disorders. The conceptual framework endorsed by SAMHSA identifies three levels of service coordination:

- **Consultation**

Consultation involves informal relationships among providers especially suitable with regard to identification, assessment and engagement phases of intervention and appropriate for individuals with less severe disorders
- **Collaboration**

Collaboration involves formal relationships among providers that ensure both problem areas are addressed in a treatment regimen. Collaboration is envisioned as most appropriate for persons with one disorder more severe than the other
- **Integration**

Integration is defined as an array of appropriate substance abuse and mental health interventions identified in a single treatment plan based on individual needs and appropriate clinical standards and provided or coordinated by a single treatment team. It is the recommend treatment approach for individuals with two or more equally severe co-occurring disorders.

In the report entitled, National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders (1999) the National Associations of State Mental Health and Alcohol and Drug Abuse Program Directors identified a list of “desirable system characteristics” in the provision of care for people with co-occurring disorders. These characteristics were subsequently endorsed by SAMHSA.

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- **Ongoing commitment** by all key stakeholders to building and sustaining a strong foundation of shared principles and values.
- **A consumer-centered system** where clients and their families are involved in treatment decisions, program design and evaluation.
- **A “no wrong door” approach** to service accessibility
- **A comprehensive, long-term care approach**
- **Strong focus on engagement** as a system of care that is welcoming, empathetic and hopeful
- **Integrated service delivery** to achieve a “seamless” system experience for the consumer. While integrated programs are not necessary, the experience of integrated delivery should be present.
- **Respect and trust** should characterize the relationships between staff and clients and between the providers across systems.
- **Cross-training** must be sufficient to create effective collaboration and give staff enough knowledge to know what they do not know and need to seek through consultation.
- The use of **common data, assessment tools and performance indicators**

In February of 2000, the American Association of Community Psychiatrists (AACP) approved the following Principles of Comprehensive, Continuous, Integrated System of Care for Persons with Co-Occurring Psychiatric and Substance Disorders:

- Optimism
- Acceptance
- Accessibility
- Integration
- Continuity of Care
- Comprehensiveness
- Individualized Treatment
- Quality Care & Responsible Implementation

With regard to this last point, the AACP Principles include a useful list of process guidelines for ensuring quality care and responsible implementation. They include:

- Identification of existing services and specifications for the role of those services in the system of care
- Identification of services enhancement needs and service gaps
- Development of clinical competency standards and a training plan
- Development of policies, procedures and mechanisms to ensure the implementation of the system of care
- Creation of an infrastructure empowered to oversee implementation
- Development of mechanisms for enhancing consumer and family involvement
- Identification and monitoring of quality markers

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## In Canada...

In Canada, the 1995 discussion paper from Health Canada which looked at ways to improve the links between MH and SA included three key recommendations for improving services to people with dual disorders: Improve collaboration and partnership; improve client-centred services; and, strengthen community services and their links to formal services.

In 1997, the Canadian Mental Health Association in Ontario released a policy paper on concurrent disorders which called for more collaborative efforts and a more coordinated system of care. This paper also supported a greater role for flexible harm reduction strategies in the treatment of concurrent disorders.

In the *Review of Best Practices in Mental Health Reform* prepared for the Canadian FPT Advisory Network on Mental Health (1997), a conceptual framework for mental health and addiction services was presented. The best practice framework identified the need for provision of a comprehensive array of services which include: crisis response services; inpatient and outpatient care; assertive community outreach; consumer and family self-help; vocational services; and, housing services. This framework was adapted by the Canadian Institute for Health Information for use in its work to develop national indicators for mental health and addiction services (CIHI, 2000)

In 1999, the Centre for Addiction and Mental Health in Ontario posted a best advice paper on concurrent disorders on its website. The recommendations for improving treatment service included:

- Collaborative initiatives within and between the MH and SA systems give consideration to strategies that incorporate protocols for information sharing on existing programs and individuals in care, for staff cross-appointments and cross-training opportunities
- Services in both systems be encouraged to make program policy changes that promote flexible responses and alternatives
- Providers in both systems be open to alternative or new approaches to care including harm reduction, stepped care, motivational enhancement, brief and or early intervention and cognitive behavioural approaches
- Uniform definitions of case management be identified, with attention to roles of case manager versus primary therapist
- Self-help groups need further education regarding services and support mechanisms
- The role of 12-step programs in providing support needs to be explored
- The role of family treatment programs needs to be explored
- Staff in both systems receive education and training in the identification and assessment of concurrent disorders

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- Training in identification and referral also be provided to persons working in areas of crisis response

### Comprehensive, Integrated Program Models in Practice

*The New Hampshire Dual Diagnosis Program*, operated through the New Hampshire-Dartmouth Psychiatric Research Center, was perhaps one of the earliest models of integrated programming. This model was, however, based within the mental health service. Components include: continuous treatment teams (24 hour outreach), residential treatment beds, inpatient psychiatric services, individual and group counseling, housing stabilization, medical management, family support, and employment support services (Drake et al, 1990; also, Mercer-McFadden et al, 1998). [A similar program model is described by Kathleen Sciacca (1997)]

*The Assertive Community Treatment (ACT) Model* of community mental services is perhaps best known for having its origins in Madison Wisconsin in the early 1970's. This community outreach model combines intensive case management, cross-trained multidisciplinary teams and a comprehensive array of support services in a 24 hour, 7 day a week, primary provider program. It is a model of care that is well suited to the inclusion of dual disorder clients and incorporates most of the principles of integrated service delivery identified in this paper. In many cases expertise for working with dual disorder clients is incorporated into the range of skills available on the ACT team. One of the recommendations of the Canadian Mental Health Association's position paper on ACT Teams (June, 2000) was that all ACT teams should develop the capacity to serve people with concurrent (dual) disorders. In the case at the Harborview Mental Health Services Program in Seattle, the ACT model may also be specifically augmented to include special dual disorder teams (Wingerson and Ries, 1999). Although the model continues to draw criticism for being paternalistic and coercive (Gomory, 1999), the general consensus appears to be that it is effective in reducing hospitalizations and improving client outcomes.

### Themes in the Literature

Several issue themes appear to emerge from this literature:

- One is the issue of **availability and accessibility** of appropriate services to meet the needs of this specific population.
- Another is the issue of **engagement and retention** of these people in the services that are available and accessible.
- A third is the issue of **effectiveness and satisfaction** produced as result of participation in a service or program

Availability and accessibility are perhaps the most predominant themes in the integrated services literature. Service principles that address comprehensiveness, system capabilities and competencies, and horizontal integration fall into this

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category. Engagement and retention themes relate to service principles that address outreach capacity, stepped/staged care, flexibility, individualization, and motivational enhancement (acceptance, empathy and optimism) as aspects of vertical integration. Effectiveness and satisfaction themes arise in relation to principles which support consumer involvement and accountability, but these themes are also present in the literature that deals with the effectiveness of specific therapeutic strategies applied to dual disorders.

This literature view has largely exclude examination of specific therapeutic strategies and their bearing on engagement and retention or effectiveness and satisfaction. This is an area that may require further attention as the community initiative moves into implementation planning phases.

### Some Practical Issues and Challenges

Perhaps the greatest challenge to service providers comes when attempts are made to apply the principles and models of best practice to the unique aspects and contingencies of the local mental health and addiction service systems. Drake and Mueser (2000) point out that “despite the encouraging findings regarding integrated treatment programs and the widespread acceptance that integrated treatment is superior to nonintegrated treatment for this population, implementation continues to be slow because of problems related to the organization and financing of programs.” Local services operate within set organizational structures and current service configurations are often protected. Structural and procedural changes typically arise as the result of separate initiatives which do not immediately threaten the existing order.

Although comprehensive service integration approaches related to dual disorder may not be a new concept, if we look at service integration initiatives in Canada, there is a very short history and relatively little experience to draw upon. The programs that seem to have generated the greatest interest and seem to have benefited from the greatest support, are those which follow the ACT model. Although these programs, by necessity, focus on a limited number of the highest need clients in any community, to the extent that they incorporate dual disorder competence, they may offer a powerful springboard, or a means to jumpstart community effort toward achieving a more comprehensive array of integrated services for all people with dual disorder.

Language differences between MH and SA service providers will vary and may create confusion in the context of integration efforts. These differences can only be addressed through local dialogue. In some cases the language and treatment approaches which appear in the literature, may not be suitable for application to local needs or may be confusing. For example, the addiction services field is not uniform in terms of the philosophical perspectives and languages used in conceptualizing the problems and service responses. Addiction services in Canada also tend to differ

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from those in the United States in terms of the predominant program philosophies and languages. Unfortunately, most of the literature on dual disorder is U.S. based. Even in Canada, the terminological differences related to dual disorders can be confusing. In Ontario, for instance, “dual diagnosis” is not used to refer to MH/SA combinations, but rather to refer to multiple MH. The term used to refer to MH/SA in Ontario is “concurrent disorder”.

## Conclusions

Although the literature reviewed for this paper could not be considered extensive, variations in terminology aside, it does reveal that there is a relatively high level of concurrence with respect to the key principles of quality service for people with dual disorders. Unfortunately, there does not appear to be an abundance of rigorous program evaluation literature to draw upon in this area. Much of the apparent consensus around best practices is largely a reflection of expert opinion supported by clinical experience and a limited number of clinical trials. The sources utilized in this paper reflect that reality. It is clear, however, that many of the organizational and therapeutic principles identified as best practices in this literature are also principles that are widely supported in psychosocial therapeutic literature as a whole. One of the overriding aims reflected in the dual disorder literature is the desire to create consumer experiences characterized by respect, acceptance, empathy, optimism, responsiveness, coherence and continuity. These qualities are readily identified in current literature that examines the common factors in therapy most effective in supporting positive outcomes (Hubble, et al., 1999).

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