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Integrated Dual Disorders Treatment — A New Wave in Recovery
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A collaborative approach integrating systems that treat clients with mental illness and substance abuse disorders not only gains momentum—it makes sense.

Ric Kruszynski, director of consultation and training for the Ohio Substance Abuse and Mental Illness (SAMI) Coordinating Center of Excellence (CCOE), was working as a case manager in a community mental health center in Ohio 15 years ago when he had an experience that would shape the direction of his professional life.

One of his clients was struggling with mental health and substance abuse issues. Although Kruszynski, who holds MSSA, LISW, and LICDC credentials, and his coworkers had been somewhat successful at stabilizing the client’s psychiatric condition, they had not been as successful in dealing with the client’s substance abuse issues. Kruszynski sought the help of providers who portrayed themselves as a SAMI service.

"I took a gentleman to that program for an assessment,” Kruszynski recalls, “and their message to me was, ‘Well, we can take him in the program once you get him sober for a week.’ And my response was, ‘If we could get him sober for a week, we wouldn’t need your services!’"

This was Kruszynski’s first face-to-face encounter with how mental health and substance abuse providers play “pass the buck” with clients diagnosed with dual, or co-occurring, disorders.

"Basically, the logic is that we’re requiring people to be better from the problem they need help with in order to get the help,” Kruszynski says. “It’s how we’ve treated folks with co-occurring disorders for a long time. ‘Here, go get stable and then you can come to our addictions clinic. Go get sober and then you can see our doctors.’ We bounced them back and forth within the system.”

The phenomenon of co-occurring disorders has been well known for decades. Mental health clinicians and substance abuse specialists alike have long been aware that people with severe and persistent forms of mental illness often have serious substance abuse issues. However, slow in coming has been a way of dealing with these co-occurring disorders that makes sense by giving clients integrated treatment options under one roof.

One such model is the integrated dual disorder treatment (IDDT) model developed at Dartmouth Medical School. Integrated Treatment for Dual Disorders: A Guide to Effective Practice was published in 2003, and one of the authors is Kim T. Mueser, PhD, a professor of psychiatry and community and family medicine at Dartmouth.
In the mid 1980s, Mueser was coordinating a National Institute of Mental Health clinical research project at Drexel University in Philadelphia, evaluating family psychoeducational programs and pharmacological maintenance strategies for people with schizophrenia. "Whenever the issue of substance abuse came up, we mostly tried to work around it," Mueser recalls. "We'd tell people that using alcohol and drugs wasn't good for them and that it tended to exacerbate symptoms, but that was all we did."

At that point, Mueser, in his own words, "decided to take the bull by the horns" and conducted a review of the available literature on the epidemiology of substance abuse of people with schizophrenia. Mueser found that the prevalence of substance abuse in people with schizophrenia was much higher than in the general population—about 50% over the lifetime as opposed to 15%. In addition, it was abundantly clear that the outcomes for people with co-occurring disorders were much worse than for the average person with schizophrenia.

"People with severe mental illness tend not to follow through on referrals for addiction treatment," Mueser explains. "So it became clear that there was a greater problem than the actual methods used to treat substance abuse in this population. The system was ineffective because it tended to segregate mental health and addiction treatment providers. At that point, there was already a growing consensus about the importance of integrating treatments for both mental illness and addiction, as reflected by the seminal work of Robert E. Drake, MD, PhD, and Kenneth Minkoff, MD."

Existing approaches for treating dual disorders were generally informal, not research driven, and "not the product of everyone’s best efforts," according to Kruszynski.

"The best I can describe it is that a lot of 'winging it' was going on," says Kruszynski. "In terms of ensuring consistency of treatment and, more importantly, consistency of outcomes, there wasn’t a whole lot out there."

The IDDT model uses a collaborative, multidisciplinary team approach to coordinate every aspect of a client’s recovery and ensure that all the service providers involved in the client’s care are working toward a common goal. Another important aspect of IDDT is “stagewise interventions” based on the understanding that clients with a dual diagnosis benefit most from incremental successes in recovery, which the authors of IDDT have formalized as “Four Stages of Treatment.” IDDT also takes a radically realistic perspective on the phenomenon of relapse, encouraging organizations to provide clients with continuous services throughout their entire life span, even when symptoms are infrequent, and not to discharge clients when they return to using drugs or alcohol or stop taking their medication.

Meeting Resistance
New ways of conducting treatment are inevitably met with resistance, and IDDT is no exception. At the administrative or service provider level, one major point of resistance is eligibility requirements. Some mental health providers take the stand that they can't verify a client’s mental illness diagnosis if the client has an active substance abuse problem and will not consider him or her an appropriate candidate for mental health treatment until the substance abuse problem is under control.

Other providers may say they can’t treat the person’s mental health problem pharmacologically for fear of interactions with their substance abuse problem. Conversely, substance abuse treatment providers may require a client to have his or her mental illness stabilized before accepting him or her for substance abuse treatment. Also, because many states and communities still have a systemic split between mental health and substance abuse services, providers must deal with two sets of billing structures and two sets of regulatory guidelines that make the task of integrating services even more daunting.

Dealing with the challenges that organizations face in implementing IDDT is what Kruszynski does every day at Ohio’s SAMI CCOE, which emerged as a partnership between Case Western’s Mandel School of Applied Social Science and psychiatry department. Kruszynski and the Ohio SAMI CCOE provide training and technical support...
to 60 teams in 40 different organizations, which have grown from nine pilot treatment teams in 2000. In Kruszynski’s words, “The growth of IDDT in Ohio has been nothing short of staggering.”

When it comes to understanding the bureaucratic hurdles IDDT faces, Kruszynski cuts to the chase: “What you have to realize is that all current policy is in place to support current practice. Any time you attempt to update or innovate your practice, your policy or your platform becomes potentially obsolete. So a major challenge for any program that attempts to implement IDDT is the fact that they are set up from a policy and procedures standpoint to do things the way they’ve always done them.”

In addition to major bureaucratic challenges, IDDT also faces resistance from providers on a more personal, human level. “You get resistance from providers on a couple of levels,” says Mueser. “They sometimes say, ‘Hey, I went into this field to treat people with mental health problems, not to treat people for addiction.’ Those providers are unaware that many people with mental illness have a problem with addiction, and it’s difficult or impossible to treat one disorder without dealing with the other.”

Then there’s the ever-present issue of resources and funding. Providers who are required to implement IDDT may feel that they’re being asked to take on more than they can handle. “Providers in that situation sometimes say, ‘I have more than enough on my plate,’” says Mueser. “‘You expect me to attend to a person’s housing, their family, their social relationships, their illness self-management, and now you want me to attend to their addiction. I can’t do that with the amount of resources available to me.’”

While Mueser concedes that this argument may be somewhat true, it’s based on a short-term view of how IDDT can affect day-to-day practice. “My belief is that because we know the addiction worsens all the other aspects of functioning,” says Mueser, “whether you intend to treat the addiction or not, you’re treating the consequences of addiction. So if you’re working on stabilizing the client’s housing, your work would actually be easier if you spent some time focusing on treating the addiction and maybe less time on just stabilizing housing.”

Kruszynski credits forward-thinking policy makers at the state level for the success of IDDT in his state. “The great thing about Ohio is that both state departments have been extremely committed to breaking down those old barriers. A few larger system issues may never change, but our policy makers have been able to step up and make a number of changes in the interest of doing treatment that works,” he says.

Other Kinds of Resistance
As many social workers know, clients can become just as accustomed to the old ways of doing things as their providers and, as such, can present a whole other level of resistance to IDDT. Mueser believes this is especially true for clients who encounter IDDT in a mental health setting rather than an addiction treatment setting.

"Most people in addiction treatment are propelled into treatment by virtue of legal consequences or the dire social or health consequences of their addiction,” explains Mueser. “They may have limited motivation, but they have some motivation if only because they’ve been persuaded or coerced into treatment and thus they usually have some awareness of their substance abuse problems. On the other hand, people who are in the mental health treatment system are in treatment for mental health problems, and they don’t see themselves as being in treatment for an addiction. They often don’t have the insight and motivation to address it, and if you push it too hard and too fast, they just bolt because they often have a very tenuous treatment relationship in the first place.”

Cynthia Godin, MA, project director of a co-occurring state incentive grant for the Minnesota Department of Human Services, believes it’s the uniquely person-centered focus of IDDT that allows providers to overcome some client-based resistance. She also believes that substance abuse treatment providers have a clinical perspective that makes them particularly adept at tailoring treatment to meet clients’ present needs.
"A lot of advanced training, especially in mental health, is based on theory," says Godin. "Substance abuse treatment is more behavioral and less abstract and theory based. Your client might be in different areas of recovery and might feel like giving up alcohol but not crack cocaine, for instance. That's what IDDT does—it allows you to work in a person-centered way and help people recover at their own pace."

**Customizing IDDT: CDP**

While IDDT focuses on individuals with co-occurring severe and persistent mental illness and substance abuse, other mental health and substance abuse treatment professionals are taking the lead in developing integrated treatment for people with less severe forms of mental illness.

To address this need, the Hazelden Foundation began collaborating with Dartmouth Medical School faculty to develop the Co-occurring Disorders Program (CDP). "We started our discussions with the faculty of Dartmouth Medical School about a year ago," says Richard Solly, MA, senior acquisitions editor of Hazelden's Publishing and Educational Services, "and everything went full steam in September."

According to Sue Hoisington, PsyD, executive director of Hazelden’s mental health centers, 70% to 80% of clients admitted to Hazelden residential programs for substance use disorders also have a co-occurring mental health disorder, such as depression, anxiety, or posttraumatic stress disorder. Hoisington recognizes that addiction treatment providers such as Hazelden have not always done the best job when dealing with their clients’ mental health issues.

"Back in 1996, I had a patient who had been through one outpatient treatment with us at Hazelden," Hoisington recalls. "When he came into treatment, he was pretty depressed." Through the course of his treatment, the client's depression improved, and he left with what Hoisington felt was a good sense of how to handle his recovery. However, six months later, he was back in Hazelden’s medical unit.

"I went to see him," Hoisington recalls, "I said, 'What happened?' And he said, 'You know, Sue, I went home, I did what you told me to do. I was going to meetings, my wife and I were working on our relationship, I was back at work, I had a good sponsor—and I felt like crap. And I said to myself, 'If this is what recovery is, I don’t want it.' That's when I told myself, maybe there's something to these symptoms that persist after abstinence."

**In Education**

When it comes to IDDT, as is often the case with new models of practice, the training that young social workers receive in school has some catching up to do. As is the case with policy in the workplace, the standards for accreditation are tied to current practice.

"For the most part, social workers—even clinical social workers—are not required to learn anything about treating substance abuse in order to become social workers," says Kenneth Minkoff, MD, a clinical assistant professor of psychiatry at Harvard Medical School. "A message you don't want to send is, 'Hey, social workers, if you're interested in co-occurring disorders, you can go work in a special integrated program. But if you don't want to do that, don't worry, you'll never need to know how to deal with substance abuse as long as you live,' because that's not true."

Despite the apparent dearth of information about substance abuse and IDDT in social work degree programs, Godin points out some positive developments and strategies for raising awareness of IDDT at the educational level.

"I’ve heard from new graduates that they are receiving some training in IDDT principles such as motivational counseling," says Godin. "But most of the training in IDDT is through continuing education or conferences rather than the actual graduate degree programs. The state of Minnesota is very interested in working with universities to add specialties to already established curriculum."

Kruszynski is also actively involved in getting IDDT woven into the fabric of social work
education. “When I went to the ... Mandel School of Applied Social Sciences as a master’s student in 1993, there were courses that were addressing some of what we now know to be core components of this model,” says Kruszynski. “The model had yet to fully emerge as IDDT, but they were talking about these kinds of things. We now interface with a number of university social work programs; the school of social welfare at Kansas University is very committed to IDDT and has been doing some great work for years now. The University of Cincinnati includes IDDT in their coursework.”

A strategy that Kruszynski favors for exposing young social workers to IDDT involves field placements with organizations that use it. “You can get a lot of core structural elements in the classroom around the model,” says Kruszynski, “but it’s no substitute for being in and around the work from a practice standpoint in real life.”

Hoisington and Solly both understand the importance of education and training in furthering the IDDT’s cause. Hazelden Recovery Services has already incorporated important aspects of the CDP into their treatment model and teach about co-occurring disorders in their graduate school. They will be collaborating with Dartmouth Medical School faculty to provide clinicians with training in CDP and education about the complex issues associated with integrated treatment.

**Looking Ahead**

Mueser believes that education will play a major role in dissolving the barriers that IDDT faces. “That’s where the greatest impact can be made,” says Mueser.

Minkoff says IDDT is just part of a bigger picture. “The Dartmouth model, IDDT, is just one type of program,” says Minkoff. “The Dartmouth model is a set of tools and practices for people with serious mental illness. There are other tools and practices for women who have been the victims of trauma and are in the addiction system or for kids and families and adolescents. And there are core elements to all these tools and practices that can be matched within any type of program for its particular type of population.”

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**Integrating Systems**

Kenneth Minkoff, MD, a clinical assistant professor of psychiatry at Harvard Medical School, provides consultation to state, county, and regional systems in more than 30 states, helping systems meet the challenges of reforming themselves to become what Minkoff refers to as “welcoming, recovery-oriented, integrated systems of care in which every program becomes a co-occurring disorder capable program, and every clinician becomes a co-occurring disorder competent clinician.”

Minkoff points out that one difficulty of establishing an integrated system is defining what an integrated system actually is. "What an integrated system isn't is a kind of administrative merger," says Minkoff. "What you have to do in an integrated system is develop the capacity to deliver integrated services to the people who need them wherever they show up. It has to be translated into all of your system instructions, funding instructions, program contract instructions, clinical practice standards, and everything else. You have to realize that co-occurring disorders are the expectation, not the exception.”

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