Co-Occurring Disorders: Integrated Dual Disorders Treatment

Implementation Resource Kit

DRAFT VERSION
2003

Implementation Resource Kit User's Guide

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Acknowledgments

We wish to acknowledge the many people who contributed to the development of the materials on integrated dual disorders treatment for the Implementing Evidence-Based Practices Project:

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This document is part of an evidence-based practice implementation resource kit developed through a contract (no. 280-00-8049) from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) and a grant from The Robert Wood Johnson Foundation (RWJF), and support from the West Family Foundation. These materials are in draft form for use in a pilot study. No one may reproduce, reprint, or distribute this publication for a fee without specific authorization from SAMHSA.

Foreword

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) is a proud sponsor of this implementation resource kit for integrated treatment of dual disorders. As the federal agency responsible for promoting the quality, availability, and accessibility of services for people with mental illness, CMHS is responsible for identifying treatments for mental illness that work. The materials in this resource kit document the evidence for the effectiveness of integrated treatment of dual disorders and provide detailed information to help communities to implement the practice in real world settings. During development of the implementation resource kit, we placed special emphasis on 1) strengthening the consensus-building process, 2) expanding the involvement of consumers and families, 3) including practical orientation to issues involving service organization and financing, and 4) insisting on paying careful attention to issues of ethnic and cultural sensitivity and overall cultural competence. We are well pleased with the result.

Many other organizations contributed to developing this implementation resource kit. This broad coalition of researchers, providers, administrators, policy makers, consumers and family members, gives the resource kit its strength and vitality. We are especially appreciative of the support provided by The Robert Wood Johnson Foundation that sponsored the early stages of the Project, when evidence-based integrated treatment of dual disorders was identified as a practice ready for widespread implementation. We agreed. Substance abuse is the most common and clinically significant comorbid disorder among adults with serious mental illnesses. Research and clinical experience have yielded four basic and consistent findings regarding co-occurring psychiatric and substance use disorders: 1) about 50 percent of people with serious mental disorders are affected by substance abuse; 2) dual disorders are associated with increased rates of relapse, violence, incarceration, homelessness, and serious infections such as HIV and hepatitis; 3) most mental health providers are not trained to deliver substance abuse treatment interventions; and 4) the parallel, but separate, mental health and substance abuse treatment systems that are common in the United States deliver fragmented and ineffective care for individuals with dual disorders.

This implementation resource kit reflects the current state-of-the-art concerning evidence-based integrated dual disorders services. It addresses both the "key ingredients" of the clinical model and many practical considerations essential for successful implementation. It also describes the need for each community to adapt the model to its particular needs and characteristics. Careful attention to unique community needs, coupled with fidelity to the key ingredients of the practice, equals successful implementation. The closer the kit user comes to

following the implementation resource kit guidance, the more likely the practice will yield good results for consumers.

As mental health services research and evaluation progress, CMHS hopes to support the development of implementation resource kits for additional evidence-based practices, and to refine this and other previously-developed resource kits to take new evidence into account. Indeed, evaluation of planned pilot projects for implementing this resource kit and associated implementation strategies will tell us much about how to make improvements in future versions. We hope that this and other evidence-based practice implementation resource kits will be helpful to communities across the nation as they strive to provide the most effective services possible for persons suffering from mental illness.

Introduction

Welcome to the Integrated Dual Disorders Treatment implementation resource kit. It has been produced by the Implementing Evidence-Based Practices Project as part of an effort to promote treatment practices in community mental health service settings that are known to be effective in supporting the recovery of adults with severe mental illnesses. The goal: to improve the lives of consumers by increasing the availability of effective mental health services.

The User's Guide begins by providing general information about the Implementing Evidence-Based Practices Project, including the goals and values of the project. This is followed by descriptions of the materials contained in the resource kit and their proposed role in the implementation process. The basic structure of an implementation plan is outlined. Specific suggestions for implementing the practice of integrated dual disorders treatment are presented in the Implementation Tips documents. This guide also contains a list of annotated references on integrated dual disorders treatment and a special populations appendix which provides a review of the literature addressing the range of populations for which this practice has demonstrated efficacy or effectiveness.

If you have any questions or comments about these materials or the implementation process, please contact Kristine Knoll at the NH-Dartmouth Psychiatric Research (e-mail address: Kristine.M.Knoll@Dartmouth.EDU). We look forward to supporting your efforts to improve services to people with severe mental illness. Also, please share your experience in using these materials. Feedback from users will help refine and improve future versions of these implementation materials.

Background

What are "evidence-based practices"?

Evidence-based practices are services for people with severe mental illness (consumers) that have demonstrated positive outcomes in multiple research studies.

Over the past 15 years, researchers in mental health service systems have gathered extensive data to support the effectiveness of several psychosocial and pharmacological treatments. In 1998, the Robert Wood Johnson Foundation convened a consensus panel of researchers, clinicians, administrators, consumers, and family advocates to discuss the research and to determine which practices currently demonstrated a strong evidence base. This project is an offshoot of these efforts.

The six evidence-based practices:

Six practices were identified as currently demonstrating a strong evidence base:

- standardized pharmacological treatment
- illness management and recovery skills
- supported employment
- family psychoeducation
- assertive community treatment
- integrated dual disorders treatment (substance use and mental illness)

Other evidence-based practices for the treatment of persons with severe mental illnesses are being identified and will be promoted as the research evolves. This project is only a beginning attempt to establish models and procedures. This list of identified practices is not intended to be complete or exclusive. There should be many evidence-based practices in the future. Some promising practices being researched currently include peer support programming, supported housing, trauma services, and treatment for people with borderline personality disorder.

What is an implementation resource kit?

An implementation resource kit is a set of materials—written documents, videotapes, PowerPoint presentations, and a website—that support implementation of a particular treatment practice.

Specific materials in this resource kit have been developed for each of the key stakeholder groups involved in the implementation effort:

- consumers of mental health services
- family members and other supporters
- practitioners and clinical supervisors
- program leaders of mental health programs
- public mental health authorities

Research has shown that providing practice guidelines to practitioners alone does not change practice. Change is most likely to occur and be sustained if all the major stakeholders in the mental health system are engaged and involved in the process of change. Therefore the materials and guidelines in this implementation resource kit are geared toward five different stakeholder groups. The materials for each specific stakeholder group were either written by representatives of that group or in close collaboration with them.

The resource kit materials are also designed to address three stages of change:

- engaging and motivating for change (why do it)
- developing skills and supports to implement change (how to do it)
- sustaining the change (how to maintain and extend the gains)

What is an implementation package?

An implementation package is a set of implementation materials (the resource kit) combined with complementary training and consultation that support implementation of the evidence-based practice. The resource kit materials are designed to be most effective when used with consultative and training services. As part of the Implementing Evidence-Based Practices Project, EBP implementation centers are being established in various states across the country to provide consultation and training (see www.mentalhealthpractices.org).

How was this implementation resource kit developed?

A team made up of multiple stakeholders developed each resource kit: researchers, clinicians, program managers and administrators, consumers, and family members. Documents oriented toward specific stakeholder groups were either written by the stakeholders or in close collaboration with them. A consensus panel, also comprised of multiple stakeholders, reviewed the materials developed for all of the six implementation resource kits to ensure consistency of presentation and attention to the various perspectives of the different constituencies.

For more information

For a more detailed discussion of the project and the implementation strategies, refer to the enclosed *Psychiatric Services* articles:

Drake RE, Goldman HH, Leff HS, et al: Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services* 52:179–182, 2001.

Torrey WC, Drake RE, Dixon L, et al: Implementing evidence-based practices for persons with severe mental illnesses. Ps*ychiatric Services* 52:45–50, 2001.

Project Philosophy and Values

The project rests on two philosophical tenets:

First, mental health services for people with severe mental illnesses should have the goal of helping people to develop high-quality, satisfying functional lives. That is, services should aim not just at helping consumers stay out of the hospital and reducing or stabilizing symptoms, but also at helping them to pursue their own personal recovery process. People want services that help them to manage their illnesses and to move ahead with their lives.

Second, consumers and their families have a right to information about effective treatments, and in areas where evidence-based practices exist, consumers and family members have a right to access effective services.

Evidence-based practices are not intended to be exclusive, mandatory, or rigid. Rather, they imply self-knowledge, self-determination, choice, individualization, and recovery.

Defining recovery

There have been many efforts to define the recovery philosophy. The Consumer Advisory Panel for the Implementing Evidence-Based Practices Project drafted the following brief statement. The principles of recovery that informed the development of the implementation resource kit materials are:

- hope
- personal responsibility
- education
- self-advocacy
- support

The cessation of symptoms is not necessarily equal to recovery. Each person develops their own definition of recovery, which many view as a process rather than a destination.

It is important to know what is meant by “support.” While the support of others is a valuable element in recovery, it does not include solving problems for another person or giving advice.

Empowerment is another critical component to recovery. A person becomes dis-empowered when choices are made for them, even when well-meaning supporters do it.

Disempowerment also occurs when assumptions or judgments are made concerning an individual and their choices.

Recovery is most easily achievable when a person and those around them recognize the individual as a whole and complete person regardless of symptoms. One of the most valuable things a person can do for someone with psychiatric symptoms is to listen.

For more information

Copeland, Mary Ellen. *Wellness Recovery Action Plan*. 1997. Peach Press.

Ralph, Ruth O. *Review of Recovery Literature: A Synthesis of a Sample of Recovery Literature 2000*. Report produced for NASMHPD/National Technical Assistance Center for State Mental Health Planning.

Components of the Integrated Dual Disorders Treatment Implementation Resource Kit

The following describes the purpose and content of the individual resource kit materials. This section is followed by a description of the use of these materials in the implementation process.

Implementation Resource Kit User's Guide

This document describes the implementation resource kit and how to use it. It includes annotated references for the particular evidence-based practice.

Introductory Videotape

This short videotape functions as an introduction for all stakeholders to the evidence-based practice. Much of the film consists of different stakeholders speaking of their experience or demonstrating the practice in action. A Spanish-language version of this videotape is also available.

www.mentalhealthpractices.org

This website contains basic information about each of the six evidence-based practices. It includes references and links to other relevant websites. Information for consumers and family members is available in Spanish.

Information for Stakeholders (five documents)

These documents describe the evidence-based practice and highlight features of the practice most pertinent to the particular stakeholder being addressed. These are engagement pieces that address the question: why should I, as consumer, family member, practitioner, program leader, or administrator be interested in this practice? The documents for consumers and family members are available in Spanish-language versions.

Statement on Cultural Competence

This document addresses the need for practitioners and policymakers to integrate the design and delivery of the evidence-based practices within a culturally responsive context.

Practice Demonstration Videotapes

These videotapes model clinical skills critical for the implementation of the practice. They are designed for use in training and supervisory settings.

Workbook

The workbook is designed as a primer for practitioners regarding skills needed to provide the evidence-based practice. It emphasizes the knowledge and skill practitioners need in order to provide an effective intervention, one with high fidelity to the model. It is designed for use in training or supervisory settings.

Implementation Tips for Mental Health Program Leaders

This document provides practical guidance for agency program leaders on how to implement the evidence-based practice in a community mental health setting. It includes strategies for building consensus in organizations preparing for change and tips on how to develop policies and procedures to support the practice.

Implementation Tips for Public Mental Health Authorities

This document provides practical guidance for public mental health authorities on how to provide incentives and remove barriers to implementation of the evidence-based practice within their mental health system. Advice is given based on the experiences of mental health systems that have been successful in implementing the practice. This document emphasizes the importance of consensus building, creating incentives for change in practitioner and agency behavior, and identifying and removing barriers to change.

Client Outcome Measures

Using outcome measures to evaluate and track consumer gains and program success is critical for effective implementation of an evidence-based practice. Simple outcomes are identified that can be monitored as part of routine clinical practice. The tracking of outcome measures is used as a feedback mechanism for clinicians, supervisors, and administrators.

Fidelity Scale

Research indicates that the quality of implementation of the practice—adherence to principles of the model—strongly influences outcomes. The fidelity scale enables mental health program leaders to evaluate their program in comparison to the recommended principles.

Articles

Copies of general articles about evidence-based practices and implementation and an article describing the research evidence for this particular practice are included in the implementation resource kit.

Additional Implementation Materials

PowerPoint presentations are available to supplement the Integrated Dual Disorders Treatment resource kit materials. Contact the West Institute at the New Hampshire-Dartmouth Psychiatric Research Center (603-271-5747).

How to Use the Resource Kit Materials—An Implementation Plan

Effective implementation of evidence-based practices is best achieved by using the materials with a structured complementary consultative and training program. As part of this project, a number of evidence-based practices implementation centers have been established throughout the country. For more information on these centers, go to www.mentalhealthpractices.org.

A brief description of a basic implementation plan that includes these supports is provided below. See the *Implementation Tips for Mental Health Programs Leaders* and *Implementation Tips for Public Mental Health Authorities* for more detailed suggestions regarding the implementation of Integrated Dual Disorders Treatment.

Consensus building

Build support for change

- identify key stakeholders
- provide information to all stakeholders
- develop consensus regarding a vision for the practice at your agency
- convey a vision and a commitment to all stakeholders

Enthusiasm for the implementation of the evidence-based practice can be generated by communicating how the practice benefits consumers and family members.

Use implementation resource materials:

- Distribute information materials to the key stakeholder groups.
- Hold informational meetings with key stakeholder groups. Have opinion leaders within the different stakeholder groups co-host these meetings. Include a viewing of the introductory videotape. An introductory PowerPoint presentation can be used to structure the informational meeting.

Developing an implementation plan

An action plan

- identify an agency implementation leader
- establish an implementation steering team that includes representatives from all stakeholder groups
- secure a consultant from an EBP implementation institute
- develop an implementation plan

Responsibilities of the implementation leader and implementation steering team include identifying and utilizing personnel, resources, and processes (administrative support and system changes) needed to support the evidence-based practice; an assessment of training needs; and development of an implementation timeline.

Consultants from EBP implementation centers can work with public mental health authorities and program leaders to inform them about the practice, to evaluate an agency's or system's commitment to change, and to assess current realities of financial incentives, staffing, and structure.

By developing partnerships with community organizations including peer support programs, consumer and family advocacy groups, police, homeless shelters, food banks, department of vocational rehabilitation, and others depending on the specific practice, the implementation leader and the implementation steering team can most effectively develop support for the practice. These groups may contribute to the development of an implementation plan.

Use of implementation resource materials:

- *Implementation Tips for Public Mental Health Authorities* is designed for individuals at the municipal, county, or state mental health authority.
- *Implementation Tips for Mental Health Program Leaders* is designed to be shared with the individuals in an agency that make and carry out decisions about the local resources and processes. This includes people who have responsibility for program management, training, policy development, program standards, data management, and funding.

Enacting the implementation

Making it happen

- involve agency personnel at all levels to support the implementation
- host a "kick-off" training where all stakeholders receive information about the practice
- host a comprehensive skills training for agency personnel who will be providing the practice
- arrange opportunities to visit programs that have successfully implemented the practice
- work with an implementation center for off-site support for the practice
- review current agency outcome measures relative to the practice and modify outcome data to monitor the practice. Learn how to make use of outcome measures in clinical practice and supervision
- work with a consultant/trainer to learn how to use the fidelity scale to identify strengths and weaknesses in the implementation effort

Trainers can work with the agency to offer an initial or "kickoff" training for all stakeholders. The trainer can then provide comprehensive skills training for those personnel within the agency who will be providing the practice. The trainers may offer to visit the program at least one day per month for the first six months, then one day every other month for the next six months, for ongoing training, consultation, supervision as needed by the program. The trainer may also be available on a weekly basis for phone consultation.

Use of implementation resource materials:
Many agencies find it useful for the implementation leader and agency staff to familiarize themselves with the structure and processes of the practice by visiting an existing program. Before a site visit, the implementation leader and clinical supervisor(s) should review:

- Information for Practitioners and Clinical Supervisors
- Information for Mental Health Program Leaders
- Implementation Tips for Mental Health Program Leaders
- Workbook for Practitioners and Clinical Supervisors

Materials that support training and clinical supervision

- Workbook for Practitioners and Clinical Supervisors
- Practice demonstration videotapes
- PowerPoint training presentation (available from the West Institute)

Trainers may also serve as consultants to the administrators of the program. This includes demonstrating the usefulness of outcomes data as a clinical feedback tool. See *Monitoring Client Outcomes*.

Monitoring and evaluation

Sustaining change: How to maintain and extend the gains

- establish a mechanism for continuous feedback regarding how the practice is being provided in an agency
- publicize outcome improvements from the practice
- use fidelity scales to monitor the practice implementation

Monitoring and evaluation occur in several ways. First, the use of consultants to provide side-by-side, ongoing consultation during the first one to two years of the program is very helpful. Consultants who are experienced in the practice can recognize problems and recommend changes to address them.

Use of implementation resource materials:
It is useful for programs to become comfortable early on with the measures that will be used for monitoring and evaluating the delivery of the practice: outcome measures and the fidelity scale. The information collected can be used not only to identify areas that are problematic, but also to identify areas of excellence. See *General Organizational Index*. Feedback from these measures may be used to promote and strengthen clinical and programmatic effectiveness.

A Word about Terminology

Terms used in the Implementation Resource Kit materials

The materials were developed by people from a variety of backgrounds and perspectives. During development, 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 implementation resource kits. In some situations more precise, or alternative, terminology is used. For instance, in the Supported Employment implementation resource kit, the term 'employment specialist' is often used rather than "practitioner."

Consumers, clients, people who have experienced psychiatric symptoms

These terms refer to persons who are living with severe mental illness and who use professional mental health services—the consumers of mental health services. The term 'consumer' is most frequently employed in the resource kit materials. In the Integrated Dual Disorders Treatment workbook and in the outcome measures document, the term 'client' is used. The Illness Management and Recovery resource kit uses the term 'people who have experienced psychiatric symptoms'.

Family and other supporters

This terminology refers to families and other people who provide support to a consumer, and recognizes that many consumers have key supporters who are not family members.

Practitioners and clinical supervisors

The term practitioner refers to the people who deliver the evidence-based practice. This is used instead of clinician, case manager, nurse, psychiatrist, therapist, etc. except when referring to a specific kind of role (e.g., the employment specialist in supported employment, or the prescriber in medication management). The term clinical supervisor is used to distinguish between an administrative supervisor and the person supervising the clinical work of the practitioner.

Mental health program leaders

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

Public mental health authorities

This term is used to describe the people who determine the regulations and funding structures of the public mental health system. We recognize that evidence-based practices are also implemented and overseen in the private sector.

Phases of the Implementing Evidence-Based Practices Project

The Implementing Evidence-Based Practices Project was planned to take place in three phases over a five to six year period, as described below.

Phase I: Development of the Implementation Resource Kits—Fall 2000 to Summer 2002

During Phase I the core principles and critical elements of each of the six evidence-based practices were identified and guidelines for their implementation developed. This resulted in the development of a comprehensive implementation plan—production of implementation resource kits and development of a structured program of training and consultation—to facilitate the adoption of evidence-based practices in routine clinical settings.

Phase II: Pilot Testing the Implementation Resource Kits—Summer 2002 to Summer 2005

Phase II entails a multi-state demonstration of implementation using the resource kit materials in conjunction with a structured program of consultation and training. The goals are (1) to demonstrate that evidence-based practices can be successfully implemented in routine practice settings; (2) to improve the implementation resource kits including the recommendations for consultation and training support based on information gathered from pilot experiences; and (3) to learn more about the range of variables that facilitate or impede implementation in routine treatment settings.

Phase III: National Demonstration—starting in 2006

Phase III is designed to be a broad implementation effort in which the modified implementation resource kits will be made available throughout the United States. Research will focus on both evaluating the success of implementing evidence-based practices and their effects on client outcomes.

Annotated Bibliography for Integrated Dual Disorders Treatment

Practice Manuals

Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (expected publication date: Spring, 2003). *Integrated Treatment for Dual Disorders: Effective Intervention for Severe Mental Illness and Substance Abuse*. New York: Guilford Publications.

- Comprehensive clinical guide for the treatment of dual disorders from which some of the material in the implementation resource kit is drawn.
- Information on assessment, including forms and instruments, is provided.
- Ancillary treatment strategies described, such as residential and other housing approaches, involuntary intervention, vocational rehabilitation, and psychopharmacology.
- Detailed guidelines and vignettes provided. Individual (including case management, motivational interviewing, and cognitive behavioral counseling), group (including persuasion, active treatment, social skills training, and self-help groups), and family (including individual family and multiple-family group) approaches are described.
- Educational handouts covering different topics on mental illness, substance abuse, and their interactions are provided which can be duplicated for education with clients and family members.

Watkins, T. R., Lewellen, A., & Barrett, M. C. (2001). *Dual Diagnosis: An Integrated Approach to Treatment*. Thousand Oaks, CA: Sage Publications.

- Discusses strategies for integrating substance abuse treatment with care for mental illness.
- Separate chapters address different psychiatric disorders, including schizophrenia, bipolar disorder, depression, anxiety disorders, and severe personality disorders.

Ries, Richard and Consensus Panel (1994). *Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse*; Treatment Improvement Protocol (TIP) Series 9: DHHS Publication No. (SMA) 94-2078.

- Provides practical information about the treatment of patients with dual disorders.
- Separate chapters on treatment systems, linkages for mental health and substance abuse treatment, mood disorders, anxiety disorders, personality disorders, psychotic disorders and pharmacologic management.

Research and Conceptual Background

Reviews of the literature

Drake, R. E., Mercer-McFadden, C., Mueser, K. T., McHugo, G. J., & Bond, G. R. (1998). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin*, *24*, 589-608.

- Comprehensive review of research on integrated treatment for dual disorders
- Review covers a wide range of research, including early demonstration programs in establishing the feasibility of integrated treatment in community support service settings

Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., Lynde, D., Osher, F. C., Clark, R. E., & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, *52*, 469-476.

- Update on research on integrated treatment of dual disorders

Mueser, K. T., & Kavanagh, D. (2001). Treating comorbidity of alcohol problems and psychiatric disorder. In N. Heather, T. J. Peters, & T. R. Stockwell (Eds.), *Handbook of Alcohol Dependence and Related Problems* (pp. 627-647). Chichester, England: John Wiley & Sons.

- Provides an updated review of the epidemiology of dual disorders
- Describes integrated treatment approaches for dual disorders, with specific recommendations for different types of psychiatric disorders, including schizophrenia, bipolar disorder, depression and anxiety disorders

Mueser, K., Drake, R., & Wallach, M. (1998). Dual diagnosis: A review of etiological theories. *Addictive Behaviors*, *23*, 717-734.

- Reviews the research literature on different theories accounting for the high rate of substance abuse in persons with severe mental illness
- Challenges the prevailing hypothesis of high rates of substance abuse and severe mental illness could be explained by "self-medication" of distressful symptoms
- Marshals evidence suggesting that some excess comorbidity is due to increased biological sensitivity to the effects of drugs and alcohol in persons with severe mental illness

Drake, R. E., & Brunette, M. F. (1998). Complications of severe mental illness related to alcohol and other drug use disorders. In M. Galanter (Ed.), *Recent Developments in Alcoholism* (Vol. XIV, Consequences of Alcoholism, pp. 285-299). New York: Plenum Publishing Company.

- Summarizes research on the effects of alcohol and drug abuse on the course of severe mental illness

Selected research articles

Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S., Moring, J., O'Brien, R., Schofield, N., & McGovern, J. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and

family intervention for patients with comorbid schizophrenia and substance use disorders. *American Journal of Psychiatry*, *158*, 1706-1713.

- Describes a randomized control trial of an integrated treatment for dual disorders, including motivational interviewing, cognitive behavioral counseling, and family intervention with services as usual.
- Excellent outcomes were found for the integrated program, including substance abuse, relapse and rehospitalization.

Drake, R. E., McHugo, G. J., Clark, R. E., Teague, G. B., Xie, H., Miles, K., & Ackerson, T. H. (1998). Assertive community treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. *American Journal of Orthopsychiatry*, *68*, 201-215.

- Describes large randomized controlled trial comparing two different case management approaches for the delivery of integrated dual disorder services: assertive community treatment versus standard case management.
- Following three years of treatment, positive outcomes were found for both approaches to integrated treatment, with assertive community treatment showing modest advantages over standard case management.

Principles of Integrated Treatment for Dual Disorders

Mueser, K. T., Drake, R. E., & Noordsy, D. L. (1998). Integrated mental health and substance abuse treatment for severe psychiatric disorders. *Practical Psychiatry and Behavioral Health*, *4*, 129-139.

- Summarizes the fundamental ingredients of effective integrated dual disorder programs, including comprehensiveness, assertive outreach, assertive and protective living environment, motivation based intervention, and long-term perspective.
- Provides an explanation of the stages of treatment (engagement, persuasion, active treatment, relapse prevention), which serve to guide clinicians in selecting interventions appropriate for our clients level of motivation to address substance use problems.

Carey, K. B. (1996). Substance use reduction in the context of outpatient psychiatric treatment: A collaborative, motivational, harm reduction approach. *Community Mental Health Journal*, *32*, 291-306.

- Describes conceptual foundation to a treatment approach based on motivational enhancement and the reduction of harmful consequences of substance abuse.

Minkoff, K. (1989). An integrated treatment model for dual diagnosis of psychosis and addiction. *Hospital and Community Psychiatry*, *40*, 1031-1036.

- Describes essential ingredients for an integrated service system for the treatment of severe mental illness and substance use disorders.

Ziedonis, D., & Fisher, W. (1996). Motivation-based assessment and treatment of substance abuse in patients with schizophrenia. *Directions in Psychiatry*, *16*, 1-7.

- Provides overview of motivation-based approach to assessment and treatment of dual disorders.

Historical context for Integrated Treatment for Dual Disorders

Ridgely, M. S., Goldman, H. H., & Willenbring, M. (1990). Barriers to the care of persons with dual diagnoses: Organizational and financing issues. *Schizophrenia Bulletin*, *16*, 123-132.

Ridgely, M. S., Osher, F. C., Goldman, H. H., & Talbott, J. A. (1987). Executive summary: Chronic mentally ill young adults with substance abuse problems: A review of research, treatment, and training issues. Baltimore: Mental Health Services Research Center, University of Maryland School of Medicine.

↴ These two publications summarize problems with traditional approaches to dual disorders, including administrative, clinical, and philosophical barriers to accessing intervention for both disorders.

Polcin, D. L. (1992). Issues in the treatment of dual diagnosis clients who have chronic mental illness. *Professional Psychology: Research and Practice*, *23*, 30-37.

↴ Describes obstacles in traditional treatment approaches to effective intervention for dual disorders.

Kushner, M. G., & Mueser, K. T. (1993). Psychiatric co-morbidity with alcohol use disorders. *Eighth Special Report to the U.S. Congress on Alcohol and Health* (Vol. NIH Pub. No. 94-3699, pp. 37-59). Rockville, MD: U.S. Department of Health and Human Services.

↴ Early comprehensive review of the epidemiology, correlates, and outcome of dual disorders.

↴ Summarizes research on the negative effects of psychiatric comorbidity on the course and outcome of treatment for substance abuse.

Consumer and Family Perspectives

Ethnographic and first person reports

Alverson, H., Alverson, M., & Drake, R. E. (2000). An ethnographic study of the longitudinal course of substance abuse among people with severe mental illness. *Community Mental Health Journal*, *36*, 557-569.

Alverson, H., Alverson, M., & Drake, R.E. Social patterns of substance use among people with dual diagnoses. Mental Health Services Research, 3(1), 3-14, 2001.

Fox, L. (1999). Missing out on motherhood. *Psychiatric Services*, *50*, 193-194.

Green, V.L. The resurrection and the life. American Journal of Orthopsychiatry, 66(1), 12-16, 1996.

Family perspectives

Clark, R. E. (2001). Family support and substance use outcomes for persons with mental illness and substance use disorders. *Schizophrenia Bulletin*, *27*, 93-101.

↴ Describes family members financial and time contributions to helping a relative with dual disorders, and the relationship between family assistance and improved outcomes.

Schwab, B., Clark, R. E., & Drake, R. E. (1991). An ethnographic note on clients as parents. *Psychosocial Rehabilitation Journal*, *15*(2), 95-99.

↴ Describes challenges faced by clients with dual disorders who are parents.

Practice Issues

Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (expected publication date: Spring, 2003). *Integrated Treatment for Dual Disorders: Effective Intervention for Severe Mental Illness and Substance Abuse*. New York: Guilford Publications.

↴ ↴See description of book under Practice Manuals section.

↴ ↴This book has chapters covering the specific topics listed below.

Assessment and treatment planning

Carey, K. B., & Correia, C. J. (1998). Severe mental illness and addictions: Assessment considerations. *Addictive Behaviors*, *23*, 735-748.

↴ ↴Discusses common issues faced by clinicians in assessing substance abuse in persons with severe mental illness, and provides solutions to those problems.

Connors, G. J., Donovan, D. M., & DiClemente, C. C. (2001). *Substance Abuse Treatment and the Stages of Change*. New York: Guilford Publications.

↴ ↴A helpful book on treatment planning based on clients' motivation to change their addictive behavior.

Donovan, D. D. and Alan Marlatt, G. A (Eds.) New York: Guilford Publications, (1988). *Assessment of Addictive Behaviors.*

↴ ↴The introductory chapter on assessment of addictive behaviors is outstanding.

↴ ↴This book also contains many chapters on specific drugs and approaches that are quite good.

Drake, R. E., Rosenberg, S. D., & Mueser, K. T. (1996). Assessing substance use disorder in persons with severe mental illness. In R. E. Drake & K. T. Mueser (Eds.), *New Directions for Mental Health Services* (Vol. 70, pp. 3-17). San Francisco: Jossey-Bass.

↴ ↴Describes many of the obstacles to accurate assessment of substance abuse in persons with dual disorders and strategies for overcoming these obstacles.

McHugo, G. J., Drake, R. E., Burton, H. L., & Ackerson, T. H. (1995). A scale for assessing the stage of substance abuse treatment in persons with severe mental illness. *Journal of Nervous and Mental Disease*, *183*, 762-767.

↴ ↴Contains information regarding the assessment of stages of treatment for persons with dual disorders.

Mueser, K. T., Drake, R. E., Clark, R. E., McHugo, G. J., Mercer-McFadden, C., & Ackerson, T. (1995). *Toolkit for Evaluating Substance Abuse in Persons with Severe Mental Illness*. Cambridge, MA: Evaluation Center at HSRI.

↴ ↴Summarizes the Substance Abuse Treatment Scale for assessing clients' stage of treatment, and provides psychometric data on this scale.

↴ ↴ Describes three clinician-administered scales for clients with dual disorders, including the Alcohol Use Scale, the Drug Use Scale, and the Substance Abuse Treatment Scale.

↴ ↴Includes software that contains the scales.
↴ ↴Information provided on training clinicians on the use of the scales, establishing and maintaining reliability, and validity.

Noordsy, D. L., McQuade, D. V., & Mueser, K. T. (2002). Assessment considerations. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 159-180). Chichester, England: John Wiley & Sons.

↴ ↴Describes principles of assessment of substance abuse in persons with severe mental illness.
↴ ↴Explicates four steps of assessment: identification, classification, functional assessment and analysis, and treatment planning.
↴ ↴Specific methods for linking assessment to treatment are described.

Rosenberg, S. D., Drake, R. E., Wolford, G. L., Mueser, K. T., Oxman, T. E., Vidaver, R. M., Carrieri, K. L., & Luckoor, R. (1998). The Dartmouth Assessment of Lifestyle Instrument (DALI): A substance use disorder screen for people with severe mental illness. *American Journal of Psychiatry*, *155*, 232-238.

↴ ↴Describes brief screening instrument (DALI) for identifying substance abuse in persons with severe mental illness.
↴ ↴Presents data showing that DALI outperforms other screening instruments in persons with dual disorders.

Engagement

Rapp, C. A. (1998). The Strengths Model: Case Management with People Suffering from Severe and Persistent Mental Illness. New York: Oxford University Press.

↴ ↴Excellent book that describes the engagement process in persons with severe mental illness.
↴ ↴Very helpful for anyone attempting to engage dual disorder clients in a treatment relationship.

Stages of treatment and motivational enhancement

Carey, K. B., Purnine, D. M., Maisto, S. A., Carey, M. P., & Barnes, K. L. (1999). Decisional balance regarding substance use among persons with schizophrenia. *Community Mental Health Journal*, *35*, 289-299.

↴ ↴Describes use of decisional balance approach to helping persons with dual disorders weigh the advantages and disadvantages of continued substance abuse versus sobriety.

Miller, W. R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change.* (Second ed.). New York: Guilford Publications.

↴ ↴An outstanding book, a “classic” in the addiction field, about stages of change and recovery from substance abuse.
↴ ↴An excellent place to start; mandatory reading for all clinicians working with clients with dual disorders.

Osher, F. C., & Kofoed, L. L. (1989). Treatment of patients with psychiatric and psychoactive substance use disorders. *Hospital and Community Psychiatry*, *40*, 1025-1030.

- Introduces and describes the concept of stages of treatment (engagement, persuasion, active treatment, relapse prevention) that help clinicians gear treatment interventions to clients' individual motivational states.

Rollnick, S. and others. (1999). *Health Behavior Change: A Guide for Practitioners*. Churchill Livingston.

- Another helpful reference on the stages of change and recovery from substance abuse.
- Describes substance abuse counseling and relapse prevention counseling.

D'Zurilla, T. and Nezu, A. (1999), *Problem Solving Therapy (Second Edition).* New York: Springer.

- To learn more about problem solving therapy, which can be applied to substance abuse and/or mental illness problems in clients with dual disorders.

Graham, H., Copello, A., Birchwood, M. J., Orford, J., McGovern, D., Maslin, J., & Georgiou, G. (2002). Cognitive-behavioral integrated approach for psychosis and problem substance use. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 181-206). Chichester, England: John Wiley & Sons.

- Describes cognitive-behavioral approach to treating substance abuse in persons with severe mental illness.
- Includes numerous useful clinical examples.

Marlatt, G. A., & Gordan, G. R. (1985). Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors. New York: Guilford Publications.

- Describes principles of substance abuse relapse prevention.
- Written originally for work with the substance abuse population.
- Much of the book applies to persons with severe mental illness who have achieved sobriety and are motivated to prevent relapses of their substance abuse.

Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). *Treating Alcohol Dependence*. New York: Guilford Publications.

- An excellent book on cognitive-behavioral treatment of substance abuse.
- Offers a simple introduction to basic techniques that are effective with dual disorder clients in the active treatment stage.

Group treatment for dual disorders

Bellack, A. S., & DiClemente, C. C. (1999). Treating substance abuse among patients with schizophrenia. *Psychiatric Services*, *50*, 75-79.

- Describes social skills training approach to dual disorders treatment.

Bellack, A. S., Mueser, K. T., Gingerich, S., & Agresta, J. (1997). *Social Skills Training for Schizophrenia: A Step-By-Step Guide*. New York: Guilford Publications.

- Addresses how to conduct social skills training groups for persons with severe mental illness.

- Specific curriculum provided (steps of skills) for helping clients refuse substances and deal with substance abuse situations.

Mueser, K. T., & Noordsy, D. L. (1996). Group treatment for dually diagnosed clients. In R. E. Drake & K. T. Mueser (Eds.), Dual Diagnosis of Major Mental Illness and Substance Abuse Disorder II: Recent Research and Clinical Implications. New Directions for Mental Health Services (Vol. 70, pp. 33-51). San Francisco: Jossey-Bass.

- Describes four different types of group interventions for dual disorders, including educational, stage-wise (persuasion and active treatment), social skills training, and self-help groups.
- Brief clinical vignettes used to illustrate different group treatment methods.

Noordsy, D. L., Schwab, B., Fox, L., & Drake, R. E. (1996). The role of self-help programs in the rehabilitation of persons with severe mental illness and substance use disorders. *Community Mental Health Journal*, pp. 71-81.

- Summarizes difficulties and solutions associated with using self-help groups, such as Alcoholics Anonymous, for persons with dual disorders.

Roberts, L. J., Shaner, A., & Eckman, T. A. (1999). *Overcoming Addictions: Skills Training for People with Schizophrenia*. New York: W.W. Norton.

- Manual for providing social skills training to clients with dual disorders.

Weiss, R. D., Greenfield, S. F., & O'Leary, G. (2002). Relapse prevention for patients with bipolar and substance use disorders. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 207-226). Chichester, England: John Wiley & Sons.

- Describes group intervention program for bipolar disorder and substance abuse.
- Useful clinical examples provided illustrating group treatment methods.

Self-help

Alcoholics Anonymous (1990). *The AA Group: Where It All Begins (rev.)*. New York: Alcoholics Anonymous.

- Alcoholics Anonymous (AA) is the largest self-help organization for addiction.
- This book describes its history, traditions, and approach to recovery from addiction, base on the "12-Steps" of AA.

Hamilton, T., & Sample, P. (1994). The Twelve Steps and Dual Recovery: A Framework of Recovery for Those of Us with Addiction and an Emotional or Psychiatric Illness. Center City, MN: Hazeldon.

- Explains 12-Step approach to self-help substance abuse treatment in persons with a mental illness.

The Dual Disorder Recovery Book (1993) Hazelden, Center City, Minnesota, 1993.

- Discussion of 12-step self-help approach to recovery for persons with dual disorders.

Trimpey, J. (1996). Rational Recovery: The New Cure for Substance Addiction. New York: Pocket Books.

- Rational Recovery (RR) is a self-help alternative to 12-Step approaches (such as Alcoholics Anonymous).

- RR is less spirituality oriented, and more focused on helping clients take control over their lives through accepting personal responsibility to themselves and others.

Vaillant, G. E. (1995). *Natural History of Alcoholism Revisited*. Cambridge, MA: Harvard University Press.

- Offers a brilliant analysis of natural pathways to recovery and explains how self-help and treatment can enhance the process.

Family treatment

Barrowclough, C. (2002). Family intervention for substance misuse in psychosis. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 227-243). Chichester: John Wiley & Sons.

- Describes family intervention approach for dual disorders.

McFarlane, W. R. (2002). Multifamily Groups in the Treatment of Severe Psychiatric Disorders. New York: Guilford Publications.

- Provides detailed guidance on formation and running of multi-family groups for persons with severe mental illness and their families.
- Similar groups have been run for persons with dual disorders and their families (see Mueser & Fox, 2002, next reading).

Mueser, K. T., & Fox, L. (2002). A family intervention program for dual disorders. *Community Mental Health Journal*, *38*, 253-270.

- Describes family intervention program for dual disorders that includes single-family sessions and multiple-family group sessions.
- Presents pilot data from study of family program.

Mueser, K. T., & Gingerich, S. L. (in press). *Coping with Schizophrenia: A Guide for Families (Second Edition)*. New York: Guilford Publications.

- Among many helpful books on family interventions, we recommend this book that is written for families.
- Includes a chapter on how family members can help a relative with a dual disorder.

Mueser, K. T., & Glynn, S. M. (1999). *Behavioral Family Therapy for Psychiatric Disorders (Second Edition)*. Oakland, CA: New Harbinger Publications.

- Treatment manual for clinicians that describes family intervention model for severe mental illness, including strategies for addressing substance abuse in clients with dual disorders.
- Includes educational handouts on different psychiatric disorders, medications, and the interactions between mental illness and substance abuse.

Psychopharmacological treatment

Day, E., Georgiou, G., & Crome, I. (2002). Pharmacological management of substance misuse in psychosis. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 259-280). Chichester, England: John Wiley & Sons.

↴ ↴Detailed chapter that describes pharmacological management of substance use disorders, including stimulants, opioids, other drugs and alcohol.

Drake, R. E., Xie, H., McHugo, G. J., & Green, A. I. (2000). The effects of clozapine on alcohol and drug use disorders among schizophrenic patients. *Schizophrenia Bulletin*, *26*, 441-449.

↴ ↴Summarizes positive effects of clozapine on alcoholism outcomes in persons with schizophrenia.

Green, A. I., Zimmet, S. V., Strous, R. D., & Schildkraut, J. J. (1999). Clozapine for comorbid substance use disorder and schizophrenia: Do patients with schizophrenia have a reward-deficiency syndrome that can be ameliorated by clozapine? *Harvard Review of Psychiatry*, *6*, 287-296.

↴ ↴Theoretical paper in which authors suggest that the neurobiology of schizophrenia makes persons with this disorder more susceptible to substance abuse, and more likely to benefit from clozapine.

Mueser, K. T., & Lewis, S. (2000). Treatment of substance misuse in schizophrenia. In P. Buckley & J. Waddington (Eds.), *Schizophrenia and Mood Disorders: The New Drug Therapies in Clinical Practice* (pp. 286-296). Oxford: Butterworth & Heinemann.

↴ ↴Brief chapter that includes recommendations for pharmacological treatment of clients with dual disorders.

Mueser, K. T., Noordsy, D. L., Fox, L., & Wolfe, R. (in press). Disulfiram treatment for alcoholism in severe mental illness. *American Journal on the Addictions*.

↴ ↴Quantitatively describes positive long-term outcomes of 30 persons with severe mental illness and alcoholism treated with disulfiram (Antabuse).

Infectious diseases

Bartlett, J. and others (1998). *Guide to Living with HIV Infection.* Baltimore: John Hopkins U. Press.

↴ ↴Coping with HIV and hepatitis.

Eversen G. and Weinberg, H. L (1999). *Living with Hepatitis C.* Hatherleigh.

↴ ↴Coping with HIV and hepatitis.

Razzano, L. (2002). Issues in comorbidity and HIV/AIDS. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 332-346). Chichester, England: John Wiley & Sons.

↴ ↴Practical chapter on the nature of HIV/AIDS in persons with dual disorders and treatment approaches.

Implementation, Administration, and Cost

Implementation and administrative issues

Drake, R. E., Essock, S. M., Shaner, A., Carey, K. B., Minkoff, K., Kola, L., Lynde, D., Osher, F. C., Clark, R. E., & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services*, *52*, 469-476.

↓ ↓Covers issues related to the implementation and dissemination of integrated programs for dual disorders.

Fox, T., Fox, L., & Drake, R. E. (1992). Developing a statewide service system for people with co-occurring severe mental illness and substance use disorders. *Innovations and Research*, *1*(4), 9-13.

↓ ↓Describes the development of integrated dual disorder services in the state of New Hampshire.

Torrey WC, Drake RE, Cohen M, et al. "The Challenge of Implementing and Sustaining Integrated Dual Disorders Treatment Programs" *Community Mental Health Journal* (in press 2002).

State and local administrative perspectives

Fox, T., & Shumway, D. (1995). Human resource development. In A. F. Lehman & L. Dixon (Eds.), *Double Jeopardy: Chronic Mental Illness and Substance Abuse* (pp. 265-276). New York: Harwood Academic Publishers.

↓ ↓Describes how to cultivate clinicians and administrators in developing integrated programs for dual disorders.

Mercer-McFadden, C., Drake, R. E., Clark, R. E., Verven, N., Noordsy, D. L., & Fox, T. S. (1998). *Substance Abuse Treatment for People with Severe Mental Disorders: A Program Manager's Guide*. Concord, NH: New Hampshire-Dartmouth Psychiatric Research Center.

↓ ↓Useful guide for program managers and anyone else with administrative responsibility for establishing and maintaining high quality integrated programs for dual disorders.

Financing and cost-effectiveness of integrated dual disorders treatment

Clark, R. E., Teague, G. B., Ricketts, S. K., Bush, P. W., Xie, H., McGuire, T. G., Drake, R. E., McHugo, G. J., Keller, A. M., & Zubkoff, M. (1998). Cost-effectiveness of assertive community treatment versus standard case management for persons with co-occurring severe mental illness and substance use disorders. *Health Services Research*, *33*, 1285-1307.

↓ ↓Describes cost-effectiveness analysis of study comparing assertive community treatment (ACT) with standard case management for dual disorders.

Clark, R. E., Ricketts, S. K., & McHugo, G. J. (1999). Legal system involvement and costs for persons in treatment for severe mental illness and substance use disorders. *Psychiatric Services*, *50*, 641-647.

↓ ↓Addresses cost of legal system involvement in persons with dual disorders.

Dickey, B., & Azeni, H. (1996). Persons with dual diagnoses of substance abuse and major mental illness: Their excess costs of psychiatric care. *American Journal of Public Health*, *86*, 973-977.

↓ ↓Documents the high cost of standard (non-integrated) treatment approaches to substance abuse in persons with severe mental illness.

Fidelity measures for integrated dual disorders treatment

Jerrell, J. M., & Ridgely, M. S. (1999). Impact of robustness of program implementation on outcomes of clients in dual diagnosis programs. *Psychiatric Services*, *50*, 109-112.

➘ Documents that better substance abuse outcomes in persons with dual disorders are associated with higher program fidelity to integrated treatment model.

McHugo, G. J., Drake, R. E., Teague, G. B., & Xie, H. (1999). Fidelity to assertive community treatment and client outcomes in the New Hampshire dual disorders study. *Psychiatric Services*, *50*, 818-824.

➘ Shows that clients in assertive community treatment (ACT) programs that implemented dual disorders treatment with high fidelity to the integrated treatment model had better substance abuse outcomes than low fidelity programs.

Special Populations Appendix

A review of the literature addressing the range of populations for which the skills/strategies of integrated dual disorders treatment has demonstrated efficacy or effectiveness, including factors such as age, race, ethnicity, gender, institutional setting, sexual orientation, and geographic location.

Research on integrated treatment for dual disorders has focused mainly on the development and evaluation of comprehensive programs that incorporate the core ingredients of assertive outreach, motivation-based intervention (including stages of treatment), comprehensiveness, and a long-term perspective (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, 1998b; Ley & Jeffery, 2002). While the general findings across the different studies provide support for the effectiveness of integrated services (Drake et al., 2001), only limited research has directly examined the question of whether integrated treatment is more effective for some clients than others. As a result, the evidence base for judging the differential effectiveness of integrated treatment for different subgroups of clients is quite limited at this point.

Despite the limited data available, research on integrated treatment for dual disorders has included clients with a wide range of different backgrounds. With respect to age, while there is a tendency for clients with dual disorders to be younger, all research on the topic includes a wide range of ages, with most clients between 18 and 55 (Barrowclough et al., 2001; Carmichael et al., 1998; Drake et al., 1998a; Drake, Yovetich, Bebout, Harris, & McHugo, 1997; Godley, Hoewing-Roberson, & Godley, 1994; Jerrell & Ridgely, 1995). Similarly, all these studies included both males and females, with males making up the majority of participants, consistent with the higher prevalence of substance abuse in men than women (Mueser, Yarnold, & Bellack, 1992; Mueser et al., 2000). Special issues have been identified related to the unique needs of women with dual disorders (Brunette & Drake, 1998; Brunette & Drake, 1997; Gearon & Bellack, 1999), but there is no evidence suggesting that women with dual disorders benefit less from integrated treatment.

Race or ethnicity have varied across the different studies, with most studies including a majority of Caucasian clients but also including some African American clients (Carmichael et al., 1998; Drake et al., 1998a; Godley et al., 1994; Jerrell & Ridgely, 1995). One study included only African American clients and reported very positive results from integrated treatment (Drake et al., 1997). A large, randomized controlled trial comparing the assertive community treatment approach with standard case management for integrated treatment of dual disorders in an inner-city, homeless population has recently been concluded and results are expected soon (Mueser, Essock, Drake, Wolfe, & Frisman, 2001). This study included predominantly African

American clients, but some Caucasian and Latino clients also participated. More work is needed to evaluate the effectiveness of integrated dual disorders treatment for Latino clients.

The majority of studies of integrated treatment for dual disorders have been conducted on an outpatient basis, with positive results (Barrowclough et al., 2001; Carmichael et al., 1998; Drake et al., 1998a; Drake et al., 1997; Godley et al., 1994; Jerrell & Ridgely, 1995). Less research has examined the effectiveness of integrated treatment provided in inpatient, residential, or intensive day treatment programs. Most of the studies examining short-term residential or intensive day treatment (3-6 months) programs suffer from high dropout rates (Blankertz & Cnaan, 1994; Burnam et al., 1995; Penn & Brooks, 1999; Rehav et al., 1995). One longer-term residential program, integrated into the community with a gradual transition from the residence into the community, found very positive long-term outcomes (Brunette, Drake, Woods, & Hartnett, 2001). Shorter-term integrated inpatient treatment for dual disorders may have an important role to play in stabilizing clients, engaging them in treatment, providing education about mental illness and substance abuse interactions, and motivating them to work on their substance abuse problems (Franco, Galanter, Castaneda, & Patterson, 1995; Rosenthal, 2002). Research is needed to evaluate the effectiveness of programs such as these when they are provided in a coordinated fashion with integrated outpatient treatment for dual disorders.

Research studies on integrated treatment programs for dual disorders have included significant numbers of clients with housing instability and homelessness (Carmichael et al., 1998; Drake et al., 1998a; Drake et al., 1997; Meisler, Blankertz, Santos, & McKay, 1997). The evidence from these studies indicates that integrated treatment is effective at improving both substance abuse and housing outcomes. Presumably, the outreach component of integrated treatment is critical to successful outcomes in work with this challenging population.

Geographically, research on integrated treatment for dual disorders has been conducted in a variety of places. Several studies of treatment have been done in large urban areas (e.g., Washington, DC, Austin, Texas) (Carmichael et al., 1998; Drake et al., 1997; Jerrell & Ridgely, 1995), with two studies in more rural settings (Drake et al., 1998a; Godley et al., 1994). One study of integrated treatment for dual disorders was conducted in Manchester, England (Barrowclough et al., 2001). All of these studies have reported positive effects of integrated treatment, suggesting that the treatment principles are robust across a variety of geographical settings.

References

Barrowclough, C., Haddock, G., Tarrier, N., Lewis, S., Moring, J., O'Brien, R., Schofield, N., & McGovern, J. (2001). Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. *American Journal of Psychiatry, 158*, 1706-1713.

Blankertz, L. E., & Cnaan, R. A. (1994). Assessing the impact of two residential programs for dually diagnosed homeless individuals. *Social Service Review, 68*, 536-560.

Brunette, M., & Drake, R. E. (1998). Gender differences in homeless persons with schizophrenia and substance abuse. *Community Mental Health Journal, 34*, 627-642.

Brunette, M. F., & Drake, R. E. (1997). Gender differences in patients with schizophrenia and substance abuse. *Comprehensive Psychiatry, 38*, 109-116.

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Carmichael, D., Tackett-Gibson, M., O'Dell, L., Jayasuria, B., Jordan, J., & Menon, R. (1998). *Texas Dual Diagnosis Project Evaluation Report 1997-1998* . College Station, TX: Public Policy Research Institute/Texas A&M University.

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Drake, R. E., Mercer-McFadden, C., Mueser, K. T., McHugo, G. J., & Bond, G. R. (1998b). Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin, 24*, 589-608.

Drake, R. E., Yovetich, N. A., Bebout, R. R., Harris, M., & McHugo, G. J. (1997). Integrated treatment for dually diagnosed homeless adults. *Journal of Nervous and Mental Disease, 185*, 298-305.

Franco, H., Galanter, M., Castaneda, R., & Patterson, J. (1995). Combining behavioral and self-help approaches in the inpatient management of dually diagnosed patients. *Journal of Substance Abuse Treatment, 12*, 227-232.

Gearon, J. S., & Bellack, A. S. (1999). Women with schizophrenia and co-occurring substance use disorders: An increased risk for violent victimization and HIV. *Community Mental Health Journal, 35*, 401-419.

Godley, S. H., Hoewing-Roberson, R., & Godley, M. D. (1994). *Final MISA Report* . Bloomington, IL: Lighthouse Institute.

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Ley, A., & Jeffery. (2002). Cochrane review of treatment outcome studies and its implications for future developments. In H. L. Graham, A. Copello, M. J. Birchwood, & K. T. Mueser (Eds.), *Substance Misuse in Psychosis: A Handbook of Approaches to Treatment and Service Delivery* (pp. 349-365). Chichester, England: John Wiley & Sons.

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