

Handout for

DUAL DIAGNOSIS:

*An Integrated Model for the Treatment of
People with Co-occurring Psychiatric and
Substance Disorders in Managed Care
Systems*

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A Videotaped Lecture Produced by:



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DUAL DIAGNOSIS

Dr. Kenneth Minkoff

“Co-occurring Psychiatric & Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies & Training Curricula” - copies of this report can be obtained by visiting:

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Individuals with Co-occurring Disorders Principles of Successful Treatment

- Comorbidity is an expectation, NOT an exception.
- Treatment success derives from the implementation of an **empathic, hopeful, continuous** treatment relationship, which provides integrated treatment and coordination of care through the course of multiple treatment episodes.
- Within the context of the empathic, hopeful, continuous, integrated relationship, **case management/care** and **empathic detachment/ confrontation** are appropriately balanced at each point in time.
- When substance disorder and psychiatric disorder co-exist, each disorder should be considered **primary**, and **integrated dual primary treatment** is recommended, where each disorder receives appropriately intensive diagnosis-specific treatment.
- ***There is no one type of dual diagnosis program or intervention.*** For each person, the correct treatment intervention must be individualized according to diagnosis, phase of recovery/treatment, level of functioning and/or disability associated with each disorder, and level of **acuity, dangerousness, motivation, capacity for treatment adherence**, and availability of continuing empathic treatment relationships and other recovery supports.

SUB-GROUPS OF PEOPLE WITH COEXISTING DISORDERS

Patients with "Dual Diagnosis" - combined psychiatric and substance abuse problems - who are eligible for services fall into four major categories.

<p>PSYCH. HIGH SUBSTANCE HIGH Serious & Persistent Mental Illness with Substance Dependence</p>	<p>PSYCH. LOW SUBSTANCE HIGH Psychiatrically Complicated Substance Dependence</p>
<p>PSYCH. HIGH SUBSTANCE LOW Serious & Persistent Mental Illness with Substance Abuse</p>	<p>PSYCH. LOW SUBSTANCE LOW Mild Psychopathology with Substance Abuse</p>

PSYCH HIGH / SUBSTANCE HIGH SERIOUS & PERSISTENT MENTAL ILLNESS WITH SUBSTANCE DEPENDENCE

- Patients with serious and persistent mental illness, who also have alcoholism and/or drug addiction, **and** who need treatment for addiction, for mental illness, or for both. This may include **sober** individuals who may benefit from **psychiatric** treatment in a setting which also provides sobriety support and Twelve-step Programs.

PSYCH LOW / SUBSTANCE HIGH PSYCHIATRICALY COMPLICATED SUBSTANCE DEPENDENCE

- Patients with alcoholism and/or drug addiction who have significant psychiatric symptomatology and /or disability but who do **NOT** have serious and persistent mental illness.
- Includes both **substance-induced** psychiatric disorders and **substance-exacerbated** psychiatric disorders.
- Includes the following psychiatric syndromes:
 - Anxiety/Panic Disorder
 - Depression/Hypomania
 - Psychosis/Confusion
 - Symptoms Secondary to Misuse/Abuse of Psychotropic Medication
 - Personality Traits/Disorder
 - Suicidality
 - Violence
 - PTSD Symptoms

PSYCH HIGH / SUBSTANCE LOW SERIOUS & PERSISTENT MENTAL ILLNESS WITH SUBSTANCE ABUSE

- Patients with serious and persistent mental illness (e.g. Schizophrenia, Major Affective Disorders with Psychosis, Serious PTSD) which is complicated by substance abuse, whether or not the patient sees substances as a problem.

PSYCH LOW / SUBSTANCE LOW MILD PSYCHOPATHOLOGY WITH SUBSTANCE ABUSE

- Patients who usually present in outpatient setting with various combinations of psychiatric symptoms (e.g. anxiety, depression, family conflict) and patterns of substance misuse and abuse, but not clear cut substance dependence.

DSM III-R Diagnostic Criteria

PSYCHOACTIVE SUBSTANCE ABUSE

- **A maladaptive pattern of psychoactive substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:**
 - Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home
 - Recurrent substance use in situations in which it is physically hazardous
 - Recurrent substance-related legal problems
 - Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance use
- **The symptoms have never met the criteria for Substance Dependence for this class of substance.**

DSM IV Diagnostic Criteria

PSYCHOACTIVE SUBSTANCE DEPENDENCE

- **A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:**
 - Tolerance, as defined by either of the following:
 - A need for markedly increased amounts of substance to achieve intoxication or desired effect
 - Markedly diminished effect with continued use of the same amount of the substance
 - Withdrawal, as manifested by either of the following:
 - The characteristic withdrawal syndrome for the substance
 - The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms
 - The substance is often taken in larger amounts or over a longer period than was intended
 - There is a persistent desire or unsuccessful efforts to cut down or control substance use
 - A great deal of time spent in activities necessary to obtain the substance, use the substance, or recover from its effects
 - Important social, occupation, or recreational activities are given up or reduced because of substance use
 - Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance
- NOTE: The following items may not apply to cannabis, hallucinogens, or phencyclidine (PCP)***
- Characteristic withdrawal symptoms
 - Substance often taken to relieve or avoid withdrawal symptoms

BARRIERS TO INTEGRATED TREATMENT

Addiction System

Mental Health System

Peer Counseling model	vs.	Medical/Professional model
Spiritual Recovery	vs.	Scientific treatment
Self Help	vs.	Medication
Confrontation and expectation	vs.	Individualized support and flexibility
Detachment/empowerment	vs.	Case management/care
Episodic treatment	vs.	Continuity of Responsibility
Recovery ideology	vs.	Deinstitutionalization ideology
Psychopathology is secondary to addiction	vs.	Substance use is secondary to psychopathology

PARALLELS

Alcoholism/Addiction

Major Mental Illness

- | | |
|--|--|
| 1. A biological illness | 1. A biological illness |
| 2. Hereditary (in part) | 2. Hereditary (in part) |
| 3. Chronicity | 3. Chronicity |
| 4. Incurability | 4. Incurability |
| 5. Leads to lack of control of behavior and emotions | 5. Leads to lack of control of behavior and emotions |
| 6. Positive and negative symptoms | 6. Positive and negative symptoms |
| 7. Affects the whole family | 7. Affects the whole family |
| 8. Progression of the disease without treatment | 8. Progression of the disease without treatment |
| 9. Symptoms can be controlled with proper treatment | 9. Symptoms can be controlled with proper treatment |
| 10. Disease of denial, relates to both disease & chronicity of disease | 10. Disease of denial, relates to both disease & chronicity of disease |
| 11. Facing the disease can lead to depression and despair | 11. Facing the disease can lead to depression and despair |
| 12. Disease is often seen as a "moral issue", due to personal weakness rather than biological causes | 12. Disease is often seen as a "moral issue", due to personal weakness rather than biological causes |
| 13. Feelings of guilt & failure | 13. Feelings of guilt & failure |
| 14. Feelings of shame & stigma | 14. Feelings of shame & stigma |
| 15. Physical, mental and spiritual disease | 15. Physical, mental and spiritual disease |

PARALLELS

PROCESS OF RECOVERY

- **PHASE 1: Stabilization**
 - Stabilization of active substance use or acute psychiatric symptoms
- **PHASE 2: Engagement/
Motivational Enhancement**
 - Engagement in treatment
 - Contemplation, Preparation, Persuasion
- **PHASE 3: Prolonged Stabilization**
 - Active treatment, Maintenance, Relapse Prevention
- **PHASE 4: Recovery & Rehabilitation**
 - Continued sobriety and stability
 - One year - ongoing

PROCESS OF RECOVERY PHASE 1: Stabilization

Detoxification

- Usually inpatient, may be involuntary
- Usually need medication
- 3-5 days (alcohol)
- Includes assessment for other diagnoses

Stabilize Acute Psychiatric Illness

- Usually inpatient, may be involuntary
- Medication
- 2 weeks to 6 months
- Includes assessment for effects of substance, and for addiction

PROCESS OF RECOVERY PHASE 2: Engagement/Motivational Enhancement

Addiction Treatment

- Engagement in ongoing treatment is crucial for recovery to proceed
- Begins with empathy and proceeds through phases of education and empathic confrontation, before patient commits to ongoing active treatment
- Motivational interviewing techniques
- Education about substance use, abuse, and dependence & empathic confrontation of adverse consequences are tools to overcome denial. Patient accepts powerlessness to control drug without help
- Education of the family, & involving them in interviews to promote motivation
- Engagement may take place in a variety of treatment settings...may need extended inpatient or day treatment rehabilitation (2-12 weeks)
- Engagement may be initially coerced
- Multiple cycles of relapse usually occur before engagement in ongoing treatment is successful (revolving door)

Psychiatric Treatment

- Engagement in ongoing treatment is crucial for recovery to proceed
- Begins with empathy and proceeds through phases of education and empathic confrontation, before patient commits to ongoing active treatment
- Motivational interviewing techniques
- Education about mental illness and the adverse consequences of treatment non-compliance are tools to overcome denial. Patient accepts powerlessness to control symptoms without help
- Education of the family, & involving them in setting limits on non-compliance
- Engagement may take place in a variety of treatment settings...may need extended inpatient or day treatment rehabilitation (1-6 months)
- Engagement may be initially coerced
- Multiple cycles of relapse usually occur before engagement in ongoing treatment is successful (revolving door)

PROCESS OF RECOVERY

PHASE 3: Prolonged Stabilization

Continued Abstinence

- One-Year
- Patient consistently attends abstinence support programs
- Usually voluntary, but ongoing compliance may be coerced or mandated
- Ongoing education about addiction, recovery and skills to maintain abstinence
- Focus on asking for help to cope with urges to use substances and drop out of treatment
- Must learn to accept the illness and deal with shame, stigma, guilt, and despair
- Must learn to cope with “negative symptoms”: social, affective, cognitive, and personality development
- Family needs ongoing involvement in its own program of recovery to learn empathic detachment and how to set caring limits
- May need intensive outpatient treatment and/or 6-12 months residential placement
- Continuing assessment
- Risk of relapse continues

Continued Medication Compliance

- One-Year
- Patient consistently takes medication and attends treatment sessions regularly
- Usually voluntary, but may be coerced or mandated
- Ongoing education about mental illness, recovery and skills to prevent relapse
- Focus on asking for help to cope with continuing symptoms and urges to discontinue treatment
- Must learn to accept the illness and deal with shame, stigma, guilt, and despair
- Must learn to cope with “negative symptoms”: impaired cognition, affect, social skills, and lack of motivation/energy
- Family needs ongoing involvement in its own program of recovery to learn empathic detachment and how to set caring limits
- May need extended hospital, day treatment and/or residential placement
- Continuing assessment
- Risk of relapse continues

PROCESS OF RECOVERY

PHASE 4: Recovery & Rehabilitation

Continued Sobriety

- Voluntary, active involvement in treatment
- Stability precedes growth; no growth is possible unless sobriety is fairly secure. Growth occurs slowly (One Day at a Time)
- Continued work in the AA program, on growing, changing, dealing with feelings
- Thinking begins to clear
- New skills for dealing with feelings, situations
- Increasing responsibility for illness, and recovery program brings increasing control of one’s life
- Increasing capacity to work and to have relationships
- Recovery is never “complete”, always ongoing
- Eventual goal is peace of mind and serenity (Serenity Prayer)

Continued Stability

- Voluntary, active involvement in treatment
- Stability precedes growth; no growth is possible unless stabilization of illness is fairly solid. Growth occurs slowly (One Day at a Time)
- Continued medication, but reduction to lowest level needed for maintenance. Continued work in treatment program
- Thinking begins to clear
- New skills dealing with feelings, situations
- Increasing responsibility for illness, and recovery programs brings increasing control of one’s life
- Increasing capacity to work and relate (voc rehab, clubhouse)
- Recovery is never “complete”, always ongoing
- Eventual goal is peace of mind and serenity (Serenity Prayer)

Individuals with Co-occurring Disorders

Treatment Rules

- All good treatment proceeds from empathic, hopeful, clinical relationship.
- Consequently, promote opportunities to initiate and maintain continuing empathic, hopeful relationships whenever possible.
- Specifically, remove arbitrary barriers to initial assessment and evaluation, including initial psychopharmacology evaluation (e.g., length of sobriety, alcohol level, etc.)
- Moreover, never discontinue medication for a known serious mental illness because a patient is using substances.
- Never deny access to substance disorder evaluation and/or treatment because a patient is on a prescribed non-addictive psychotropic medication.
- In fact, when mental illness and substance disorder co-exist, both disorders require specific and appropriately intensive primary treatment.
- There are no rules! The specific content of dual primary treatment for each person must be individualized according to diagnosis, phase of treatment, level of functioning and/or disability, and assessment of level of care based on acuity, severity, medical safety, motivation, and availability of recovery support.

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Attn: Discussion Notes.

For more information about Dr. Kenneth Minkoff, please visit his website at:
www.kenminkoff.com

The Mental Illness Education Project seeks to improve understanding of mental illness through the production of video-based programs for use by people with psychiatric conditions, their families, mental health practitioners, administrators, and educators, as well as the general public.

Our videotapes and books are particularly concerned with providing an insight into the nature of mental illness and providing a glimpse of the psychiatric challenges that many people live with. We offer visions of recovery and hope. We strive to address the pervasive issues of prejudice and discrimination through first-hand accounts of personal experience.

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