Severely and Persistently Mentally Ill Substance Abusers: Clinical and Policy Issues

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Abstract—Communities that are struggling to provide effective treatment for the challenging population of severely mentally ill clients who use alcohol and drugs have a growing research base on which to make policy decisions. Integrating outpatient treatment for mental health and addictive disorders appears to be more effective than treatment in two separate systems. Integrated treatment at a single site allows for individualizing treatment priorities without fragmenting care. Harm reduction approaches provide a low threshold entry, which can be followed by interventions to enhance motivation. Managing patient benefits to discourage drug use reduces the likelihood of their becoming homeless, hospitalized or incarcerated. Inadequate treatment capacity plays a large role in the growing number of disturbed clients who end up in the criminal justice system. Effective community treatment requires vigorous collaboration between care providers. Ultimately, professional training programs need to produce clinicians who are competent and comfortable addressing alcohol and other drug use to implement effective treatment systems.

Keywords—addiction treatment, drug policy, severely and persistently mentally ill

Clients with severe and persistent mental illness who use alcohol and other drugs constitute one of the most difficult challenges facing clinicians and treatment systems today. Treating severe mental illness alone is a complex task, and it is widely agreed that alcohol and other drug use undermines treatment efforts. Clinicians seek ways to stabilize these patients and improve their functioning as much as possible given their difficult social and economic circumstances. The public system faces thorny questions in setting appropriate goals and using resources wisely, particularly since substance use tends to drive up expensive service utilization (RachBeisel, Scott & Dixon 1999; Rosenthal & Westreich 1999; Drake et al. 1998). Systems are typically slow to reorient themselves, but transitions are well underway in many communities and there are currently promising models for effective treatment, based on emerging research findings. This article will review key issues and findings in this arena.

Since funding streams have a powerful influence on system design and clinical practices, a key issue is what type of entity administers the money. The perspectives of the decision makers in local jurisdictions determine how that system is designed. Addiction treatment providers usually become concerned when mental health personnel without a strong background in addiction administer the money. Both practical and philosophical issues can divide practitioners. In the absence of data, controversies such as abstinence versus harm-reduction oriented intervention can become intense and polarize practitioners in a community. However, there
is a growing body of research on the effectiveness of various treatment models, as well as on other questions that inspire policy debate, such as whether managing patient benefits makes sense. Once this type of information becomes disseminated, and practitioners in a given community have a chance to assimilate it and decide on a direction, they confront the issue of how to bring about orderly change. This vision and plan must include a process for cross-training practitioners so they are able to implement new solutions.

**SYSTEM DESIGN ISSUES**

Barriers to good system design grew out of the separation of funding streams and the resistance of some professional training institutions to change. Training issues will be discussed in more detail later in this article. In the early 1970s, several government entities were developed to address policy issues and allocate resources, in a manner which continues to shape the way our country responds to alcohol and drug problems (Margolis & Zweben 1998). The National Institute on Alcoholism and Alcohol Abuse (NIAAA) and the National Institute on Drug Abuse (NIDA) were set up as special entities to insure that the funds remained focused on the designated areas. This bifurcation spawned separate systems for both alcohol and drug problems that endured into the 1980s, to the great frustration of treatment providers who increasingly dealt with clients who used both. Clients were obliged to present their alcohol problem when they sought help from an “alcohol” treatment program, and their drug problem if they approached a “drug program.” As the cocaine epidemic gathered momentum in the 1980s, barriers were gradually removed because it was widely acknowledged that these clients often used both cocaine and alcohol and separate treatment systems did not make sense. By the time the Center for Substance Abuse Treatment was created in 1990 (originally as the Office for Treatment Improvement), it was acknowledged that restrictions based on drug of choice were inappropriate and that treatment programs needed to be capable of handling both. Clinical staff are usually knowledgeable about both, although the alcohol/drug division is still evident among some researchers.

Integration of services for mental health and substance abuse is at a much earlier stage in the process. The original separation was based on the assumption that money for addiction would likely be diverted for other needs unless clear boundaries were in place. It is understandable that professionals would define problems that confront them in terms of familiar frameworks, and since most in leadership roles knew little about addiction, there was good reason to be concerned about how well alcohol and drug use would be addressed. The two systems grew quite separate, despite the fact that people with other mental disorders were likely to use alcohol and other drugs (Kessler et al. 1997, 1994; Regier et al. 1990). The mental health system focused increasingly on those with chronic and persistent mental illness, while those with other coexisting disorders tended to fall into the AOD (alcohol and other drugs) treatment system. Mental health providers were frustrated by the resistance of AOD providers to addressing the needs of the severely mentally ill. AOD providers noted the immense funding differential favoring mental health and suggested that these providers get training to deal with the addictive behavior of their clients.

In many communities, change is occurring from both directions. The mental health system, or remnants thereof, has been providing or encouraging training in AOD problems for some time, and the general level of skill of practitioners is improving. The blending of mental health with the AOD system, often designated behavioral care, has resulted in varying degrees of cross-fertilization. More and more addiction treatment providers are developing the capability of dealing with a population that has thought disorders for periods of time. However, much of what occurs in the community is either parallel or sequential treatment.

With parallel or sequential treatment (Ries 1994, 1993), it is necessary to deal with multiple systems in order to get an appropriate treatment plan implemented. In parallel treatment the client is simultaneously involved in both mental health and addiction treatment. For example, a client may have a case manager and a psychiatrist managing antipsychotics in the mental health system, while attending outpatient groups and self help meetings in the addiction treatment system. In sequential treatment, the goal is to stabilize the client with one disorder before the other is addressed. For example, a client may remain on an inpatient unit for an acute psychotic episode before his or her alcohol and drug-using behavior is addressed. In both examples, the prioritizing may be entirely appropriate. However, parallel or sequential treatment often occurs by default, because integrated treatment does not exist. The clinicians may work within different systems and may rarely, if ever, communicate with each other. If the patient becomes caught between conflicting expectations and philosophies, there may not be an existing mechanism to resolve issues. The client is burdened with meeting the demands of two systems. This situation is less likely to produce good treatment outcome.

Integrated treatment combines mental health and addiction care at one site, involving clinicians who have been cross-trained in both fields and applying unified case management. Differences in philosophy are reconciled within the program. For example, staff members entering via the route of addiction treatment need to be completely comfortable with patients taking medication. They also cannot rely on the aggressive confrontations characteristic of many addiction treatment programs, but well known to disorganize schizophrenics (Leff & Vaughn 1985; Vaughn & Leff 1976). Staff members accustomed to working in psychiatric settings need to be comfortable with supportive but forthright feedback about alcohol and drug use and with
setting limits based on this behavior. Integrated treatment is particularly useful for the many patients with severe problems in more than one area. This approach places the burden of consistency and continuity of treatment on staff, not clients. In a setting designed for simultaneous treatment of both disorders, flexibility promotes the most effective resolution of conflict.

A growing body of research supports the effectiveness of integrated rather than parallel treatment models for outpatient care (Drake et al. 1998; RachBeisel, Scott & Dixon 1999). A series of studies on the Combined Psychiatric and Addictive Disorders (COPAD) outpatient program at Beth Israel Medical Center in New York indicates that engagement in integrated outpatient treatment may decrease rehospitalization and lessen both psychiatric and substance abuse severity (Hellerstein, Rosenthal & Miner 1995; Rosenthal, Hellerstein & Miner 1992a, b). This model is based on the premise that an integrated treatment approach at a single site, featuring coordination of treatment philosophy, services, and timing of intervention will be more effective than a mixture of discrete and loosely coordinated services provided at different locations. A harm reduction approach rather than a strict abstinence-oriented model was seen as the more realistic engagement strategy. Patients were required to express motivation to decrease substance use, but they were not initially expected to be totally abstinent from abuse of substances. However, the environment was less permissive than that of a traditional psychiatric milieu, which might not detect much less address substance use. The confrontational style characteristic of traditional addiction treatment programs was avoided. Self-help group participation was encouraged, with appropriate preparation for handling issues around medication. Psychoeducational sessions dealt with both substance use and schizophrenia, and staff was cross-trained to deal with both disorders. The COPAD model was designed to be sufficient rather than comprehensive, in an effort to define a manageable number of elements which can be integrated into outpatient programs and still achieve benefits.

Both pilot studies and a subsequent random assignment prospective study (Hellerstein, Rosenthal & Miner 1995) of this model showed a decrease in hospital days, a decrease in psychotic symptoms, and a decrease in drug use. Standard care consisted of comparable levels (number of hours) of substance abuse and psychiatric services consisting primarily of case management, group psychotherapy, and psychopharmacology. These were provided without a formal mechanism for case coordination at separate locations in the community. Most patients in integrated treatment developed and maintained ongoing participation in treatment, whereas those in standard care either dropped out early in the treatment process or failed to engage altogether. The authors attribute the superior outcome to the temporal, physical and philosophical integration of the COPAD program.

In a subsequent study, the authors examined which patients did not comply with outpatient referrals, and were thus at heightened risk for rehospitalization. They found that women and patients with negative symptom schizophrenia were compliant with outpatient referral, whereas those with mixed syndromes were most likely to be noncompliant (Miner et al. 1997). Current studies explore the benefits of adding targeted assertive outreach (TAO) to integrated treatment, and preliminary evidence indicates strong differential efficacy of TAO over and above the gains of integrated treatment (Rosenthal, Miner & Hellerstein 1997).

Other models for dual disorder programs exist in the United States. The Harborview Advocates for Recovery and Rehabilitation Program (HARRP) in Seattle, Washington exemplifies an outpatient dual disorder program offering comprehensive (as contrasted with sufficient, as in the COPAD program) services. There are additional provisions for crisis intervention; case management; socialization; supportive housing; recreational therapy; vocational assessment, training, and support; and family support and self-help groups. The HARRP program blends harm reduction and an abstinence-oriented program by offering a pre-phase program for those who are unwilling to address their drug use, or agree to abstain, and a phase program with incentives for progress for patients who are willing to address their drug use (Wingerson & Ries 1999; Ries 1994). Patients in the harm reduction component are relatively unengaged in treatment and are unstable either in their behavior or their substance use disorder. They are not ready for interactive groups or many types of structured activities. On referral from their case manager, they may attend “Club Med,” a one-hour group that meets every morning, in which they receive coffee and snacks and take their medication in front of a case manager. At the end of this session, they may receive a small amount of money, though in general their benefits are tightly managed. This group encourages a routine daily activity, promotes medication compliance, and provides a structure to budget funds on a daily basis, and limits the amount of money available at one time to spend on alcohol and drugs. It is designed to be a low-demand group that prepares patients to take advantage of other opportunities.

Patients are assessed according to the severity of their behavioral disorder and their substance use disorder, and their degree of engagement in the program (a combination of motivation and treatment compliance) (Comtois, Ries & Armstrong 1994). As patients become more stable, other possibilities emerge; they have access to different kinds of group activities, clean and sober housing, and job possibilities when feasible. For example, patients may become part of a crew that recycles office paper and aluminum throughout the medical center. They wear badges and colorful hats identifying them as part of the recycling program, and are highly visible around the hospital. This type of intervention confers status and helps to cultivate a “program of attraction” that motivates others to engage more fully in treatment.
PHILOSOPHICAL DIFFERENCES

Engagement Strategies

Attitudes about how much effort should be expended to engage patients in treatment have historically differed significantly. Addiction treatment components that grew out of the 12-Step tradition were likely to come from the perspective that the individual had to be “ready” for treatment and that except for “confronting denial,” programs should focus on those who were strongly motivated. Over time, this stance has shifted as data about how treatment retention improves outcome is more widely assimilated and programs are more willing to incorporate engagement strategies. Public health data documenting the costs of untreated addiction (Gerstein et al. 1994; Gerstein & Harwood 1990; Hubbard et al. 1989) encouraged providers to incorporate these approaches. Practitioners working with the chronically mentally ill had long recognized the importance of enhancing motivation and included persuasion and engagement as part of the early tasks of treatment (Minkoff 1989; Osher & Kofed 1989). Forming a relationship with the patient, providing education about alcohol and other drugs and their consequences for that individual, and helping them obtain benefits such as food and housing all serve to increase the patient’s willingness to accept treatment. Extensive recent publications in the area of motivational enhancement have provided materials to be adapted for use with the severely and persistently mentally ill (Miller 1999; Miller et al. 1994; Miller & Rollnick 1991); however, there does not appear to be any refined adaptations in current use. Such tools could contribute to preventing premature treatment dropout in this population. For example, Brown and her colleagues (Brown, Melchior & Huba 1999) developed a system for measuring levels of burden arising from substance abuse, psychological problems, cognitive impairment, and general health status. They found that high levels of burden in the severely mentally ill population led to earlier treatment dropout, and recommended additional interventions to increase treatment preparedness. Such interventions would be designed to help those with high burden adjust to residential treatment and comply with program rules and expectations.

Harm Reduction versus Abstinence

Another area of division focuses on the goals of treatment. The dominant expectation in most treatment programs in the United States has been that patients will work towards complete abstinence from alcohol and other drugs. This is based on the disease model tenet that once a person has crossed the boundary of uncontrolled use, he or she will not be able to sustain controlled use over time (Margolis & Zweben 1998). Proponents of the disease model believe it is not only unwise but also unethical to encourage the idea that controlled use is possible. Thus abstinence is seen as the most reliable solution. With the advent of the HIV epidemic, public health discussions centered on ways to reduce the spread of the virus by addressing high-risk behavior in drug users. In this context, it became more acceptable to endorse strategies that reduced harm, even if they did not require acceptance of abstinence goals. For example, needle exchange programs have been well documented to reduce the spread of the virus (School of Public Health, University of California 1993). Other risk reduction strategies were incorporated into HIV intervention efforts. Once the dialogue on harm reduction was begun, the approach was extended into other arenas (Marlatt 1998). Clinicians treating the severely and persistently mentally ill did not expect to see straight line progress and enduring stability, but were accustomed to thinking of their task as maximizing and prolonging periods of good functioning. They had greater acceptance of mental illness as a chronic relapsing disorder, and were accustomed to slow progress with many setbacks. Harm reduction approaches were attractive as an engagement strategy, and also because they represented what many practitioners viewed as more realistic goals. On the far end of the continuum are programs or systems that completely endorse harm reduction without much expectation, encouragement, or assistance for the client to become totally abstinent. Although many practitioners see total abstinence as one end of the harm reduction continuum, there are settings in which it is practically taboo to mention that it is desirable to give up illicit drugs completely. In fact, mentally ill clients do achieve abstinence and sustain it for considerable periods of time, so clinicians need to remain mindful of setting expectations too high or too low.

Importance of Benefits Management

The appropriateness of tightly managing benefits for mentally ill substance abusers is a point of contention in some communities. Although it is considered acceptable to manage benefits while clients are severely psychotic, using this tool to reduce alcohol and other drug use in clients who are somewhat more intact can raise some difficult issues.

Benefit management has shown promise as a means of improving outcome. Despite the fact that it is considered a key element of assertive community treatment, it has seldom been studied in its own right. Severely mentally ill substance users can quickly spend most of their income on alcohol and drugs, increasing their symptoms and disruptive behaviors. This has been shown to increase acute inpatient admission, involuntary commitment, or incarceration (Kivlahan, Heiman & Wright 1991). One study demonstrated that psychiatric symptoms, hospitalization and cocaine use peaked the week after the receipt of disability benefits and that these patients spent half their benefit money on drugs (Shaner, Eckman & Huba 1999).

In their integrated treatment program in Seattle, Washington, Ries and Comtois studied the impact of disability benefit management as a treatment intervention (Ries & Comtois 1997) through a health services report using their
Clinical information management system. The goals of the payee intervention were to: (1) insure that the payments went toward food, shelter and other basic needs rather than toward AOD use; and (2) increase treatment compliance, thereby decreasing the suffering, morbidity and/or public cost associated with noncompliance.

The voluntary payee program, in place for many years, evolved into a computerized system run by one full-time employee who manages 180 consumer accounts. Payee management ranges in level of control, from paying the rent and disbursing the remainder of the cash two to four times per month, to providing meal tickets (rather than cash) and supervised shopping. Participants who demonstrate better treatment participation and decreased substance use can earn more monetary freedom. If a participant with an outside payee demonstrates persistent diversion of payments to AOD use, they are persuaded through their payee to move their benefits to the program. Case managers disburse benefits in conjunction with treatment activities. Participants are free to transfer to other community mental health centers, but virtually none do so.

Payees (compared to nonpayees) were more likely to be male, have a diagnosis of schizophrenia, have a history of high inpatient utilization, and have higher current ratings of psychiatric symptoms, substance use and functional disability. Although these characteristics usually predict poor outpatient compliance and more adverse outcomes, the payee participants attended about twice the number of outpatient sessions and were no more likely to be currently homeless, hospitalized or incarcerated. Thus the payees, who historically had more adverse outcomes, achieved outcomes comparable to a less impaired group when they participated in benefit management (Ries & Comtois 1997).

CRIMINAL JUSTICE SYSTEM ISSUES

Funding policies have created a de facto mental health system within prisons and jails. The 1990 Epidemiological Catchment Area Study documented that prisoners with severe disorders were five times more likely to have a substance use disorder (Regier et al. 1990). Prisoners with schizophrenia, bipolar disorder, and antisocial personality disorder had an addictive disorder 92% of the time. Other reviews and studies confirm the high prevalence of co-occurring disorders (Abram 1991; Lamb & Weinberger 1998; Teplin, Abram & McClelland 1996). These authors echo the voices of clinicians urging more careful screening of incoming detainees and diversion to the mental health system of those who have committed minor offenses. Lack of adequate social support and access to community treatment are frequently cited factors in the problem. One survey of 260 family members about their mentally ill relatives’ contact with the criminal justice system indicated substance abuse and noncompliance with psychiatric medications were significant predictors of arrest. These families had repeatedly sought help from community treatment systems; over 50% had made a failed attempt at commitment prior to the arrest (McFarland et al. 1989).

The rapid evolution of Treatment Drug Courts in the 1990s offers the possibility of a promising approach. These specialized courts consist of a relatively tightly structured system in which drug users are given the option of participating in treatment or going to jail or prison (Hora, Schma & Rosenthal 1999; Sherin & Mahoney 1996). Unlike conventional diversion programs, the court brings together the elements of the criminal justice system to insure that noncompliance with court requirements or treatment recommendations results in immediate and predictable consequences for the client. At the same time, clients are supported and rewarded for evidence of progress. Research and evaluation methods have become more sophisticated over the last decade, and indicate drug courts are showing great improvement over previous approaches. Retention rates are much greater than those observed for treatment clients in general. Supervision is more comprehensive, including frequent drug testing and other monitoring. Drug use and criminal behaviors are reduced during and after the program. Cost savings are evident, at least in the short term (Belenko 1999). Careful, continuing studies are in process and should continue to clarify important issues. Drug court judges are well aware of the increasing numbers of severely mentally ill clients in their system and hopefully specialized interventions will be developed and evaluated.

COLLABORATION ACTIVITIES AND SKILLS

Successful integrated treatment requires a high level of commitment and skill. When needed services are not available at one site, it is necessary to form a communication and decision-making process to coordinate care. It is desirable to designate a team leader, rather than allow ambiguity as to who is the primary caregiver and coordinator. Care providers will ideally agree on how collaboration will be managed, how disorders will be prioritized and how these priorities can be changed as appropriate. This requires an understanding of differences between care providers. Specialty systems can be viewed as subcultures that have their own goals, language and set of assumptions. These often can remain unstated until conflict arises over how to address the needs of a particular client. For example, perspectives on medications and psychoactive drugs can be quite different among mental health and addiction treatment providers. Collaboration is a skill as complex as clinical intervention; yet except among social workers, it may receive little emphasis in professional training. It is important to create a framework for clinical decision making that can guide collaboration and inform care, without artificially combining theoretical approaches that are fundamentally different (Zweben & Denning 1998).

On a practical level, it is useful to discuss a preferred
communication process between team members. Voice mail, fax machines, and e-mail are tools for systematic and rapid communication, but it is important for each team member to specify most accessible times and preferences for method of contact. It is also important to clarify varying types of client/provider interaction. Confidentiality requirements must be addressed and appropriate releases signed in the initial phases of treatment to avoid communication barriers at the time of the first client crisis. General parameters for handling anticipated crises can be discussed. Finally, it is necessary to clarify insurance issues and, if needed, assist the client in navigating the public assistance system.

CROSS-TRAINING ISSUES

Training issues are at the heart of system change. So long as those in leadership roles are not thoroughly trained in handling addictive disorders as well as severely mentally ill populations, it will be difficult to implement all the changes that are needed. The problem begins with graduate or professional training, in which faculty lacking these skills design course requirements without adequate grounding. Many states have passed laws or regulations mandating training in substance abuse for initial licensure or renewal of license for professionals in a variety of disciplines, but this merely tacks on a minimal training sequence that rarely if ever includes adequate skill practice. Material on alcohol and other drug use must be integrated into the core assessment and treatment curriculum in order to adequately train professionals who are completely comfortable addressing both disorders.

Training in the treatment community focused on chronically mentally ill substance abusers currently appears to take the form of workshops of one or more days given by well-known researchers and providers as well as local community leaders. It is rare to find a sequence of training experiences designed to build basic skills in providing integrated treatment. Although growing numbers of professionals are acquiring the skills to address alcohol and other drug use, systematic cross training would do a great deal to accelerate the development of the necessary work force and enhance overall capability.

CONCLUSION

There are myriad clinical issues that relate to policy concerns in this population, only a few of which could be covered in this article. A growing research base indicates that integrated treatment is effective for clients after the acute care phase of treatment, with assertive case management indicated for more severe cases. Although philosophical differences may create barriers to a pragmatic approach, it appears that a low threshold for entry into treatment, motivational enhancement, and benefit management are important elements in a system that effectively manages this population. Ample evidence exists that the criminal justice system is the default mental health system when community treatment capacity is inadequate or access barriers are too formidable. Community treatment requires vigorous collaboration on the part of appropriately trained practitioners who view this as an integral part of their treatment tasks.

REFERENCES


