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Dual diagnosis treatment models

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Abstract

The increase in the size of the identified Dual Diagnosis population and the increase in focus on cost effectiveness of treatment interventions and outcomes, has made clear the need for improvements in the knowledge base of treatment providers. Treatment models currently in use as partially developed approaches need to be studied in order to provide the DD population with the most effective treatment possible. (Minkoff, 1994).

This paper will examine literature pertaining to the three current treatment models: the serial, the parallel, and the integrated. It will also report findings regarding one innovative program currently under study for clients who have been diagnosed as having both substance disorders and psychiatric disorders.

Dual Diagnosis Treatment Models

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I dedicate this research paper to my son-in-law, Michael, who struggled with a dual diagnosis, who was supportive during the research and writing period of this paper, but who did not live to see it completed.

The addiction treatment industry and the mental health care community commonly refer to a client carrying a diagnosis of substance disorder and serious mental illness as a client with a dual diagnosis (DD). D. Fowls, (personal communication, July 19, 1996) medical director of Options Mental Health in Norfolk, VA considered DD as a misnomer in that DD does not refer specifically to a substance disorder along with a psychiatric disorder, but to any diagnosed medical or psychiatric problem accompanied by a substance disorder. Fowls believed that where there are two diagnoses, such as substance disorder and mental illness, there are usually more diagnoses which would also be applicable. For the purposes of this paper the term DD will refer to a client with a substance disorder who carries a second diagnosis of a major psychiatric disorder as identified in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (1994, 4th ed.).

Drake, McLaughlin, Pepper and Minkoff (1991) identified the widespread prevalence of DD as being well documented. Reiger, Meyers and Kramer (cited in Drake, McLaughlin, et al., 1991), found in their Epidemiologic Catchment Area (ECA) study found that more than one-third of patients in general psychiatric settings also met diagnostic criteria for some form of substance abuse or dependence. Bachmann, Moggi, Hirsbrunner, Donati, and Brodbeck (1997) stated that the increase in the size of the DD population was due to more accurate and comprehensive diagnoses. The authors cite others in agreement.

Sciacca (1991) reported the finding by the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) that at least fifty percent of the 1.5 to 2 million Americans with severe mental disorders such as bipolar disease or schizophrenia also abuse illicit drugs and/or alcohol, as compared with fifteen percent in the general population. This finding is consistent with ECA study findings which

reported fifty percent of newly admitted psychiatric patients had co-occurring alcohol and/or drug abuse.

Drake, McLaughlin, et al. (1991) believed that two primary factors have contributed to the increase in the prevalence of DD clients among treated populations. Those factors are deinstitutionalization, the movement of mentally ill patients from institutions back into the mainstream of society, and the changing drug use pattern which has made experimental drug use more socially acceptable in our culture. Clients may be prompted to use drugs for the purpose of self-medicating. Deinstitutionalization has allowed the client to obtain long-term treatment in the community where he or she has easy access to alcohol and other drugs.

The acute awareness of DD within the psychiatric community was coupled with the advent of the DSM III (1980) and its inclusion of substance disorders as diagnosable psychiatric disorders, according to W. Yates, MD (personal communication, May 22, 1996), Department of Psychiatry, University of Iowa College of Medicine. Drake, McLaughlin, et al. (1991) corroborated the psychiatric community's awareness of DD by calling attention to a 1982 conference sponsored by the ADAMHA during which coexisting serious mental illness and substance disorders were identified as a major problem.

Minkoff (1991) recognized the increased prevalence of clients with DD has created controversy among behavioral health treatment providers as to which of the three basic treatment models affords the most positive results for the client with DD while remaining cost effective. These three basic models are: serial treatment, parallel treatment, and an integrated treatment approach. The long-standing, seemingly irreconcilable differences in philosophies that have driven the addiction treatment system and the mental health care system fuel the controversy over such issues as medication use, the quasi-religious nature of

twelve-step programs, and which diagnosed disorder should take precedence as the treatment focus.

Minkoff (1991) observed that areas of conflict made the move toward an integrated treatment model appear incompatible with the addiction treatment system and the mental health care system, mutually. However, while appearing to be incompatible, Minkoff contended that concepts utilized within each system are basic and compatible to the benefit of the DD client.

The increase in the size of the identified DD population and the increase in focus on cost effectiveness of treatment interventions and outcomes, has made clear the need for improvements in the knowledge base of treatment providers. Treatment models currently in use as partially developed approaches need to be studied in order to provide the DD population with the most effective treatment possible. (Minkoff, 1994).

This paper will examine literature pertaining to the three current treatment models: the serial, the parallel, and the integrated. It will also report findings regarding one innovative program currently under study for clients who have been diagnosed as having both substance disorders and psychiatric disorders.

Serial Treatment Model

Ries (1993) referred to serial treatment of substance disorder and psychiatric disorders as the longest established treatment delivery system and the most common model currently in use. Ries, as well as Minkoff (1989), and Ryglewicz and Pepper (1996), characterized serial treatment as referring to treatment of either the substance disorder or the psychiatric disorder of the client which is then followed by treatment of the opposite disorder. For the client, involvement in one system "typically precludes or limits access to the other" (Drake, 1995, P. 6). Ries (1993) is in agreement with Drake.

Government funding was identified by Minkoff (1994) as the entity that established the separation of substance disorder treatment and psychiatric disorder treatment more than fifty years ago. Minkoff also noted that "no category of psychiatric illness in the DSM III R (1987) other than substance abuse disorders is represented by a distinct service system" (Minkoff, 1994, p. 55). This separation of substance disorder and psychiatric disorder treatment has brought about the secondary impact of both state and federal monies being available for service to clients. Without the separation there would be less money available for treatment programming because there are few provisions made for increased funding when treating both disorders.

Ries (1993) believed the benefit of the serial treatment model lay in its allowing the two approaches (substance abuse and psychiatric treatment) to remain separate. Ries saw one advantage of the two treatment systems remaining separate as being in the reduction of cost. Also, the need to cross-train staff is eliminated, the use of existing separate facilities, administration and billing can continue undisturbed, and the approach is consistent with the long-standing history of the separateness of substance disorder treatment and psychiatric disorder treatment.

Minkoff (1991) saw a benefit of the serial approach as being its allowance of more flexibility for the client. He pointed out that some clients may find it easier to engage in services that do not deal with mental illness while other clients may find it easier to engage with services that do not deal with substance abuse.

Mueser, Drake, and Miles (in press) and McHugo, Drake, Burton, & Ackerson (1995), (as cited in Carey 1996), provided clinical and empirical evidence that not all clients with co-occurring disorders are ready to accept their substance use as a problem nor are they ready to accept their mental illness. Such clients may not be ready to engage in active steps to reduce substance

use. Brown, Ridgely, Pepper, Levine & Ryglewicz (1989) are in agreement with Carey.

Mary (personal communication, 1997) serves as one example of DD clients who do not receive treatment for both disorders. Mary is an alcoholic with a second diagnosis of bipolar disorder who has experienced multiple detoxification's and addiction treatments. Mary takes psychotropic medication, but she has never been hospitalized for the psychiatric disorder due to the usual entry into the system by way of detoxification and committal for substance abuse. She expressed frustration related to her lack of education concerning the bipolar disorder. She stated her mental health treatment consisted of pharmacological intervention, a single class session on DD given during inpatient substance abuse treatment and some pamphlets by Hazelden Press dealing with DD.

Mary (personal communication, 1997) has reached a point in her life at which she has multiple health issues at least in part related to her alcohol consumption. She expressed her frustration with the system as is now exists because she believes, correctly, that she has two problems, but in the past one has always been ignored.

The serial treatment model has not given Mary what she needs to deal with her psychiatric illness. Although it is the oldest established model of treatment for the DD client it is no longer considered the best by everyone in the field. The following discussion examines some of the reasons.

The serial model presents a fragmented treatment approach according to Miller (1994) and Chafetz (1994) that allows a split staff of psychiatric professionals and substance abuse professionals to decide which area is the most important to be treated first when, in fact, both areas require appropriate and effective treatment. Yates (personal communication, May 22, 1996) is in agreement with Miller and Chafetz, but added that treatment must be aggressive,

as well. Baker (1993) expressed the belief that this fragmented system interferes with client accessibility due to the narrowly defined target groups. When this fragmented serial approach is used the philosophical differences of the providers involved make agreement on treatment delivery very difficult.

Within the serial model clients are often given contradictory information, explanations and therapies, especially with regard to chemical use (Ries, 1993). Brown et al (1989) identified abstinence as an area in which the differing treatment philosophies between the mental health community and the addiction treatment industry could be clearly seen. These authors observed that the mental health field, while desiring the client to be abstinent, does not place abstinence as the primary goal. Brown et al. pointed out that in many psychiatric day treatment programs, the issue of substance abuse may appear as a side issue or not be addressed at all.

In contrast to the mental health delivery system, the substance abuse treatment delivery system, the substance abuse treatment field adheres to abstinence as a major requirement (Ries, 1993). Ries further recognized that when a psychiatric patient is admitted for substance abuse treatment the message he/she will hear either overtly or covertly is "a drug is a drug is a drug," which calls into question their use of prescribed psychiatric medication.

Minkoff (1991) believed when the twelve-step program is used in the treatment setting and abstinence is not mandated, the program loses credibility and effectiveness. Minkoff cited other authors (Atkinson, Kania, Kofoed, and Walsh, 1986; Kofoed, and Osher, 1989; Sciacca, 1987) who have emphasized that, for the DD client, requiring abstinence at the outset discourages or prevents engagement in treatment. Fine agreed the abstinence goal is difficult for the patient, but because it can be a difficult goal to achieve, it must be addressed early in treatment by means of explaining the value of it to the patient.

Treatment delivery within the serial model was observed by Ries (1994) as presenting difficulty when the psychiatric client was psychotic or paranoid or when the substance abuse client was in need of detoxification at the time of treatment. Clients are less compliant and more problematic at those times. Levy (1994) was in agreement with Ries. In addition, the DD client may often disrupt the flow and routine of the substance abuse program related to unusual behaviors according to Evans and Sullivan (1990).

The confrontive nature and the emotionally charged material used in substance abuse programs was identified by Evans and Sullivan (1990) as problematic to the DD client. The authors recognize the DD client may be seriously hampered in the understanding and utilization of information being disseminated in treatment, a factor which impedes the client's ability to translate learning's into appropriate behavior.

Material used in the substance abuse treatment setting is not only confrontive, but is also requires clients to assume responsibility and ask for the help they need to stay sober/clean with negative consequences as the stimulus for the client, according to Minkoff (1994). Minkoff noted that hospitalization is one of the avenues seen by the substance abuse professional team as providing the extra help that clients often need.

Mental health treatment providers, on the other hand, protect clients from negative consequences by assuming responsibility for client needs and providing for those needs Minkoff (1994), believed. The move toward deinstitutionalization and replacement of hospitalization by community-based services is in conflict with the addiction treatment philosophies of empathic detachment and recovery according to Minkoff. Detachment and recovery require the client to assume responsibility by asking for help, which is the basis of most addiction treatment.

Kitchens (1991) further defined detachment as the process where family and others stop taking responsibility for the client's feelings and behaviors.

Miller, Belkin and Gibbons (1994) pointed out that there are few requirements for training in addictive disorders in medical residency programs or in clinical practice. This calls into question the medical community's ability to identify and deal with substance abuse problems found in psychiatric patients. Albanese, Bartel, Bruno, Morgenbesser, and Schatzberg (1994) indicated in their research that psychiatric and psychological trainees were not apparently sensitive to the identification of current chemical use. One hundred and seventy-eight inpatients were administered the Structured Clinical Interview for DSM III R-Patient Version test, urine toxicology screens and admission and discharge diagnoses performed by the primary clinician. Results showed that trainees were not sensitive in diagnosing psychoactive substance abuse. In the study, some patients were diagnosed with substance abuse on admission, but not on discharge, which indicated that substance abuse was overlooked and, therefore, possibly inadequately treated. Ananth, Vanderwater, Kamal, Gama! and Miller's study (cited in Drake, Rosenburg and Mueser, 1996) agreed with Albanese et al. (1994).

Miller et al. (1994) pointed out there are no uniformly accepted methods of diagnosis and treatment of addictive disorders in psychiatric populations. Evans and Sullivan (1990) found that the issue of under-diagnosing extends to medical professionals working with the DD population, as well, because symptoms of substance abuse can mimic those of psychiatric disorders and visa versa. Fine (1994) added that an initial definitive diagnosis for the DD client can be almost impossible so that general diagnosis may need to be accepted early in treatment. Evans and Sullivan (1990) stressed the need for medical professionals to keep substance abuse in mind so it is not overlooked as a potential diagnosis.

Alcoholics Anonymous (AA) was started in 1935 and has become the most successful recovery program in America. (What is A. A.?, 1982). The fellowship continues on the premise that one alcoholic is the best therapist for another alcoholic who wants sobriety. Their twelve-step program has been followed by over one million men and women, seeking recovery.

The twelve-step model used in AA is difficult for the mental health community to accept because it is unscientific and relies on self-help, according to Minkoff (1994). Chappel (1994) agreed with Minkoff that the mental health community has difficulty accepting AA although AA had its roots in medicine, psychoanalysis and religion and despite the fact that AA fosters a process toward growth and development made clearly evident by psychiatrists who support patients in twelve-step work.

According to Evans and Sullivan (1990) the debate regarding the nature of what constitutes appropriate treatment for DD clients was a prime reason for the lack of outcome studies. Yates (personal communication, May 22, 1996) considered the differing philosophies between the addiction and the mental health treatment communities as the prime reason for the lack of studies. Burnam (1996) disagreed, citing the burden of increased cost involved with outcome studies and the need for more record keeping on top of an already heavy load of paperwork as the prime reason for the lack of outcome studies.

Ryglewicz and Pepper (1997) presented costs to the client in staying with the older, less expensive, established system of serial treatment. They described the serial model as one which finds the consumer, "wishing in vain for a floor plan and directory showing where to go, what to do, and how to get help. The reality in many cases is more like a maze, with many blind alleys, unfinished corridors and DO NOT ENTER signs blocking the way" (p. 172). Ries (1993) claimed the

serial treatment model allowed many clients with DD “to fall through the cracks” (p. 169).

The serial model allows for the use of existing programs, facilities and the existing staff utilization. These work to keep costs from greatly escalating at a time when cost effectiveness is strongly stressed. One disadvantage of the use of the serial model involves the most effective treatment for the client. A second disadvantage is that staff are most often trained in one field or the other and are not fully able to meet client needs in both areas.

Parallel Treatment Model

Lehman, Myers, Dixon and Johnson (1994) identified the parallel treatment model as one in which the substance disorder and psychiatric disorder are treated simultaneously, but in separate treatment programs and facilities. This definition of the model is generally accepted in the behavioral health field and is specifically cited by Drake (1995), Miller (1994), Minkoff (1991), Ries (1994), and Rygewicz and Pepper (1997).

Points of controversy and conflict that are apparent in the serial model for treatment of substance disorders and mental disorders also apply to the parallel model. The major points that are shared by the serial model and the parallel model are philosophical differences, treatment delivery style differences, abstinence issues and cost issues. Ries (1993) noted that the parallel model is somewhat better than the serial model because the controversy is lessened by the requirement of more system and therapist change and adaptation than is required from the serial model. In the parallel model staff must work together because clients are attending both treatments at the same time and will experience and point out conflicts in either system.

The parallel treatment model, according to Lehman et al. (1994), may be acceptable for later stages of treatment and with well stabilized clients who are

not severely disabled. This is related to the additional stress from longer treatment time involved when addressing both client disorders on the same day. Ries (1993) was in agreement with Lehman et al.

The parallel model is helpful when the psychiatric problem of the client requires intensive intervention because the psychiatric problem can be addressed with more intensity. This increased flexibility of programming allows for services at two agencies and at a level the client can handle as noted by Lehman et al. (1994).

Ries (1994) pointed out the parallel model does utilize existing treatment programs and settings, thereby allowing those with expertise in each area, substance abuse and psychiatry, to work with the client on issues involving the clinician's area of expertise. The models use of existing resources also makes it more cost effective according to Minkoff (1991).

Community size was identified by Ries (1993) as a consideration in using the parallel model in small communities with limited resources. Larger communities' systems are less flexible, which complicates the use of the parallel model.

Data collection can also be hampered under the parallel treatment model, according to Ries (1994), because the DD client is very often serviced by many agencies and systems which may be covered by very strict confidentiality laws to protect the client. Therefore, the sharing of clinical data among professionals is more difficult to accomplish.

The parallel treatment model offers the client the opportunity to be treated for both substance abuse and mental illness at the same time. It also utilizes the expertise of both the substance abuse staff and the mental health staff, but with very little cross-training. The basic philosophical differences of use of hospitalization, responsibility, and abstinence, however, remain in place.

Confidentiality laws interfere in the sharing of information between the substance abuse staff and the mental health staff. For the client who is already under undue stress and very fragile, according to Ries (1993), the need for increased time involvement is a draw back to the use of the parallel model.

Integrated Treatment Model

The mental health community and the substance abuse community are parallel and separate as are the serial and parallel treatment models (Drake, 1995). Ries (1993) identified the parallel model as the model which has caused the mental health community and the substance abuse community to begin working more closely together and as being the force that has pushed both systems to look at and move toward the development of an integrated model.

The view that an integrated treatment approach which involves concurrent application of core concepts from both treatment disciplines is the most promising for the future is shared by numerous writers. They include Chafetz (1994), Daley et al. (1993), Drake, McLaughlin et al. (1991), Drake and Mueser (1996), Evans and Sullivan (1990), Jerrell (1996), Miller (1994), Minkoff (1989), Minkoff and Drake (1991), Ries (1993), Ryglewicz and Pepper (1996), and Yates (personal communication, May, 22, 1996). Minkoff (1989) qualified his belief by adding that for the DD client any treatment model must be individually matched to the client's needs. The early data from projects funded by ADAMHA and reported by Drake, McLaughlin et al. (1991) demonstrated the integrated approach produced the most promising results and productive outcomes and offered the most promise for the future direction of DD treatment.

Drake and Mueser (1996) referred to (but did not present details of) research indicating integrated treatment is more effective than is parallel. They do, however, contend that specific aspects of treatment require empirical validation which will lead to more precise clinical guidelines. Yates (personal

communication, May 22, 1996) was adamant that both the client's mental illness and the substance abuse must be treated aggressively and concurrently. He expressed the belief that such treatment is not generally happening at present.

The differing philosophies of addiction treatment programs and mental health treatment programs created barriers to developing and implementing integrated treatment in the area of DD programs according to numerous sources including Minkoff (1994), Ries (1993) and Ryglewicz and Pepper (1997). Minkoff (1994) considered the development of DD treatment modalities to be in its infancy related to the seemingly irreconcilable differences of the philosophical debate.

Minkoff (1989) made the point that conflicts which might otherwise occur in the absence of clarity can often be avoided by careful preliminary work. Evans & Sullivan (1990) reached a similar conclusion and emphasized the need for a clear philosophy and a mission statement when an integrated program is being formed so that staff may join and organize toward real integration.

DD clients may be experiencing significant problems from both of their disorders and with the integrated model both can be better addressed (Ries, 1993). Cross-training and understanding by both sets of treatment teams are required to translate principles in a harmonious manner. Ries also contended that client denial can be better addressed in the integrated model.

Levy (1994) found the DD client to be commonly more resistant to treatment and less apt to follow up on treatment recommendations than either the substance abuser or the psychiatric client when either has only the one affliction. Levy saw this as presenting a challenge to staff. Integrated treatment teams are working together. Levy's believed that the DD client requires specialized psychotherapeutic intervention which can be better accomplished in an integrated program is shown to be highlighted by the following statement; "While there are

two (or more) problems, there is only one patient, and the entire patient must be treated holistically” (p. 246).

Ries (1993) questioned why more integrated programs do not exist. His answer to his own question is that costs of cross-training or retraining of staff would be high, programs would have to be altered, few outcome studies are available to lead the way, and funding is now separate for the two treatment areas. In order to combine treatment areas it would be necessary for each to relinquish some funding.

Integrated treatment would be improved, according to Ries (1993), by cross-training of all staff involved in the delivery of treatment including counselors, nurses, social workers and doctors. Ries identified such barriers as bureaucratic splits, the long-standing separation of professionals in each of the fields, the under-training of medical doctors regarding addictions, and the separate certification of personnel in both fields.

Jerrell (1996) described the only study found in the literature that examined both costs and effects of substance abuse interventions for severely mentally ill clients. The study was done in 1995 by Jerrell and Ridgely (cited in Jerrell, 1996) with a final sample of 132 clients. The three interventions were the twelve-step recovery model, the behavioral skills training model and the case management mode which all were used in an integrated treatment program. Subjects were screened, interviewed and assigned to one of the three types of interventions. A reduction in psychiatric symptoms and in drug and alcohol symptoms were found with the behavioral skills training model and with the case management model. Costs with the twelve-step recovery model were higher for supportive services during the first year of the study, but were comparative with the other models at the eighteen month time period. Supportive services correlated significantly with enhanced functioning and reduced intensive mental health service costs.

Jerrell (1996) concluded that the study's findings reinforced evidence of the positive benefits of treatment for DD clients when both substance abuse and psychiatric treatment interventions were used simultaneously. Interventions that addressed client deficits in cognitive and behavioral areas were important in both disciplines. The results of this research offer encouragement for clinicians and program managers to become active partners with researchers in the areas of DD interventions and the promotion of cost-effective regular care.

Accurate diagnosis by health-care givers is necessary due to the fact that clients often understate their substance use or may be delusional and unable to give an accurate history (Milling, Faulkner, and Craig, 1994). Under-diagnosing often occurs in such circumstances. Other possible explanations offered by Milling et al. for the under-diagnosis of substance abuse in the psychiatric patient were cultural acceptance, lack of educational programming, and the separation of substance abuse program professionals and psychiatric treatment professionals. Milling et al. concluded that integrated treatment could be helpful in reducing these difficulties with diagnosis and assessment.

McGovern (1994) speculated as to how many diagnoses a person can handle without feeling overwhelmed. He advocated keeping diagnoses more broad so as not to become burdensome and for keeping therapy simple so as not to complicate the therapeutic process. McGovern further identified diagnoses as being at their worst when they label and segregate people, and at their best when they bring about relationships between the therapist and the client. McGovern recognized the integrated model allows the diagnosis to be kept simple, the therapy to be kept simple and that it does not segregate the client as would the serial or the parallel model.

The integrated approach was accepted by Levy (1994), Minkoff (1991), Ridgely (1991), Sciacca (1991), and Ryglewicz and Pepper (1996) as holding the

most promise and potential for the future direction of treatment for the DD client. Costs involved in such a change in approach from serial or parallel treatment models, have slowed progress in that direction. The client would be better served by the treatment industry with a move toward integrated treatment.

There are several barriers Levy (1993) pointed out that the DD client may experience which make treatment delivery more problematic. The first barrier identified was that of trust. Clients are hesitant in forming relationships with treatment providers. Levy noted the client may be paranoid, mistrustful and may have had painful and hurtful relationships in the past. He said a relationship of trust must be built before the client can successfully engage in treatment. Evans and Sullivan (1990) were in agreement with Levy on the trust issue.

Levy (1993) saw client lack of a clear overall identity as a second barrier to treatment delivery. He said that chemical use can make relationships easier to establish, but also can make it easier for the DD client to deny the existence of mental illness. Levy observed that without chemical use the client is left with only an extremely poorly formed identity which makes active participation in treatment more difficult and with a less positive outcome.

The third barrier to treatment delivery that Levy (1993) presented was abstinence. Abstinence is a recommendation of substance abuse treatment programs. The prospect of abstinence looks overwhelming to the DD client. Minkoff (1994) and Drake, Rosenberg and Mueser (1996) were in agreement with Levy. Levy (1993) said that it is only when the client sets goals for him/herself, sees hope for a better life, or wants to develop the desire to change in a positive direction will he or she entertain the thought of stopping chemical use. Levy offered that client goals are not achieved because of the using behaviors and that only when the client sees this relationship between the using behaviors and the achievement of goals can abstinence occur.

Ryglewicz and Pepper (1996) placed behavioral health treatment as currently being at a time of promise, but they also pointed out that the current government trend toward overhauling entitlements, balancing the budget, and transferring the responsibility for human service delivery costs to the state governments places that time of promise in jeopardy and a barrier to treatment delivery. The authors called attention to the current trend of managed health care which makes the outlook for funding of behavioral health treatment bleak and, therefore, a strong barrier to the new treatment possibilities on the horizon.

Caulfield House: An innovative integrated program

Caulfield House is one of the earliest treatment units changed into an integrated program from an existing serial program and, as such, is important to examine in the pursuit of establishing further integrated programming. Minkoff was hired in 1984 as chief of psychiatry and he is the primary contributor of information concerning Caulfield House.

Minkoff (1989) described Caulfield House as an integrated program developed on a general psychiatric unit in a community hospital in the Boston area. When the hospital administration made the decision to move in the direction of an integrated unit, Minkoff expanded and strengthened the psychiatric unit's program and still retained the strong addiction program already in existence. Continuing as chief of psychiatry and director of Caulfield House, Minkoff was instrumental in formulating and implementing this integrated program and currently is further refining the program. The first step taken was that of identifying and adopting an integrated philosophy.

Minkoff (1989) described issues that needed to be confronted and resolved in order to bring about the Caulfield house integrated program. Issues included consistent validation of each discipline as a specific treatment for each problem, the statement in writing that AA does accept the use of medication, the

need for anti-psychotic medication in order for the client to be able to participate in treatment, emphasis on using medication to treat only the psychotic symptoms for the DD client, education of mental health staff on AA concepts and their acceptance of them, and belief that regular AA attendance helps the DD client maintain sobriety. Minkoff acknowledged that this approach needed further testing in different treatment situations before conclusive recommendations could be made as to the adaptability of the model.

Minkoff (1989) and Ridgely (1991) agreed concerning the described parallels in the concepts of illness that lend themselves toward an integrated approach as set forth at Caulfield house. These parallels are that the diseases are considered to be incurable with relapse exacerbations, complex with hereditary or congenital biologic predisposition, require treatment to be stabilized, and that clients exhibit extreme denial and are characterized by loss of control and brain chemical changes.

The parallel concepts of recovery and rehabilitation at Caulfield House that Minkoff (1989) recognized as a process of continued growth despite the presence of a chronic, biologic, incurable mental illness. The client must first be stabilized then engaged in active participation in both treatment and rehabilitation. The AA twelve-step program that moves the client beyond denial to admit powerlessness has been successfully adapted for the use of those with chronic mental illness, according to Minkoff.

Minkoff (1989) pointed out that special preparation was needed to prepare the client with a DD for active AA participation. Included in this preparation was individualized education for the client on how to behave in meetings, selection of suitable meetings for the DD client by staff who are in recovery, integration of the DD client into meetings and groups with non-psychotic addicts so they will not stand out, and consideration of resistance to AA as a manifestation of client

denial of addiction. Minkoff reported that clinicians at Caulfield House have come to believe that once the psychiatric disorder is stabilized with medication, the addiction can be treated much the same as it was for other addicted clients.

Caulfield House has no one best treatment track according to Minkoff (1989). There are four different treatment schedules that differ according to the patient's primary problem with both diagnoses being treated in a specially constructed parallel fashion. Each patient is matched to the schedule that best fits his/her specific needs on a one-to-one basis with adjustments during treatment.

The conclusion drawn by Minkoff (1989) was that the Caulfield House model does present limits to generalizability. It was developed in a short-term acute care setting from a primarily addiction focus to integration with a psychiatric focus. The model may not work in the reverse. Another limit to generalizability was that the variety of AA meetings available to clients was great in the large urban area in which the program came to be and this may have greatly influenced the success of Caulfield House. The last point that the author made as to the generalizability of the model was need for resolution of the philosophical differences between the addiction and the mental health communities. Despite these limits, Caulfield House does present movement in a positive direction toward an integrated treatment.

Conclusions

On the basis of the findings of this literature search the conclusions are:

1. The integrated model is widely accepted as the model offering the most promise for the future of treatment for the DD client.
2. Research in the area of treatment of clients/patients carrying DD has barely been touched. Much more is needed to insure that progress in treatment of these persons moves in an orderly and positive direction.

3. Integrated programs need to be developed and assessed to insure their effectiveness.

4. Clinicians in the behavioral health field need to be better equipped through education and experience to more accurately diagnose both the mental disorder and the addiction disorder of the DD client.

5. Attention needs to be paid to the costs involved with treatment programming and delivery to keep treatment as cost effective as possible while providing clients with quality treatment programs.

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