The Substance-Abusing Mentally Ill Patient: Challenges for Professional Education and Training

Vivian B. Brown
Thomas E. Backer

Vivian B. Brown, Ph.D., is a Partner in B & B Research and Chief Executive Officer of Prototypes, a nonprofit center for innovation in health, mental health, and social services. She has worked in mental health and substance abuse for over 25 years, and has designed a number of model treatment programs.
Thomas E. Backer, Ph.D., is a Partner in B & B Research and President of the Human Interaction Research Institute, a nonprofit center for research on organizational change in health care and human resources. He also is an award-winning writer-producer of educational films and videos, many of which have focused on severe mental illness.

Abstract: Both mental health and substance abuse professionals need specialized training on how to deal effectively with the dual disordered patient. A multi-part research study is helping to determine preferred formats and content for such training programs. The first part, which has been completed, administered a questionnaire to professionals about training needs. The second part, currently in progress, involves telephone interviews with professionals to provide more specific training input. The third part, also in progress, is studying audiovisual training media. Results suggest some consistent directions to be followed in developing training and education programs on dual diagnosis.

Dual disordered patients highlight gaps in the mental health and substance abuse service delivery systems. They have been called "treatment resistant," "difficult patients," and "patients who don't fit." These patients, most commonly young adults with drug and alcohol problems, do not fit well into present treatment systems because these systems have not been designed to serve them. In fact, the separation of services into two or three systems (mental health, drug, alcohol) virtually guarantees that interventions will be fragmented for this population, which is so much in need of a well-coordinated treatment system.

These patients typically are shuttled between mental health and substance abuse facilities. Mental health professionals are not comfortable with patients who do not comply with treatment and who may self-medicate. Substance abuse program staff members often are not comfortable with severe psychopathology. Sometimes these patients were admitted to psychiatric hospitals and no one ever assessed the drug and/or alcohol problem. In addition, recent epidemiological studies of the homeless pop-

ulation show that a significant percentage of these individuals have drug and alcohol-related problems as well as psychiatric problems (Wright, Knight, Weber-Burdin, & Lam, 1987; Koegel & Burnam, 1987; Farr, Koegel, & Burnam, 1986).

A series of eight program principles for treating chronically mentally ill patients was outlined by Bachrach (1982). Effective programs for these patients, including young chronic adult patients, assign top priority to the care of the most severely impaired patients; enable patients to gain access to a full range of comprehensive services; are realistically linked to other agencies and resources; are characterized by personally designed and highly individualized services; emphasize the need for specially trained staff; show flexibility in their formats; are tied in some manner to a complement of hospital beds; and are relevant to and compatible with the patient's cultural background.

For dual disordered patients two additional principles must be added to Bachrach's list: (1) mental health professionals working in such programs must be knowledgeable about drug and alcohol use/misuse (and their relationship to assessment problems); and (2) professionals must develop interdisciplinary teams and new collaborations if they are to meet the complex and varied needs of dual disordered clients. These two principles will guide the following discussion of the need for changes in education and training for professionals regarding dual diagnosis.

Many dual disordered patients utilize hospital emergency rooms and other mental health/substance abuse facilities when they are in crisis. Or, when they have been picked up by the police for inappropriate behavior in the community, they may be brought to such facilities involuntarily. Readily accessible and culturally relevant services need to be provided in the community in order to take advantage of the opportunity that these crises give us to reach this population. We not only need to change the nature of the interventions in both mental health and substance abuse systems, but also to change the education and training of professionals and other staff who will implement these interventions. Program design and curriculum redesign need to move together.

A recent "futures study" regarding the mental health delivery system in the year 2000 (Brown & Fraser, 1985) also adds to our understanding. A number of respondents interviewed for this study saw the need for enhanced services for the dual crises of mental illness and substance abuse, and a need for mental health training programs to include issues of substance abuse. Currently, a number of specialized training programs are being developed for mental health professionals and substance abuse specialists. These training programs are designed to increase knowledge and skills in treating the dual disordered population. However, little research has been reported to date about how to make these programs as content appropriate and effective as possible.

Research on Professional Education and Training

The most recent work by Talbott and his colleagues (Ridgely, Osher, & Talbott, 1987), which focused on treatment issues for the dual disordered population, states that there is consensus about the need for additional inservice training for professionals and revised curricula within professional schools. One of the pioneering studies mentioned in the report is being implemented by B & B Research, under research funding support from the National Institute on Drug Abuse.* This study is designed to determine (1) what the training needs are of mental health and substance abuse professionals regarding dual diagnosis; (2) what training is now available, and how adequate it is; (3) what training media would best help professionals learn the skills they need to work with their dual diagnosis clients; and (4) how training media can best be disseminated to professionals. Three studies in this research program are reported here.

Study 1. This completed research investigation involved 117 professionals responding to a survey questionnaire distributed at two major training conferences: (1) the 1987 Substance Abuse and Mental Illness Conference ("Are They Falling Through The Cracks?") in Orange County, California; and (2) the Eighth Annual Drug and Alcohol Institute at the University of California at Los Angeles (UCLA). At both conferences, the senior author led training workshops on the issue of dual diagnosis clients.

Study 1 was guided by the following assumptions: (1) Potential participants can identify knowledge and skills to be worked on which are especially likely to be implemented "on-the-job" by busy professionals; (2) Mental health professionals and substance abuse specialists may have different needs for training content and methods.

The questionnaires addressed both the content of training and the techniques to be used to impart this content. Based on an extensive review of the drug, alcohol, and mental health literature and the experience of workers in these areas, a list of 34 topics and 10 training methods was developed. The topics section included three divisions: information about mental illness and mental health interventions; information about substance abuse and substance abuse interventions; and specialized and more generic issues, such as ethnic minority issues and AIDS. As a measure of readiness to treat the dual disordered client, a question was asked regarding the respondent's comfort level.

Analysis of the 117 completed questionnaires yielded the following:

(1) Participants in the two conferences represent a diversity of specializations. In the Orange County sample, 53% of the respondents identified themselves as mental health professionals and another 33% identified themselves as both mental health and drugs/alcohol specialists (combined category). Fourteen percent identified themselves as either drug or alcohol

specialists. In the UCLA sample 30% identified themselves as either drug or alcohol specialists and another 67% identified themselves as substance abuse (combined drug and alcohol) specialists. Three percent identified themselves as mental illness specialists only.

(2) There was little difference in the topics rated the most useful by the two conference samples. The topics considered the most useful were:

Addictive Personality
Interactive Effects of Drugs/Alcohol and Medications
Role of the Family
Young Adult Chronic Patient
Multiple Addictions
Suicide Potential
Assessment Instruments

(3) The topics considered the least useful were Methadone Maintenance and Urinalysis.

(4) There was little difference between the two conference samples in ratings of the most useful training techniques. The methods rated most useful were:

Team Teaching by Mental Health and Substance Abuse Specialists
Videotape
Print Materials
Case Studies

(5) The training method considered least useful was Audiotape. Respondents showed the most conflicted attitudes about Role-playing; i.e., participants rated it either extremely useful or not useful.

(6) With regard to comfort in treating the dual disordered client, results showed that both groups were in the midrange; the Mean and Mode were 3.1 and 3, respectively, out of a range of 1 to 5.

Discussion of the results will focus on both strategies for developing training programs that incorporate these results and the barriers to implementation that must be addressed.

Study 2. The second study in this research program is in progress. Structured telephone interviews are being conducted concerning treatment strategies, training models, and dissemination techniques for learning about dual diagnosis. Mental health professionals and substance abuse specialists identified as knowledgeable with regard to this population will be the interview subjects. Thirty interviews in all will be conducted.

Study 3. This in-progress study involves 20 structured telephone interviews concerning the content, format, and dissemination of print and visual training media on dual diagnosis. Professionals in mental health and substance abuse education with media backgrounds are being asked to identify training media they regard as successful, and to specify reasons for success. Most of the media identified will concern either mental illness or substance abuse, not dual diagnosis. Also, most of the media identified will combine film or video with print materials. Interviews also are being conducted with professional film-makers who specialize in producing training films or videotapes for pre-service or inservice education in the health care fields.

Findings from this component will be used to develop alternative training media designs that may be effective in conveying the content identified in Studies 1 and 2. Some input on media formats already was derived from Study 1, e.g., professionals do not appear to desire training delivered by audiocassette.

Development of a Model Education and Training Program

The following ten strategies are significant parts of an effective dual diagnosis training program, according to research findings so far gathered by the authors:

1. *Knowledge and skills of mental health professionals* on specific substance abuse issues. There are issues and situations concerning abuse of substances by patients that mental health professionals are not trained to identify. The use of drugs and alcohol within treatment facilities is well understood by substance abuse staff members. The issue of substitution of drugs is common knowledge among drug staff members; when individuals cannot obtain their drug of choice, they will likely use another available drug. Such behaviors, if not understood, can interfere with the ability to assess some of the substance abuse situations dual diagnosis patients bring to treatment.

Substance abuse specialists are comfortable assessing and asking about drug and alcohol use. They understand that even a small amount may be too much. In addition, the fast pace of the spread of street drugs is not something that mental health professionals have been trained to follow. By the time that they are looking at which drugs at which dose are connected with what age of onset, that problem has been superceded by two new drugs. These are some of the relevant issues mental health professionals need to know about when treating young adult chronic patients who are part of the street culture.

2. *Team teaching by mental health and substance abuse specialists.* Given that the problems of dual diagnosis patients represent an intersection of mental health, drug, and alcohol issues, several team teaching approaches may be relevant. For instance, it is important to consider expanding training in graduate and continuing education settings by including recovering substance abuse staff members.

Other combinations of mental health and substance abuse training teams are of likely value. Overall, most graduate schools (in psychology in particular, but also in most other disciplines) do not expend much effort on substance abuse topics. Most doctoral students in these areas graduate without extensive knowledge or practical experience in the treatment of substance abuse. This neither helps the clinician faced with problems of dual disordered patients in the community, nor does it assist the researcher who will need to design and implement research programs to develop better assessment techniques and intervention for this problem.

To relate easily to other perspectives, it is important to have good models in graduate education. It is difficult to learn to work as a team player when education is geared solely to teaching students to be independent professionals with a very clear identity as psychologists, or psychiatrists, or social workers, or psychiatric nurses. Treatment of the chronically mentally ill typically does not occur as an isolated, single-discipline activity; nor does research. Graduate education thus needs to include experience as a team member in such activities, as well as experience as solo practitioners and researchers.

In this context, it is interesting to recall a finding of Study 1: that the majority of respondents rated team teaching by mental health and substance abuse experts as the most useful method of training.

3. *Specific topics related to substance abuse.* As part of mental health training curricula, it would be helpful to include specific course content on such topics as the Addictive Personality; Interactive Effects of Drugs/Alcohol and Psychotropic Medications; the Role of the Family; The Young Adult Chronic Patient; Assessment Instruments for Dual Disordered Patients; and Multiple Addictions. However, there are other issues that could be included in a number of seminars/courses. These include the concept of "disease;" the issue of children at risk (for mental illness and substance abuse); and concepts of "control" as seen by mental health and by substance abuse systems.

Most of the respondents in Study 1 felt they needed training in suicide issues with the dual diagnosis client. This was true for both the mental health and substance abuse specialists. This may point to the need for additional training because we are fearful of suicide in this high risk population, or it may simply highlight that the respondents were aware that this is an important training topic.

4. *Participation in self-help groups.* Participation in meetings of such self-help groups as Alcoholics Anonymous and the Alliance for the Mentally Ill Would be an important addition to the training for professionals and staff members working with dual disordered patients. This would allow mental health professionals to experience first-hand the power of these two major self-help groups. In addition, attendance at other groups such as NA (Narcotics Anonymous), CA (Cocaine Anonymous), and Double Trouble groups would help the mental health professionals to understand these interventions and to make appropriate referrals. This would also help mental health professionals learn that there are many different types of groups within AA or 12-step programs.

Recently it became apparent that many mental health professionals and some substance abuse specialists were not aware of the AA policy on medications (Alcoholics Anonymous, 1984). Over and over professionals state, without hesitation, that the 12-step approach will not allow any person using medications into AA groups. It is important that we know that this is *not* the policy of AA. The report from a group of physicians in AA states: "At this same time that we recognize this dangerous tendency to readdiction, we also recognize that alcoholics are not immune to other diseases. Some of us have had to cope with depressions that can be suicidal; schizophrenia that sometimes requires hospitalization; manic depression; and other mental and biological illnesses." Later, it states: "It becomes clear that just as it is wrong to enable or support any alcoholic to become readdicted to any drug, it's equally wrong to deprive any alcoholic of medication which can alleviate or control other disabling physical and/or emotional problems."

5. *Rotation through drug and alcohol treatment facilities.* Mental health professionals need to experience various drug and alcohol treatment and recovery programs, just as they experience a variety of mental health treatment and intervention programs. There are major differences among detoxification programs (both medical and social models), therapeutic communities, recovery homes, 28-day inpatient drug and alcohol hospital programs, outpatient drug and alcohol programs, 12-step programs, and methadone maintenance programs. Some of the interventions used in these different programs are relevant for the dual disordered population, and more contact with such programs, e.g., through internship rotation, would be useful.

6. *Changing attitudes.* Education and training need to include sufficient time to explore and change attitudes. Although we spend time to increase knowledge and enhance skills, we often ignore attitudes that have great impact on students and trainees. If we believe that "a drug abuser never changes," "doesn't work well in psychotherapy," "always manipulates,"

etc., then it will be difficult to enthusiastically treat the dual diagnosis patient. We also cannot ignore that professionals are likely to experience their own anger, frustration, and helplessness when treating dual diagnosed patients (Schwartz & Goldfinger, 1981). It is important that we acknowledge this and help students learn strategies to deal with their own stresses.

7. *Team teaching with family members.* In addition to including the three major content areas of knowledge needed to truly understand the dual diagnosis patient, we also need to consider adding to the education staff family members who, by virtue of their experience with their chronically mentally ill family member, are often incredible "knowledge packages." Family members know a great deal with regard to issues of substance abuse and multiple problems in this population. Family members began saying many years ago that their sons and daughters were using drugs and that the drugs and alcohol seemed to precipitate hospitalizations. We professionals didn't listen.

In Study 1, "Involvement of Family Members" was considered a useful method of training. Study respondents in Brown & Fraser (1985) raised the same idea. And we know from collaborative efforts with family groups such as the National Alliance for the Mentally Ill that family members would be willing, even eager, to participate in such training (Backer & Richardson, in press).

8. *Task forces.* With the dual diagnosed patient, most professionals believe that we are dealing with a biopsychosocial approach or a three-pronged approach to intervention — pharmacological, behavioral, and environmental. No one discipline has the knowledge and skills to do all three well. In fact, it will take many fields to create innovative and effective interventions for the dual diagnosis population. In addition to mental health, drug, alcohol, and family systems, this population impacts on the criminal justice system, homeless shelter workers, public health, vocational rehabilitation, and children's services. Partners from such fields can help us develop innovative research programs and creative networks. The combining of perspectives will create new visions.

Two models of interdisciplinary teams can serve as examples here. The postdoctoral model created by Caplan at the Harvard School of Public Health in the 1950s demonstrated the effectiveness of an interdisciplinary model. Training in consultation and crisis intervention spanned the boundaries of the mental health professions. A more recent model can be found in the University of Maryland Task Force on Dual Diagnosis (Ridgely, Osher, & Talbott, 1987). This Task Force consists of university faculty from a variety of disciplines and programmatic focuses, including Medicine, Law, Social Work, Nursing, Pharmacy, Family Life/Child Study,

and Epidemiology. Task forces in a variety of topical areas within the field of dual diagnosis can be created, using this model as a starting point.

9. *Non-categorical conceptualizations.* Another strategy is to include non-categorical conceptualizations in education regarding the dual disordered. A number of writers have discussed the importance of looking at disability and dysfunction rather than at diagnosis and category. Researchers and practitioners are looking at issues of the level of burden on the individual patient and the family. The level-of-burden concept includes disability and dysfunction for the individual patient as well as the patient's family and significant others. This concept can include problems resulting from mental illness, drug use, alcohol use, the individuals's reaction to illness, and the family reaction to illness. The traditional categorical approach may not be enough.

10. *Rapid knowledge transfer.* In addition to pre- and postdoctoral education concerns, professionals need to share, as quickly as possible, information on the dual diagnosis patient. We cannot wait for formal publication channels. An important model of rapid information sharing (including research data, outcome evaluations, promising innovations in treatment and programming), is The Information Exchange on Young Adult Chronic Patients (TIE)** initiated by Pepper and his colleagues.

Barriers to Implementation

There are reasons why these recommendations will not easily be implemented, even if everyone agrees that they should be. The slow pace of progress in treating dual diagnosis patients and in educating professionals represents more than political priorities or funding shortages; it also represents our resistance as professionals. Some of the barriers include the following:

1. With regard to new partnerships and collaborations, we have hardly shown great respect for one another's perspectives within mental health. Recently the senior author sat patiently while a young psychiatrist gave her recovering drug treatment staff a lecture (unasked for) on the MMPI. It is not difficult to imagine what will happen when we take on new partners outside of the mental health establishment, such as substance abuse specialists and family members. We also have listened to a psychiatrist discuss how recovering substance abuse counselors were afraid of dual diagnosed clients because they were unpredictable and were not known to a staff outside of mental health; the psychiatrist was not aware that he was talking to recovering heroin addicted staff members who had in their early treatment histories been placed on psychiatric wards in the state hospitals in California. During those periods in their addiction careers, they experi-

enced fear of the unpredictable, fear of being like those people who were more out of control than they were, anger at being judged like them, and happiness at having the opportunity to manipulate these vulnerable chronically mentally ill patients. Professionals must stop looking for simple answers, and each must stop thinking that the other is the one that doesn't want to treat or doesn't have the skills to treat. As mentioned, the National Alliance for the Mentally Ill (NAMI) family members for years told us that they thought their sons and daughters were using drugs and that might have something to do with their hospitalizations, only to be told that they were trying to deny their child's mental illness. It is not always easy to look at ourselves and know that we, the professions that are known for an ability to listen and understand, hardly listen and hardly understand.

It will not be easy to collaborate, but it is important to try. Not "pseudo-collaborations" in which we pretend to get along so that we can obtain funding. Or the type of collaboration where everyone sits down for a treatment plan meeting, and only the mental health professionals are listened to. But real collaborations, in which each partner has equal weight in the process. This task will take hard work. It will take some humility on the part of mental health professionals to listen to paraprofessional substance abuse staff pointing out that we have missed a significant number of substance abuse problems because we didn't know how to ask the right questions, or we didn't call for a urine test immediately after the client went out on pass, or we didn't believe the family member. And it will be difficult for mental health professionals to hear from substance abuse counselors that these patients need to be "clean and sober" for at least a year before they can take advantage of psychotherapy.

2. It is also difficult for each field to give up some of its autonomy and power. Mental health, drug treatment, and alcohol recovery have grown larger; they have their own constituencies, their own budgets. Now the crisis of the dual diagnosis patient leads to the conclusion that sharing and collaborative effort is essential.

3. With regard to substance use, there will be obstacles to examining practices with regard to medications. We rarely question the value of pharmacological interventions and we do not like some one else, without our education, questioning us. However, we need to acknowledge that we do not fully understand all the interactions between neuroleptic, street drugs (with their impurities), and alcohol. Substance abuse counselors prefer total abstinence, rather than to have a patient misuse medications. We have not always been so wise in the use of medications to solve drug and alcohol problems. Some people still question the wisdom of going from opium to heroin to methadone as solutions. It is not difficult to understand why some substance abuse staff might cringe when they hear that

Lithium and Antabuse might be given to a patient who is known to misuse drugs.

The Future

Given the dual crisis of mental illness and substance abuse, professionals in both fields have the opportunity to make significant advances in the education and training of professionals. Curriculum redesign can move along with program redesign, if we set this as a priority. The possible danger is that we will not make the major revisions that are necessary to prepare us for dealing with these patients.

While many of these recommended changes can be made without significant new funding, it is important that federal funding for mental health training be available and not reduced from earlier levels. We have entered a period of crisis, in which we must respond in immediate and innovative ways to the problems of a new generation of mentally ill patients. The education and training innovations described here, and others being pursued in ongoing research, will permit us to develop the new kind of professional needed to provide effective service to these patients.

---

[1] * NIDA # 1-R43-DA04250

---

[2] ** TIE, in Rochland, New York, is a clearinghouse which gathers, generates, and disseminates information on and rehabilitation for young adults with mental illness. Dr. Bert Pepper is Executive Director.

REFERENCES

Alcoholics Anonymous. (1984). *The A.A. member: Medications and other drugs.* New York: A.A. World Services, Inc.

Bachrach, L. L. (1982). Program planning for young adult chronic patients. In B. Pepper & H. Ryglewicz (Eds.), *New directions for mental health services: The young adult chronic patient,* No. 14. San Francisco: Jossey-Bass.

Backer, T. E., & Richardson, D. (in press) Building bridges: Psychologists and families of the mentally ill. *American Psychologist.*

Brown, V. B., & Fraser, M. (1985). Planning and shaping of the mental health delivery system of the future. *Consultation, 4*(3), 220-231.

Farr, R. K., Koegel, P., & Burnam, A. (1986). *A study of homelessness and mental illness in the Skid Row area of Los Angeles.* Los Angeles: Los Angeles County Department of Mental Health.

Koegel, P., & Burnam, A. (1987). Traditional and nontraditional homeless alcoholics. *Alcohol Health and Research World, 11*(3), 28-34.

Ridgely, M. S., Osher, F. C., & Talbott, J. A. (1987). *Chronically mentally ill young adults with substance abuse problems: Treatment and training issues.* Baltimore, MD: University of Maryland, Mental Health Policy Studies.

Schwartz, S. R., & Goldfinger, S. M. (1981). The new chronic patient: Clinical characteristics of an emerging subgroup. *Hospital & Community Psychiatry, 32*(7), 470-474.

Wright, J. D., Knight, J. W., Weber-Burdin, E., & Lam, J. (1987). Ailments and alcohol: Health status among the drinking homeless. *Alcohol Health and Research World, 11*(3), 22-27.