

FOREWORD

By

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Over the course of the past several decades, both the mental health field and the substance disorder treatment field have experienced an ever-increasing influx of individuals with "dual diagnosis" - individuals who have co-occurring mental health and substance use disorders. From the time these individuals first began to be identified, in the early 1980s, they have been recognized as a group of clients who are difficult, and they are difficult in many ways. First of all, individuals with co-occurring disorders are difficult because they do worse. It may not be terribly surprising that individuals with more than one problem would do worse than those with only one problem, but nonetheless it has been very well studied, and we know that from the perspective of either service system these individuals have poorer outcomes in multiple domains. Specifically, individuals with co-occurring disorders are more likely to relapse and be rehospitalized, be treatment resistant and noncompliant, be medically involved (e.g., with sexually transmitted diseases), criminally involved, impoverished, and homeless, engage in self-destructive, aggressive, and violent behavior, and suffer from histories of trauma and victimization. In addition, these individuals tend to have poor outcomes in terms of service utilization as well, and are likely to be over represented among the highest cost recipients of scarce system resources in either system.

These individuals are further difficult because they are, as Leona Bachrach described them 15 years ago, "system misfits," and they are misfits at every level of the system. At the systems level, these are individuals who dare to have more than one disorder in systems of care that have been designed as if everyone had only one primary disorder at a time. In addition, the programs within those systems have been similarly designed, so that clinicians working with "real" clients in "real" programs constantly experience a need to contort programs to fit clients, or contort clients to fit programs. Finally, these individuals are misfits at the level of most clinicians as well, since most of us were trained to be either mental health clinicians OR substance clinicians, but not both, so that when we encounter these individuals we immediately experience a misfit between what they need and what we know.

Furthermore, it has become increasingly clear over the past several decades that this population is not only not going away; it appears to be steadily growing. Partly this is due to the continuing impact of deinstitutionalization, but it is also due to a growing onslaught of more dangerous psychoactive drugs (e.g., designer drugs, methamphetamine, inhalants), as well as increasing awareness of the wide variety of biologically based brain disorders which can be identified as mental illnesses, and treated psychopharmacologically. These latter disorders are increasingly common in the general population, and two to three times more common in populations of people with substance disorders. In fact, two recent high quality epidemiologic studies (the Epidemiologic Catchment Area Survey and the National

Comorbidity Survey) have clearly identified a sufficiently high prevalence of comorbidity in all populations that SAMHSA's 2002 Report to Congress on co-occurring disorders has clearly stated that "dual diagnosis is an expectation, not an exception".

In the face of the increasing number of high utilizing, poor outcome clients with co-occurring disorders, there has been a slow, but steadily increasing accumulation of data from a wide variety of demonstration projects, model programs, and clinical intervention studies that identify evidence based best practices for the treatment of these individuals. The most important message that has emerged from this research is that treatment interventions need to be integrated, that is, the mental illness and the substance disorder need to be addressed at the same time, and the same place, ideally in the context of an empathic, hopeful, primary treatment relationship that promotes the ability of the client to develop skills for managing both disorders in a coherent, person centered way. Another important message that is emerging from this research is that integrated treatment interventions can be quite variable, and need to be individualized for clients based on diagnosis, stage of change, level of acuity, extent of disability, and level of care requirement. Consequently, it is becoming increasingly clear that in any system of care, there need to be many types of integrated programs, ranging from intensive integrated case management programs, to integrated addiction residential treatment programs, to integrated dual diagnosis psychiatric inpatient units and partial hospitalization programs.

Moreover, based on the principle that dual diagnosis is an expectation rather than exception, there have been increasing efforts to develop integrated systems of care in which all available resources are mobilized to treatment of individuals with co-occurring disorders in all treatment venues. Essentially, in this model of a Comprehensive, Continuous, Integrated System of Care (CCISC), all programs become dual diagnosis programs, with some expectation of basic integrated dual diagnosis competency, and all clinicians are expected to have basic competencies in this area as well. The most recent version of the American Society of Addiction Medicine Patient Placement Criteria (PPC 2R, 2001), in fact, specifies criteria for Dual Diagnosis Capability (DDC) that are viewed as basic requirements for all addiction programs, and SAMHSA has recently committed funding to support a national training center and broad availability of technical assistance to support state and local level system development strategies for co-occurring disorders.

As the expectation of system wide dual diagnosis capability has grown, and as the prevalence of integrated treatment interventions have become widespread, there has been increasing need for basic educational materials, for both staff and clients, regarding dual diagnosis and dual recovery. In the absence of such material, development of effective integrated treatment curricula becomes much more difficult and problematic. For this reason, this treatment manual by Rhonda McKillip is a welcome and necessary addition to the programmatic armamentarium for integrated treatment of co-occurring disorders.

Rhonda McKillip is a highly experienced mental health and addiction counselor, who has been providing group treatment, training, and education for individuals with co-occurring disorders and the staff who work with them for many years. This book is the result of her compilation of this experience into a curriculum and manual that can be readily

utilized by even novice dual diagnosis clinicians to develop a treatment program, in either addiction or mental health settings, for dually diagnosed clients who are seeking education regarding co-occurring disorders. The book is organized into a series of subjects that contain concrete material with which clients can be educated in a group format. The subjects are further designed to be flexible, so that the group leader can adjust the content based on the length of the group, and the level of functioning of its participants. Most important, each subject includes an extensive set of "Tips for Facilitators" that help both experienced and novice clinicians to implement the subjects successfully. As a result, Ms. McKillip is able to simultaneously train clinicians while developing a curriculum workbook to educate clients.

The availability of this manual will be of great value in promoting integrated treatment programming in both mental health and addiction treatment settings. I am delighted to be able to recommend this work for clinicians in both fields.

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