Self-Help Treatment for Combined Addiction and Mental Illness

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New approaches to treating patients with combined mental illness and substance abuse continue to be developed. This rethinking of treatment is particularly important because of the acknowledged organizational barriers to effective management of persons with dual diagnoses and the excessive costs associated with their recidivism. This column describes a model for treatment that combines peer-led self-help from the addiction field with professional treatment from general psychiatry. This approach represents a paradigm shift from the way treatment is applied in the conventional mental health system in that patient peers assume many of the roles that are usually carried out by professionals, and these services are then integrated across levels of care. The model is based on a theoretically grounded perspective on behavioral change. We have evaluated its application in empirical studies in our system of acute inpatient, step-down, and ambulatory units. This column should help convey how the self-help peer-led approach can be applied to bring about systems-level change in a variety of treatment settings where people with dual diagnoses are encountered, such as large hospital centers, smaller private programs, or multisite health maintenance organizations.

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THE PROBLEM

Combined substance abuse and mental illness was evident in community-based populations at the time of the National Institute of Mental Health Epidemiologic Catchment Area survey in 1980–1985. The survey found that 29 percent of mentally ill persons had substance use disorders. Among psychiatric inpatients, a 1988 New York State survey estimated the prevalence of substance abuse to be 34 percent. In a study the following year at New York City's Bellevue Hospital Center, our treatment site, we found the remarkably high prevalence of 64 percent of substance use disorders among general psychiatric patients (1). Most notable in terms of likely recidivism was that 38 percent of those admitted to the general psychiatric service were cocaine abusers.

Addiction rehabilitation, however, was not integrated into our hospital's approach to general psychiatric care, and dual diagnosis patients were offered no resources for undertaking recovery from addictive illness. There was no access to peer-led self-help, as in the 12-step programs and drug-free therapeutic communities that were typical of community-based addiction rehabilitation. These circumstances are now widely known to lead to recidivism and a compromised clinical outlook. Furthermore, it is now understood that a material change in the care delivery system is needed to address this population's needs, and no such adaptation had been made at Bellevue—or at similar institutions.

BASIS OF THE SELF-HELP MODEL

Our model for self-help treatment originated in studies on both the 12-step movement and zealous religious sects. These highly cohesive group settings are similar in that they can lead to diminished substance use among their members. Young adults who joined the sects we studied experienced a relief in psychological distress and stopped their substance use. In addition, the degree of change in mood and substance use was significantly correlated with the level of group cohesiveness among members and their acceptance of the group's ideol-

ogy (2). This relationship between acceptance of the group's ideology and cohesiveness with fellow members is also evident in the way 12-step groups like Alcoholics Anonymous move distressed substance abusers toward compliance with the AA norm of abstinence while relieving their symptoms of distress (3).

Similar mechanisms were observed in other, comparable settings we studied, such as the group addiction recovery program Rational Recovery and the mental health program Recovery Inc. (2). The effect of peer-led mutual support, with the associated acquisition of shared attitudes, is also apparent in drug-free therapeutic communities (4). Also important is the finding that combining addiction treatment and general psychiatric care in one setting for persons with dual diagnoses has been found to improve treatment outcome (5).

We initially applied the peer-led self-help approach to the recruitment and retention of alcoholic patients with a single diagnosis and those with dual diagnoses in a hospital-based treatment program and found that it yielded improved initial engagement and diminished dropout. Cost savings were also achieved because stabilized patients assumed some of the functions usually held by counseling staff (6). Given these results, we felt that a peer-led self-help model could be used with dual diagnosis patients in a system with multiple levels of care in our large municipal hospital center.

FACILITIES DEVELOPMENT

A multilevel treatment system must be built on a variety of funding opportunities, some of which may present fortuitously. For example, a needs assessment by a state task force on the dual diagnosis population allowed us to apply a self-help-based model in a 27-bed inpatient unit at Bellevue Hospital, where we were able to restrict admissions to mentally ill patients who were also drug abusers. We established a second unit that functioned as a halfway residential program by placing a Bellevue ambulatory program in a 30-bed wing of a nearby homeless shelter. We opened a third unit, a complementary day program, with funding made available by the state to the hospital to address the growing number of patients presenting to our emergency services with acute cocaine problems.

These three programs provided the multiple levels of care that are necessary when peer-led programs are used (7). External research funding and the establishment of an addiction psychiatry fellowship program with a major research component allowed for evaluation of the programs.

CLINICAL APPROACH

An important aspect of the self-help peer-led approach is that it can be effectively applied with severely compromised patients. A large proportion of our population is homeless, HIV positive, and addicted to cocaine. In the inpatient unit, for example, 46 percent are homeless, 24 percent are HIV positive, and 51 percent are addicted to cocaine (7). Most of our patients have had previous psychiatric hospitalizations (91 percent) and have a record of arrests (77 percent) (8). However, one indication of potential openness to a common mission among these patients is their attitude toward shared spirituality, which is central to 12-step programs. In one study, we found that the inpatients endorsed spirituality and belief in God as issues they felt most important to their recovery and ranked them higher than material benefits conferred by the social welfare system and by physicians; these results were at variance with those anticipated by staff members, who indicated that patients would endorse more materially grounded responses (9). In fact, 12-step groups meet several times a week in each of the dual diagnosis units, supporting patients in a commonly felt mission.

This shared experience also serves as a bridge to patients' accepting mutuality and collaboration in the treatment context. On the acute inpatient unit, a modified token economy is operated by patients who have been stabilized over the initial period of hospitalization (10). In the halfway residency and the day program, patients collaborate with staff in program management (11,12). Senior patients from the halfway residence and clinic lead discussion groups to introduce patients on the acute ward to the nature of treatment on step-down units and to enlist them in focusing on long-term rehabilitation. Patients have a hierarchy of roles through which they progress, assuming increasing responsibility for the unit's functions, much as in drug-free therapeutic communities (13).

ALTERED PROFESSIONAL ROLES

Because this treatment model combines traditional and peer-led mental health paradigms, physicians, nurses, and social work staff must adapt to a new perspective on their activities. Some staff functions are materially altered, such as leadership of therapy groups, which are now led or co-led by patients. The staff's focus on remission of acute symptoms in this general hospital setting is now augmented by the focus on improved adaptation and attitude change.

Overall management of the units has changed as

well, because peers participate along with staff in many clinical and managerial meetings. The community overall, rather than individual or group therapy, is seen as the instrument for rehabilitation, most clearly in the long-term residential and ambulatory settings. However, functions such as psychiatric assessment and discharge planning remain relatively unchanged in the hands of staff.

SYSTEM CHANGE

When a self-help peer-led model was implemented, the entire clinical system, both within the program itself and in relation to the hospital and shelter, had to be modified. The peer-led approach is applied to solving clinical problems that arise in each unit; thus patient-staff collaboration in joint management meetings is used to address acting out and to keep day-to-day activities in order.

In relation to the hospital, continuing effort is needed to ensure that only dual diagnosis patients are referred from the emergency service to the inpatient unit. In the shelter-based unit, ongoing group efforts are needed to ensure that patients can cook their meals as a cooperative effort, rather than having food prepared centrally by the shelter system, and arrangements must be made to have the community play a role in managing patients' welfare checks, which might otherwise lead them to drop out to buy drugs.

In support of these efforts, which go against the current of the larger system, is the fact that other hospital units are eager to divest themselves of problematic dual diagnosis patients. Also, the esprit de corps generated among patients is apparent to outsiders. Participants are encouraged by awards given to the program, such as the 1993 Gold Achievement Award from the American Psychiatric Association, and by interest shown by state officials and site visitors.

EVALUATION

We have conducted a number of studies of our patient population and their treatment outcome. On the inpatient unit, we have found that the degree of remission of psychiatric symptoms is about the same for all patients over the course of hospitalization, regardless of the severity of previous drug use (14).

In a 1997 study we found that only 12 percent of patients in the halfway house had positive results on random urine toxicology screens during their stay, even though it is not a locked unit. A more recent study of the halfway house found that patients' psychiatric symptoms became less severe in the first month and over the remaining course of their stay (15), even with a rigorous interactional program. Another study found that a history of fewer psychiatric admissions and greater job experience were predictors of better retention in treatment (16); however, halfway house patients with a record of criminal convictions (61 percent) did not differ from other patients in length of stay or improvement in social adjustment (8).

A recent evaluation of the day program found that 69 percent of patients had three consecutive negative urine toxicology screens immediately before discharge, the criterion set for a positive outcome (17). Substance-abusing patients with a diagnosis of schizophrenia or depression actually had better outcomes in terms of duration of treatment and negative urine screens than those who were not diagnosed as having comorbid major mental illness. This finding suggests that the treatment approach might be adapted successfully for more severely disabled patients (18).

The peer-led self-help approach was also adaptable to the needs of subpopulations, such as addicted perinatal women; their outcome was enhanced by adding family-related services to the day treatment program (19).

More research is needed to ascertain the effectiveness of this intervention, particularly in relation to recidivism over the long run. We need to understand clearly the characteristics of patients who respond best to this treatment, and some research in this area has been done in other settings (16). Furthermore, the peer-led approach should be compared with other approaches used to treat the same dual diagnosis population. Nevertheless, our findings suggest that this peer-led self-help model can be adapted to a complex professional treatment system to achieve reasonable benefit over the course of treatment.

REFERENCES

1. Galanter M, Egelko S, De Leon G, et al: Crack/cocaine abusers in the general hospital: assessment and initiation of care. American Journal of Psychiatry 149:810–815, 1992
2. Galanter M: Cults and zealous self-help movements: a psychiatric perspective. American Journal of Psychiatry 147:543– 551, 1990
3. Galanter M, Talbott D, Gallegos K, et al: Combined Alcoholics Anonymous and professional care for addicted physicians. American Journal of Psychiatry 147:46–48, 1990
4. De Leon G: The Therapeutic Community: Theory, Model, and Method. New York, Springer, 2000
5. Rosenthal RN, Hellerstein DJ, Miner CR: A model of integrated services for outpatient treatment of patients with comorbid schizophrenia and addictive disorders. American Journal on Addictions 1:339–348, 1992
6. Galanter M, Castaneda R, Salamon I: Institutional self-help for alcoholism: clinical outcome. Alcohol Clinical and Experimental Research 11:424–429, 1987
7. Galanter M, Egelko S, Edwards H, et al: A treatment system for combined psychiatric and addictive illness. Addiction 89:1227–1235, 1994

8. Taylor SM, Galanter M, Dermatis H, et al: Dual diagnosis patients in the modified therapeutic community: does a criminal history compromise adjustment to treatment? Journal of Addictive Diseases 16:32–38, 1997
9. McDowell D, Galanter M, Goldfarb L, et al: Spirituality and the treatment of the dually diagnosed: an investigation of patient and staff attitudes. Journal of Addictive Diseases 15:55–68, 1996
10. Franco H, Galanter M, Castaneda R, et al: Combining behavioral and self-help approaches in the management of dually diagnosed patients. Journal of Substance Abuse Treatment 12:227–232, 1995
11. Galanter M, Egelko S, De Leon G, et al: A general hospital day program combining peer-led and professional treatment of cocaine abusers. Hospital and Community Psychiatry 144:644–649, 1993
12. Westreich L, Galanter M, Lifshutz H, et al: A modified therapeutic community for the dually diagnosed. Journal of Substance Abuse Treatment 13:1–4, 1997
13. Sacks S, Sacks J, De Leon G, et al: Treatment for MICAs: design and implementation of the modified TC. Journal of Psychoactive Drugs 31:19–30, 1999
14. Munsey DF, Galanter M, Lifshutz H, et al. Substance abusing schizophrenics: antecedents, severity of abuse, and response to treatment. American Journal of Addictions 1:210–216, 1992
15. Egelko S, Galanter M, Dermatis H, et al: Improved psychological status in a modified therapeutic community for homeless MICA men. Journal of Addictive Disorders 21:75–92, 2002
16. Mierlak D, Galanter M, Spivak N, et al: Modified therapeutic community treatment for homeless dually diagnosed men: who completes treatment? Journal of Substance Abuse Treatment 15:117–122, 1998
17. Galanter M, Dermatis H, Egelko S, et al: Homelessness and mental illness in a professional and peer-led cocaine treatment clinic. Psychiatric Services 49:533–535, 1998
18. Galanter M, Egelko S, Edwards H, et al: Can cocaine addicts with severe mental illness be treated along with singly diagnosed addicts? American Journal of Drug and Alcohol Abuse 22:497–507, 1996
19. Egelko S, Galanter M, Dermatis H, et al: Evaluation of a multi-systems model for treating perinatal cocaine addiction. Journal of Substance Abuse Treatment 15:251–259, 1998

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