The Village was originally created as a self contained system. We were given 120 people to work with who all had disabling, persistent mental illnesses and told that we weren't permitted to give up on any of them and discharge them. We were a "no fail" program.

As time went on we realized that lots of our members had serious substance abuse problems. Beyond that, we realized that their substance abuse was destroying their lives and our program. The normal "treatment" for people with serious substance abuse problems at that time was to kick them out of mental health services. "Come back when you're clean and sober for 30 days so we can safely diagnosis and treat you" was the approach I was taught.

But we weren't permitted to do that. We were getting desperate.

We began searching for consultants and programs everywhere that could teach us what to do to survive, including most notably Jerry Vaccaro at UCLA with his early version of harm reduction, and the first generation NIMH dual diagnosis demonstration programs. I wrote this paper a few years later putting together what we had learned and what we were doing.

Working Towards Services for All Substance Abusing Mentally Ill People

(1994)

Large numbers of people with mental illness also abuse drugs and alcohol. Accurate figures are hard to obtain. My estimates, which approximate those in the literature, are 40% of outpatients, 70% of emergency room and inpatients, 80% of homeless and 90% of incarcerated mentally ill people abuse substances. These figures have two implications: 1) More money is spent on mentally ill people that abuse substances than those that don't, and 2) they primarily use expensive services.

Clearly services are needed that address both problems simultaneously. Trying to separate out primary mental illness with secondary substance abuse from primary substance abuse with secondary mental illness, in order to assign responsibility to separate bureaucracies is in general impossible, especially since many people are lying to get what they want. Furthermore, clinically this division makes no sense. Their needs (benefits with money management, supportive housing, medication, substance abuse treatment, rehabilitation, etc.) are identical. Dividing these services, and populations, is harmful and should be stopped. The division is an artificial bureaucratic one and can be eliminated bureaucratically with jointly funded and staffed programs.

Substance abusing mentally ill people have several common features:

1) They lie and say they're not abusing substances. This is in general effective. A recent study at Harbor General's psychiatric emergency room showed that 70% of people whose charts contained no mention of even a suspicion of substance abuse tested positive for drugs or alcohol. The fragmentation of our

system makes this deception much easier. The bureaucratic division actually encourages this lying as do policies excluding people "under the influence."

2) They say their substance abuse isn't causing any significant problems. This is sometimes a lie and sometimes they're fooling themselves. It is far more popular to blame their mental illness or the treatment system for their problems, but it's almost never true. In my experience with mentally ill people, substance abuse is the most common cause of not getting benefits, of eviction and homelessness, of hunger, of incarceration, of losing jobs, of destroying relationships and families, of medical and psychiatric emergencies and of death. It is exceedingly rare not to have significant negative consequences from substance abuse.

3) They say they don't want to stop their substance abuse. A very small fraction identifies decreased substance abuse as a goal and even fewer are willing to go to treatment.

Our treatment system, where it exists, is designed for people who say they abuse substances, that it's causing problems, and that they want to stop, despite the fact that the vast majority of people don't meet these criteria. This selection is generally justified by saying that very few of the rest will attain sobriety and therefore it's a waste of limited resources to serve them all. Plenty of data would seem to confirm this pessimism. In actuality, however, we are spending considerable resources on these people even while we're trying to exclude them. All this approach does is eliminate them from any continuous, coordinated, reasonably priced, proactive treatment. In addition, this line of reasoning contains two generally unchallenged assumptions: Firstly, that there are no legitimate goals besides sobriety, and secondly that there are no ways to organize services to help people attain those desirable criteria.

A pervasive counter argument usually surfaces at this point: Having these people suffer as much as possible, and experience as many negative consequences as possible, is, in fact, the best way to get them into treatment. They need to "bottom out." Although it's so pervasive, I see very little evidence that this is true. It is not the amount of loss that correlates with "bottoming out," but the meaning people attach to these losses. Data from substance abuse programs routinely show that people with families, with jobs, with money, with social networks, etc., are most likely to attain and maintain sobriety. They have more resources to help them. They have more left to lose, and more reasons to stay clean and sober. They have "higher bottoms." I would advocate for a treatment that "raises bottoms" instead of one that maximizes suffering.

"Enabling" can to be avoided by allowing the "natural consequences" of substance abuse to occur and by dealing with problems directly without taking responsibility for solving them or "rescuing." If people have control of their lives, and the opportunities to both succeed and fail, they will more likely take responsibility for their failures and for making changes.

There is an added inhumanity to the "bottoming out" approach. The majority will never attain sobriety. They are suffering for no apparent purpose.

Unfortunately anger and frustration, fueled both by society's general moral negativity towards people who abuse substances and by the annoying, destructive things people who abuse substances often do,

often distort the process of working with these people. I think it has also distorted our whole thinking about treatment approaches.

Within the context of these premises, we have developed a 4-stage treatment system that includes all substance abusing, mentally ill people. This treatment system fits together almost seamlessly with our psychosocial recovery program for mental illness.

Clearly this approach needs a great deal of work. There is no theoretical and value consensus surrounding my underlying premises. I purposely presented them starkly to highlight the discussion that is needed. The system organization needed to provide these services in a continuous, integrated, responsible manner exists only sparsely. And the technology, although promising, needs refinement and yields only modest results at present. Nonetheless, I feel this approach to be worthwhile enough to urge the substantial changes its implementation would require.

Stage 1: Engagement

Target group: People lying about their substance abuse.

Substance abuse treatment goal: To engage the person in a discussion of their substance abuse.

Quality of life goals:

1) Obtaining and retaining benefits to live on.
2) Obtaining and retaining housing.
3) Obtaining food and clothing.
4) Minimizing psychiatric symptoms.
5) Minimizing medical problems.

System goals:

1) Avoiding homelessness.
2) Minimizing psychiatric emergency room and hospital treatment.
3) Minimizing medical treatment.
4) Diverting incarcerated people to substance abuse treatment.
5) Deal with quality of life issues directly to minimize "system abuse".

Treatment Approach:

Form a long standing, "no fail," relationship with the person in a variety of out of office settings. Tolerate ongoing substance abuse, without becoming angry or punitive but confront as often as possible the denial of the substance abuse, and the "natural consequences" of it. Help achieve the quality of life goals, involuntarily if necessary. Undermine the secrecy around the substance abuse as much as possible. Try to understand as much as possible the role of substance abuse in the person's life. Try to educate about the reality of substance abuse. Work with others in the person's social network and family to increase confrontation.

Services Needed:

1) Mobile, continuous case management with emergency response

2) Benefit assistance, money management, and payee program

3) Supportive housing

4) Psychiatric medication, medication management

5) Drug testing

6) Liaison with medical treatment

7) Liaison with the court system

8) Substance abuse education

Stage 2: Persuasion

Target group: People who admit to substance abuse but deny it is causing problems.

Substance Abuse treatment goal: To persuade people that their substance abuse is causing problems in their lives.

Quality of Life goals:

1) Stage 1 goals continue.

2) Increase material possessions, quality of housing, social network, employment, education and whatever other positive "rehabilitation" goals the person can be encouraged to pursue.

System goals:

Same as Stage 1

Treatment Approach:

Continue the established relationship through multiple cycles of helping the person get things they want and then watching them lose them due to their substance abuse. Do not protect from the natural losses, but always confront that substance abuse caused the loss, and help to rebuild. Try to avoid getting frustrated and punitive through these cycles. Try to avoid the program losing things as the person loses things. This up-and-down process is a more effective persuasion/learning process than unrelenting suffering and hopelessness. Coach other skills besides substance abuse that are useful in living successfully.

Services Needed:

1) Same as Stage 1
2) Supportive socialization
3) Supportive education
4) Supportive employment
5) Successful living groups
6) Money management training
7) Medication management training
8) Symptom management training

Stage 3: Active Treatment

Target group: Those who say their substance abuse is problematic and are willing to consider, at least temporarily, sobriety as an alternative.

Substance Abuse treatment goals:

1) To attain significant periods of sobriety.
2) To convince people that it is preferable to be clean and sober.
3) To teach them how to maintain sobriety.

Quality of Life goals:

This is not a real focus during this stage. In fact, many people may give up a significant amount, temporarily, to attain sobriety.

System goal:

Minimize treatment costs using residential programs instead of inpatient programs.

Treatment Approach:

Maintain enough support system to help the person become and stay sober. Often, temporarily, some isolation is necessary from their substance-abusing network. As much as possible, build a sober support system into their environment as they return to the community. Teach skills needed to live sober (e.g. "work a program"). The intensity of the program should be able to be increased as the person allows and should be continued in the community. Some people may succeed without entering a program but they will need to leave their old substance abuse network. The case manager should not be the primary substance abuse treatment staff in this stage, to allow their relationship to continue even if the person drops out of a given program. The case manager does help coordinate treatment and support and is an active part of the ongoing support system.

Services needed:

1) Same as Stage 1
2) "Pre - AA groups"
3) AA/NA/CA groups
4) Residential substance abuse programs
5) Sober living residences
6) Other social support for sobriety.

Stage 4: Relapse Prevention

Target group: People who have attained significant periods of sobriety and desire ongoing sobriety and have at least some understanding of what that would require.

Substance Abuse treatment goals:

1) To maintain sobriety as long as possible.
2) To limit the length and destructiveness of relapses.
3) To develop a sober identity and lifestyle.
4) To become active promoters of sobriety in others.

Quality of Life goals:

1) Return to Stage 2 goals, this time expecting to maintain gains instead of losing them due to substance abuse.

2) To attain increasing freedom and responsibility.

3) To reintegrate into the community.

4) To achieve rehabilitative goals as desired by the person.

System goals:

To retain the participation of sober people to enrich the overall treatment environment.

Treatment Approach:

The vast majority of people in active treatment are able to attain significant periods of sobriety. The vast majority will later relapse. The support system needs to be maintained as strong and as long as needed. Assist in not catastrophizing relapses and limiting their length and damage including returning to active treatment if needed. Encourage the relationship to change from dependent to adult-to-adult without terminating it. Staff need to be available, but not restricting.

Services Needed:

Same as previous stages.

When I presented this approach to the State Mental Health Advisory Board, a very impassioned, sincere lady rose and told me about how when she was deteriorating from alcoholism, her doctor had given her an ultimatum that she had to stop drinking, and she did. As a result her entire life has turned around. She asked why I didn't do this with the people I was working with.

Three weeks later I figured out the answer: While it may be acceptable for her to attribute her recovery to her doctor and for him to become her "Higher Power", it isn't acceptable for her doctor to believe that.

I too, on occasion, have had the skill, timing, and good fortune to do something that drastically facilitated someone's recovery. More often, however, the addiction progresses and the person deteriorates despite my efforts. If I begin to believe I have power over substance abuse I will ultimately have to blame the people I work with for their lack of recovery. I will either conclude that they don't really want to recover and tell them to return when they're really ready to get better, or conclude that they're manipulating me to get something besides assistance with recovery from me and I'd better closely guard and limit what I give them to avoid "enabling" them and strengthening their illness instead of their recoveries.

These two reactions, both of which stem ultimately from my failure to accept my own powerlessness, are the defenses that underlie much of our substance abuse treatment policies today and keep us from creating an effective treatment system.

Most of us did not enter the field of mental health because we wanted to work with substance abuse. We weren't well trained in either understanding it, dealing with our own reactions to it, or effective treatment techniques. Yet we find that substance abuse is destroying everything around us. Substance abuse is the single most powerful predictor of all negative outcomes and cost of services. We've found that to actually implement a treatment system like one I've outlined we had to learn more about substance abuse and change our reactions.

Most of us generally accept AA's original breakthrough conception that substance abuse is an illness. But an illness of what? AA doesn't really say.

We observe people ingesting pleasant, but poisonous, substances that damage and ultimately kill them. If that is as far as we go, we have not really defined an illness, but we can begin to design an ineffective "Just Say No" program and withdraw into self-righteousness.

Many of us have progressed beyond this observation to an understanding of physical addictiveness, including withdrawal and tolerance, as medical reasons for their inability to stop using. Unfortunately, this doesn't explain what actually happens. Some people who are physically addicted, for example an elderly person addicted to sleeping pills do not deteriorate, and some chemicals like cocaine, PCP and marijuana that are not especially physically addictive man be incredibly destructive.

It seems to me, although I'm certainly not an expert on it, that a formulation regarding the pleasure centers in our brain has much more promise. Virtually all addictive substances including drugs, alcohol, caffeine, nicotine, and chocolate cause this system to release endorphins and enhance our feeling of well being. Apparently, so do non-chemical addictive experiences like love and long distance running, (I wonder about sex, empathy, religious ecstasy, and violence.)

People who feed their pleasure centers with specific chemicals or experiences will cause an overdevelopment of those pathways that respond to their drugs of choice into superhighways of neurons. (They may have been somewhat abnormal in the first place giving some people a susceptibility to certain addictions.) Other "normal" pathways begin to wither away leaving people needing to use or drink just to feel normal and feeling like they can't function without using. People develop rationalizations to explain what their pleasure centers are telling them is real. (You can listen to any alcoholic, addict, smoker, or Bill Clinton to see just how convoluted an addiction serving these rationalizations can become.)

If they stop using, they're left with an empty superhighway causing cravings and drug dreams and under-stimulated pleasure centers. These are "dry drunks" and motivated people who leave programs because they are so miserable. 12 step meetings offer a buffet of substitute pleasure center stimulators – coffee, cigarettes, sugar, empathy, God, and sometimes even sex – trying desperately to help people hang in through this period. After a long time, usually 6 – 12 months, long after withdrawal has gone

away, the neglected pathways start to bring pleasure again and people can enjoy life without using. They can maintain sobriety.

Unfortunately, the empty superhighway is still there. If they relapse, it's all ready to carry them rapidly to full fledged addiction again, seemingly picking up right where they left off when they got sober, no matter how long ago.

This pleasure center illness explanation seems to explain a lot of what we actually experience.

Another potentially useful illness model is the hospice model. Many alcoholics and addicts are, in fact, dying from an incurable condition, just as cruel and unrelenting as cancer.

Before the hospice movement, people dying of cancer were treated somewhat similarly to addicts today. Their diagnoses were clothed in secrecy. They and their families were ashamed, almost as if there had been a moral failing. Treatments were filled with suffering sometimes driven by the doctor's inability to accept their own powerlessness more than by realistic hope of efficacy.

Within the hospice movement things have radically changed. Diagnoses are openly talked about. People get support from others who share their diagnosis. People are proud of their struggles to become survivors instead of victims, or at of least their efforts to die with dignity. Families are included. Treatment efforts have become more person centered than illness centered, allowing each person the dignity to make their own treatment choices. As we face more openly the difficulties of curing cancer, we've turned more towards prevention to avoid getting the illness in the first place, with many survivors becoming passionate advocates for prevention and humane treatment.

These same changes are already beginning to occur for substance abuse. Hopefully we can get to the point where if addicts and alcoholics don't recover and most don't, we won't abandon them, blame them or stop caring for them any more than we would for a cancer patient.

Before concluding, I would like to focus on using psychiatric medications with people who abuse substances. I readily try to help people with medications while they're abusing substances. I try to avoid medications like benzodiazepines and stimulants that may further distort their pleasure centers and accelerate their substance abuse illnesses unless the benefits are overwhelming. I often have to dispense medications carefully using ether long acting injections or a medication management system to increase the chances the medications will be used in a reasonably therapeutic way.

I do not think it is better for someone to be psychotic and drug abusing than just drug abusing. Increased symptoms of almost any mental illness (with the possible exception of panic attached and marijuana) do not appear to assist in recovery from substance abuse. They usually make a person less rational, less emotionally and spiritually strong and less hopeful and motivated; all of which make recovery more difficult. In addition, the combination of psychiatric symptoms and substance abuse leads to incredibly high levels of violence and suicide.

I believe the benefits from assisting with whichever illness we can, far outweighs the modest pharmacological and medical risks of combining medications with alcohol and drugs. Once again, I believe our prevalent policy of not using medications with people who are abusing substances has been developed out of our' own emotional reactions and need for self-protection from liability, rather than any pragmatic study of relative effectiveness.

Our program, the Village Integrated Services Agency in Long Beach, has implemented the philosophies and techniques contained in this paper in a pervasive way. Our results, though difficulty to measure and modest, appear to be better than any reported elsewhere. We also have a far greater degree of emotional comfort ever thought possible.

That paper was written before harm reduction or motivational interviewing was really developed. Since then we've incorporated both techniques heavily into our approach especially in the engagement and persuasion stages of treatment. We have, however, noticed that for both us, and seemingly everyone else, these techniques are difficult for staff to use comfortably. They just feel "wrong" somehow.

It is my contention that neither harm reduction, motivational interviewing, or indeed hardly any of the approaches in my article can be comfortably implemented in a traditional medical model setting (or, for that matter, in a strict traditional 12 step model). I believe that the Village was only able to implement these techniques because we had a psychosocial rehabilitation/recovery culture to build on.

We were already person centered, not diagnosis centered so we were able to meet people where they were at instead of get lost trying to figure out which condition was primary and which one secondary. We were already goal driven instead of symptom relief driven so we could focus on quality of life instead of sobriety. We were already collaborative and empowering so we could more easily accept our own powerlessness and resist forcing people to get clean and sober. We were already focused on long term learning and personal growth instead of short term crisis response and stabilization.

Most systems first approach to building dual diagnosis competency is to cross-train their staff. Instead, I would recommend beginning by transforming into a recovery based culture so there's a nurturing soil for dual diagnosis competency to grow out of.