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FIVE YEARS, TWELVE STEPS, AND REBT IN THE TREATMENT OF DUAL DIAGNOSIS

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ABSTRACT: A five-year NIDA-funded grant is described that compared client-centered 12-step-oriented and REBT/SMART Recovery-oriented intensive outpatient treatment/partial hospitalization programs with severely impaired clients with dual diagnosis (serious mental illness/substance abuse). Results are presented and suggestions made for applying the findings.

People with co-existing serious mental illness (SMI) and substance dependence (referred to as dual diagnosis) can be some of the most challenging to treat. Studies have found that anywhere from 22% to 74% of the people with a serious mental illness also abuse substances (for example, Caton, Gralnick, Bender, & Simon, 1989; DonGiovanni & VandeCreek, 1990; Kahn, Hannah, Kirkland, Lesnik, & Chatel, 1992; Regier, Farmer, Rae, Locke, Keith, Judd, & Goodwin, 1990; Regier, Narrow, Rae, Manderscheid, Locke, & Goodwin, 1993). Research has demonstrated that individuals with dual diagnoses are at higher risk for hospitalization, incarceration, homelessness, violence, depression, suicide, HIV infection, and family problems (Frances, 1988; Kahn, Hannah, Kirkland, Lesnik, & Chatel, 1992; Kay, Kalathara, & Meinzer, 1989; Osher & Kofoed, 1989). They also tend to receive fragmented, inconsistent, and even conflicting treatment as a function of dual systems of treatment (Bartels & Thomas, 1991; Center for Substance Abuse Treatment, 1995; DonGiovanni & VandeCreek, 1990; Menicucci, Wermuth, & Sorensen, 1988; Zweben, Smith, & Stewart,

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1991). There is little research on the efficacy of different treatment approaches with this population. The primary goal of this 5-year National Institute on Drug Abuse-funded project was to compare two treatment models with different philosophies and methods in terms of their effectiveness with dually diagnosed people receiving case management in a large non-profit community behavioral health organization.

One model was the 12-step/disease model treatment approach that is the heart of 93% of the formal substance abuse treatment programs in the United States (Roman & Blum, 1997). We modified it for use in a treatment setting for the dually diagnosed. A planned modification was our deciding to allow non-abstinent clients to remain in treatment. Another modification that evolved during implementation of the research was making the 12-step/disease model non-confrontational and client-centered (see "Interventions" section, below). We define "client-centered" as a style of counseling that is empathic, warm, accepting, non-judgmental, non-lecturing, and builds on strengths.

As originally conceived, the second model was to be Rational Recovery® within the context of its parent approach, Rational Emotive Behavior Therapy (REBT) (Ellis & Velten, 1992; Olevitch, 1995; Robin & DiGiuseppe, 1997). However, at about the time the project was to commence, the founder of Rational Recovery® radically changed it (Trimpey, 1994), precipitating the departure of most of RR®'s board, who formed a new organization, Self Management And Recovery Training®. Some of RR®'s new positions—such as a thoroughly biological model of addiction and the notion that only former "addicts" can understand the problem of addiction—echoed those of Alcoholics Anonymous. In addition, RR® became unsympathetic both to research and to formal substance abuse treatment, declaring "treatment is dead." Therefore, we sought an alternative model that could be researched, used REBT methodology, and provided more contrast with 12-step. Thus, we chose Self Management And Recovery Training (SMART®), again within the context of its grandparent, Rational Emotive Behavior Therapy (REBT).

SMART is not a treatment program, but a community self-help program, as are AA, NA, and other free-standing 12-step programs. However, in its self-help discussion groups, SMART teaches methods extrapolated from empirically supported research findings, which presently are largely cognitive-behavioral. In its core literature, SMART is very clear in its aim to adhere not to any one theory, but to research findings (for example, see Horvath & Velten, in press, this journal; SMART,

1996). SMART is more closely related to REBT than, it could be argued, free-standing community 12-step meetings are related to institutional 12-step/disease model *treatment* (see, for instance, Miller & Rollnick, 1991, for analysis of the differences between 12-step meetings and 12-step treatment). Therefore, it is important to note that this research project did *not* compare SMART meetings and 12-step meetings in terms of their efficacy. True, as part of the research design, clients in the two treatment modules did attend free-standing community SMART meetings or free-standing community 12-step meetings, but meetings were only one part of the overall intervention. Instead, with a population of multiple-problem, dual diagnosis clients, this research project compared an intensive outpatient treatment/partial hospitalization program that had an REBT/SMART orientation, with an intensive outpatient treatment/partial hospitalization program that had a modified 12-step/disease model orientation.

A second objective of our project was to investigate whether individuals responded to the two models differentially based on specific subject characteristics, such as degree of spirituality, locus of control, and belief in the cause of substance use. A third objective of the research project was to evaluate the general efficacy of the intensive day treatment/partial hospitalization approach with our case-managed, dually diagnosed population. With funds for traditionally used, more intensive services (such as residential, which we originally proposed to evaluate) having become very limited in many states, alternatives are more important than ever. A fourth objective was to investigate whether individuals in later stages of change would show better treatment outcomes than those in earlier stages of change.

INTERVENTIONS

The general intervention was a six-month intensive outpatient treatment/partial hospitalization program (up to five hours a day, five days a week), with an optional, less intensive aftercare component. Participants were randomly assigned to either the 12-step or SMART program, which met at different sites. Other than differences in philosophy and methods, the two programs were identical in structure, time involvement, and access to other services. The programs both included the following weekly activities and topics: relapse prevention, SMI management, daily living skills, goal setting, mental health and substance abuse education, lunch (including shopping and prepara-

tion), healthful recreation (including a weekly outing), in-house and community 12-step or SMART meetings, written assignments, and individual sessions as needed. Participants also received case management services. Clients were allowed to complete the program in multiple segments if needed.

In designing our project, we confronted the complicated issue of whether complete abstinence from alcohol and illicit drugs would be required for clients to remain in the project. REBT, the forebear of SMART, has no simple, inflexible ideological position on abstinence and strives to operate within the goals and values of individual clients. Most traditional 12-step-oriented *treatment* programs, on the other hand, require abstinence for clients to receive treatment. Twelve-step *community meetings* promote abstinence as an absolute necessity for recovery and rarely would allow people "under the influence" to be present at meetings. However, community 12-step meetings do not require any time period of abstinence before people can attend meetings and stress that the only requirement for membership is the desire to abstain. Like 12-step meetings, SMART® meetings are abstinence-based and aim to serve people who desire to completely stop an addictive behavior.

Differences, some of them qualitative and some of them quantitative, do appear to exist between SMART and 12-step meetings in their reactions to two aspects of the "abstinence issue," namely (1) lapses disclosed by participants and (2) the necessity for cessation of *all* psychoactive substance use. In 12-step meetings, there tends to be repeated emphasis on the absolute need for complete abstinence from alcohol and illicit drugs (aside from nicotine and caffeine, which are very much in evidence at most 12-step meetings) before anything else beneficial can happen. In SMART meetings, on the other hand, there tends to be much more discussion of the lapsers' ambivalent motivations and what lapsers "told" themselves to get themselves to use. As well, SMART meetings generally display a fairly "live and let live," harm reduction philosophy, depending on the problem the participant is attending SMART to work on. A cocaine addict, for example, who aims to abstain from cocaine but mentions that he occasionally has a beer after work or wine at dinner would probably cause little consternation at a SMART meeting *if* he has no history of problems with alcohol or of a linkage between drinking and cocaine use.

With the above considerations in mind, we also reviewed the existing literature regarding the treatment of dual diagnosis clients. Based upon this review and our prior experience with dual diagnosis clients,

we felt concerned that if non-abstinent clients were dropped from our 12-step component, attrition rates would be too high for meaningful comparisons to be made with the SMART component. Therefore, we elected not to *require* abstinence of members of this severely impaired population for them to receive services. Abstinence, of course, was always strongly encouraged and was a goal of treatment for all clients, but any client could be present if he or she was not "under the influence." This particular adjustment to the traditional 12-step/disease model treatment approach was planned. Other adjustments were made during the course of the research in order to keep the 12-step component viable.

METHODS

A multivariate multiple baseline comparison group design was used. Measures included selected items from the following instruments and measures: the Addiction Severity Index (ASI) (McLellan, Luborsky, O'Brien, & Woody, 1983), which assesses substance, psychiatric, legal, medical, and employment domains; the Lehman Quality of Life Scale-Short Form (Lehman, 1988); the SOCRATES (Miller, 1985), which assesses stage of change and treatment readiness; Strength of Spiritual Beliefs; the Rotter I-E Scale (locus of control) (Rotter, 1966); a measure of belief about the causes of substance abuse; urinalyses; treatment completion; attendance rates; participation levels; and hospitalization rates.

Participants were screened for dual diagnosis eligibility with the Psychiatric Diagnostic Interview-Revised (Othmer, Penick, Powell, Read, & Othmer, 1989) and through a review of medical records and other historical information from case managers. Outcome questionnaires were given at baseline (shortly after intake), after three months in the program, at six months (completion), and at three- and 12-month follow-ups. Urinalysis tests were given unannounced every two months and at follow-up data collections. Hospitalization data were collected post hoc for three time periods: three months prior to treatment, the last three months of treatment, and three months after the completion of treatment.

Ongoing process measures were both quantitative and qualitative. They included: participation and attendance levels (dosage), client and counselor feedback, attrition, substance use during treatment, con-

sumer satisfaction, measures of adherence to methods, and supervision documentation.

DEMOGRAPHICS

The project received 194 referrals and screened 190 individuals. Of those screened, 170 met the eligibility criteria, and 112 (66% of the eligible clients) received a full intake. Fifty clients (44% of intakes and approximately 29% of the 170 eligibles) completed the full program. Thirty-four percent (58) of the 170 eligible clients dropped out before intake was completed. The main reasons for exiting the program following intake were circumstances beyond the client's control, client uninterested, and continuous substance abuse. Fifty-eight percent (65) of the intake sample was male, 70% (78) Caucasian, 13% (15) Hispanic, with an age range from 19 to 59 and an average age of 34.

This socially marginalized population was found to have serious impairments in multiple areas. Over 80% were single or divorced, 61% were unemployed and 22% were partially employed, over one-third had a chronic medical problem, and three-fourths had no automobile. Forty-six percent of the clients spent most of their time alone and experienced several days of family conflict a month. More than half of the clients recently resided in a controlled environment (jail or hospital), half of the clients had past incarcerations, and a quarter of them were on probation or parole. The clients in our program had an average of 3.6 substance dependence diagnoses, 3.3 psychiatric diagnoses, and multiple past treatment episodes; their longest voluntary periods of abstinence averaged 6.5 months.

RESULTS

Positive changes in outcome for those completing either program module were found on the ASI alcohol, drug, psychiatric, legal, and employment composites. Improvements were also seen on the ASI in terms of need for alcohol, drug and psychiatric treatment. In addition, there was improvement in quality of life, especially in satisfaction with leisure activities. Completion rates were higher than the average for comparable clients receiving other kinds of treatment services in the community. There was no change in urinalysis results (one-third tested positive at each time point), in the ASI medical composite, and in number of hospitalizations (Penn & Brooks, 1999; Penn & Brooks, 2000a).

Only one difference was found between groups in the results of the analyses predicting response to treatment. There was a trend for 12-step clients with strong spiritual beliefs and a belief that substance abuse was a disease to have *more* psychiatric problems at three-month follow-up.

Regarding treatment group differences, it was found that the 12-step clients showed greater improvement on the alcohol composite, a greater decrease in need for alcohol treatment by the 12-month follow-up, and had less overall substance use at the three-month follow-up. The SMART clients received significantly lower ratings on need for psychiatric treatment, and no SMART clients had hospitalizations during treatment (several 12-step clients were hospitalized). No other differences existed between the groups on the outcome variables.

Factors influencing treatment completion by clients in either SMART or 12-step were identified. These included the following: (1) court-ordered clients participated less but were more likely to complete treatment; (2) dropouts had greater substance abuse early in treatment, were more likely to have a chronic medical condition, and were more often in independent living situations at intake; (3) clients with polysubstance dependence were less likely to enter treatment following screening; and (4) clients with thought disorders tended to have better attendance.

Results partially supported the hypothesis that clients in later stages of readiness for treatment would have better outcomes. Clients in the "taking steps" subscale on the SOCRATES were more likely to complete treatment and had better alcohol outcomes at the three-month follow-up. Clients who were more "ambivalent" had worse alcohol outcomes in the middle of treatment.

The main findings of the extensive process evaluation were multiple lines of evidence indicating notable differences between 12-step and SMART counselors in their styles of interacting with clients. SMART counselors, trained in the mental health field, were much more client-centered and had much better rapport with clients overall. The 12-step counselors, trained in the substance abuse traditions, required continuous remediation in the area of rapport and client-centeredness. Without this intensive remediation, completion rates would likely have been significantly different between the programs, and the 12-step program might not have survived at all. A client-centered, empathic approach was found to be critical in working with this population. Other findings of the process evaluation included identifying counselor characteristics that helped clients, and program characteristics that

helped the clients and the counselors. In addition, it was found that few clients of either group attended community self-help groups on their own initiative, but more SMART clients did voluntarily attend the program aftercare component (Penn & Brooks, 1999; Penn & Brooks, 2000b).

CONCLUSIONS

Conclusions were made pertaining to clinical and research considerations for this population. Clinically, the results indicate that SMART and the 12-step treatment approach (if it is delivered in a nonconfrontational, client-centered manner) can be effective with this multiply and severely impaired dual diagnosis population. With the exception of clients with polysubstance dependence, both approaches worked relatively well across a population diverse in diagnoses, ethnicities, genders, and severity levels. However, it is imperative that these or any techniques be applied in a client-centered style (for example, empathic, warm, acceptant, nonjudgmental, non-lecturing, building on strengths). Concluding from our experience, counselors trained in the mainstream substance abuse field (12-step/disease model) may especially need to acquire additional skills in client-centered approaches. Most, if not all, counselors believe they are thoroughly client-centered—what counselor would ever say otherwise?—but this belief is often false from the perspective of traditional mental health (Rogerian) counseling. With training and ongoing support, however, it is possible that many such counselors can integrate client-centered approaches with 12-step treatment. Our research suggests that SMART is a promising new treatment option for dual diagnosis treatment. It is easy to learn, has concrete methods, is inherently client-centered, is easily applicable to a wide variety of problems and habits, has motivational components, and can be used in a group setting (Velten & Penn, forthcoming).

With our data, we were not able to predict which types of clients would benefit from the two treatment conditions. This has been the finding with many recent treatment studies (for example, Ouimette, Gima, Moos, & Finney, 1999; Project MATCH Research Group, 1997). However, some support was found for the hypothesis that clients in more advanced stages of readiness for treatment will have better outcomes, regardless of the treatment type. Clients at earlier stages of readiness thus may require specialized interventions.

The intensive day treatment/partial hospitalization level of care was found to work relatively well in public sector treatment with this population. It is quite cost effective, can easily be used to provide multifaceted integrated treatment, and can serve as the coordinating hub for comprehensive treatment. Further, the intensive outpatient treatment/partial hospitalization level of care is more congruent with clients' lives in the real world than is residential treatment, making generalization easier. This approach proved to an be important addition to case management services for our agency.

Process and outcome data suggested that teaching clients how to engage in healthful recreational activities is a important facet of treatment that is not often mentioned in the literature. Our data also suggested that harm reduction rather than abstinence is often the most advisable proximal goal for the severely dually diagnosed population. Long-term treatment is optimal if it has options for engagement at varying intensity levels and allows clients to move in and out of treatment as needed. Although having treatment manuals is important to research design and helpful clinically, it is not possible or desirable to mandate rigid schedules in these; the important elements of treatment and equivalency of the programs can still be maintained with a flexible schedule.

Other important findings included: (1) providing food and including clients in food planning, shopping and preparation was a major draw and taught needed skills; (2) transportation was a major issue for most clients, so providing some transportation and teaching the use of public transportation was helpful; (3) finding ways to enhance utilization of medical treatment might have helped retention of a large segment of clients with chronic medical problems; (4) inclusion of family and significant others in treatment was difficult due to their scarcity, and this fact may point to the need for more social skills training for clients; (5) client diagnoses reported in charts frequently disagreed with diagnoses based on thorough assessment and months of continuous treatment, suggesting a staff training need or a need for rethinking how we use diagnoses with multiple-problem clients; and (6) multimethod approaches are probably optimal with this population.

In terms of research considerations, instrumentation for this population needs improvement because most popular questionnaires are designed for assessment of substance abuse or mental illness, not both. For example, the ASI is very long given the attention span of these clients, is too brief in the psychiatric section, could use more detail in terms of housing and social contacts, is often irrelevant in the social

and employment sections, and even needs more detail in the substance use section to be able to illuminate harm reduction outcomes. Existing quality-of-life measures also are not entirely applicable to this population. Measures of system utilization need to be incorporated, although these are often difficult to obtain or analyze. While process evaluations are not frequently reported in the substance abuse literature, we found that our ongoing process evaluations proved not just helpful but even critical to the integrity of the study. In addition, they had important implications for our outcomes, and provided valuable insight for working with this population.

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