Sciacca, K. 1997. Removing barriers: dual diagnosis and motivational interviewing. *Professional Counselor* 12(1): 41-6. Reprinted with permission from Health Communications, publisher of *Counselor* (formerly *Professional Counselor*), www.counselormagazine.com.

"Removing Barriers: Dual Diagnosis Treatment and Motivational Interviewing"

In the past, traditional treatment methods for drug addiction and alcoholism have been characteristically intense and confrontational. They are designed to break down a client's denial, defenses, and/or resistance to his or her addictive disorders, as they are perceived by the provider. Admissions criteria to substance abuse treatment programs usually require abstinence from all illicit substances. Potential clients are expected to have some awareness of the problems caused by substance abuse and be motivated to receive treatment.

In contrast, traditional treatment methods for mental illness have been supportive, benign and non-threatening. They are designed to maintain the client's already-fragile defenses. Clients entering the mental health system are generally not seeking treatment for their substance abuse problems. Frequently clients within the mental health system who actively abuse drugs and alcohol are not formally identified. If they are, they do not admit to such substance use.

As some attention began to focus on clients with both substance abuse problems and mental illnesses, it quickly became apparent that new methods and interventions were necessary. Working with dual disorder clients who deny substance abuse, who are unmotivated for substance abuse treatment, and who are unable to tolerate intense confrontation, required a new model, a non-confrontational approach to the engagement and treatment of this special population. I first developed such a treatment model in 1984, with the goal of providing nonjudgmental acceptance of all symptoms and experiences related to both mental illness and substance disorders.

A brief history

Such treatment interventions and integrated programs -- which truly adapted to the needs of severely mentally ill chemical abusers -- had their genesis in 1984 at a New York state outpatient psychiatric facility. In 1985, these integrated treatment programs were implemented across multiple program sites. Concurrently, treatment and program elements were taught through training seminars in New York as well as nationally.

In September 1986, the New York State Commission on Quality of Care (CQC) released the findings of 18 months of research. In their report, they described the detachment and downward spiral of dually diagnosed consumers, who were bounced among different systems with "no definitive locus of responsibility." As a result, New York's governor designated the state Office of Mental Health as the lead agency responsible for coordinating collective efforts for this population. The commission visited the dual diagnosis programs developed in 1984, and declared the treatment interventions, the training, and integrated programs to be positive solutions to the dilemma.

When a 1987 *Time* magazine investigation of these programs revealed that at least 50 percent of the 1.5 million to 2 million Americans with severe mental illness abuse illicit drugs or alcohol -- as compared to 15 percent of the general population -- the "doubly troubled" were brought to the attention of the general public.

A gubernatorial task force declared its vision for statewide program development and a training site for program and staff development in the treatment of mentally ill chemical abusers was created to attain that vision. Short-term and on-going training and program development was provided to hundreds of New York's treatment providers at both state and local mental health and substance abuse agencies. Consumer-led and family-support programs were also developed. The state produced a training video that demonstrated the integrated treatment model, however, the training site closed in 1990 due to budgetary considerations. Programs and groups that grew out of this model continue to be an important nucleus of current services in New York and nationally.

These treatment interventions evolved in adaptation to the needs of the dual diagnosis clients. Methods and philosophies clearly differed from traditional substance abuse treatment. Consumers who were actively abusing substances, physically addicted, unstable, and unmotivated, were engaged through a "non-confrontational" approach to denial and resistance, and acceptance of all symptoms. Consumers participated in treatment groups without pressure to self-disclose, and explored topics from their own perspectives. Subsequent providers either learned from this model, or came upon similar processes through their own experimentation.

How it works

The phase-by-phase interventions from "denial" to "abstinence" begin by assessing the client's readiness to engage in treatment. Readiness levels are accepted as starting points for treatment, rather than points of confrontation or criteria for elimination. Mental health and substance abuse programs who integrate these programs, implement screening forms to identify clients who have dual disorders.

Identified clients are followed up for engagement and assessment of readiness. Clients are encouraged to participate in dual diagnosis treatment even if they do not accept or agree to the presence of a substance disorder. Clients may participate on the basis of their interest in learning more about mental health and substance disorders, or with the belief that they may be able to lend support to others who are seeking help, among other reasons. The process then proceeds from identification to the engagement phase.

The objective in the engagement phase is to develop comfortable and trusting relationships and, if possible, to expose the client to information about the etiology and processes of these illnesses in an empathic and educational manner. The client is given the opportunity to critique the information presented, rather than being told about any particular fact. Interaction effects between symptoms of mental illness and substance disorders are also included in this exploration. Clients at this phase are not required to disclose personal experiences or to admit they use or abuse substances until they are comfortable doing so.

The inclusion of educational materials and discussion topics allows for discussion of the issues and impersonal participation. Clients are encouraged to move along a continuum from "exploration" to "acknowledgment" of their symptoms. This includes:

* attaining a level of trust necessary to discuss their own use of substances and/or symptoms of mental illness;

* the exploration and subsequent discovery of any problems or interaction affects that

result from substance use and mental health symptoms;

* considerations and motivation for addressing these problems;
* active engagement in a process of treatment that seeks to eliminate symptoms;
* attainment of partial or full remission;
* and participation in an individualized maintenance regime for relapse prevention.

These programs are implemented as components of existing mental health, and substance abuse programs, and thereby provide integrated treatment.

Materials developed for the implementation of this treatment process include screening instruments, with separate instruments used for detecting substance abuse among persons who are known to have a mental illness, and detecting mental illness among those persons who are known to have substance abuse/dependence.

The pre-group interview provides engagement strategies and a scale to indicate the client's level of readiness or motivation to participate in treatment. The comprehensive assessment reviews past and present mental illness, substance abuse, and interaction effects. Forms for progress reviews and updates include criteria necessary to measure change throughout the phases of movement toward readiness for treatment, active treatment, and relapse prevention. Forms for data collection include programmatic information regarding statistics, client participation, and outcome. See Figure one.

Figure 1: Sciacca Treatment Model for Dual Diagnosis*

Program Form/Intervention	Process and Outcome
1. Screening: Mental health, dual disorders, DD CAGE, substance abuse, MISF.	Identification of potential dual diagnosis clients.
2. Pre-group interview and readiness scale. Engagement.	a. Engagement into group treatment; b. Assessment of readiness level (1-5).
3. Continuation of engagement (when applicable).	Client requires engagement beyond pre-group interview.
4. Provide group treatment.	Phase 1: Client does not disclose personal situation, participates in discussions or educational materials/topics, develops trust.
5. Complete monthly data form for each group.	
6. Administer comprehensive assessment (phase two):	Phase 2: a. Client discusses own

a. Integrate information into treatment plan; b. Make diagnosis.	substance abuse/mental health.
7. Client progress review updated periodically, includes readiness scale.	Continuation of Phase 2: b. Client identifies adverse effects, and/or interaction between dual disorders
8. Client continues in treatment and/or relapse prevention.	Continuation of Phase 2: c. Client recognizes impact of symptoms upon well being.
	Phase 3: a. Client becomes motivated for treatment. b. Client actively engages in treatment and symptom management until stability and/or remission is achieved. c. Client participates in relapse prevention.

*from *Journal of Mental Health Administration, Vol.23,No.3 Summer 1996, SAGE Publications "Program Developmnet A*cross Systems for Dual Diagnosis: Mental Illness Drug Addiction and Alcoholism, MIDAA" by: Sciacca, K. & Thompson, C.. pp. 288-297.

Motivational interviewing

As the dual diagnosis treatment model for substance abuse treatment evolved within the mental health system, motivational interviewing evolved within the field of alcoholism treatment. Some striking similarities can be found -- in both philosophy and methodology -- in comparison to dual diagnosis treatment, including the points of departure from traditional substance abuse treatment:

Dual disorder treatment and motivational interviewing:

* forego traditional treatment-readiness criteria and begin at the client's stage of readiness/motivation and degree of symptomatology.

* do not utilize intense, confrontational interventions in response to denial or resistance.

* advocate the need for the development of trust as essential to the treatment process.

* advocate acceptance, empathy and respect for the client's perceptions, beliefs and opinions. They tolerate disagreement and dispel moral and judgmental beliefs.

* do not interpret relapse as treatment failure, or employ punitive consequences.

* convey and/or provide a hopeful vision, a belief in the possibility of change, and support self-efficacy.

The authors of motivational interviewing (Miller and Rollnick, 1991) detailed the underlying beliefs that form the foundation for intense confrontational traditional substance abuse treatment. They have conducted literature searches and research around the principles of this foundation and have found no supporting evidence for these widely held beliefs.

One main example is the belief that motivation is a personality problem. This assumption is that alcoholics, addicts, offenders, etc., possess extremely potent defense mechanisms that are

deeply ingrained in their personality and character. These defenses are considered to be non-responsive to ordinary means of therapy and thereby justify aggressive confrontational interventions.

In view of their findings Miller and Rollnick assert that "...there is not, and never has been, a scientific basis for the assertion that alcoholics (let alone people suffering from all addictive behaviors) manifest a common consistent personality pattern characterized by excessive ego-defense mechanisms."

Within motivational interviewing, confrontation is recognized as a treatment "goal" not a style. It is part of the change process that includes "awareness raising." It is likened to Carl Rogers' client-centered philosophy, which sought to provide a safe atmosphere for the examination of self and change. Like dual diagnosis treatment, confrontation is not used in response to client's denial or resistance.

A state of readiness

Motivational interviewing strategies correlate to client readiness based upon the stages of change theory (Prochaska and DiClemente, 1984). Stages of change are represented in the form of the "wheel of change," which indicates that one can go around the wheel several times. (See Figure 2 for stages, motivational interviewing and dual diagnosis correlates.) The five principles of motivational interviewing that entail a therapist's style as well as strategy also correlate to dual diagnosis treatment interventions. (See Figure 3 below.)

Figure 2: Stages of Change and Accompanying Tasks

Stages of Change Prochaska and DiClemente	**Motivational Interviewing Task** Miller and Rollnick	**Dual Diagnois Phase** Sciacca	**Dual Diagnosis Intervention Task** Sciacca
1. Precontem-plation stage: Person does not con-sider the possibility for change.	Raise doubt; increase client's perception of risks and problems with current behavior.	Identification and Engagement: Client identifica-tion; engage-ment process; assessment of readiness level.	Engage client to participate in a treatment process that includes exposure and discus-sion of numerous elements of addictive disorders, recovery, mental illness and interactions effects. Client participation does not require acknowledgment of substance abuse problem.
2. Contempla-tion stage: Marked by am-bivalence; person both considers change and rejects it.	Tip the balance, evoke reasons to change, risks of not changing, strengthen self-efficacy.	Phase One: Client is not required to disclose personal situation; participates in discussions of educational topics and materials; develops	Provide information about discrete disorders and dual disorders; express empathy regarding the real properties of these disorders, including physiology and the process of recovery; dispel moral beliefs and judgements; allow client to participate as critic of information; respect client's knowledge and opinions.

		trust.	
3. Preparation -Deter- mination stage: Person considers various strategies for change.	Help client determine best course of action.	Phase Two: Client discusses own substance use and mental health; iden- tifies adverse effects and/or interactions between dual disorders; re- cognizes impact of symptoms upon well being.	Assist client to identify and understand adverse effects of symptoms and behavior; provide information and discussion of strategies and treatment ap- proaches that have potential to bring symptoms into remission; administer comprehensive as- sessment and convey findings to client.
4. Action stage: Person engages in particular actions de- signed to bring about change.	Help client to take steps toward change.	Phase Three: Client becomes motivated for treatment; ac- tively engages in treatment or symptom management until stability and/or remission is achieved.	Support client’s efforts toward change, including self- efficacy; assist client to make necessary adjustments to utilization of strategies and/or adjunct services or interventions; assist client to recognize or acknowledge positive effects of change as it occurs; assist client to recognize need for continued supports for sustained change.
5. Maintenance stage: Person strives to sustain changes made in action phase.	Help client identify and use strat- egies to prevent relapse; client may exit wheel, into permanent maintenance.	Phase Three: Client participates in relapse prevention.	Assist client to develop network of supports; utilize and adjust to each of these supports; gain a working understanding of client's motivation for change; explore and understand client’s use of deterrents from previous behaviors; explore and avoid potential relapse pitfalls.
6. Relapse stage: Person has minor slips or major relapses; seen as normal part of change process.	Help client renew process of contem- plation, determination and action, without becoming stuck or demoralized due to relapse.	Relapse: Client has minor slip or major relapse.	Assist client to renew motivation and efforts; explore utilization of, or failure to, utilize previous deterrents to relapse; explore and discover possible pitfalls; help client to learn from relapse; relapse is not considered to be a failure of treatment; client does not suffer treatment- model-imposed consequences; empathy, support and encouragement are provided until client moves beyond relapse.

Removing barriers

Dual diagnosis treatment approaches and motivational interviewing interventions represent far-reaching changes for substance abuse treatment and comprehensive services, within both the mental health and substance abuse systems. The removal of the long-standing barriers of traditional substance abuse treatment readiness criteria opens the way for persons with various profiles of singular, dual and multiple disorders, including the homeless, the incarcerated, and others who have been disengaged. These people will be provided an opportunity to develop the trust necessary to participate in an exploration of their situation, and thereby to make informed decisions regarding change

These non-confrontational, non-threatening approaches that are necessary for those who have a severe mental illness will also embrace others who might never have the opportunity to participate in substance abuse treatment due to their inability to acknowledge substance abuse as a problem, become motivated, or tolerate intense confrontational interactions.

Figure 3: Motivational Interviewing Principles And Dual Diagnosis Correlates

Motivational Interviewing Technique	Dual Diagnosis Correlate
1. *Express empathy*. This is seen as the corner-stone of the intervention process and relates to all and any experiences conveyed by the client. It is marked by the underlying attitude of "acceptance." It includes warmth and reflective listening in an effort to understand the client's feelings and perspectives without judging, criticizing or blaming. It conveys respect. Ambivalence is accepted as a normal part of human experience not as psychopathology.	Acceptance of all symptoms in all phases is essential. The development of trust is a part of the treatment process. Understanding and pro-viding information about the real properties of each disorder, and dispelling moral beliefs, stigma and judgments is a formative goal.
2. *Develop discrepancy*. Awareness of consequences is important. A discrepancy between present behavior and important goals will motivate change. The client should present the arguments for change.	Provide atmosphere that is conducive for client to move toward self disclosure through trust. Assist client to recognize adverse effects and consequences of singular/dual disorders and interaction effects through an integral understanding of information and personal experience. Acknowledge and actualize client's con-siderations for change through discussion.

3. *Avoid Argumentation*. Arguments are counter productive. Defending breeds defensiveness. Resistance is a signal to change strategies. Labeling is unnecessary.	Client's opinions and beliefs are respected. Therapist and peers may hold different views but they are not expressed in rebuttal to client's beliefs. Defending is unnecessary. A "non-confrontational" approach to resistance or denial is utilized. Client explores effects or symptoms of various disorders and does not have to accept labels.
4. *Roll with resistance*. New perspectives are invited by not imposed. The client is a valuable resource in finding solutions to problems.	Topic areas are explored from many different perspectives, with client as critic versus student. The client is a valuable resource in finding solutions to problems. In group treatment all clients participate in finding solutions for themselves and one another.
5. *Support self-efficacy.* Belief in the possibility of change is an important motivator. The client is responsible for choosing and carrying out personal change. There is hope in the range of alternative approaches available.	Support, encouragement and the belief in the possibility of change is essential. For clients who have severe mental health symptoms that may impair a vision for the future, the therapist must envision the outcome of change and pre-sent such possibilities to the client. The client participates in the course of action for change.

As the number of mental health and other providers who find the new non-confrontational approaches to be comfortable and in keeping with their therapeutic style increases, the total number of substance abuse treatment providers will rise correspondingly. This will greatly increase the availability of substance abuse services. Most important, the quality of care will proceed in the direction of the development of trust, respect, empathy, empowerment, and will measure success along a multitude of criteria.

The systemic changes will yield both mental health and substance abuse agencies more comprehensive in scope. This will change the course of history that has eliminated dually diagnosed clients and other client profiles who have been deemed "unmotivated" or "not ready" for treatment. Agencies may readily include services that employ an "exploratory" versus "expert" approach. This will provide many opportunities to provide education within all models of service. For some substance abuse practitioners dual diagnosis treatment and motivational interviewing interventions may represent a dramatic departure from their current practice and

techniques. Miller and Rollnick suggest that motivational interviewing techniques be included in one's "tool box" of interventions and be utilized when traditional approaches fail.

It is clear that these new interventions and efforts to accomplish comprehensive care will carry forward into the new millennium. Each of these changes represents models of "inclusion" and will replace the "exclusionary" models that have resulted in serious casualties among persons who suffer with singular, dual or multiple disorders.

Kathleen Sciacca is founding executive director of Sciacca Comprehensive Service Development for Mental Illness, Drug Addiction and Alcoholism (MIDAA) in New York City. She is a nationally and internationally known consultant, program developer, lecturer, and seminar leader for dual diagnosis and a trainer of motivational interviewing. Sciacca is author of the *MIDAA Service Manual: A Step by Step Guide to Program Implementation and Integrated Treatment for Dual Disorders*, and producer of the education and training video, *Integrated Treatment for MIDAA: The Alaska Example*. Dual Diagnosis Website: http://pobox.com/~dualdiagnosis