Discussion of “Substance Use Reduction in the Context of Outpatient Psychiatric Treatment”

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INTEGRATION WITH THE DISEASE AND RECOVERY MODEL

Kate Carey’s excellent description of a collaborative, motivational, harm reduction approach for treating substance abuse disorders in people with serious mental illness represents a significant advance in the development of clinical technologies and techniques for addressing the needs of this challenging population.

Dr. Carey first of all identified the importance of “stages of change” in designing treatment interventions for dual diagnosis patients. In traditional addiction treatment programs, patients (usually non-mentally ill) who present for treatment usually do so as a consequence of some outside intervention or confrontation (whether by family, employers, or the legal system) which creates some motivation to accept help to address substance dependence. In the mental health system, by contrast, patients with serious mental illness have been engaged in treatment for their mental illness, not for substance abuse. Although substance abuse may be a significant problem for many of those patients—the patients may not be in any way ready to change their substance use—or even to acknowledge that it is a problem. As Dr. Carey implies, efforts by mental health caregivers to “get patients sober” are
likely to backfire; rather, as Dr. Carey observes, "interventions designed to enhance readiness to change may be necessary before people can engage in active treatment strategies".

Dr. Carey's most significant contribution in this regard is to identify such interventions in the substance abuse literature and to demonstrate how those same concepts can be successfully applied to substance abuse problems in seriously mentally ill patients in mental health settings. These concepts include: (a) Prochaska and DiClemente's (1992) precontemplation/contemplation model of readiness for addiction treatment; (b) Miller and Rollnick's (1991) motivational interviewing strategy for engagement of resistant patients; and, (c) Marlatt and Tapert's harm reduction approach (1993) to engage patients initially to consider reduction of substance use rather than total abstinence.

Dr. Carey's discussion of how to implement these techniques in the development of a working alliance is particularly valuable. Dr. Carey emphasizes the need for clinicians to maintain a stance of what is known in addiction treatment as "empathic detachment". "Empathy... is needed in order to promote honest self-disclosure." "As therapists, we must respect the functions of substance use and validate the needs underlying the desire to use... taking too active a role in defining costs may create psychological reactance". The corollary of the clinician's detachment is the patient's empowerment. Dr. Carey demonstrates that the patient must be empowered to truly decide whether substance use is in his interest—not coerced or cajoled to please-consistent with the more broad-based consumer empowerment philosophy that underlies recovery not only from substance disorders, but from mental illness as well.

In fact, one of the major weaknesses of Dr. Carey's discussion is that she does not go far enough in the application of her excellent clinical techniques to the complexity of the engagement process in dual diagnosis patients, and to elucidating the boundary between the "motivational harm-reduction" approach and more standard addiction treatment interventions so that the role of this particular intervention within a comprehensive spectrum of dual diagnosis treatment methodologies can be better understood.

First, although Dr. Carey states that "relatively few interventions address concerns about engaging dual diagnosis clients in treatment", there is actually a fairly extensive literature that describes a variety of such interventions, both in standard psychiatric settings (e.g. Kofoed et. al. (1986); Sciacca (1991); Drake et. al. 1990, 1993) and in homeless outreach programs (Kline et. al. 1991). As described by Sci-