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Two Group Therapy Models for Clients With a Dual Diagnosis of Substance Abuse and Personality Disorder

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Objective: The relative effectiveness of two types of group therapy—the disease-and-recovery model and the cognitive-behavioral model—was examined in a public inpatient and outpatient setting with consumers who had a dual diagnosis of a personality disorder and a substance use disorder. Outcomes in four areas of problem severity were measured: alcohol use, drug use, social and family relations, and psychological functioning. **Methods:** Using a quasiexperimental group design, 19 subjects in an inpatient mental health facility and 19 in a public outpatient facility were randomly assigned to the two experimental groups. The groups met three times a week for 12 weeks, and specific group leadership protocols were used. A third group at each setting received usual group treatment. Diagnoses of all subjects were verified using the Structured Clinical Interview for DSM-III-R. The Addiction Severity Index measured changes in problem severity. **Results:** In the inpatient setting, subjects in both experimental groups had significantly improved social and family relations compared with the usual-treatment group; no posttest changes in the other three areas were noted. In the outpatient setting, cognitive-behavioral group therapy was significantly more effective than the other two group approaches in reducing alcohol use, improving social and family relations, and enhancing psychological functioning. **Conclusions:** Results suggest that the severity of mental health consumers' substance abuse problems can be substantially decreased in several areas in an outpatient public setting. In an inpatient setting, the use of either group therapy model was more effective in reducing problem severity than using no specific model. (*Psychiatric Services* 47:1244–1250, 1996)

Consumers of mental health services who abuse substances present special challenges to clinicians in inpatient mental health facilities and in community mental health treatment settings. Although the co-occurrence of long-standing mental health problems and substance abuse problems is not a new phenomenon, it is only within the

past 20 years that it has received the professional attention it deserves from both the mental health and the substance abuse treatment fields (1).

There is evidence that persons with diagnosed mental disorders are more likely than people without mental health problems to be abusers of psychoactive substances (2). Strong relationships between sub-

stance abuse and various personality disorders have been well documented in the literature (3–7). The strongest relationship is found between substance use disorders and antisocial personality disorder (8). Likewise, persons who abuse substances are at increased risk to develop a mental disorder (9).

At least two conceptual frameworks have been used to guide the treatment of dually diagnosed consumers—the parallel perspective and the integrated perspective (10–12). In the parallel perspective, services are rendered concurrently but separately by mental health and substance abuse clinicians. In the integrated perspective, services are delivered by mental health and substance abuse clinicians conjointly and simultaneously.

Several authors have described a parallel philosophical perspective to address the co-occurrence of mental illness and substance abuse (10–13). In theory, this perspective allows for efficient concurrent use of existing treatment resources from both mental health and substance abuse treatment systems. This perspective allows more flexible personal choice in permitting clients to move through both care systems as they progress and participate in traditional types of addiction treatment, such as Alcoholics Anonymous (AA).

In more recent years, clinicians and others have advocated for substance abuse and mental health treatment that is integrated and conjoint (10, 14–16). Initial attempts at integration have generated a multitude of suggested clinical and programmatic

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treatment components that include such tasks as accurate problem identification, assessment, and diagnosis; formulation of treatment goals focused on abstinence; drug screening to increase motivation; treatment; skills training such as assertiveness and anger management; education; and relapse prevention (15,17,18).

Proponents of integrated service delivery tend to favor two major treatment approaches to accomplish this integration: the disease-and-recovery approach and the cognitive-behavioral approach. Minkoff (12), Daley and colleagues (19), and Evans and Sullivan (20) have described the disease-and-recovery model as holistic in its approach to the treatment of mental health and substance abuse problems. Each of these authors has argued that the disease-and-recovery approach to substance abuse treatment is philosophically similar to approaches used in mental health treatment. For example, they have claimed that mental health and substance abuse problems can be best understood based on concepts of illness (12) and that treatment of both types of problems has the common goal of recovery (20) and uses complementary interventions, such as group therapy and peer support (19).

Other proponents of the integrated philosophical perspective have advocated a cognitive-behavioral approach rather than a disease-and-recovery approach. For instance, Cooper (21) argued that a cognitive-behavioral approach relies on the self-medication theory of substance abuse, meaning that clients abuse substances to manage symptoms, particularly painful affective states, in the same way that they might take medication to control physical symptoms. Beck and associates (22) argued that an approach using cognitive-behavioral therapy is "ideally suited" for clients with substance abuse problems who have depression, anxiety, and personality disorders.

In essence, both treatment approaches make strong clinical claims to be both integrated and comprehensive. However, neither has been empirically verified using clinical outcomes studies with dually diagnosed clients in inpatient or outpatient settings. The study reported here was

undertaken in hopes of extending clinical treatment knowledge about clients with dual diagnoses of substance use and personality disorders.

Methods

Research design

This study used a quasiexperimental group comparison design and was conducted at both an inpatient and an outpatient public substance abuse treatment site. Three groups were developed at each site; two groups were formed for the integrated treatment of

The cognitive-

*behavioral approach
assumes that substance abuse is a set of learned, maladaptive behaviors that have led to distorted beliefs about the power of the abused substance and a general reliance on substance use as a coping behavior.*

dually diagnosed consumers (diagnoses of a substance use disorder and a personality disorder), and a usual-treatment comparison group was used.

One of the experimental groups was developed in accordance with the disease-and-recovery approach. Its purpose was acceptance of substance abuse as a disease that is chronic, progressive, and eventually fatal. Similarly, although mental illness (for example, a personality disorder) is not necessarily fatal, its course is typically conceptualized as chronic and progressive. This approach assumes that

consumers have an underlying biological vulnerability characterized by a loss of control over the substance abuse and the mental disorder.

A second experimental group at each site was developed in accordance with the cognitive-behavioral approach. Its purpose was acceptance of cognitive, behavioral, and affective responsibility for substance use and abuse, as well as the development of some basic understanding of the relationship between substance abuse and specific mental disorders. Moreover, this treatment approach assumes that substance abuse is a set of learned, maladaptive behaviors that have led to distorted beliefs about the power of the abused substance and a general reliance on substance use as a coping behavior.

A third group developed at both sites was a usual-treatment comparison group.

Interventions

The structure and function of both the experimental treatments were quite similar. Each group met three times weekly in 45-minute sessions for four weeks (12 meetings in June and July 1994). Group membership of seven or eight patients was closed after treatment had begun. The groups were co-led by the lead investigator and another clinician assigned by the site administrator; neither group leader was involved in data collection. Subjects randomly assigned to the comparison groups were involved in whatever treatment groups the particular setting mandated. The comparison groups were open-ended and met three times weekly.

Each of the two experimental groups functioned as therapy groups; there was nominal distribution of educational material in both. Proximal objectives in the cognitive-behavioral treatment model were enhanced self-efficacy, more realistic and appropriate expectations about the effects of the abused substance on symptoms of personality disorders, increased adaptive coping skills, and enhanced relapse prevention capacity. Proximal objectives in the disease-and-recovery treatment model included the development of an "alcoholic" or "addict" identity acknowledgment of a

Table 1

Characteristics at baseline of 38 subjects with dual diagnoses recruited from public outpatient and inpatient substance abuse treatment settings

Characteristic	Total sample (N=38)		Outpatient setting (N=19)		Inpatient setting (N=19)	
	N	%	N	%	N	%
Demographic						
Gender						
Male	29	76	13	68	16	84
Female	9	24	6	32	3	16
Race						
White	15	40	8	42	7	37
Black	23	61	11	58	12	63
Marital status						
Married ¹	4	11	3	16	1	5
Widowed	2	5	1	5	1	5
Separated ²	8	21	5	26	3	16
Divorced ³	8	21	2	11	6	32
Never married	16	42	8	42	8	42
Unstable living arrangement	12	32	6	33	6	31
Age (mean±SD years)	37.5±10.1		35.3±4.3		39.7±6.5	
Education (mean±SD years)	11.3±2.1		11.0±2.1		11.5±2.0	
Employment						
Has a skill or trade	19	50	9	46	10	54
Employed ⁴	9	24	9	47	0	—
Longest employed period (mean±SD years)	1.5±.8		1.3±.6		1.8±.8	
Legal						
On probation or parole ⁵	11	30	11	60	0	—
Has forensic charges ⁶	12	31	0	—	12	62
Ever incarcerated	38	100	19	100	19	100

¹ $\chi^2=15.38$, df=4, p<.01⁴ $\chi^2=12.38$, df=2, p<.05² $\chi^2=11.78$, df=4, p<.05⁵ $\chi^2=15.45$, df=2, p<.05³ $\chi^2=15.12$, df=4, p<.01⁶ $\chi^2=9.65$, df=2, p<.05

loss of control over the substance abuse and the effects of the personality disorder, acceptance of abstinence as a treatment goal, and participation in support group activities such as AA.

The comparison groups were not deprived of any treatments typically rendered by each site except that neither group received the experimental interventions. To ensure adequate and distinct implementation of the two group therapy models as described, a specific protocol that reflects a process orientation (as opposed to an outcome orientation) of the group therapists was developed (23).

Research sample

Participants at each site were referred to the study by professionals on the treatment teams based on specific inclusion criteria provided to them. The staff at each site were encouraged to refer all consumers meeting these criteria. The inclusion criteria remained unchanged throughout the recruit-

ment process. Using a random numbers table and a randomly assembled sampling list of potential subjects, the researcher assigned subjects to one of the three group conditions at each site. Seven or eight adult clients between the ages of 18 and 64 were randomly assigned to each group treatment without consideration of gender, race, or ethnicity.

Clients who met the criteria of having a diagnosis of a substance use disorder (type unspecified) and an axis II personality disorder (type unspecified) were considered eligible for participation in the study. The study was aimed at clients who were not psychotic (that is, actively hallucinating) to increase chances of facilitating group interaction among the membership. Consumers with current *DSM-III-R* axis I diagnoses other than a substance use disorder were excluded.

To ensure the reliability of the diagnosis of mental disorder, the inves-

tigator used the Structured Clinical Interview (SCID) for *DSM-III-R* (24, 25). Each subject referred to the project at both sites was diagnostically screened using a brief unstructured assessment modified from the SCID-P (patient version) to rule out persons who did not have a personality disorder or who were too psychotic or affectively disturbed to participate (24). Furthermore, the investigator used the SCID-II (the version for persons with personality disorders) to ensure that a discernible *DSM-III-R* personality disorder existed and to attempt to validate the type of disorder (25).

Data collection

Two research assistants who were clinical social work students were assigned to collect all pre- and posttest data. To increase interrater reliability, each was given ample opportunity to practice administration of the Addiction Severity Index (ASI) with a substance-abusing population at an unrelated program in another state mental health facility and at an outpatient clinic. The research assistants' results compared favorably with those of staff who had already administered the ASI; interrater reliability was approximately 83 percent. Also, it was noteworthy that both research assistants who collected the data remained active throughout the entire year-long project, which increased the overall reliability.

The two research assistants administered the ASI to each subject both before and after the intervention to assess the relative impact of each group method (the independent variable) on the selected dependent variables of alcohol use, drug use, social and family relations, and psychological functioning. The ASI is a 147-item structured interview designed for use in clinical settings with patients who have problems related to abuse of drugs or alcohol (26). Information obtained from the ASI produces a quantitative measure of problem severity in the following treatment-related areas: chemical abuse (separate scores for alcohol and drug severity); medical, psychological, and legal problems; social and family relations; and employment and support. Comparisons of the ASI severity

ratings and composite measures with a battery of previously validated tests show evidence of concurrent and discriminant validity (27).

Analyses

Analyses were conducted in several stages using SPSS 6.1 for Windows. First, to determine group comparability at the outset of the study, 2-by-3 multivariate analysis of variance (MANOVA) was used in which group therapy type and treatment setting were the independent variables. The baseline composite scores from the four selected ASI problem areas served as the dependent variables.

Second, to determine specific posttest differences between the group models used and between settings, 2-by-3 multivariate analysis of covariance (MANCOVA) procedures were used to adjust the posttest dependent variables by parceling out among the group treatments any effects on the dependent variables of potentially different levels of pretest severity. Third, post hoc analyses consisting of separate univariate analyses of covariance were carried out.

Results

Descriptive analysis

Referrals from both the inpatient and the outpatient substance abuse treatment sites yielded a total of 57 subjects. At the outset, five persons declined to participate. The SCID interviews screened out an additional eight persons. Of the 44 subjects who initially began the project, 38 completed the study. Thus at each of the two settings 19 people were assigned to the three groups.

As shown in Table 1, among the 38 subjects who completed the project were 23 African Americans and 15 Caucasians not of Hispanic origin. Twenty-nine subjects were male. Ages of the 38 subjects ranged from 27 to 52 years, with a mean of 37.5 years. Four subjects were married, eight were divorced, eight were separated, two were widowed, and 16 had never married. At pretest, 12 subjects reported that when they finished treatment they would have unstable living arrangements.

As highlighted in Table 2, a signifi-

Table 2

Psychological problems at pretest of 38 subjects with dual diagnoses recruited from public outpatient and inpatient mental health treatment settings

Psychological problem	Total sample (N=38)		Outpatient setting (N=19)		Inpatient setting (N=19)	
	N	%	N	%	N	%
Previous psychiatric treatment ¹	20	53	6	33	14	72
Lifelong depression ²	17	44	4	22	13	67
Attempted suicide	14	37	7	37	7	37
Violence problems	30	80	15	80	15	80
Diagnosis of cluster B personality disorder	20	53	11	58	9	47
Diagnosis of cluster C personality disorder	18	47	8	42	10	53

¹ $\chi^2=14.9$, df=5, p<.05

² $\chi^2=17.9$, df=5, p<.001

cant number of subjects reported periods of serious psychiatric problems at some point in their lives. For example, 20 had previous psychiatric treatments in mental hospitals, 30 reported problems controlling violent tendencies, 17 reported a lengthy history of depressed affective states, and 14 had attempted suicide. The mean \pm SD number of previous mental hospitalizations for the sample was $3.1 \pm .6$. Although many of the subjects had a history of thought or mood disorders, none had axis I disorders at the time

of the study, but several clearly had adjustment problems.

All 38 subjects had a *DSM-III-R* diagnosis of a personality disorder. Approximately half of the sample (20 subjects) had a cluster B personality disorder, with antisocial type being the most common diagnosis (15 subjects). Half of the sample (18 subjects) had a cluster C personality disorder, with avoidant type the most common (13 subjects). None of the subjects had a diagnosable cluster A personality disorder.

Table 3

Substance use problems at pretest of 38 subjects with dual diagnoses recruited from public outpatient and inpatient mental health treatment settings

Substance use problem	Total sample (N=38)		Outpatient setting (N=19)		Inpatient setting (N=19)	
	Mean	SD	Mean	SD	Mean	SD
Years of problem use						
Alcohol ¹	8.4	.7	9.5	.6	7.5	.5
Heroin	.8	.1	.5	.1	1.0	.1
Cocaine ²	4.9	.4	6.5	.3	3.4	.4
Sedatives	1.1	.1	1.1	.1	1.1	.1
Marijuana ³	5.5	1.1	7.0	1.5	3.9	.9
Hallucinogens	1.4	5.5	1.5	.5	1.3	.4
Mixed use and polysubstance use	5.3	1.7	6.1	1.8	4.4	1.9
Previous episodes of alcohol treatment	1.2	.5	1.0	.5	1.4	.4
Previous episodes of drug treatment	1.2	.6	1.0	.5	1.4	.4
Longest period of abstinence (months)	11.8	1.5	7.9	.8	15.7	.9

¹ F=9.11, df=1,36, p<.001

² F=10.73, df=1,36, p<.05

³ F=8.12, df=1,36, p<.05

Table 4

Pre- and posttest unadjusted mean \pm SD scores on four subscales of the Addiction Severity Index for dually diagnosed inpatients and outpatients treated in three different therapy groups

Subscale and therapy group	Inpatient setting						Outpatient setting					
	Pretest score		Posttest score		Difference		Pretest score		Posttest score		Difference	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Alcohol use												
Disease-and-recovery group	.469	.12	.070	.11	.399	.02	.725	.11	.521	.11	.204	.01
Cognitive-behavioral group	.441	.13	.018	.05	.423	.09	.598	.16	.152	.15	.446	.02
Usual group treatment	.349	.22	.141	.21	.208	.04	.682	.17	.492	.27	.190	.11
Drug use												
Disease-and-recovery group	.107	.09	.001	.01	.106	.09	.219	.11	.167	.10	.052	.02
Cognitive-behavioral group	.116	.10	.008	.02	.108	.09	.200	.12	.044	.05	.196	.08
Usual group treatment	.117	.12	.087	.12	.030	.02	.322	.05	.216	.15	.106	.11
Social and family relations												
Disease-and-recovery group	.342	.21	.083	.10	.259	.13	.683	.04	.641	.06	.042	.03
Cognitive-behavioral group	.419	.12	.103	.10	.316	.03	.584	.05	.233	.16	.351	.12
Usual group treatment	.450	.24	.489	.18	-.039	.07	.571	.09	.514	.12	.057	.04
Psychological functioning												
Disease-and-recovery group	.393	.17	.319	.14	.074	.04	.464	.14	.432	.18	.032	.05
Cognitive-behavioral group	.498	.13	.442	.16	.056	.04	.476	.12	.232	.07	.244	.06
Usual group treatment	.605	.15	.601	.18	.004	.04	.487	.16	.472	.18	.015	.03

Twenty-eight of the subjects (74 percent) had been previously treated for a substance use problem. The mean number of previous treatment episodes, in either an inpatient or an outpatient rehabilitation setting, was the same for both alcohol and drugs other than alcohol—1.2 episodes. The majority reported regular use of more than one substance; the model pattern was alcohol, cocaine, and marijuana. As Table 3 shows, problematic alcohol use averaged 8.4 years, cocaine use 4.9 years, and marijuana use 5.5 years. Less than 1 percent of the subjects had used injectable drugs. Cocaine was used by inhalation (30 percent) or by smoking and freebasing (70 percent).

As can be seen in Table 1, differences were found between subjects at the inpatient and the outpatient sites in marital status, employment status, and legal problems. As shown in Tables 2 and 3, small but significant differences were also found in the number of years subjects had experienced problems with alcohol, cocaine, and marijuana use and in the proportion of subjects who had previous mental health treatment and who had life-long depression. Given the nature of treatment in inpatient and outpatient settings, these differences were not particularly surprising.

In summary, the subjects had significant levels of multiple substance use and abuse and lengthy psychiatric histories. In addition, even though the subjects were not randomly assigned to the two sites, few overall differences in demographic and background characteristics were found between subjects at the two settings, and no differences were considered problematic in terms of making comparisons.

Pretreatment analysis

As shown in Table 4, neither the pretest analysis for the group therapy approach nor the interaction of group therapy approach by setting revealed any overall differences between mean ASI scores in the problem areas of alcohol use, drug use, social and family relations, and psychological functioning. However, the MANOVA with setting as the main effect indicated significant overall differences in scores between the inpatient and outpatient setting ($F = 9.1$, $df = 4,29$, $p < .001$).

Posttreatment analysis

To determine specific differences between the group therapy models used and between settings, MANCOVAs were employed. Results of initial MANCOVAs showed significant overall main effects for sites ($F = 7.57$,

$df = 4,25$, $p < .01$) and for group therapy approaches ($F = 10.1$, $df = 8,48$, $p < .05$). Moreover, an approach-by-setting interaction was found ($F = 5.54$, $df = 8,48$, $p < .01$). In essence, these findings indicate that there were significant posttreatment differences in the mean adjusted ASI scores between the three group therapy approaches and the two settings (Table 4).

Separate univariate analyses of covariance between posttest scores on the dependent variables were conducted. These analyses showed that the differences indicated by the main effect of the group therapy approach were significant for all four dependent variables. The differences indicated by the main effect of setting were significant for all of the dependent variables except psychological status, and the differences indicated by the interactive effect of approach-by-setting were significant only in the area of social and family relations. Given the overall main effect differences, further MANCOVA analyses were conducted among the three groups at each setting.

Although the analyses showed that the inpatient groups had significantly different rates of improvement in the severity of their problems in social and family relations ($F = 5.53$, $df = 8,16$, $p < .01$), they did not find any

significant differences among the inpatient groups in the rates of improvement in alcohol use, drug use, and psychological functioning. The analyses also showed that the outpatient groups had significantly different rates of improvement in all problem areas except drug use ($F=3.19$, $df=8,16$, $p<.05$).

Univariate analyses of covariance were used to discern which group therapy approach accounted for the observed statistical differences. These analyses revealed that in the inpatient setting the scores of both experimental groups indicated significant improvements over the comparison group in the area of social and family relations ($F=19.67$, $df=2,15$, $p<.001$). The results suggest that conducting either of the experimental groups in a structured and thoughtful manner was effective in reducing overall problem severity in the area of social and family relations.

The analyses showed that in the outpatient setting the cognitive-behavioral group was significantly more effective than either the disease-and-recovery group or the comparison group in reducing alcohol use ($F=6.12$, $df=2,15$, $p<.01$), improving social and family relations ($F=13.76$, $df=2,15$, $p<.001$), and enhancing psychological functioning ($F=8.13$, $df=2,15$, $p<.004$).

Discussion and conclusions

At baseline, the general comparability within each treatment setting of subjects assigned to the three groups probably reflects the facts that admissions at each site were driven by lack of insurance coverage and geographic proximity and that both sites are within the same client catchment area. In addition, the random assignment procedures produced three groups within each setting that were quite similar at the start of treatment and at least generally comparable to other samples of dually diagnosed consumers in central Virginia.

Although our findings may not be generalizable to other public inpatient and outpatient programs, we believe that the study provides preliminary empirically based outcome data on two group approaches to treating consumers with dual diag-

noses—the disease-and-recovery model and the cognitive-behavioral model—that are theoretically integrated and that the literature suggests are effective. The study specifically explored which of the two models had the greatest impact on clinical outcomes in both inpatient and outpatient settings.

In general, in a public outpatient substance abuse treatment setting, the cognitive-behavioral model was superior from a statistical perspective in reducing the severity of consumers' overt alcohol use, their problems in the area of social and family relations, and their psychological problems. Unfortunately, no single group model yielded the same outcomes in the public inpatient setting. However, significant statistical evidence indicated that both experimental models were more effective in the inpatient setting than use of a nonspecific intervention (the comparison group) in reducing alcohol use and the severity of problems in social and family relations.

As hoped, this study illustrated the potential utility of clinical measures such as the ASI and supported the relevance and usefulness of the ASI in assessing dually diagnosed consumers. No studies in which the ASI was used to measure change in dually diagnosed subjects have been published, even though it has been widely suggested that the ASI should be used with this population (1,28,29).

In general, the study reported here demonstrated the effectiveness of group therapy with dually diagnosed consumers, providing initial empirical evidence of the efficacy of such therapeutic approaches. In addition, the study demonstrated that the two models can be successfully implemented at a typical public inpatient mental health facility and a typical public outpatient setting without a large research staff and extensive grant monies. The results supported many of the findings suggesting that brief group therapy interventions seem to be most appropriate with mentally ill or substance-abusing consumers, and with dually diagnosed consumers (30). Therefore, therapists may use the results to encourage dually diagnosed consumers to participate in group therapy.

Although further study is needed in public inpatient settings, it appears that the use of cognitive-behavioral group therapy in a public outpatient setting with dually diagnosed consumers may be effective in ameliorating problems in a variety of areas related to addiction. However, both models of group therapy used in this study employ techniques of support, confrontation, and feedback in a group environment that encourages dually diagnosed consumers to lower their defenses and begin to explore the impact of having co-occurring problems. The cognitive-behavioral model specifically reduces symptoms and distorted cognitive beliefs related to mental disorders—including personality disorders—and substance abuse. ♦

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Applications for 1997 Achievement Awards

The American Psychiatric Association is now accepting applications for the 1997 Achievement Awards. The awards will be presented at the Institute on Psychiatric Services, to be held October 24-28, 1997, in Washington, D.C. The deadline for receipt of applications is January 10, 1997.

The American Psychiatric Association presents the awards each year to recognize programs that have made an outstanding contribution to the mental health field, that provide a model for other programs, and that have overcome obstacles presented by limited financial or staff resources or other significant challenges.

The winners of the 1997 awards will be selected by next year's Achievement Awards board, chaired by Ruth E. Frydman, M.D., of Portland, Maine. The winner of the first prize, the Gold Achievement Award, receives a \$10,000 grant, made possible by a grant from the Roerig division of the U.S. Pharmaceuticals Group, Pfizer, Inc. If more than one program is chosen as a Gold Award winner, the programs share the grant. The winner of the Gold Award also receives a plaque, and the winners of Significant Achievement Awards receive certificates.

Applicants should submit six copies (including the original) of a completed application form and a program description. Each program that applies will be visited by a representative of the local district branch of the American Psychiatric Association. The site visitor's evaluation will assist the Achievement Awards board in selecting the winning programs.

To receive an application form or additional information, write Achievement Awards, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005, or phone 202-682-6173.

The Effectiveness of Outpatient Civil Commitment

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The effects of outpatient civil commitment on community tenure and functioning were studied in a group of 20 patients with a history of recurrent hospitalizations, noncompliance with outpatient treatment, and good response to treatment. During the first 12 months of outpatient commitment, patients experienced significant reductions in visits to the psychiatric emergency service, hospital admissions, and lengths of stay compared with the 12 months before commitment. They significantly increased the number of appointments kept with their psychiatrist. It appears that when used judiciously, outpatient civil commitment is a helpful tool in maintaining hospital recidivists in the community. (*Psychiatric Services* 47:1251-1253, 1996)

Use of outpatient civil commitment has been advocated as a means to reduce the rehospitalization rate for a group of severely mentally ill recidivists. However, its potential pitfalls have also been well described,

and its effectiveness has yet to be convincingly demonstrated (1-4).

Although Ohio's Mental Health Act of 1988 does not use the term "outpatient commitment," it appears compatible with a preventive commitment approach (5,6). The act allows for patients to be committed to the county mental health board, whose chief clinical officer is responsible for ensuring that treatment occurs in the least restrictive setting. The act also has provisions to return a committed patient to an inpatient setting if the patient presents a substantial risk of harm to self or others if allowed to remain in the community.

The Summit County Alcohol, Drug Addiction, and Mental Health Services Board developed a protocol to use outpatient civil commitment. The protocol incorporated Geller's clinical guidelines (7) for patient selection and was based on four understandings. First, criteria for commitment in Ohio are the same for hospitalized patients and those committed to community settings. Second, commitment does not allow forcible administration of medication. Third, noncompliance with treatment does not in itself allow a patient to be involuntarily returned to the hospital. Fourth, outpatient civil commitment lowers the threshold for ordering an evaluation to consider returning the patient to the hospital; if a committed patient begins to evidence signs or symptoms consistent with an established pattern of decompensation and dangerous behavior, then the treating psychiatrist can request a court-ordered evaluation to determine if rehospitalization is indicated.

To examine the effects of outpatient civil commitment on community tenure and functioning, this study reviewed the cases of patients who were committed to the Summit County Alcohol, Drug Addiction, and Mental Health Services Board and maintained on a commitment order for at least 12 months.

Methods

Data about the first 20 patients who were committed to the Summit County board between January 1992 and November 1993 and who were maintained on an outpatient civil commitment order for at least 12 months were gathered from patients' records and the county's management information system. Outpatient commitment for all patients had been initiated with an involuntary state hospitalization.

Clinical records at the outpatient agency—Community Support Services, Inc.—and data from the county's management information system and the state's patient care system were reviewed. Basic demographic and diagnostic characteristics were noted. Data on lifetime history of state hospitalizations, alcohol and drug problems, and criminal arrests and convictions were collected. For the 12-month periods before the index hospitalization and after discharge under the commitment order, data were recorded on hospital use; criminal arrests and convictions; drug and alcohol abuse; use of the county's psychiatric emergency services, case management services, psychiatric and nursing services, and day treatment—partial hospitalization services; and residential and employment status.

Dr. Munetz is chief clinical officer; Mr. Grande is a program evaluator, and Dr. Kleist was formerly a program evaluator for the Summit County Alcohol, Drug Addiction, and Mental Health Services Board, 405 Tallmadge Road, Cuyahoga Falls, Ohio 44221. Dr. Munetz is also director of community psychiatry at Northeastern Ohio Universities College of Medicine, where Dr. Peterson is assistant professor of psychiatry. Dr. Peterson is also clinical director of Community Support Services, Inc., in Akron, Ohio. A preliminary report of this study was presented at the All Ohio Institute on Community Psychiatry held March 25, 1995, in Beachwood, Ohio.