Psychosocial rehabilitation and family intervention for people with dual disorders

Rehabilitación psicosocial e intervención familiar en personas con trastorno dual

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Abstract

In dual disorder, two serious and chronic disorders converge that are still a challenge to health and social care networks. In this context, families play an important role in keeping these people included in the community. Dual disorder is associated with a series of negative effects on the family environment, with a greater burden of care and conflict. For this article, four models of family intervention in dual disorder have been reviewed.

Conclusions. Family intervention has proven to be an important element of dual disorder treatment. The four intervention programs presented coincide in share some common components: single / multi-family intervention, theoretical bases of the models of with proven efficacy, psychoeducation, communication training, problem solving, and the motivational interview across the entire program. Even so, some areas still persist without improvements and areas that do not improve persist and the results are not conclusive, so it is necessary to continue looking for formulas that point towards more flexible therapeutic resources according to the needs and circumstances of each of these people.

Key Words

Dual disorder; severe mental disorder; drug abuse; family intervention; multi-family; psychoeducation; motivational interview.

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Resumen

En el trastorno dual confluyen dos trastornos graves y crónicos que aún hoy son un desafío a las redes de atención sanitaria y social. En ese contexto las familias desempeñan un papel importante en el mantenimiento de estas personas en la comunidad. El trastorno dual se asocia con una serie de efectos negativos sobre el entorno familiar, con mayor carga de cuidados y conflictos. Para este artículo, se han revisado cuatro modelos de intervención familiar en el trastorno dual.

Conclusiones. La intervención familiar ha demostrado ser un importante elemento del tratamiento del trastorno dual. Los cuatro programas de intervención presentados coinciden en unos componentes comunes: intervención uni/multi familiar, bases teóricas de los modelos de probada eficacia, psicoeducación, entrenamiento en comunicación, resolución de problemas y la entrevista motivacional transversal a todo el programa. Aun así persisten áreas que no mejoran y los resultados no son concluyentes, por lo que es necesario seguir buscando fórmulas que apunten hacia recursos terapéuticos más flexibles según las necesidades y circunstancias de cada una de estas personas.

Palabras clave

trastorno dual; trastorno mental grave; abuso de drogas; intervención familiar; multifamiliar; psicoeducación; entrevista motivacional.

1. DUAL DISORDERS. CONCEPTUAL APPROACH

In the early 1990s R. Stowell (1991) used the concept of "dual diagnosis" to "define the coexistence of a mental disorder, such as schizophrenia or psychosis, and a substance use disorder".

Since then, the conjunction of a mental disorder (MD) and a substance use disorder (SUD) in the same person has been given different names: dual disorder, dual diagnosis, co-morbidity, dual pathology, co-occurring disorders, etc. Some of these terms have been used with different combinations of disorders: MD and SUD, severe mental disorder (SMD) and SUD, bipolar disorder and SUD, non-substance addictions in people with a mental disorder, intellectual disability and mental disorder (Novell et al., 2015), etc.

Within the framework of this article, the term dual disorder (DD) refers to the presence in the same person of both a SMD and a SUD (it does not include addictions without substance use: pathological gambling, excessive use of information technology, compulsive sex, etc.).

DD is a complex phenomenon that combines two serious and chronic disorders. Its treatment is a challenge for health and social networks, as well as families who play an important role in maintaining keeping these people in the community.

According to the National Plan on Drugs (PND 2009-2016), SUD is a phenomenon conditioned by social and economic factors, with local, national and international dimensions. The development of addiction is influenced by biological characteristics, instrumental psychological function, lifestyles,

evolution of cultural values, etc. According to a report made by the World Health Organization (WHO, 2005), substance dependence is multifactorial and is therefore determined by psychosocial, cultural and environmental factors as well as biological and genetic factors. All these postulates also affect people with a SMD.

In the words of Drake et al (2008):

> "... the current psychiatric emphasis on neurobiology is apparent in clinical approaches, journal articles, and research institutes. Nevertheless, substance abuse and dependence, particularly among dual diagnosis clients, are strongly influenced by socioenvironmental factors (Drake, Wallach, Alverson, & Mueser, 2002). It has been clear for years that many of these individuals are able to be abstinent in some settings but not in others (Bartels & Drake, 1996). Thus, research needs to attend to social and environmental context—the sociological point again".

2. EPIDEMIOLOGY

There has been very little scientific production on DD in recent years in Spain. We must refer to international epidemiological studies as a reference (Table I, Fernández J.A. 2010) where it is confirmed that the presence of DD is to be expected and not an exception.

In Spain, epidemiological studies among the general population have not investigated the comorbidity of SUD in people with mental disorders. There are descriptive and retrospective studies in people with SMD attending Psychosocial Rehabilitation Center (Fernández and Marquina, 1995; Fernández et al., 2003) where they have found prevalence rates of use of around 25-30%. In another study, in people who consult a mental health device, 25% suffer from DD and this proportion rises to 63% in those who consult a drug dependency device (Arias et al., 2013).

3. IMPACT OF DD

It has been shown in different studies that comorbidity is associated with an increase in the severity of the duration of the disorder, disability and consumption of health services (Compton et al., 2008). The profile of people with substance abuse-schizophrenia comorbidity is similar to the general population: more frequent in young males (Mueser et al., 1990), alcohol is the most consumed substance (Smith and Hucker, 1994), is often in concurrence with other substances, and cannabis is the

Table I. Prevalence of drug use and SUD in people with schizophrenia

		Pepper 1984	Caton 1989	Drake 1989	Ananth 1989	Test 1989	ECA 1990 USA	CRPS 1993 Madrid	Duke 2001 Londres	Barnes 2006 Londres	CATIE 2006 USA
No. of subjects				187				62	352		1600
SUD History							47%			68%	
Current consumption	Use	48%	51%		75%	60%		53%		35%	60%
	Abuse			33%			28%	30%	21.5%		37%

most consumed illegal substance (Smith and Hucker, 1994). In people with SMD, the first psychotic episode occurs earlier than in non-users, being more frequently in lower socio-economic levels. Use is lower when negative symptoms predominate.

The course of SMD could be more favorable if they stop drug use, along with receiving pharmacological treatment and psychosocial support. Drug use may be the best predictor of the course of schizophrenia, even better than neuroleptic medication (Swofford et al., 1996).

4. TREATMENT AND TERRITORIAL DIVERSITY

According to the study by Ortega-Fons (2021) the Integrated Dual Disorders Treatment (IDDT) (Xie et al., 2005) is the most effective treatment for schizophrenia with SUD and to improves life quality. It was also found that ambulatory type treatments with integrated models, multidisciplinary teams and with psychosocial integration goals have the best results.

Both SUD and MDD are disorders whose care requires shared case strategies, interdisciplinary and intersectoral approaches between addiction, mental health, social and socio-health services for their caring.

Therefore, cooperation between subsystems, coordinated and complementary interventions with caring circuits that guarantee continuity and effectiveness is required (PISMA 2016).

The most effective strategy is aimed at deploying a range of resources (psychotherapy, assertive treatment, social coverage programs such as housing, access to employment, etc.), which cover all the needs of people with DD and their families (Drake et al., 2008; Shilony et al., 1993). The NDP (National Drug Strategy 2009-2016) includes three essential components in the dual disorder (DD) within the actions for "demand reduction":

1. Prevention.
2. Risk/harm reduction (two close, but not identical concepts).
3. Assistance and social integration.

The problem, according to the NDP, is not abandoning consumption, but the associated circumstances: poly-consumption, mental disorder, economic precariousness, social, work and/or family uprooting, and in general the rupture or non-existence of inclusive social ties.

Most DD studies support the effectiveness of Integrated Models and integration of services (Mueser et al., 2013), but quality evidence from a Cochrane perspective has not yet been found (Hunt et al., 2019). This study did not find support for psychosocial treatment over standard care in outcomes such as staying in treatment, reducing substance use or improving mental or global state in people with SMD and SUD. The available evidence on the efficacy of these Integrated Models needs further evaluation, but it is still the most supported approach in this area (Kavanagh and Mueser, 2007). In our country we clearly need experiences that implement and evaluate Integrated Models that include psychotherapeutic, psychopharmacological and psychosocial treatment addressed to the person's needs and their circumstances, which sometimes sustain or precipitate treatment abandonment, or favor relapses, etc., precipitating or favoring relapses, treatment abandonment, etc.

4.1. Territorial diversity

There is a single person with DD and several treatment networks, whose entry is random and conditioned by the cross-sectional presence of their symptoms.

Currently in Spain there is a very differentiated treatment network for addictions (Andalucía, La Rioja, Madrid, Galicia, Canary Islands, etc.) with irregular coordination with mental health services, which leads to difficulties in the delimitation of responsibilities, mismatched interventions, etc. Of the total of the 17 Autonomous Communities and INGESA (which groups together the two autonomous cities), 3 have the two networks fully integrated, 5 are functionally integrated (the attention to addictions is in devices belonging to the mental health network) and 10 are separated. In other words, almost half of the Autonomous Communities (8) have a functional integration of both healthcare networks: Asturias, Cataluña, Castilla-La Mancha, Castilla-León, La Rioja, Murcia, Navarra and the País Vasco.

In general, within Mental Health care, there aren't specific strategies or action plans for the treatment of people with DD, except in communities where they are functionally integrated. In other communities, specific actions have been developed, mainly on drug networks (Institute of Addictions of the City of Madrid). The Mental Health Strategy of the NHS considers DD to be one of the 14 priority areas and includes four specific objectives (within general objective 5): to adapt services with specific programs for DD; to implement clinical protocols for the most prevalent care processes in DD; to have an Individualized Therapeutic Plan (ITP) based on clinical typology; to initiate integration or coordination between all the networks that treat DD.

5. FAMILY INTERVENTION IN DUAL DISORDER

In a community care model, attention to families is not only a strategic issue, but also ethical duty. A family intervention program for people with DD should be considered as a component in the overall treatment strategy, in addition to psychosocial rehabilitation in a recovery perspective.

As we have seen above, integrated treatment of DD has supported its effectiveness, (Drake et al., 2008) although the data are not definitive (Hunt, 2019). Less attention has been paid to family interventions (Barrowclough et al., 2001) despite their relevance in DD treatment. Increasing family skills to cope with stress can allow families to continue to provide critical supports that help improve outcomes.

FI in schizophrenia. The effectiveness of family intervention (FI) for people with schizophrenia has been well demonstrated by many studies (Camacho-Gomez and Castellvi, 2020; Inglot et al., 2004; Pilling et al., 2002). It has been proven to be effective in reducing psychotic relapses, improving family harmony and social functioning. Currently, FI is recommended in schizophrenia treatment guidelines and expert consensus protocols.

Lehman and Steinwachs (1998) in the PORT study (Schizophrenia Patient Outcomes Research Team) recommend family intervention for a period of at least 9 months, including a combination of psychoeducation about the illness, support, problem-solving training and crisis intervention. Family interventions have also been proven to be effective when used by clinicians in community services.

FI in drug addiction. In the field of SUD, family intervention was initially driven by the results obtained in the field of mental health and expressed emotion (EE) (Brown, et al., 1972). In the caring facilities for people with SUD, the concept of "schools for parents" (last third 20th century) was extended to attend to the profile of heroin addicts. As addicts started trying other substances (Cocaine, etc), these practices diminished. On the other hand, systemic family therapy had a great impulse thanks to the studies of Selvini, Cancrini, Haley, etc. (Becoña and Cortés, 2008). It is a model that rose expectations at the time, but currently it has found limitations within the field of drug addiction (Selvini, 2002) and it is difficult to extrapolate it to the multi-complexity of DD.

6. MODELS OF FAMILY AND MULTIFAMILY INTERVENTION IN DUAL DISORDERS

Very few studies refer to FI in people with dual disorder (DD) even though there is a significant percentage of people with schizophrenia who use drugs (20-60 %) (Barrowclough, 2009) and that many people with DD live with or have regular contact with family members, who invest time and money to provide support and care (Mueser et al., 2013). Family involvement in the lives of people with DD is associated with a better outcome. However, compared to SMD alone, DDs are associated with a series of negative effects on the family, including an increased burden of care and family conflict (Mueser et al., 2013). A DD often entails the loss of family support with consequent negative social and clinical consequences.

If the medical and mental health services themselves often do not know what is the best way to treat people with DD, being considered difficult, refractory: How can we expect family members to adequately solve these problems? Stressful circumstances are likely to not only harm the caregiver in the short, medium and long term, but also have an impact on the course of DD itself. Many studies have shown that high expressed emotion (EE) is associated with an elevated risk of relapse. It is quite possible that drug use problems and schizophrenia tend to boost high EE the problems of drug use and schizophrenia more easily feedback high EE, and the risk of relapse will be even higher for people with DD living with their family members or carers.

The scarce research on FI and DD has been reviewed by Barrowclough (2009) finding few studies, with small samples, that unequivocally corroborate the intensity of family stress with people with DD. Caregiver burden is magnified when two severe, chronic and complex disorders are involved. Given the significant prevalence of DD (20%-60%), this means that many families are facing very intense levels of stress and strain. For this article we have reviewed four models of family intervention in DD. Three of them have been designed for families of people with schizophrenia, and subsequently have been adapted to the field of DD. The fourth model was designed since the beginning for families of people with DD. They are presented from least to most specific adaptation to DD.

6.1. Gran Canaria Family Support and Collaboration Program (PACF)

It is a manualized program (Baena et al., in press), adapted to clinical practice in a health

area (Gran Canaria). It has been trained and used in other areas of Spain (Madrid, Catalonia, Castilla-LM, Castilla-L, Murcia, etc.). It was designed following the main proven models: the socio-family interventions of Leff (2000), the psycho-educational model of Anderson et al. (1998), the behavioral family therapy of Fallon et al. (1993), the cognitive-behavioral interventions of Tarrier (Birchwood and Tarrier, 1995), and the multi-family groups of McFarlane et al. (2002). The target population is family members of people with schizophrenia, adaptable to other SMD. Prior individual work with the family, a certain acceptance of the illness, a minimum of mourning, etc., is important. The program consists of 2 stages: connection/assessment and intervention stage, which combines the multi-family group, as the backbone, with single-family interventions.

Connection-evaluation. - The aim is to foster a climate of trust. The family member affected by schizophrenia usually participates in the interviews. It comprises three tasks: therapeutic alliance, evaluation and setting objectives for the multifamily group.

Intervention. - is carried out in a multi-family group in combination with the single-family group, it has three modules:

- Sharing Information. It is a psycho-educational module, its name is not free, it is about sharing information; professionals what they know and family members what they know and live daily. It takes place over six weekly two-hour sessions.
- "Improving family communication and self-care. The objective is to improve intra-family communication and to reorganize the dynamics of caring for the carer". It takes place in 4-6 monthly two-hour sessions. The content of each session is reinforced with practical exercises and homework.
- "Supporting recovery. How to improve coping with problems". Work with problems' solving techniques to provide strategies and tools for daily living. Duration around 6-8 sessions each month.

Approach to DD from the PACF model. The families of people with DD, if they meet the requirements, are invited to join the PACF program and are integrated as members of these multi-family groups. Because of this, therapists have a new tool to respond to the difficulties inherent to DD, considered a factor of refractoriness. DD is approached from the 3 modules, in the psycho-educational part, at the initiative of the professionals, the subject of drug use and its influence on the course of the disease is introduced (if there are families affected by DD). The influence of drug use on people with schizophrenia is addressed. Professionals invite families to express their opinions or comments on the subject. It is reported that drugs can influence particularly vulnerable people, worsen the course of the illness and increase the chances of relapse. In the next two modules, it is expected that families who propose the problem of drug use within their families. From there, practical exercises can be presented on communication problems and, in the third module, on the resolution of practical problems in each family (discussions, behavioral limits, commitment to treatment, etc.). The multi-family group often provides a "grounding" for families affected by DD, they can find, from other families, alternatives to solve some of the problems of everyday life. Many of these proposals will require a single-family

format for their implementation, including the person with DD within this single-family group. In the single-family format the main changes are negotiated and concretized, but the therapist has the multi-family group where some resistances of the user and the family can be unblocked. Certain issues that do not work in the single-family format can be seen differently in the multi-family group, for example: that the family gives money for the purchase of drugs, or that someone buys drugs to avoid arguments at home, or to protect him/her from the street, etc.

6.2. Model of Stavanger Hospital in Norway

> "If the needs and suffering of the family are not addressed, not only the family but also the patient is neglected, as the family is often the main support structure for a person with psychosis" (Thorsen et al., 2009, p.47).

The model of family and multi-family work in psychosis at Stavanger University Hospital in Norway (Thorsen et al., 2009) seeks to build a family-centred support organization. Clinicians build an alliance with family members so that families are part of the therapeutic team, along the lines of the experiences of Falloon, Leff, Anderson and McFarlane. This model has been applied to specific populations such as: "young psychotics", family work in early psychosis, drug use, including DD of psychosis and drug abuse, etc.

The theoretical framework is cognitive-behavioral, using the techniques most used in the FI of psychosis: single-family and multi-family framework, group and individual psychoeducation, problem-solving techniques, management of motivation and change processes, etc. The method consists of:

- Single family meetings with the family and the person affected by DD to:
- Analyzing the crises experienced by the family.
- Family tree and social network design.
- Detection of early warning signs.
- Contact between the group leader and the person with DD.
- One-day multi-family psychoeducational seminar without patients. This seminar is repeated every year including patients with more emphasis on rehabilitation processes.
- Multifamily group with fortnightly meetings (90 minutes) for 2 years.

Each group consists of 4-6 families. The program has three main components: problem solving, communication improvement and psychoeducation.

In the treatment of people who identify a drug abuse problem, exposure of the problem in the Multifamily Group is used to reduce negative emotions and better manage the situation. Abstinence is not sought directly, what is sought is the modification of some of the user's behaviors and the improvement of family relationships.

The multi-family group, on the one hand, wants to convey solidarity and understanding, helps to set limits to unacceptable behavior, mutual learning between all participants and between the different families. On the other hand, users who participate in these groups are more willing to listen to other members of the group than to their own family members. The idea is that if the reduction of intra-family stress is achieved, the need to use drugs is reduced.

6.3. The Manchester model

This is a DD intervention program with a family intervention component (Barrowclough et al., 2000; Haddock et al., 2003). The effectiveness of the model was evaluated in a 9-month intervention study with sessions preferably in the home of the affected persons. The program assigned a family support worker to provide information, subsidies, legal advice and practical help.

The therapeutic group was made up of people with DD who received a combined treatment of:

- Motivational Interviewing (MI),
- Cognitive Behavioral Therapy (CBT)
- Family Intervention (FI).

The hypothesis is that coexisting drug use motivations, symptoms, environmental and social stress are associated in a mutually reinforcing cycle. In this way MI would reinforce motivation, CBT would reduce psychotic symptomatology, while family intervention could influence symptomatology and persistence of use. The intervention starts with MI in five weekly sessions.

The Rhode Island Change Assessment Scale (McConnaughy et al., 1983; Fernandez, 2010) was used to assess readiness to change. CBT begins in the sixth session, but without losing the MI style, for eighteen weekly sessions. CBT addresses psychotic symptoms, self-esteem, depressive mood, disease knowledge and relapse prevention. The FI adapts the program proposed by Birchwood and Tarrier (1995) which includes Prochaska and DiClemente's (1986) model of change and Miller and Rolnick's (1999) interview. The basic assumption in this FI is that the user's motivational state may be affected by the family environment.

The common goals between the user and the family member or carer were established with a duration of 10-16 sessions, either with the family member alone or integrating the user. The key concept of this model is that the user is responsible for the problems and consequences, the family does not make any effort to change until the user has committed to specific goals and strategies. The family was instructed to respect that only the user should be responsible for his or her problems; that drug use should not be confronted directly (so as not to generate more resistance) and that family help will be most effective if it corresponds to the stage of change of the user.

It was very important for the family to leave it up to the user to make changes, which meant not rescuing the user from the consequences of use, not helping the user financially if they had been wasteful, not hiding their periods of drunkenness, setting minimum rules for living together at home, etc. This emphasis on user responsibility also requires family members to clearly support changes once they have occurred, but not to initiate them.

The FI model (Barrowclough and Tarrier, 1992) starts with an evaluation of family members' problems and needs, and a list of cooperative problems and needs is drawn up.

FI has three components: (1) psychoeducation; (2) stress and tension management and coping skills; (3) setting common goals between user and relatives.

Psychoeducation includes the usual issues: vulnerability-stress model, causes of psychosis, symptoms, treatments, course, prognosis, etc. There is flexibility in the family members attending in each case, but the user is always encouraged to

participate in the description of their experience of psychosis.

The KASI Interview (Barrowclough et al., 1987, Touriño et al., 2010) was used to assess the family's understanding of drug use in schizophrenia, adding additional sections on aspects of DD. The usefulness of the family members' opinions is to be evaluated with regard to the motivational approach, whereby the most useful opinions are those that are able to lead to a less blaming attitude. A less critical stance favors the situation The best strategies are non-confrontational, non-critical and non-intrusive, underlining that no self-sacrifice is required on the part of the family member.

Stress management and environmental stress focuses on situations associated with family stress. The model highlights the importance of family reactions, how family members interpret situations. For example, family persuasion for the user not to use, or arguments when the user arrived intoxicated. These forms are not only sterile but sometimes perpetuate the problem. The aim was to help family members to re-evaluate behaviors and situations, to improve their own self-care, to devote more time to themselves.

Setting common objectives. The main objective of FI is to improve the social functioning of all family members. The main assessment tool for this is a list of resources/problems/needs. When working with the needs of the whole family, pathologizing of the patient's problems is avoided and teamwork of the whole family is encouraged.

The results of this study (Haddock et al., 2003) support the efficacy of a combined program in which FI was integrated. The study showed that an intensive treatment program incorporating FI achieves a significant improvement in the main outcome of patients' general functioning and that this improvement was maintained at 18 months. However, other improvements in positive symptoms, days of abstinence were maintained up to 12 months but not at 18 months. The authors acknowledge that the intervention was relatively short (the shortest of the four presented in this article) and that more far-reaching interventions are required for some DD families where interactions between drug use and psychosis have entrenched problems with very high levels of family stress.

6.4. The Family Intervention for Dual Diagnosis (FIDD)

FIDD is a manualized program that includes single-family and multi-family group formats (Mueser et al., 2002). It combines psychoeducation techniques on DD, communication skills to reduce family stress and problem solving to resolve conflicts and improve the motivation of the person with DD. To evaluate the effectiveness of the program a clinical trial (randomized controlled trial) was conducted (Mueser et al., 2013) where FIDD was compared to a short intervention (2-3 months) of a Family Education (FE) program.

The main hypothesis was that training family members in communication and problem-solving skills, combined with increased motivation to address substance abuse, would lead to improvements in SUD as well as psychiatric and family functioning.

A psychoeducational module with the usual contents was delivered. In addition, FIDD aimed to reduce family stress, increase the family's ability to deal with SUD

problems by improving communication and problem solving. The adoption of the staged motivational treatment approach (Prochaska, 1984) modulated the motivation of family members to recognize that the user's drug use is a problem and must be addressed. The concept of a staged treatment conditions the organization and pace of family sessions by specifying appropriate stages of therapeutic interventions, consistent with family members' motivation to address substance use. FI was in four phases:

1) Building a therapeutic alliance with the family (commitment stage).
2) Providing information (and other strategies, such as MI approaches to family problem solving) to motivate to work on the user's SUD (persuasion stage).
3) Reduce consumption when there has been clear evidence of user motivation (active treatment stage).
4) Relapse prevention strategies and more attention to the needs of other users (relapse prevention stage).

Family sessions had a decreasing frequency of contact, starting with weekly sessions (3 months), followed by fortnightly sessions (6 months) and finally monthly sessions, with a total duration of 9 to 18 months (Mueser and Fox, 2002).

Sometimes family members, or the user, mention the drug use of a family member. The therapist encourages family members to talk spontaneously about substance use and its consequences. When the family member's substance use could influence the patient's use or is problematic, the therapist adopts a non-confrontational style, consistent with the stages of treatment to address it through family problem solving.

Multi-family groups. Families were invited to participate in monthly multi-family support groups where they could find information about DD and strategies for everyday problems (Mueser and Fox, 2002). However, attendance rates at these sessions were low in the FE group as in the FIDD group, usually less than 50% of the invited families attended. Due to low attendance, these groups were discontinued 3 years into the study (Mueser et al., 2009).

Users of both programs (FIDD and FE) improved in substance abuse, general psychiatric symptoms, days of stability in the community and global functioning (the influence of the natural course of disorders and "regression to the mean" cannot be ruled out).

Key family members in the FIDD and FE programs also showed significant improvements in mental functioning, financial support in the patient's life, worry and stigma about mental illness. These improvements in family burden and distress are consistent with findings from other FIs for SMD, (Drake et al., 1998) although previous studies have not evaluated the impact of family treatment on people with DD. Users of the FIDD program had less general psychiatric symptoms (specifically psychotic symptoms) and showed a significant trend towards better general functioning than those in FE.

Haddock et al. (2003) also found that FI combined with individual user MI and CBT improved the functioning of people with DD more than standard treatment. The present study is the first to demonstrate these effects for FI alone in people with DD. The results are in line with other research showing that long-term FI is more effective than short-term programs in preventing relapse and improving functioning in people with MDD (Pharoah et al., 2010). The trend towards

improved functioning for users in the FIDD in this study is similar to research on integrated treatment for MD, especially group interventions. The FIDD program also had more benefits on family member mental health than the EF program, which suggests that the reduction of psychiatric symptoms may contribute to the mental health well-being of family members with a DD member. An unexpected finding was that family members in the FIDD program improved their knowledge of concurrent disorders more than those who received FE. This improvement occurred even though the curriculum and number of educational sessions were similar in the two programs. It's possible that the longer duration of the FIDD provided more opportunities for family members to assimilate the educational content than the FE.

Contrary to the initial hypothesis, FIDD was not more effective than FE in improving substance abuse, although both groups improved significantly in SUD outcomes, including alcohol use disorder (AUD), drug use disorder (DUS), and progress in substance abuse treatment (SATS, Fernandez, 2010). In addition, in the FIDD program, participants' results did not confirm increases in social problem-solving skills. The insufficient level of exposure to the problem-solving component of FIDD was a factor that may have contributed to these results: only 66% of families stayed in treatment for long enough to have substantial exposure.

In addition, the finding of higher severity of SUD predicted lower levels of long-term adherence to FIDD (Mueser et al., 2009). Therefore, those families most in need of problem-solving training were less likely to receive it. All this suggests that, in DD, families require early care treatments to evaluate and improve motivation to work on SUD problems in the family.

Although people with DD often have moderate contact with their family member, there were significant difficulties in recruiting family members and retaining them in treatment. Problems with recruitment and retention in treatment raise important questions about the feasibility of family treatment in this population. More work is needed to develop family programs that engage and retain families in treatment, provide them with information and the skills needed to overcome DD problems. Focus groups with families and clinicians aimed at assessing what families need could be a valuable strategy to improve the program.

In summary, DD clients and their family members who participated in a short educational program for 2-3 months (FE) or a longer-term (18 month) program, which included education, communication and problem-solving skills (FIDD), showed improvements in psychiatric disease severity, substance abuse, psychosocial functioning, and family functioning over the 3-year period. FIDD program was associated with greater improvements in psychiatric symptoms, patient functioning, family knowledge of DD and mental health functioning, but not in substance abuse. However, recruitment and retention of families in the 2 programs was problematic, suggesting the need for an even shorter and more targeted intervention aimed at engaging and motivating families to participate in treatment.

7. CONCLUSION

FI has proven to be an important element in the treatment of DD, understood as a set of coordinated actions of the different care systems (health, social...). We have presented four representative programs for

FI in DD. The four programs have common elements: conjugate single/multi-family intervention, support based on the most research-supported models (Anderson, Leff, Fallon, McFarlane), psychoeducation, communication training, problem-solving and motivational approach and MI as a transversal style throughout the program. Time is an important factor in the intervention, long-term interventions are required in SMD. Positive results have been found and there is no doubt that these techniques are very helpful in addressing the refractoriness of DD. Even so, there are still areas that do not respond as clinicians expect, so it is necessary to continue searching for more effective formulas, probably more holistic, with the involvement of social resources that have a clearer impact on the needs and circumstances of these people.

In this line, Drake et al., (2008) found three consistent interventions on SUD: residential treatment of DD; support groups, advice and counselling (mainly with MI) and the "contingency management" technique. Other interventions on DD were significant in other areas, for example, case management and assertive treatment improve maintenance in the community, as well as legal interventions increase participation in treatment.

People with SMD recover from SUD gradually, over months and years, and in stages (Drake et al., 2008). Stages of treatment and stages of change are clinically relevant because different interventions are effective at different stages of the recovery process. In addition, people with DD respond variably to a particular intervention or program. At this point, diagnosis does not serve as a predictor of treatment response; other ways of identifying intervention subgroups must be sought (Mueser et al., 1999). For example, one study identified four subgroups (Drake et al., 2008): a group of fast and stable responders, a second group of fast but unstable responders, a third group of slow but steady responders and a fourth group of complete responders (Xie et al., 2006). These groups are characterized in part by the severity of the substance use disorder. There is therefore no single pathway as a therapeutic response to DD, but there is a need to further explore different types of treatment for different types of people with DD.

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