Sustainable change can occur only through awareness and consciousness. Facilitating awareness and consciousness enables people to understand how they make decisions and how their behaviors affect their lives. For triply diagnosed clients—those with the combination of HIV, a substance use disorder, and a psychiatric disorder—a key obstacle to awareness and consciousness, and therefore, to appropriate treatment, is the way in which they relate to others.

Such “relationship problems” are caused by a variety of factors, but they can usually be traced back to a response to a range of events, whether a reaction to trauma or a coping mechanism to a psychiatric stressor. For example, trauma may lead a person to distrust others or undermine his or her understanding of how relationships function. In addition, pre-existing psychiatric conditions may exacerbate the way in which a person experiences trauma.

For individuals with histories of trauma, the world can appear dangerous. It is not surprising, given this perception, that such individuals might distrust the attempts of service providers to engage them, nor is it surprising that this might complicate HIV, substance-related, and psychiatric care, lead to missed appointments, strained relationships with providers, and the use of medical or psychiatric emergency services for primary care. It is particularly useful to understand the behaviors of these clients as potentially stemming from a traumatized individual’s lack of understanding of what is expected from him or her. This insight further supports the goal of structuring interventions that highlight relationship skills building.

This article looks at triple diagnosis care through the lens of its ability to help individuals improve their relationship skills, whatever the cause of their relationship problems. It offers an overview of assertive case management as a way of nurturing trust and these relationship capacities.

Traditional Triple Diagnosis Treatment

Traditionally, treatment models for people with triple diagnosis have been divided along two polarities: harm reduction versus the abstinence model; and substance use treatment versus psychiatric treatment. The harm reduction model emphasizes the continuation of care regardless of a client’s adherence to substance-related or psychiatric treatment. Conversely, the abstinence model requires abstinence from substance use and absolute adherence to substance-related and psychiatric treatment in order to continue in treatment.

Regardless of which approach a program uses, care for people with triple diagnosis should seek to address behaviors that interfere with the individual’s ability to maintain their engagement with service providers. Programs that employ a harm reduction approach, however, are more likely to provide a realistic framework for engagement than are programs that rely solely on abstinence. In abstinence-only programs, difficulties in adherence to treatment goals may become a reason for discharge from a program, by definition undermining the priority of sustaining engagement. It is important to note that a harm reduction approach does not exclude the use of abstinence-based interventions, but these interventions can be applied in a more flexible way.

As with harm reduction and abstinence, substance use and psychiatric treatment have traditionally been perceived as mutu-
People with HIV who use substances and have a psychiatric disorder present providers with the greatest challenges. This month’s issue of FOCUS documents two creative approaches to the problem.

Ramon Matos describes a model—assertive case management—that prioritizes the goal of helping a client sustain relationships with service providers, most prominently the case manager. Matos suggests that this single activity not only helps clients access the practical, mental health, substance-related, and medical services that they need most, it can also have a direct effect on the client’s overall capacity to function.

Edward MacPhee and Antoine Douaihy discuss the importance of coordinating care for people with triple diagnosis across a combination of social service, mental health, and medical disciplines. Like Matos, they emphasize the complex nature of triple diagnosis and the importance of creating models that are flexible enough to respond to multiple and changeable treatment targets.

Both articles outline the varying manifestations of triple diagnosis and the challenges that can arise when mental health care, substance-related treatment, and medical care are balkanized, pursuing different treatment goals in isolation and sometimes at odds with a client’s overall goals. The power of both assertive case management and integrated treatment is that they elevate the client’s goals. As MacPhee and Douaihy state, “Treatment begins ‘where the patient is,’” a statement that may represent common sense for many mental health providers, but which may be less achievable in standard (and underfunded) medical, psychiatric care, and substance abuse treatment settings.

Ultimately, the fact that an individual is having difficulties maintaining relationships—regardless of the cause of the difficulties—is indicative of the need to focus on the development of support systems for the client. The case management framework can be used successfully in this process, because it supports and requires more intensive and interactive involvement from both clients and providers.

The term case management defines a working relationship between a client and a provider based on the client’s needs for, and access to, specific services. These services may address concerns ranging broadly from basic needs such as housing or financial benefits to mental health care and medical care. Case management objectives are defined either by clients or providers and relate to the competencies of the provider’s agency. Case management services may be limited to information and referral or extend to skills building and counseling. Assertive case management focuses specifically on developing, fostering, and sustaining engagement between staff and clients in the context of meeting the range of practical needs the client and case manager identify.
In the context of mental health, the key difference between assertive case management and traditional psychotherapy is that the activity of the case manager is not limited to a specific task, site, or outcome. Case managers are able to move through the provider and social support system with a client and, in doing so, are better able than psychotherapists to experience both a client's reality and the full range of his or her ways of relating. Further, unlike psychotherapy, which also employs engagement and relationship to achieve change, case management uses the active resolution of the client's practical concerns as the forum in which the relationship is formed and nurtured.

In 2003, the UCSF AIDS Health Project developed an Assertive Case Management program to undertake this challenge. The program's focus was to reduce the use of crisis and emergency services by clients. To achieve this, planners conceived as an integral component of the program the ability of staff to go off-site, accompany clients to appointments, and keep connected with clients regardless of treatment outcomes. The program does not provide clients with any entitlements, such as vouchers, housing, or money. Instead, it offers clients the capacity for relationship building, highlighting the commitment of staff to help clients maneuver through the treatment and social service system and to facilitate resolution of problems that reduce access to these services. Focusing on the relationship enables both the client and the case manager to experience the client's problems, work together to resolve these problems, and become more aware and conscious of the interpersonal relationship and its effect on well-being.

Within a framework that prioritizes the client-provider relationship as the medium of change, services can be managed in different ways. The Assertive Case Management program uses narrative therapy theory to facilitate treatment planning. Narrative therapy is based on the idea that people give meaning to their experiences and use a narrative to express this meaning. Further, narrative therapy acknowledges that the same problem will affect different individuals differently and that people are capable of making changes to their narratives once they better understand the specific problems affecting them.

The program, using its relational perspective, assumes that clients want to engage others and have the capacity to do so. Further, the case manager uses the difficulties he or she experiences in relating to a client to better understand the client's case management needs. That is, if a client's problems in relating manifest as anxiety, social phobias, or tendency to isolate, as is demonstrated in the scenario in the next section, these problems can be addressed while continuing to work on accessing a particular service or entitlement. The relationship problem is seen as a barrier to accessing services, and the service continues to be the focus of the treatment plan.

The relationship between the case manager and client is also the framework in which clients can observe practical skills and build these skills. In this way, the case manager serves as a model of interacting and behaving with others, including other providers and other agencies. Additionally, the case manager and client can use these model interactions as starting points for discussing the varieties of both effective interacting and barriers to interaction.

Finally, within the context of narrative therapy, the program also employs other interventions that vary from motivational interviewing to play therapy. No method is considered sacrosanct: how case managers engage clients is less important than the fact that they continue to engage with clients and assist in the process of creating awareness and consciousness.

**Applying Assertive Case Management**

The first client referred to the Assertive Case Management program was a 60-year-old, gay-identified, White man with HIV, major depression, and a history of alcohol use. "Thomas" would not keep his outpatient appointments with his primary medical provider at a local clinic, instead relying...
on San Francisco General Hospital’s Emergency Room for everything from medical care to support at those times he felt overwhelmed or was having what he described as a “panic attack.”

At her initial assessment of Thomas, his case manager, “Sarah” suspected cognitive impairment: Thomas could offer only limited information about his history with other providers and, more importantly, he was not able to clearly describe why he continued to use the emergency room as his primary provider. After this first meeting, Sarah wondered what the program could possibly do for Thomas beyond getting him placed in a supported living residential program.

Sarah obtained releases of information for all of Thomas’s providers and created a schedule for meeting with Thomas. During the first month, Sarah visited Thomas twice a week and was able to secure in-home support services for him. Although she had some concerns about Thomas’s cognitive impairment and unclear medical needs, Sarah focused first on the importance of creating a solid and honest working relationship with Thomas. She recognized that authentically engaging Thomas in order to assess his capacity would be the best way of truly understanding the issues that most affected his life and would help to build the all-important client-provider relationship.

Early on, Sarah identified Thomas’s need for three services: psychiatric medication management; primary care support and treatment; and psychological support and care to help Thomas deal with longstanding grief and loss, which had resulted in alcohol use as a coping mechanism. Sarah shared with Thomas what she had observed and explained what she believed would be most useful to him.

What she had realized at first was that Thomas was afraid to leave his apartment; scheduling appointments with other providers would not be useful without first addressing this issue. Michelle helped Thomas establish a routine of leaving the apartment on a regular basis, first for small tasks such as getting the mail and then for more challenging ones like going to a medical appointment. After 12 months of participating in the program, Thomas was able to sustain his relationships with his medical providers, join a support group, and augment his existing social system with group members he met through the support group.

At the time of his discharge from the program, Thomas said the most useful aspect of his care had been his relationship with Sarah. “Having her to talk to at the beginning without feeling like I had to change anything was helpful because I didn’t feel stressed about having to do anything but talk about whatever was on my mind.”

**Conclusion**

The Assertive Case Management Program’s focus on the relationship between client and case manager has been consistently useful and productive, facilitating a better understanding of why an individual is having difficulties accessing and sustaining services. It has likewise increased staff awareness of how provider capacities to relate to others affect service provision. The model has the ability to help people redefine how they see themselves and, through this process, become more aware of personal skills and strengths as well as needs and self-defeating behaviors. These insights can help individuals stabilize their lives and develop connections to services that can help them maintain and improve this stability.

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**References**


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**Clearinghouse: Triple Diagnosis**

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King VL, Kidorf MS, Stoller KB, et al. Influence of psychiatric comorbidity on HIV risk behaviors: Changes during
A middle-aged man was recently diagnosed with asymptomatic HIV disease. He has a history of depressive episodes and of intermittent injection heroin use, although he has been clean for the past two years. When his physician started him on HIV antiviral treatment, he was fully adherent and responded well to treatment. Nonetheless, he had difficulty accepting his illness. In addition, his family and friends were not supportive, he started having conflicts with them, and he became more isolated.

Having difficulty coping with these problems, the man relapsed to heroin use. His depressive symptoms worsened and he eventually stopped his antiviral treatment. Increasingly, he felt despair. A few months later, he started experiencing severe fatigue and weight loss, which spurred him to resume treatment at the HIV clinic.

This patient’s clinical presentation describes the co-occurrence of HIV illness, a psychiatric disorder, and a substance use disorder, a condition known as triple diagnosis. This article defines triple diagnosis and its scope, the challenges of prioritizing treatment of the range of complications, and the importance of integrating medical, psychiatric, and substance-related treatment in response.

Definition and Scope of Triple Diagnosis

Triple diagnosis is an extension of dual diagnosis, which is best conceptualized as a co-existing psychiatric disorder and substance use disorder that are interrelated and require simultaneous treatment. Individuals with dual disorders have more frequent and more severe psychiatric symptoms, more hospitalizations, and poorer adherence to treatment for both conditions compared to individuals with only one of the two disorders. The addition of a third disorder can result in even more frequent and severe psychiatric acuity, which leads to more negative outcomes in medical, substance use, and psychiatric treatments. Furthermore, the multitude of psychosocial issues faced by people with triple diagnosis—including homelessness, poverty, and chaotic lives—make it more difficult for them to adhere to medical and psychiatric treatment.

Triple diagnosis is prevalent in psychiatric, substance-related, and HIV treatment settings. A review of the current literature related to triple diagnosis shows that between 10 percent and 40 percent of HIV-positive individuals have concurrent psychiatric and substance use disorders. Further, substance use disorders have been identified in close to 80 percent of HIV-infected Medicaid recipients with schizophrenia and major affective disorders. The cause and diagnosis of psychiatric symptoms in HIV-positive substance users may be complicated by multiple factors that can produce neuropsychiatric manifestations. These factors include acute and long-term effects of drugs and alcohol, substance withdrawal, encephalopathy, substance-induced cerebrovascular accidents (such as stroke), HIV-associated cognitive disorders, HIV-associated opportunistic infections of the central nervous system, and the side effects of antiviral and other medications. The most common medical manifestations in this population include severe bacterial infections, Mycobacterium tuberculosis, other sexually transmitted diseases, and the reactivation of infections such as neurosyphilis.

Patients with triple diagnosis may have higher levels of distress and physical impairment compared to individuals with...
no diagnosis, or a psychiatric, or a substance use disorder alone. In general, the most prevalent mood disorder in patients with triple diagnosis is major depressive disorder. HIV-positive injection drug users, in particular, experience relatively high levels of depressive disorders. As is generally the case, depressive disorders often present with anxiety and this combination can complicate the clinical picture. In addition, the combination of HIV disease, depression, and substance use considerably increases the risk of suicide, and prior suicide attempts and suicidal tendencies are common among this population. These issues underscore the need for early diagnosis and treatment in order to reduce depression and substance use, slow HIV disease progression, and decrease mortality.

Finally, pain commonly complicates the course of the triple diagnosis and responding to it is one of the most challenging of clinical goals. Providers treating individuals with HIV disease currently using illicit or recreational substances may have concerns about the misuse and abuse of narcotic analgesic medications. These concerns often lead to the undertreatment of pain among individuals with HIV. While recreational drug use can affect adherence to narcotic analgesic treatment, this is not necessarily true, and it is crucial to remember that individuals with triple diagnosis deserve pain control, even if they are actively using.

Accumulating evidence suggests a strong connection between each of the dual disorders and HIV infection. HIV infection increases a patient’s risk for various psychiatric disorders, including anxiety, depression, psychosis, and substance use disorders. In addition, HIV antiviral regimens may precipitate or worsen psychiatric symptoms. Furthermore, psychiatric disorders such as severe depression, personality disorders and post-traumatic stress disorder are associated with impaired judgment, higher levels of drug use, impulsivity, and high-risk sexual behavior. These factors, in turn, can increase the risk of HIV infection. Perpetuating this vicious cycle, HIV may lead to more depression, hopelessness, substance use, and impulsivity, and possible cognitive impairment.

Medical Challenges of Triple Diagnosis

Medical care, already complex for most people with HIV disease, becomes even more complicated in the context of active substance abuse and psychiatric disorders. Hepatitis C, a common co-infection among HIV-positive injection drug users, adds further treatment challenges and may lead to HIV antiviral treatment-induced liver toxicity. HIV may cause cognitive changes, including learning difficulties, slowed information processing, and memory deficits. In addition, cognitive impairment can also be worsened by or induced by psychiatric illness or substance use. This situation and psychosocial issues such as poverty, transmission-related behaviors—for example drug-related equipment sharing—inadequate social support, insufficient knowledge about the three illnesses, and fluctuating levels of motivation for treatment, all can combine to undermine adherence to all aspects of medical, psychiatric, and substance use treatment. In particular, psychiatric disorders, including high levels of depression, and active substance use negatively affect adherence to HIV antiviral treatment.

Barriers to Effective Treatment

Clinicians treating triple diagnosis should view it as a unified diagnosis comprised of three intertwined conditions. Further, the treatment of any of these conditions can act as a potential catalyst of or obstacle to the treatment of the other conditions. Yet, individuals with triple diagnosis rarely receive adequate, flexible, and integrated care incorporating and coordinating treatment for all three illnesses. Instead, they are subject to “one-size-fits-all” systems of care that are inadequate to meet the complex needs of this population.

Barriers to integrated care include the complex psychosocial conditions such as poverty, lack of health care insurance, limited social support, unstable housing, and vacillating levels of motivation for change. In addition, there is a “triple stigmatization” associated with having HIV, a psychiatric illness, and a substance use disorder. Stigma results in the extreme marginalization of this population and further reduces self-esteem, often precipitating self-destructive behaviors and potentially delaying or under-
Integrated treatment entails a holistic approach provided by an interdisciplinary, culturally sensitive clinical team.

For these reasons, health care and mental health providers are wise to be flexible about the sequence of treating the three illnesses. For example, providers should not defer HIV antiviral treatment in patients who desire it, even if such patients are ambivalent about abstinence from substance use. But these patients may benefit from more intensive interventions addressing substance use and psychiatric symptoms and the obstacles these pose to HIV medication success and adherence.

An integrated approach to care incorporates substantial efforts to connect patients to case management services, which can address a variety of psychosocial needs, including homelessness and poverty, as well as help patients with treatment adherence. The approach also includes efforts to enhance family and peer support, involve patients in self-help programs, provide education about the interactions among the disorders, offer behavioral interventions to mediate problematic behaviors, improve problem-solving skills, prevent relapse for both psychiatric illness and substance use, and initiate group and individual therapy as appropriate.

Psychotropic medications may also improve the course and prognosis of patients with triple diagnosis. For example, antidepressant therapy is effective in the majority of HIV-infected patients with major depression. Reducing depression may also slow HIV disease progression. Other interventions such as methadone and buprenorphine treatment for patients with opioid dependence may help improve HIV antiviral treatment adherence. It is crucial, however, for providers to be aware of potential interactions among medications, including herbal remedies such as St. John's wort, and with substances such as alcohol, since these interactions may lead to toxicity and changes in blood levels of antiviral medications.

Conclusion

Triple diagnosis represents a clinically challenging condition for health care professionals and researchers. Recognition of the interplay between substance abuse and mental illness in HIV-positive patients will likely contribute to improved integration of care for this population. Improved interventions targeting women with triple diagnosis are especially needed. Finally, single-site, integrated substance use, mental health, and HIV treatment services need to be developed and evaluated, because they may provide the best settings for facilitating access to care and successful treatment.
Recent Reports

Adherence and People with Triple Diagnosis

Drug use, alcohol use, and psychiatric problems each significantly reduces HIV antiviral medication adherence, according to a large, national study.

Researchers obtained a probability sample of HIV-positive patients from HIV care providers in 28 metropolitan areas and 24 rural counties. The ethnically diverse sample was comprised of 1,910 patients who were taking HIV antiviral medications at the time of their second follow-up visit. The sample was 78 percent male. Participants completed questionnaires on medication adherence, substance use, mental health, and general health during three visits (including baseline) between 1996 and 1998. Adherence was defined by self-report as being 100 percent adherent in the prior week.

At the first follow-up interview, 19 percent of participants had evidence of a psychiatric disorder(s) based on four modules from the Short-Form of the World Health Organization Composite International Diagnostic Interview. At the second follow-up visit, 46 percent of the sample reported adherence to their HIV medication regimens. In addition, 14 percent of participants reported heavy drinking in the prior month, and 28 percent reported some drug use in the prior month.

Of those participants who did not have a probable psychiatric disorder and did not use drugs, 49 percent were adherent to their medication regimens. Only 36 percent of participants with a probable psychiatric disorder and 39 percent of those who used drugs reported sustaining adherence. The percentage of adherent participants steadily decreased with increasing levels of alcohol use: 52 percent of nondrinkers were adherent, compared with 31 percent of frequent heavy drinkers. Other factors related to non-adherence were: higher drug use severity (on a scale of severity ranging from marijuana and analgesic use to heroin and cocaine); and poorer general mental health.

HIV Infection Rates and Dual Diagnosis

A national cross-sectional study of 6,593 substance treatment participants found higher rates of HIV infection among those with the combination of substance abuse and psychiatric disorders (4.7 percent) than among those with only a substance abuse disorder (2.4 percent).

Participants filled out questionnaires on drug and alcohol use, substance use treatment history, mental health, criminal justice, general health, and HIV-related risk factors. Based on the mental health section—four self-report questions—researchers identified participants with psychiatric disorders and classified 28 percent as dual diagnosis patients. The remaining patients were classified as single diagnosis patients.

The sample was 72 percent male, and 54 percent African American, 31 percent White, and 15 percent Latino.

There was a higher percentage of women among dual diagnosis subjects (37 percent) than among single diagnosis participants (25 percent). In addition, White participants were significantly more likely than African Americans or Latinos to be dually diagnosed and homeless patients were more likely than domiciled patients to be dually diagnosed.

Dually diagnosed patients were more likely than singly diagnosed patients to have shared an injection drug needle, had sex for money or gifts, had sex with someone they knew used injection drugs, or been forced to have sex against their will.

Next Issue

The HIV pandemic, particularly as it manifests in Africa, is finally getting the attention it deserves. In the April issue of *FOCUS,* Mark Winiarski, PhD, Director of HIV Mental Health Services for the North Bronx Healthcare Network and a Fulbright Scholar in Namibia in 2003, describes the metaphorical journey he took as he endeavored to provide technical assistance to Namibian providers. He also discusses some of the key cultural factors that contribute to the HIV-related mental health care of people in this west African country.

The April issue also includes a discussion of the Ugandan response to the AIDS epidemic.
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