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INTEGRATED DUAL DISORDERS TREATMENT WORKBOOK FOR MENTAL HEALTH CLINICIANS

INTRODUCTION

WHAT IS THIS
WORKBOOK
ABOUT?

This workbook aims to help clinicians learn about substances of abuse and to develop the basic skills needed to help people with substance abuse and mental illness (dual disorders) recover from both disorders. In this book, “recovery” means that the client is learning to master both illnesses in order to pursue personally meaningful life goals.

This book assumes that because dual disorders are so common, all clinicians need to learn basic skills to foster recovery. We also assume that clinicians, like others, learn in different ways. Some read textbooks, some prefer training videotapes, some rely on supervision, and some like practical, vignette-oriented workbooks like this one. We recommend that you give this book a try and see if it works for you.

WHAT DOES
THE
WORKBOOK
COVER?

This workbook covers the basic information needed to treat persons with dual disorders. Many mental health clinicians have already received training and supervision on treatment of mental illness, but they need to acquire basic skills to address co-occurring substance abuse. This workbook will help clinicians learn substance abuse treatment skills. For this purpose, we assume that every clinician needs four basic skills: (1) a working knowledge of common substances of abuse and how they affect mental illnesses, (2) an ability to assess substance abuse, (3) the skills to provide motivational counseling for clients who are not ready to acknowledge substance abuse and pursue recovery, and (4) the skills to provide integrated substance abuse counseling for clients who are motivated to address their problems with substance use.

Treatment for people with dual disorders is more effective if the same clinician or clinical team helps the client with both substance abuse and mental illness. That way the client gets one consistent, integrated message about treatment and recovery. This workbook will help you learn the skills to provide effective integrated dual disorder treatment.

HOW SHOULD
YOU USE THE
WORKBOOK?

Use this workbook in any way that fits your learning style! Supervisors may want to use the book to teach skills to clinicians, or to review the basic skills for themselves and to teach them without using the book. Some clinicians like to read the entire book at once, but most prefer to read one chapter at a time and discuss it with their treatment team members or colleagues. The book is designed so that each chapter begins with a vignette that describes a person who has problems typical of many people who have dual disorders, and then continues with a discussion of the chapter topic. One way to use the book is to read the vignette and discuss it before you read discussion in the rest of the chapter. The discussion comes from experts in the field who have been providing integrated dual disorders treatments for years, so you can examine your own ideas in relation to theirs. There is of course no one “correct” way to do clinical work, but hopefully you will find the comments by experts helpful in developing your own thinking.

HOW IS THE
WORKBOOK
ORGANIZED?

Each chapter has an introduction to the concepts, a vignette, and comments from experts about some of the issues raised by the case, and recommendations for further reading. Chapter 1 provides definitions of common terms used when talking about substance use disorders. Chapters 2-5 address the effects of substances of abuse and how they impact a person with mental illness. Chapter 6 reviews the stages of treatment. Chapters 7-15 discuss different types of clinical skills. Chapters 7-12 cover skills for stage-wise treatment of dual disorders. The final three chapters, 13-15, cover special topics of family treatment, group treatment, and self-help involvement, which may not be basic skills but are topics that every clinician will want to know something about. Chapter 16 covers infectious diseases that are common and serious in persons with dual disorders.

In each chapter, the case vignette presents common problems but also some interesting twists, such as an elderly client, a person who is homeless, or a person from a minority background. These are offered to stimulate you to think about the many special issues that arise in the context of doing this work.

Many terms can be used to describe people giving or receiving treatment. For this workbook, we chose to use the word “client” to describe persons working with treatment providers. We use case manager, clinician, and counselor to describe the people providing services. We interchange pronouns, using he or she to describe clients and clinicians at different times. We use “family” to describe a relative or spouse.

We hope you enjoy this workbook. Please let us know what you like, dislike, and how you used it by contacting the main author at the address in front of the workbook. Thanks.

Definitions

INTRODUCTION

This chapter provides definitions for words and phrases commonly used when people talk about substance use. These terms are used throughout this book. Some words that are commonly used together are grouped together below. The words and phrases are presented in alphabetical order.

ABSTINENCE, CLEAN, AND SOBER

Abstinence is when a person does not take any substances of abuse. A person abstains from taking the substance. The term *clean* usually refers to being abstinent from substances other than alcohol, whereas the term *sober* usually refers to being abstinent from alcohol. *Clean and sober* means abstinent from both. When a person is prescribed a medication, such as methadone, and takes it as prescribed, they are considered abstinent from substances of abuse.

ADDICTION

Addiction refers to when a person is physically or psychologically dependent on a substance or a practice (such as gambling) so that using the substance is beyond voluntary control.

DETOXIFICATION

Detoxification is the process whereby an individual who is physically dependent on a substance stops taking that substance and recovers from its immediate effects. Ideally, people should be monitored by professionals to make sure they are safe. The word detoxification is often used to describe the monitoring, support, and treatments people receive to cope with the withdrawal symptoms and craving for substances that emerge when people cut down or stop using the substance. Because withdrawal symptoms can be extremely uncomfortable and dangerous, monitoring, support, and medical and psychiatric treatments during the process can be helpful and even life-saving. Medications can be used to reduce the severity of symptoms during withdrawal from the substance and to prevent life-threatening illnesses. *Detoxification alone does not treat substance abuse and dependence.* Clients need to be engaged into treatment during and after detoxification.

INTOXICATION

Intoxication (or *inebriation*) refers to the experience of being under the influence of a substance that causes a person to feel different than normal. Symptoms of intoxication can be physical, such as slurred speech

when intoxicated with alcohol, or psychological, such as feeling relaxed when intoxicated with cannabis. Being intoxicated does not in itself suggest that a person has a substance use disorder.

RECOVERY

Recovery is the process by which a person learns new meaning in life beyond the illnesses of substance abuse and mental illness. When a person is “in recovery” it is implied that they are abstinent from substances, but also that they are participating in life activities that are meaningful and fulfilling for them. Recovery also implies that a person is able to function in meaningful activities despite symptoms of mental illness. Integrated dual diagnosis treatment described in this workbook is designed to help people not only become abstinent, but to enter a recovery process.

REMISSION

Remission refers to when a person who once had a substance use disorder has reduced substance use so that they no longer experience distress or impairment in functioning, and therefore no longer meet DSM-IVR criteria for substance abuse or dependence. Remission is used in the same way for reduction in symptoms of mental illness such that impairment is no longer present.

SUBSTANCE

The term *substance* refers to alcohol, drugs, prescribed medications, over the counter medications, and other substances, such as glue, that people take for recreational purposes to get high or relaxed.

SUBSTANCE
ABUSE

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IVR) is a book that mental health clinicians use to define what they mean by any particular disorder. This book defines substance abuse as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by at least one of the following in a 12 month period:

1. recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home (e.g. poor performance at work, neglect of children)
2. recurrent substance use in hazardous situations (e.g. driving while intoxicated)
3. recurrent substance related legal problems
4. continued substance use despite having recurrent social or interpersonal problems related to substance use (e.g. arguments with spouse about consequences of intoxication)

SUBSTANCE
DEPENDENCE

The DSM-IVR defines substance dependence as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by 3 or more of the following during a 12 month period:

1. tolerance (see below)
2. withdrawal (see below)
3. the substance is taken in larger amounts or over a longer period of time than intended
4. the persons experiences a persistent desire or unsuccessful efforts to cut down or control substance use
5. a great deal of time is spent in activities necessary to obtain the substance, use it, or recover from its effects
6. important social, occupational, or recreational activities are given up or reduced because of substance use
7. the substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance

S U B S T A N C E
U S E D I S O R D E R

Substance Use Disorder refers to when using substances causes distress or impairment in functioning. Substance abuse and substance dependence are substance use disorders (see above).

T O L E R A N C E ,
P H Y S I C A L
D E P E N D E N C E ,
A N D
W I T H D R A W A L

The concepts of tolerance, physical dependence, and withdrawal are linked together. With repeated use, a person has to use more and more of the substance to get the same pleasurable effect; *tolerance* occurs. Substance use causes changes in the body and the brain. These changes are probably why tolerance occurs. After regular use of a substance, physical *dependence* can emerge whereby the body adjusts to the presence of the substance being there. When a person is physically dependent on a substance, they will develop *withdrawal* symptoms, which cause distress or impairment, when they stop or cut down on the amount of substance they are using. Withdrawal symptoms are caused by rebound hyperactivity of the biological systems that the substance suppressed. Withdrawal symptoms are usually quite uncomfortable, and often lead a person to use substances to get rid of the withdrawal symptoms.

Alcohol

INTRODUCTION

Alcohol is a commonly used legal substance that is part of everyday life in our culture. Most people in the U.S. drink alcohol, and about one in five develops problems with alcohol over the lifetime. People with a mental illness experience problems related to alcohol at a higher rate and with smaller amounts of use than persons who don't have a mental illness.

This chapter begins with a vignette of a person with depression and alcohol use disorder that illustrates several features of alcohol as a drug of abuse. The chapter then discusses alcohol's effects, some features of dual disorders and dual disorder treatment.

VIGNETTE

Tanya is a 42-year-old single mother with three children. She was referred to the mental health clinic by her primary care doctor and comes to the appointment with her sister. She describes having a hard time falling asleep at night and then waking up often during the night. She feels anxious and irritable most of the day, has no appetite, has lost enjoyment in her life, and has been avoiding family and friends. Though she has felt this way off and on her whole life, it is worse now than it has ever been. Feeling anxious has interfered with her ability to work.

Tanya has been a homemaker since she had her first child at age 26. After the delivery of that child, she had a postpartum depression, was hospitalized, and did not drink for an entire year. By the time her child turned two, she was feeling better and started drinking again. She drank 3-4 glasses of wine per night for years and felt that the wine calmed her down and helped her to sleep. Over the past several years, she has been drinking more, particularly on the weekends, when she stays home and drinks up to a gallon of wine per day. Recently, she has begun to experience blackouts where she can't remember anything she did the previous day. Tanya's father is an alcoholic who stopped drinking a few years ago.

Six months ago, Tanya's primary care doctor prescribed the anti-anxiety medicine, clonazepam, once a day. Some days she takes 2 or 3 extra doses when she needs them to manage her feelings of anxiety.

Tanya divorced 2 years ago and went back to work part-time in an office. Her 16-year-old son lives with his father and her 13-year-old twin daughters live with

her. Her daughters have been angry and withdrawn lately. One of them is openly using cigarettes and alcohol. Tanya responds by yelling at her, which she later regrets. Tanya's sister reports that the children are worried about their mother's drinking.

Tanya was concerned about her mood. When her sister mentioned that her children were worried about her drinking, she expressed surprise but acknowledged that her weekend drinking might be a problem. She was willing to try to cut down on her drinking if she could get some help for her anxiety and depression. She agreed to attend an intensive outpatient evening program. She and the clinician developed a crisis plan before she left the office, which identified what situations worsened her symptoms and who were supports she could turn to if she needed help. While in the intensive outpatient program, Tanya saw a psychiatrist for a medication evaluation and a therapist for individual counseling. The psychiatrist recommended that she taper off the clonazepam and start fluoxetine, an antidepressant medication. She tried to reduce the clonazepam, but found that her anxiety and depression seemed worse and that she couldn't sleep at all.

Over the next several months she struggled to reduce her use of alcohol and clonazepam. Her depressive symptoms improved only a little when the antidepressant medication dose was increased. At the same time, she worked with her counselor on her concerns about her daughters. One day, her sister called the therapist and told her that Tanya had received a ticket for driving while intoxicated the previous weekend. In the following months, she was ordered by the court to attend self-help groups and counseling. In the months of court-ordered treatment, she became completely sober, but it took several more months for her depressive symptoms to improve.

WHEN IS
ALCOHOL USE
A PROBLEM?

Alcohol is a legal substance almost everywhere in Western cultures, and most people in the U.S. drink socially over many years without problems. When does alcohol use become a disorder? According to most definitions, *drinking alcoholic beverages constitutes alcohol use disorder (abuse or dependence) when it results in physical, interpersonal, medical, legal, or vocational problems.* The Diagnostic and Statistical Manual (DSM) requires recurrent use of alcohol in the face of such problems for a diagnosis of alcohol use disorder. In addition, several other phenomena, listed in the previous chapter, are common indicators of alcohol abuse or dependence. Tanya clearly shows many of these indicators, such as increased use and unsafe behavior resulting in a ticket for driving while intoxicated.

OTHER
SEDATING
DRUGS

Medications that are sedating or induce sleep are called "sedative-hypnotics." Sedative-hypnotic medications are a chemically diverse group of substances, including benzodiazepines such as clonazepam, that are prescribed to reduce anxiety and insomnia. Sedative-hypnotic medications are also prescribed to treat agitation and mania and to reduce

some side effects of antipsychotic medications, such as tardive dyskinesia (abnormal movements) and akathisia (restlessness). Abuse of these medications can lead to the same symptoms and problems that people get from alcohol abuse or dependence.

ALCOHOL AND
SEVERE
MENTAL
ILLNESS

People with a mental illness experience problems related to alcohol use with lower amounts of use than persons who don't have a mental illness. Those with a severe mental illness, such as schizophrenia or bipolar disorder, are especially likely to develop a substance use disorder involving alcohol. It is unclear if anyone with a severe mental illness can drink socially over time without running into difficulties, but most who drink (probably over 90%) either develop problems related to alcohol or opt for abstinence. Moreover, their alcohol use disorders are strongly associated with a variety of negative outcomes, such as destabilization of mental illness, abuse of illicit drugs, homelessness, violence, victimization, incarceration, suicidal behaviors, and hospitalizations. For all of these reasons, alcohol should be avoided by people with severe mental illness, and clinicians should recognize and vigorously treat alcohol use disorders in these individuals.

INTOXICATION
AND SHORT-
TERM EFFECTS
OF ALCOHOL

A few facts about alcohol are important for every clinician to know. Alcohol affects every organ in the body, but the brain is particularly sensitive to alcohol. The more alcohol a person consumes the greater effect it has on the body. In lower doses (e.g., one or two drinks), alcohol often leads to relaxation and increased confidence. However, slightly higher levels of use (or blood levels) typically produce euphoria, giddiness, impaired motor (physical) control, and disinhibition, the combination of which people recognize as being intoxicated, or "drunk." Similarly, low doses of alcohol can produce relaxation, while higher amounts cause drowsiness. Women are affected by alcohol to a greater degree than men because their bodies process alcohol differently, resulting in higher blood concentrations.

As the dose (or blood level) increases, all of the effects of alcohol are often reversed or exaggerated, often dangerously so. For example, euphoria can turn into depression and suicidal behavior, and extreme disinhibition often results in poor judgment, such as getting into physical fights or engaging in sexual relations with dangerous partners. Motor dyscontrol can lead to severe lack of coordination and serious accidents. Sedation can be so severe as to cause death by suppressing the breathing center in the brain.

For people with severe mental illness, many of these negative effects occur at low doses of alcohol. For example, people with a mental illness may experience impaired judgment, cognitive problems, or disinhibited behavior even when they are not intoxicated, and alcohol rapidly worsens

these problems. Alcohol may also precipitate symptomatic relapses of depression or psychosis, and may interact negatively with medications.

ALCOHOL
TOLERANCE
AND
WITHDRAWAL

People who drink heavily for years often lose control of their drinking and orient their life more and more around drinking behaviors. In addition, they drink more rapidly, consume larger amounts, drink more often, and experience withdrawal symptoms when they decrease drinking. This latter set of behaviors, which involve physiological and psychological dependence on alcohol, is called the alcohol dependence syndrome.

The amount of alcohol that Tanya drinks has increased over the past several years, but the effect she feels from alcohol hasn't changed. This indicates that she has developed an increased *tolerance* to alcohol. With regular drinking, the body breaks down and gets rid of alcohol more quickly and changes occur in the brain, so a person needs to drink more to get the same effect. Tolerance to alcohol generalizes to other drugs and medications that affect the brain in ways similar to alcohol, such as benzodiazepines.

Persons who have developed tolerance to alcohol will have a physiological reaction called *withdrawal* when they reduce the amount they drink or stop drinking completely. For Tanya withdrawal symptoms include anxiety, insomnia, and depression. Other common symptoms include nausea, headache, and tremor. When alcohol or sedative hypnotics are used over a longer period of time or in larger amounts, withdrawal symptoms are worse and include vomiting, fever, and increased blood pressure. In severe cases, people can experience seizures or a life threatening illness called delirium tremens, or the DTs.

DETOXIFICATION

During *detoxification*, medications and medical monitoring can be used to reduce the severity of symptoms and maintain safety while a person is experiencing withdrawal from a substance. Because of the serious nature of withdrawal in people who have been using large amounts of alcohol or sedative hypnotics, medical supervision during withdrawal is important, and can be provided while a person is in a hospital or as an outpatient. Medications can prevent symptoms, seizures, and DTs.

LONGER-TERM
EFFECTS OF
ALCOHOL

Heavy use of alcohol over time can cause a variety of difficulties over the long term, including the alcohol dependence syndrome described above as well as other physical, medical, psychological, and functional problems. Remember that people with a psychiatric illness are more likely to develop an alcohol use disorder than people who do not have a psychiatric disorder, and that they may develop alcohol abuse or dependence with a relatively small amount of intake or after using over a shorter period of time. Simply put, having a mental illness makes people more vulnerable to the adverse effects of alcohol.

Medical problems: Numerous medical problems can result from drinking. Every organ in the body is susceptible to illness from alcohol. Problems range from cirrhosis (scarring and inability to function) of the liver, dementia (loss of ability to remember and solve problems), neuropathy (pain and burning in the arms and legs due to nerve damage), and cancer. Alcohol use increases blood pressure, which can worsen hypertension and put stress on the heart, leading to heart disease. Alcohol affects hormones in men and women, resulting in fertility problems. If a pregnant woman drinks regularly or occasional large amounts of alcohol, the fetus may develop fetal alcohol syndrome. Fetal alcohol syndrome includes mental retardation, developmental delays, and physical defects. Women are more vulnerable to the effects of alcohol than men. As a general rule of use over time, medical problems develop in women after using more than one drink a day, whereas for men medical problems develop after drinking four or more drinks a day.

Another common problem related to alcohol use is insomnia. Tanya began using alcohol to relax and help with asleep. In the short term, alcohol helps people to fall asleep, but it quickly disturbs sleep and causes awakenings later in the night. In the long term, alcohol interrupts normal sleep, as it did with Tanya.

Mental illness: Alcohol is a central nervous system depressant, and long-term alcohol use can produce depression or worsen the symptoms of an independent mental illness, especially mood problems such as depression and anxiety. Alcohol abuse and dependence are intertwined with mood in several ways. First, long-term, regular drinking in moderate to large amounts causes most people to feel depressed or anxious, to lose their appetite, to have body aches and pains, and to feel despair. Between 10 and 20% of persons with alcoholism commit suicide, usually when they are drinking. Second, abusing alcohol contributes to other problems that cause stress, such as Tanya's interpersonal problems with her daughter and her legal problems from the drinking while driving. Tanya's story is typical of someone with mood and alcohol problems. Alcohol provides a brief escape from feeling bad, but ultimately makes everything worse.

Tanya's other symptom problem is anxiety. Alcohol can reduce anxiety in the short-term, but as the effect of alcohol wears off, anxiety can get worse. Anxiety problems are common in people who have alcohol problems, but in the end alcohol usually worsens the anxiety as it did for Tanya.

Whether alcohol causes symptoms of psychosis is unclear, though people with psychotic disorders often appear more symptomatic over time when they are drinking, probably due to disinhibition and not taking antipsychotic medications.

Functional problems: Tanya’s drinking has resulted in social and interpersonal problems, such as difficulties with her husband which led to divorce, and now difficulties with her daughter. She has experienced dangerous behavior and legal problems, indicated by a charge for driving while intoxicated. She has also had difficulty working. People with alcohol abuse and dependence typically experience social and vocational problems. For people with severe mental illness, alcohol abuse typically leads to loss of familial supports and social isolation, behavioral problems, inability to work, inability to make use of treatment, difficulties managing money, unstable housing and many other problems.

SUBSTANCE
ABUSE,
MENTAL
ILLNESS, OR
DUAL
DISORDERS?

It is often difficult to figure out whether alcohol abuse causes depression and anxiety or whether these symptoms are due to a separate and distinct co-occurring disorder. Are Tanya's depression and anxiety problems truly independent of her drinking, or might they just be the consequence of heavy drinking? If the symptoms are caused by drinking, they should go away within one month of becoming abstinent (no alcohol or other substances at all). Clinicians should look for periods of abstinence in the client’s life and ask the client whether depressive or anxiety symptoms were present during that time. Including family or supports in the assessment can help you get an accurate history. They may be able to remember a client’s symptoms and level of function during periods of sobriety better than the client can. Tanya’s year-long period of abstinence is incredibly valuable information. It was during this period that she experienced a post-partum depression, strongly suggesting that her depressive illness is distinct from her alcohol dependence.

Often the available information is insufficient to tell whether a mental illness is primary or secondary. In this case, we suggest that you assume that both the mental illness and substance abuse are important, and go ahead with assessment and treatment of both disorders in an integrated fashion. You may learn more information over time that suggests that the symptoms of mental illness are caused by substance abuse, and the diagnoses and treatment can be changed.

FAMILY
HISTORY

Both alcoholism and depression have genetic components, meaning that these illnesses run in families and that a person’s genetic make-up contributes to each of these illnesses. Neither mental illnesses nor substance use disorders are due to a “character defect.” Alcoholism seems to run in Tanya’s family; her father is a recovering alcoholic and her daughter has started to abuse alcohol. Children of alcoholics are four-times-more likely to develop alcohol use disorder. Children of parents who have depression are also more likely to develop a mood disorder.

Finding out whether family members have had substance abuse or mental illness is important to help you understand a client’s disorder. If there is a strong family history of mood problems, then the client is at risk for having

a mood problem. If there is a strong family history of alcohol problems, the client is at risk for having an alcohol problem. Some families have both problems in multiple family members. Because of Tanya's family's problems, the clinician should talk with her about why her family members are vulnerable to develop substance abuse and mood disorders and how to prevent these problems.

SHOULD
PEOPLE WITH
ALCOHOL
PROBLEMS
TAKE
SEDATIVE-
HYPNOTIC
MEDICATIONS?

This vignette raises several interesting issues about treatment, but most of these are covered in later chapters. We address medications in relation to alcohol use disorder here.

People with alcohol and anxiety problems, like Tanya, are often prescribed sedative-hypnotic medications (such as the benzodiazepine, clonazepam) for their anxiety. Use of these kinds of medications may make the alcohol problem worse and lead to abuse, however, because they have a similar effect on the brain as alcohol (they are "cross reactive").

Benzodiazepines, in particular, tend to be overused and abused in the same way as alcohol. Once a person is taking a sedative-hypnotic medication regularly, he or she may have a hard time stopping it because they experience increased anxiety and withdrawal symptoms when they do. This happened to Tanya, who had a hard time stopping the clonazepam. For some individuals with severe anxiety, the use of benzodiazepines might be necessary, but experts believe that antidepressant medications, which are very effective for treating anxiety, and behavioral treatments should be tried first.

MEDICATIONS
FOR PEOPLE
WITH ALCOHOL
ABUSE OR
DEPENDENCE

Other medications can be helpful when they are used in combination with integrated dual disorders treatment. Disulfiram (Antabuse), causes a very uncomfortable physical reaction if a person drinks while taking it.

Disulfiram is intended to help clients avoid taking a drink because they want to avoid the toxic reaction they will get to alcohol when they have disulfiram in their system. The medication provides a psychological barrier to drinking. Many clients will drink soon after starting disulfiram. Experiencing a disulfiram-alcohol reaction may help them avoid drinking in the future.

Disulfiram is most effective if it is monitored: someone should watch the client take the medication to be sure they actually take it. Practitioners or staff can observe clients take disulfiram on some days or family members can provide even more frequent supervision.

Naltrexone (Revia) is an opiate antagonist that blocks the effects of certain natural chemicals in the brain and thereby reduces craving for alcohol. Like disulfiram, naltrexone does not have abuse potential. Naltrexone helps to reduce craving for alcohol as clients are trying to reduce their alcohol use. There are no symptoms and no danger to clients if they use alcohol while taking naltrexone, so this medication is appropriate for

clients who are still drinking and have not yet developed a strong commitment to sobriety. Naltrexone also blocks the effects of opiate drugs like heroin and morphine. It can be used to treat people with opiate abuse or dependence.

Other medications are being studied for potential use to reduce drinking, but none are commonly used in persons with dual disorders as of 2002.

Recommended readings

There are many helpful books on alcohol and alcoholism. Loosening the Grip: A Handbook of Alcohol Information by Jean Kinney is a good place to start.

Cannabis

INTRODUCTION

Cannabis (also referred to as marijuana, pot, weed, herb, and hash) is a commonly used and abused substance throughout the U.S. and other countries. Many people feel relaxed and happy when using cannabis, though some experience anxiety or paranoia, and people with mental illness sometimes have severe psychotic reactions to the substance. This chapter presents a young man with schizoaffective disorder and cannabis dependence. The vignette and discussion illustrate some of the effects of cannabis on mental illness and some of the dilemmas that clinicians often face.

VIGNETTE

Corey is a 25-year-old man who has been diagnosed with schizoaffective disorder and cannabis dependence. He began smoking pot at the age of 15 with friends in high school. Corey says that marijuana always made him feel relaxed and comfortable.

At the age of 17, Corey experienced his first manic episode. He felt euphoric, powerful, and brilliant, without any need to sleep or eat. He described plans for a new fighter jet, which he was sure the US Air Force would buy to make him a famous millionaire. Corey was hospitalized during this episode, started on medication, and referred to the local community mental health center for follow-up treatment. Though he met a case manager and a psychiatrist, Corey wasn't convinced that he had a mental illness and didn't remember the symptoms he experienced while manic.

Since that first episode, Corey accepted prescriptions for medication, but did not take them regularly. He visited with his case manager every week and told her that he worried about people attempting to steal his plans for a new fighter jet. He continued to smoke marijuana daily and believed that he needed it to relax. He used to smoke with friends, but because he came to feel that they were out to get him, he smoked in his apartment by himself. Corey had several more hospitalizations for manic and psychotic symptoms. When his case manager suggested that there could be a connection between his use of marijuana, not taking medications, and ending up in the hospital, he disagreed and stated he would continue to smoke marijuana because "that is who I am."

Corey's functioning steadily deteriorated. After graduating from high school, Corey worked at a series of jobs that never lasted long, which he attributed to poor concentration and difficulty getting along with co-workers. He became isolated from family and friends. He was referred to a dual diagnosis assertive community treatment team.

For the first 2 years, team members used motivational interviewing techniques to get him interested in attending treatment and self help groups and to get him involved with a vocational specialist. He eventually chose to take medications regularly. He began holding a steady job at a book publishing company. He cut back on the frequency of his cannabis use and stated that he smoked pot occasionally on the weekends. He hadn't been hospitalized for over a year. He stopped bringing up the topic of fighter jets. After a total of 4 years with the team, he was still doing well. He graduated from the program and only saw a psychiatrist every 3 months.

BASIC
INFORMATION
ABOUT
CANNABIS

Cannabis is the most commonly abused illegal substance in most of North America. Produced from the leaves, stems, and flowering tops of the plant *Cannabis sativa*, cannabis is widely grown and distributed. It is available in several forms, which vary widely in strength. The most common form is dried plant parts. Hashish, or hash, is the resin from the female plant flowers, and is usually stronger than the dried plant form. Hashish oil, made by distilling the plant in chemicals, is even more potent. Street marijuana is considerably more potent than in past years because of current growing and harvesting techniques.

Cannabis can be smoked or eaten. The active chemical, THC, is absorbed into the bloodstream and affects the brain, resulting in its characteristic effects. The THC is absorbed from the blood into fat cells and then slowly released back into the blood so it is removed from the body over days to weeks. Thus, the typical high ends within hours, but THC remains in the bloodstream at lower levels for a long time.

CANNABIS
INTOXICATION
AND SHORT-
TERM EFFECTS
ON MENTAL
ILLNESS

Acute cannabis intoxication causes increased appetite, reduced motor performance (as in driving a car); reduced attention, concentration and memory; visual distortions and decreased recognition of visual stimuli; and a sense of time distortion. People who use cannabis report that it makes them feel anxious or paranoid, or conversely, happy, relaxed, and sleepy. High doses of the drug usually lead to paranoia and anxiety. The acute effects last approximately 3-4 hours.

Persons with mental illness who are intoxicated with cannabis may appear more paranoid or calm. They are often less able to participate in treatment or other activities due to reductions of attention and concentration. Cannabis use, even in small amounts, can precipitate acute psychotic episodes, which often require hospitalization and sometimes do not resolve quickly or easily. Because of cannabis users'

perception that cannabis is calming and sleep-inducing, however, they are often unable to recognize the adverse effects of cannabis.

TOLERANCE
AND
WITHDRAWAL

There is some evidence that regular, heavy cannabis use produces *tolerance, physiological dependence, and withdrawal symptoms*. These have been somewhat controversial, in part because these effects can be less severe than those of other drugs and because cannabis is removed from the body slowly. After a regular user stops taking cannabis, the body takes about a month to remove all the cannabis. If a person does experience withdrawal symptoms, they typically include insomnia, anxiety, and irritability, as well as thoughts and dreams about cannabis use.

DETOXIFICATION
FROM
CANNABIS

Destabilization of the mental illness can occur during withdrawal from heavy cannabis use, though symptoms of withdrawal from cannabis are usually mild and not dangerous. Medical treatment is not necessary, but monitoring of mental illness and support for avoiding substance use are important.

LONG-TERM
EFFECTS

Long-term cannabis use has negative effects on health. Cannabis smoke contains more tar and cancer-causing chemicals than tobacco smoke. Cannabis use is associated with lung damage and cancer. Cannabis is also linked with impaired immune function, heart problems, and changes in reproductive hormones.

Of great concern is the long-term effect of cannabis on mental illness. The vignette illustrates how long-term cannabis use in individuals with dual disorders is associated with poor outcomes (relapses, hospitalizations, declining functioning, and a lack of progress towards life goals). Corey's symptoms of mental illness have gradually worsened over time as he used cannabis heavily and refused mental health treatment. Heavy cannabis abuse impairs cognition (reducing attention, concentration, and memory), which impacts functioning at work, home, or school. Though Corey was interested in engineering and did well in school when he was young, he lost interest in pursuing education or work. The loss of interest and motivation may have been due to the cannabis, his mental illness, or, more likely, the combination.

MENTAL
ILLNESS,
SUBSTANCE
USE
DISORDER, OR
BOTH?

Clients and families often notice that mental illness symptoms start when a person is using substances and they wonder whether substance abuse caused the mental disorder. Current research suggests that substance abuse does not cause severe mental illnesses like schizophrenia and bipolar disorder, but may precipitate episodes of illness in those who are vulnerable. Substance abuse can cause psychiatric symptoms during intoxication and withdrawal, but they typically go away when the person stops using. For people with severe mental illness, substance abuse is considered a biological stress that can precipitate mental illness. The symptoms continue, because the individual was already predisposed to

having the mental illness by their biological make-up. Mental illness symptoms that have been present for months or years rarely resolve without treatment when substance abuse stops.

Recommended reading

The following article describes the psychiatric effects of cannabis use. Psychiatric Effects of Cannabis, Andrew Johns. *British Journal of Psychiatry*, 178,116-122, 2001.

Stimulants

INTRODUCTION

Cocaine, amphetamines, and other central nervous system stimulants increase alertness, enhance energy, decrease appetite, and induce a feeling of well-being or euphoria, but can be extremely addictive and lead to negative outcomes. In this chapter, the vignette of a young man who becomes dependent on cocaine illustrates a typical story of how stimulant abuse can affect the course of mental illness and treatment.

VIGNETTE

Jose is a 25-year-old Puerto Rican-American man who lives at home with his parents, younger sisters, and aunt. He speaks fluent English, but communicates in Spanish with family and friends. He was diagnosed with schizoaffective disorder, depressed type, and cocaine dependence when he was an 18 year old high school senior. At that time, after drinking alcohol and smoking crack cocaine, Jose became extremely depressed and heard voices telling him to kill himself. He was involuntarily hospitalized for a month and, when released, dropped out of school.

Jose was referred to the local mental health center, where he was assessed and assigned a case manager, who was Caucasian and did not speak Spanish. Jose was also referred to a substance abuse group, which he did not attend. He thought his case manager was OK “for a white guy” but made it clear that playing basketball and hanging out with his friends in the park was more important than going to the mental health center. He said that cocaine helped with his depression, and he didn’t see his use as a problem.

With his case manager’s help, Jose obtained disability income. He used his disability checks and also money he borrowed from his family to buy cocaine. His drug use created turmoil in the family. Jose spent most of his time in the park, smoking crack with his friends, or drinking in a bar down the street from his parents’ apartment.

Constant auditory hallucinations and periodic depressions resulted in several hospitalizations. Jose’s parents wanted him to return home to live with them when he left the hospital. They were sure that if they could stop him from using drugs that everything would be all right. Jose’s father drank heavily, and he argued with Jose about cocaine use but not about his drinking.

Jose's case manager and psychiatrist were so worried about his illness and substance abuse that they pursued a representative payee. The payee made sure his money from the disability checks was spent on appropriate items and not available for cocaine, and Jose's cocaine use decreased. He wanted more money, however, and began to sell cocaine in the alley next to his favorite bar, which led to an arrest and three months in jail.

The assertive community treatment team worked with Jose using engagement techniques, motivational interviewing, skills training, monitored medication, and family interventions over the next five years. He was finally able to give up cocaine use. He met sober friends through a cousin and worked part-time for his uncle. His mother helps him with medications daily.

BASIC
INFORMATION
ABOUT
STIMULANTS

Clinicians need to know basic information about stimulants, of which there are many types, including cocaine, amphetamines and other medications. Cocaine is a frequently abused street drug, especially in urban areas. It comes in various forms that are smoked, inhaled, and injected. Cocaine powder can be snorted or mixed with water and injected. When mixed with water and sodium bicarbonate, it becomes a solid "rock" that is smoked as "crack." The high is brief, lasting minutes to hours.

A variety of *amphetamines* (including methamphetamine) are also widely available. Amphetamines are usually taken orally or intravenously but can also be snorted or smoked. The amphetamine high lasts 12-24 hours. Other stimulants include *prescribed and over-the-counter medications* such as methylphenidate, a medication for attention deficit disorder; dexadrine, used for weight loss; and ephedrine, a component in many cold remedies. When these medications are used in higher amounts than recommended, they can have effects similar to cocaine and amphetamines. Caffeine is also a stimulant, and if used in very large amounts, can have similar effects.

INTOXICATION
AND SHORT-
TERM EFFECTS
ON MENTAL
ILLNESS

In small doses, stimulants increase alertness, enhance energy, suppress appetite, and induce a feeling of well-being or euphoria. The high wears off rapidly, however, and often leads to a cycle of depression and repeated use that goes on for many hours. *At higher doses, symptoms of stimulant intoxication occur*, including euphoria, hyperawareness, hypersexuality, hypervigilance, agitation, and sleeplessness. Thoughts typically race and speech becomes pressured. Anxiety, irritability, and psychosis can also occur. With very high doses, confusion and disorientation can occur, as well as seizures, strokes, and heart attacks. Inhalation and intravenous use are more likely to cause dangerous reactions, such as sudden death due to cardiac arrhythmias.

Even brief or occasional use of stimulants for a person with severe mental illness because use can induce or worsen psychiatric symptoms or precipitate major relapses. Episodes of mania or psychosis often are

initiated by stimulant use, and depression is exacerbated by the cycle of stimulant use.

STIMULANT
TOLERANCE
AND
WITHDRAWAL

The rapid onset of euphoria followed quickly by loss of action of stimulants in general and cocaine in particular make them highly addictive. Individuals often use the drug repeatedly to sustain the highs and avoid the lows. Repeated use produces *tolerance*, or diminished effects of the drug, and is followed by the use of larger amounts. This pattern can lead rapidly to addiction. While alcohol use typically transitions into addiction over years, people typically become addicted to cocaine within weeks or months.

When an individual stops heavy use of stimulants, *withdrawal* commonly ensues. Withdrawal from stimulants occurs in three phases: The first phase is a “crash” with feelings of depression, agitation and intense craving. Within days, the individual experiences fatigue, low energy and decreased interest. Weeks to months later, in the third phase, the individual may experience episodic intense craving.

LONG-TERM
EFFECTS

Addiction, by definition, involves increasing preoccupation with drug procurement and use. Long term addiction often leads to criminal behavior to obtain money for drugs, and potentially to involvement with the criminal justice system. The euphoria of stimulants also results in unsafe sexual behaviors.

Over the long term, repeated use and the development of tolerance predispose the user to more potent routes of administration, such as intravenous use (IV or injection), which dramatically increase the risk of blood-borne infections such as hepatitis and HIV. The viruses that cause hepatitis and AIDs are spread through contact with infected blood and sex fluids, which can occur when sharing a straw through which drugs are snorted, by sharing injection equipment, and by having unprotected sex. Providing clients with information about infectious diseases is extremely important (See Chapter 15).

Chronic abuse of stimulants is generally disastrous for persons with severe mental illness because it can produce or worsen most psychiatric symptoms. In the vignette above, Jose's paranoia, ideas of reference, depression, and suicidal thoughts have been intertwined since adolescence. Though he is unable to observe it, his team observes that his mental illness symptoms are less severe during periods of sobriety than during periods of active substance use. Even intermittent or moderate stimulant use can worsen symptoms of the mental illness.

POLYSUBSTANCE
ABUSE

Polysubstance abuse refers to abuse of three or more substances in the same time frame. It is associated with antisocial personality characteristics, poor functioning, and a strong family history of substance

abuse. Of the 50% of persons with severe mental illness who also have a substance use disorder, almost half abuse alcohol and other drugs together, and about one fourth abuse multiple drugs.

Demographically, cocaine users tend to be young, male, and dependent on multiple substances. Cocaine is commonly used with sedating substances including alcohol, opioids, cannabis, and sedative-hypnotic medications. People may use the sedating substances to manage agitation or withdrawal symptoms.

People who abuse substances often develop a “drug of choice,” the substance that they prefer to use when they have the option. However, people who use one substance usually have tried and used others, and they may develop new addictions over time.

TREATMENT
ISSUES

This chapter alludes to several effective techniques of treatment, like engagement, motivational interviewing, and family psychoeducation, which are discussed in subsequent chapters. Below we will discuss several salient aspects of this vignette, including the use of a payee and incarceration.

Jose initially did not believe that treatment could help him. Because his substance use was so destructive, his team pursued a *representative payee*. A judge agreed that Jose was unable to take care of his finances by himself and assigned a payee. Note that to a large degree this is a legal rather than a clinical issue. The law specifies that a person who is unable to manage his or her disability funds, for example someone who uses the money for drugs rather than food and housing, cannot receive disability payments directly, and the court must decide on who can be an appropriate payee.

When his access to money was limited by the payeeship, Jose reduced his drug use. However, he began to sell drugs and ended up in jail. Jose's team wanted to support his sobriety by managing his money and reducing his access to cocaine and alcohol, which seemed to help in the short run, but not in the long run. The use of protective payees and other forms of involuntary treatments is controversial. Most teams prefer to persuade clients to use voluntary money management.

People with dual disorders, like Jose, are particularly prone to *arrest and incarceration* for drug-related behaviors. Incarceration is often a negative experience for people with severe mental illness, who often receive inadequate treatment while incarcerated. Mental health providers should develop a relationship with court officers in order to divert people away from incarceration and into treatment, and with prison treatment providers to advocate for clients who are incarcerated. Efforts to divert people from jail often include court-ordered participation in treatment that might

improve motivation for treatment and promote behavioral change. The close monitoring resulting from probation and court ordered treatment often improve motivation for accepting help.

Another interesting aspect of this vignette is Jose's Hispanic background. Many clients would like to work with a clinician who is from the same culture as they are. Often, this is simply impossible. It is critical, however, that clinicians make an effort to understand the culture in which any client lives and to use this information to inform their efforts. Interpreters may be necessary to communicate with clients who do not speak English, and special training can be helpful to make the best use of an interpreter.

Clients' culture, race, gender, sexual orientation, age cohort, family, and social network are important parts of their identities. Clinicians can be most effective if they understand what these issues are like for each client. In Jose's case, for example, understanding how he experiences his Hispanic heritage, his friendships, and his family are essential to helping him find a path to recovery.

Recommended reading

There are many good books on stimulant abuse. A short, readable, and scientifically accurate introduction that we like is Cocaine by Roger Weiss and Steven Mirin (Washington, DC, American Psychiatric Press, 1987).

Opiates and Opioids

INTRODUCTION

The term opiate refers to morphine and codeine (which occur naturally in opium from some types of poppy plants). Similar synthetic drugs are called opioids. Some of these substances are prescribed by doctors to treat pain. Others, such as heroin, are manufactured illegally for non-medical use. These substances affect many parts of the body and can be lethal when people accidentally overdose. This chapter describes a person who became addicted to heroin. The related discussion addresses basic facts about opiates and related drugs and their effects on the body during intoxication, withdrawal, and dependence, as well as the effects on persons with severe mental illness. One specific aspect of treatment, opioid agonist therapy, is briefly described.

VIGNETTE

Jane is a 35-year-old divorced, unemployed woman with schizophrenia and polysubstance abuse. At age 18, Jane entered mental health treatment because she believed that people on the TV were talking to her and commanding her to do things like shop lift or hurt herself. She was already abusing alcohol, marijuana, and nicotine when she entered treatment.

Jane completed high school and worked as an office cleaner until she was 20. During her first two years in treatment, she was hospitalized three times. She married a man whom she met during her third hospitalization and had her oldest child, Jennifer, with him. Jennifer is now 16 and living in foster care. During and following the pregnancy, Jane was abstinent, attended all her medication evaluations, and became an active member of a relapse prevention group.

Jane's marriage ended in divorce when she was 22. She and her daughter moved back to her parent's house. Following a car accident and surgery, Jane was prescribed narcotic pain medications, which she found herself using more and more. She soon stopped mental health treatment and renewed smoking marijuana and drinking alcohol with her old friends. A new boyfriend introduced her to heroin, which she began using regularly. Gradually, her paranoia and delusions returned. She became alternately angry and aggressive or withdrawn and paranoid. Her parents, who regularly participated in an AL-ANON support group, asked her to leave and took custody of her daughter.

Jane moved in with drug-using friends, began to shoplift and trade sex for drugs. Her friends left town, her boyfriend disappeared, and she began staying with strangers and occasionally living on the streets. She was kicked out of the homeless shelter because she threatened staff. She was later arrested for drug possession and prostitution many times, and referred by police back to the clinic for treatment at the age of 33.

Though Jane said she did not want treatment, she was referred to an assertive community treatment team. For several months, team members met with her and befriended her while she was living on the streets. They helped her get clothes and food. During this time, Jane became worried that she was pregnant again, so her case manager helped her with a doctor's appointment. When she learned that she was pregnant and also that she had HIV, Jane became very delusional and was hospitalized involuntarily. In the hospital, she began taking medications for the HIV and for her mental illness. After several months in the hospital, Jane became less paranoid and more organized in her thinking. She was concerned about her baby and agreed to move into a transitional housing building that was associated with the mental health center. One of the terms of the housing was to remain substance-free. She agreed to stop using substances to comply with the rules, but also because she did not want to hurt the baby.

Jane worked intensively with the team over the next two years. Her mother became involved with her treatment as well. Jane and her mother decided that the baby should live with her parents while she lived in supported housing. She participated in treatment in the mornings and cared for her baby in the afternoons. Her mother helped her remember her medications at dinnertime. Jane had difficulty with ongoing paranoia but was able to interact with her family appropriately. Her HIV was stable while she continued to take medications.

BASIC FACTS
ABOUT
OPIATES AND
OPIOIDS

The term opiate refers to morphine and codeine (which occur naturally in opium from some types of poppy plants). Similar synthetic drugs are called opioids. Some of these substances, such as morphine, codeine and oxycontin, are prescribed by doctors to treat pain. Others, such as heroin, are manufactured illegally for non-medical purposes. All of these types of drugs have wide-ranging effects on mood, motivation, pain, stress, breathing, and many other body functions. The human body naturally makes similar substances, called endorphins, which help people to tolerate pain, cope with stress, and experience pleasure.

These drugs are often prescribed and used for medical reasons such as pain control with minimal risk of addiction, but the risk is much greater when they are used for non-medical purposes without medical supervision. The tendency to become addicted is partly genetic and partly related to psychological, social, and environmental factors. When opiates and opioids are prescribed by a doctor, red flags for abuse include running out of medication before the prescription is over, demanding medications, and obtaining extra prescriptions from other doctors and emergency

rooms. People involved in abusing prescription medications may also buy them or sell them illegally.

INTOXICATION
AND SHORT-
TERM EFFECTS

Intoxication with an opiate often produces relief from anxiety, a pleasurable sensation such as a “rush” or “thrill,” and a longer-lasting relaxed, calm and soothing state, the “high.” When the drug is injected into the bloodstream, the effect occurs faster than if it is taken by mouth. Some opiates have a slower onset than others and are less likely to cause a “rush.”

When people use opiates, they typically appear calm and/or sleepy. Their pupils are constricted or small. They can be distracted and unable to participate in regular activities. When they come down from the high, they are often anxious, agitated, depressed, or sometimes in withdrawal (described in the next section).

Due to a combination of several factors, opiates and opioids can be extremely dangerous drugs. The purity of street drugs is highly variable. When these drugs are taken in large amounts or very pure varieties, they suppress the breathing center in the brain. Additionally, most people who use opiates or opioids also abuse other drugs at the same time. Because of these factors, accidental overdoses are common and can result in coma and death. Medications that block the effects of these drugs are used to treat people in emergency rooms to prevent the severe problems associated with overdose.

TOLERANCE
AND
WITHDRAWAL

People who use opiates regularly without medical supervision are highly prone to develop abuse or dependence because of the properties of these substances. As with other substances, dependence is defined by loss of control, increased substance use, giving up usual activities, and the development of *tolerance and withdrawal*. Symptoms of withdrawal from opiates and opioids include increased pain sensitivity, dysphoric mood, anxiety, muscle and bone aches, kicking movements caused by spinal reflex hyperactivity, dilated pupils, stomach cramps, diarrhea, yawning, sweating, and runny eyes. Once a person is using these drugs regularly, he or she will often continue to use to avoid the uncomfortable symptoms of withdrawal.

DETOXIFICATION

Because symptoms of withdrawal are so uncomfortable and craving is severe, *detoxification* from opiates can be very difficult. Medical treatments are often used to reduce the severity of symptoms during this process.

LONG-TERM
EFFECTS

Unlike alcohol, cannabis, and stimulants, opiates do not tend to destabilize mental illness immediately. *Opiate use is associated, however, with many long-term risks for people with mental illness.* The long-term effects of opiate or opioid abuse and dependence include behavioral problems and

health problems related to intravenous drug use. Behaviorally, opiate addicts typically reduce and abandon usual activities in order to focus on drug-seeking and drug-using behaviors, for example, seeking prescriptions from doctors, stealing or other illegal activity to get money to buy drugs, and dangerous sexual activity related to obtaining drugs. Common health problems include serious infections, such as HIV and hepatitis, which are discussed in Chapter 15.

As Jane's story illustrates, clients with severe mental illness need all of their resources to manage their mental illness, to meet basic needs, to maintain satisfying living conditions, and to function in normal adult roles, like worker, spouse, and parent. Substance abuse quickly puts them into catastrophic circumstances. As Jane did, they often lose interest in taking care of themselves and abandon self-management, taking medications, and other therapeutic activities. They thus experience a recurrence of mental illness symptoms, which may be worsened by the direct effects of the substance they are using.

Clients with severe mental illness are more vulnerable to having problems when they use substances than people who do not have a mental illness. Jane does reasonably well when she is not using substances, but when she uses, she completely loses her ability to take care of herself, to manage her illness, to function in normal roles, and even to avoid life-threatening situations and illnesses. In short, her life becomes a disaster.

O P I O I D
A G O N I S T
T H E R A P Y

Integrated dual disorder treatment is discussed in subsequent chapters, but we present here one aspect of treatment that is unique for opiate and opioid addiction. *Opioid agonist therapy* (previously called methadone maintenance) refers to standard and well supported treatments for persons with chronic addiction to heroin or other opiates. In this treatment, a medication is prescribed in a regular dose that prevents withdrawal symptoms and improves outcomes. The medication is dispensed by health professionals in treatment facilities certified by the Substance Abuse and Mental Health Services Administration. All states are developing a process to license and regulate opioid agonist therapy. For more information, you can access the SAMHSA website at www.dpt.samhsa.gov or contact your local state substance abuse agency.

Opioid agonist therapy uses medications that attach to the same chemical receptors in the body as heroin and opioid and opiate pain medications. Methadone has been in use for many years, and two other medications, buprenorphine and L-Alpha-Acetylmethalol (LAAM), are more recent alternatives to methadone. Buprenorphine may be less likely to be abused, but was not approved for use as of 2002. LAAM is longer acting, so clients only take it three times a week, as opposed to methadone, which is taken daily.

Opioid agonist therapy reduces illegal drug use and dangerous activities to obtain drugs, such as stealing and prostitution, and also reduces the risk of serious medical problems associated with intravenous drug use (HIV and hepatitis). When opioid agonist therapy is used with counseling, case management, or other social services, clients experience improvements in housing, relationships, and work. Though it has been extensively studied in persons with opiate use disorders, opioid agonist therapy hasn't been studied in persons with severe mental illness and is rarely used for this group.

Literature

To learn more about opiate addiction, you can consult one of the basic textbooks, such as Introduction to Addictive Behaviors, by D.L. Thombs (NY: Guilford, 1999).

Stages of Treatment

INTRODUCTION

For many people with a substance use disorder, it takes many attempts over time to achieve stable remission or abstinence, but most do attain recovery. The vignettes throughout this workbook reflect this expected process of change, which occurs in stages. This chapter describes how integrated dual diagnosis treatment supports the stage-wise process of recovery. It is critical to understand that at different stages of the change process, different types of treatment are helpful. Subsequent chapters in this workbook will give more details about how to help people in each stage of treatment.

HOW CHANGE OCCURS

Change is a process that does not happen quickly or easily. Think about the last big change you made in your own behavior, such as getting on an exercise plan, changing how you interact with others in relationships, or losing weight. Cigarette smoking is a good example, since tobacco smoking is a common addictive problem that many people try to change. If you were a smoker (or have a friend who was), how long did you smoke before you considered that it could be a problem for you? From that point, how long did it take you to decide that smoking was indeed a problem, and that you should stop? This process may take years. From that point, how long did it take to develop a plan and how long before you actually tried to stop? This part of the process may take weeks or months. If you were able to stop, how many times did you have to try before you succeeded? Once you stopped, what did you do to try to keep from smoking again? Most people relapse. Did you ever go back to smoking? Did you go then go through the same process all over again? Perhaps you can see why people go through steps and take a long time to give up smoking, or other substance use.

As people recover from a substance use disorder, they go through a step-by-step process that can be described in stages. Initially, in the pre-contemplation stage, people often do not recognize that their substance use is a problem, even when many of their family and friends do, and so they are not yet considering a need to change. As people become aware that the substance use is a potential problem, they enter the contemplation stage, during which they consider the behavior and the possibility of changing. Once a person makes the decision to change,

they enter the preparation stage, where they get committed to change and develop a plan to cut down or stop using substances and develop a plan to do so. In the action stage, they attempt to change by using their plan, and this may occur many times before they are successful. Subsequently, they use strategies to maintain abstinence during the maintenance stage.

Table 1. Stages of Change

- ☞☞ Precontemplation
- ☞☞ Contemplation
- ☞☞ Preparation
- ☞☞ Action
- ☞☞ Maintenance

STAGES OF TREATMENT

The stages of change described above refer to an internal process, which is often difficult to see or measure accurately from the outside as a treatment provider. However, as people go through the process of changing substance use, they tend to interact with the treatment system in characteristic ways and to use different interventions in the process. For example, what is helpful before they consider their behavior a problem is different from what is helpful when they are actually ready to stop using or after they have stopped and are trying to maintain the change. *Stages of treatment therefore refer to the stage-specific behaviors and treatments that have been found to help people with dual disorders in the recovery process.* These stages are easily assessed by treatment providers because they describe how people interact with treatment in terms of directly observable behaviors. As persons with dual disorders participate in treatment, they typically go through the different stages of treatment listed in Table 2, described below and in the Stages of Treatment Form at the end of the chapter.

Table 2. Stages of Change and Treatment

- ☞☞Precontemplation - Engagement
- ☞☞Contemplation and Preparation - Persuasion
- ☞☞Action - Active treatment
- ☞☞Maintenance - Relapse prevention

ENGAGEMENT

Engagement is the stage when the client has no relationship with a treatment provider. The client typically does not consider substance use

or mental illness symptoms a problem. The clinician's job is to help the client get engaged in treatment. They engage the client by providing helpful outreach and practical assistance to help the client face immediate challenges, such as health problems, financial problems, and so on. Clinicians develop a working-together relationship with the client during this phase by providing help and by using good listening skills and motivational interviewing techniques (see later chapters). Clinicians do not confront clients about their substance use during this stage, though they do try to complete a basic assessment of the substance use. As regular contact with the clinician occurs, the client may progress to the persuasion stage.

VIGNETTE

Corey (Chapter 2) had symptoms of mania and psychosis. He enjoyed smoking cannabis every day, believing it helped him relax. To Corey, smoking pot was an important part of his lifestyle. Despite being hospitalized, he did not feel he had a mental illness, nor did he feel his use of cannabis was a problem in any way. Early in his treatment, he was in the engagement stage.

PERSUASION

As the working relationship develops, if the client does not perceive, acknowledge, or understand his or her substance use or mental illness symptoms, the client is in the *persuasion* stage. The clinical task is to help the client think about the role of substance use in his or her life. Active listening, exploratory questions about experiences and goals, and education are common techniques. These techniques, often called motivational interviewing, are designed to help the client think about life goals, substance use, mental illness symptoms, and whether substance use or symptoms get in the way of achieving life goals. During this stage, a detailed functional assessment of substance use can be completed (see the next chapter on assessment). Skills for motivational counseling and functional assessment are described in later chapters. During this and later stages, it is often helpful to meet with family members to provide education, get input and include the family in treatment.

VIGNETTE

Tanya (Chapter 1) presents with concerns about depression, rather than drinking, though she has problems with her children, with anxiety, and later with the law that are related to alcohol. With brief counseling, she decides that drinking may be causing problems for her and that she is willing to try cutting back. She comes to treatment in the persuasion stage, and moves rapidly into the active treatment stage.

ACTIVE
TREATMENT

Once the client recognizes that substance use is a problem and decides to reduce or stop his use altogether, the client is in the *active treatment* stage and the goal is to acquire additional skills and supports. For example, the client may need skills to avoid substances (such as assertiveness skills), to socialize without substances (social skills), and to manage feelings without substances (stress management techniques). Similarly, he or she may need new friends, a better relationship with family, and a support

group like Alcoholics Anonymous or Dual Recovery Anonymous. Helping the client to learn skills and find supports is called *active treatment*.

VIGNETTE

Jane (Chapter 4) had paranoia and polysubstance dependence on heroin, alcohol, and cannabis. She had been clean and sober while in treatment 16 years ago, but then relapsed into many years of severe illness and substance dependence. When she was hospitalized at age 33, she became clean and sober again. She moved into transitional housing. She was trying to stay away from substances so she could be involved in parenting her new baby and so she could stay in transitional housing. After going through all the stages of treatment 16 years ago and then relapsing into the engagement stage, where she stayed for many years, she is now back in the active treatment stage.

RELAPSE
PREVENTION

When the client is in stable remission (at least six months without substance abuse), the task is to avoid relapsing back into problematic substance use. The clinician can help with a relapse prevention plan, which examines triggers to use substances, such as feelings, people, or situations, and specifies new ways to avoid or handle these cues. Another common task during *relapse prevention* is to facilitate further recovery by, for example, developing other healthful behaviors and pleasurable activities.

VIGNETTE

Mark (Chapter 12) has schizophrenia and alcohol dependence. After 3 and 1/2 years of treatment, he is sober. He is attending church, building a new relationship with his sister, and considering getting a different job. With his case manager, he spends time planning how to avoid drinking again by avoiding his old drinking buddies, strengthening new sober relationships, and by keeping busy with meaningful activities. He is in the relapse prevention stage.

PROGRESS
THROUGH
STAGES OF
TREATMENT

Most people move through each stage while making progress towards recovery. Some people move steadily, others move in fits and starts, some move very slowly. People often relapse and move backwards and then forwards again. The important point for you to understand is that when people receive integrated dual diagnosis treatment, the treatment needs to correspond to the stage of treatment. In other words, it does little good to work on active treatment skills if the client is not acknowledging a problem with substance abuse. It makes much more sense at that stage to engage the client in a helping relationship and to use motivational counseling to explore the client's experience with substance use.

Table 7. The Substance Abuse Treatment Scale

Instructions: This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. The reporting interval is the last 6 months. If the person is in an institution, the reporting interval is the time period prior to institutionalization.

1. Pre-engagement. The person does not have contact with a case manager, mental health counselor or substance abuse counselor, and meets criteria for substance abuse or dependence.
2. Engagement. The client has had only irregular contact with an assigned case manager or counselor, and meets criteria for substance abuse or dependence.
3. Early Persuasion. The client has regular contacts with a case manager or counselor, continues to use the same amount of substances or has reduced substance use for less than 2 weeks, and meets criteria for substance abuse or dependence.
4. Late Persuasion. The client has regular contacts with a case manager or counselor, shows evidence of reduction in use for the past 2-4 weeks (fewer substances, smaller quantities, or both), but still meets criteria for substance abuse or dependence.
5. Early Active Treatment. The client is engaged in treatment and has reduced substance use for more than the past month, but still meets criteria for substance abuse or dependence during this period of reduction.
6. Late Active Treatment. The person is engaged in treatment and has not met criteria for substance abuse or dependence for the past 1-5 months.
7. Relapse Prevention. The client is engaged in treatment and has not met criteria for substance abuse or dependence for the past 6-12 months.
8. In Remission or Recovery. The client has not met criteria for substance abuse or dependence for more than the past year.

Recommended Reading

There are many good books on stages of change and recovery from substance abuse. We think the best place to start is Motivational Interviewing: Preparing People to Change Addictive Behavior by William R. Miller and Stephen Rollnick (Guilford, 1992). Another helpful reference is Health Behavior Change: A Guide for Practitioners by Stephen Rollnick and others (Churchill Livingstone, 1999).

To read more about stages of treatment for persons with dual disorders, see A Scale for Assessing the State of Substance Abuse Treatment in Persons with Severe Mental Illness by Greg McHugo and others (Journal of Nervous and Mental Disease, 183, 763, 1995.)

Assessment

INTRODUCTION

Half of all people with severe mental illness also have a substance use disorder sometime in their life. Those with dual disorders tend to have more problems with symptoms and with just about every area of their lives. Integrated dual disorders treatment can help clients work toward recovery and to improve their lives. As a clinician, you first have to identify those who have dual disorders and to understand both illnesses before you can provide treatment. This chapter begins with the story of a woman with bipolar disorder and substance abuse, and the following discussion addresses both how to assess substance abuse and what aspects to assess.

VIGNETTE

Marie is a 22-year-old single unemployed woman with bipolar disorder and polysubstance use disorder. She has had brief contacts with the mental health center following two hospitalizations for mania, but her story begins with a subsequent emergency room visit.

Picked up by the police for disturbing the peace, Marie was brought to the local emergency room for evaluation because she was talking about escaping from demons. On examination, she was dirty, agitated, and yelling as if there were someone else in the room. Although she smelled of alcohol, Marie refused to answer questions about alcohol or other drugs. Because she was clearly unable to care for herself, she was admitted to the hospital for further evaluation and treatment of psychosis and possible substance abuse.

The next day in the hospital, Marie was calmer and seemed more oriented to reality, though she continued to focus on her special relationship with God, who she felt would protect her from demons. Staff asked Marie again about her substance use and learned that she had been drinking alcohol since she was 13 years old and smoking pot since she was 15. Her urine screen on admission was positive for alcohol, cannabis, and cocaine. When shown the report of the urine screen, Marie said it must be a mistake. She reported drinking “a few” beers and smoking “a few” joints daily for the past six months, but denied using cocaine. She said she liked to get high with her boyfriend after work and then go to the bar and drink beer with him. She also said she couldn’t relax and sleep if she didn’t smoke pot, and that she was smoking more than she used to because she didn’t get

the same effect that she had before. She hadn't tried to cut down on alcohol or cannabis because she felt they hadn't caused her any problems.

Marie said she had been living at home with her parents and working part-time at a local record store until she stopped going to work two months ago. She hadn't really paid her parents for rent and there were disagreements about that. She felt that they had criticized her constantly and said they had threatened to kick her out of the house. Marie was vague about her activities over the past several months. With Marie's permission, the counselor called her parents, who verified the information Marie had given, and also told the counselor that Marie had had trouble with cocaine in the past and that in fact she had moved out of their house two months ago. They had feared she had been using drugs, and when they had confronted her about this, Marie had disappeared.

Marie spent six weeks in the hospital. Initially she refused to take medications, wandered the halls at night, and spent all day in bed. She remained preoccupied with God and wanted to end her life to join God in the fight against demons. Eventually she decided to try medication, and after three weeks, she became less focused on demons, no longer wished for death, and was getting out of bed for activities during the day.

When her boyfriend came to visit in the middle of Marie's hospitalization, the staff asked him if he had any particular concerns about Marie. He reported that they had both been on a cocaine binge for several weeks before Marie was picked up and that he had just gotten out of a detoxification program himself. Marie became angry and insisted that she had had nothing to do with cocaine.

DUAL
ASSESSMENT

Assessment and treatment of mental illness and substance abuse are often done separately, at different times, by different people, and in different agencies. This is a mistake because assessing and treating dual disorders separately is ineffective. All mental health assessments should include screening for the presence of possible co-morbid substance disorders (and vice versa). If the screen is positive, in-depth assessment of both disorders should proceed. The information about substance use and mental illness – and how they interact – is needed to develop an effective treatment plan (as described in the next chapter).

IDENTIFYING
SUBSTANCE
ABUSE

This vignette illustrates four key principles for gathering information about substance use (see Table 1). First, because many clients with severe mental illness have substance use disorders, it is important to ask all clients about substances. This should be done in a matter-of-fact, non-judgmental way. Remember that a substance use disorder is another illness, not bad behavior. Don't forget to ask about over-the-counter and prescribed medications also, as these are often abused.

Second, it is also important to gather information from other sources in addition to the client. Like Marie, many people are reluctant to talk about

behaviors that they believe others disapprove of, such as drug use or other illegal activities. Marie denied cocaine use, but cocaine was in her urine drug screen, and her parents and boyfriend confirmed that she was a heavy cocaine user. To get accurate information, multiple sources, such as family, hospital records, and urine drug screens often help. If a client refuses to give a urine drug and alcohol screen, you should probably assume they are using substances.

Table 1: Identifying substance abuse

- ☞☞ Ask clients about substance use in a matter-of-fact way
- ☞☞ Get information from multiple sources
- ☞☞ Try to resolve discrepancies in information
- ☞☞ Continue the assessment over time

Third, if information gathered from other sources does not agree with what the client tells you, ask the client to help resolve the discrepancy in a non-threatening and matter-of-fact way. This does not always work (as it didn't with Marie) because clients are worried about being perceived negatively, and about legal or other negative consequences. Nevertheless, asking about substances demonstrates that the clinical team will address substance use in a straightforward way, without judgment and without punishment.

Fourth, because assessments completed soon after meeting a client or in the context of intoxication, withdrawal, or severe psychiatric symptoms are often inaccurate, it is important to continue to gather information over time. The client needs to be mentally stable and to feel safe in order to give accurate information. As the clinician or team gets to know a client and develops a trusting relationship, more information is often revealed about substance use. Thus, assessment is an on-going process that continues during treatment.

To screen for substance abuse in clients with severe mental illness, we recommend the Dartmouth Assessment of Lifestyle (DALI), which was developed for this purpose (see website <http://www.dartmouth.edu/~psychrc/alcohol.html>). The DALI is an 18-item questionnaire designed for persons with severe mental illness entering mental health treatment settings. A computerized version that clients can self-administer is available.

Although the clinician in the vignette gathered some information on substance use history, it was not structured and organized to permit an accurate psychiatric diagnosis, substance use diagnosis, stage of treatment assessment, and treatment plan. The best model for organizing historical data, called a *comprehensive longitudinal assessment*, involves collecting information on functional status, mental health, substance use, and interactions between mental illness and substance use in a time line. The time line moves from points in the past to the present, in a step-by-step way (see table 2). You choose the points that seem to make the most sense. At every point on the time line, there are four steps: (1) a description of functioning; (2) mental health symptoms, mental health treatment, and response to that treatment; (3) substance use symptoms, substance abuse treatment, and response to that treatment; and (4) interactions between mental illness, substance use, and treatment. Be sure to ask about points in time when the client was functioning well, possibly before substance use started, or during a period of sobriety. Periods of good function will help you to understand psychiatric symptoms when substance use is stable (and vice versa) and whether treatment has been successful. As in assessing substance use, this information may need to be filled in over time, from multiple sources.

Table 2: Characteristics of the comprehensive longitudinal assessment

- ☞☞ Describes functioning
- ☞☞ Mental illness and substance use information is integrated
- ☞☞ Information is obtained over the whole life of the client
- ☞☞ Focus on periods of different functioning

In the case of Marie, we would recommend starting with information regarding her last stable period. The vignette suggests that this occurred a few years ago when she was living with her parents and working at a record store before her substance use escalated. At that time, what medications was she taking, and how well were they helping her symptoms? What substances was she using then, and how did they affect her symptoms and her medication use? What treatment was she receiving for each disorder? Next, we would move forward in time, asking her questions to track how her symptoms progressed leading to her

ending her job, closely following the sequence of events right up to the present admission. We would ask questions about her functioning at work, at home, and in relationships to be sure we understood her functioning. This provides a longitudinal assessment that emphasizes functional status and begins to help the client to perceive more accurately the effects of substance use. Below is an example of what we might learn from Marie.

Figure 1. Comprehensive Longitudinal Assessment for Marie

Time	Functional Status	Mental Illness Sx/Treatment	Substance Abuse Sx/Treatment	Interactions
1991-93	?? Working ?? Abstinent boyfriend	?? Moderate depression ?? Not taking meds or attending other treatment	?? Weekly cannabis ?? No alcohol or other drugs ?? Attending AA	?? Depression cued cannabis use
Nov-Dec 1993	?? No work ?? Drug using boyfriend	?? Severe depression ?? Hospitalized twice ?? Not taking meds	?? Daily cannabis and alcohol ?? No treatment	?? Depression cued greater use ?? Substance use with boyfriend
Jan-March 1994	?? Homeless ?? Drug using boyfriend	?? No sleep, paranoid, hyperactive ?? Not taking meds	?? Daily cannabis and cocaine ?? No treatment	?? Severe symptoms and substance use
April-May 1994	?? Living in state hospital	?? Symptoms improving ?? Not taking meds	?? No substance use	?? Structure and sobriety reduces sleep problem and paranoia
May-June 1994	?? Living in state hospital	?? Depression, sleep and hyperactivity improves ?? Taking medication	?? No substance use ?? Attending persuasion groups	?? Structure, sobriety and meds reduce symptoms further

Another important part of the substance assessment is a detailed description of current use patterns, including factors that reinforce use (cause a person to continue to use) and consequences for continued use (which may be viewed positively or negatively by the client). This is called a *contextual assessment* (see table 3). Some clinicians have learned about a similar type of assessment, called a functional assessment. Because this type of assessment addresses the context of substance use, we call it the contextual assessment. You can get this information from clients by asking open-ended questions about when, where, and with whom substances are used. We try to identify the internal cues or triggers (e.g., anxiety about leaving the house or boredom) and external cues or triggers (e.g., friends smoking pot or smelling cigarette smoke) that lead to substance use. We do this by asking about feelings, thoughts, situations, and environments that precede craving or actual use of substances.

Table 3: Examples of questions to ask for the contextual assessment

1. When do you usually use alcohol?
2. Who do you usually drink with? Where?
3. What makes you think about wanting to have a drink?
4. What is it like when you drink? How do you feel? What do you do?
5. What do you enjoy about drinking?
6. What are the down sides to drinking for you?
7. What do other people think of your drinking?

The social pattern of use is particularly important to help us plan how to help a client stop using. Does the person use substances alone, in a small tight-knit group of friends, or in a large social network? Is the person involved with other substance users in high-risk or illegal activity (e.g. trading sex for drugs)? You also need to find out what the person expects from using the substance and how people around them respond when they use. For example, how does he or she feel after using? Does he believe that there are ways in which substance use helps him or her to feel better or cope with stress? What do his friends think of his substance use? His family? Are there positive or negative consequences to using?

The more details the team gathers, the more effective and specific the treatment plan can be. Marie said she found cannabis and alcohol

relaxing, and she needed to smoke cannabis to fall asleep. She did not mention any negatives to using, though the vignette suggests that her use of cocaine led to interpersonal problems, unemployment, and homelessness. Sometimes it is useful to have a client like Marie describe a recent day in her life in minute detail, so that you can experience what using substances is like for her and see the pros and cons as she sees them. Note that this approach does not imply that we accept the client's view as totally accurate, since we know that substance abuse and psychiatric symptoms can lead to misperceptions and rationalizations, but rather that we believe it is critical to understand the client's view of her world.

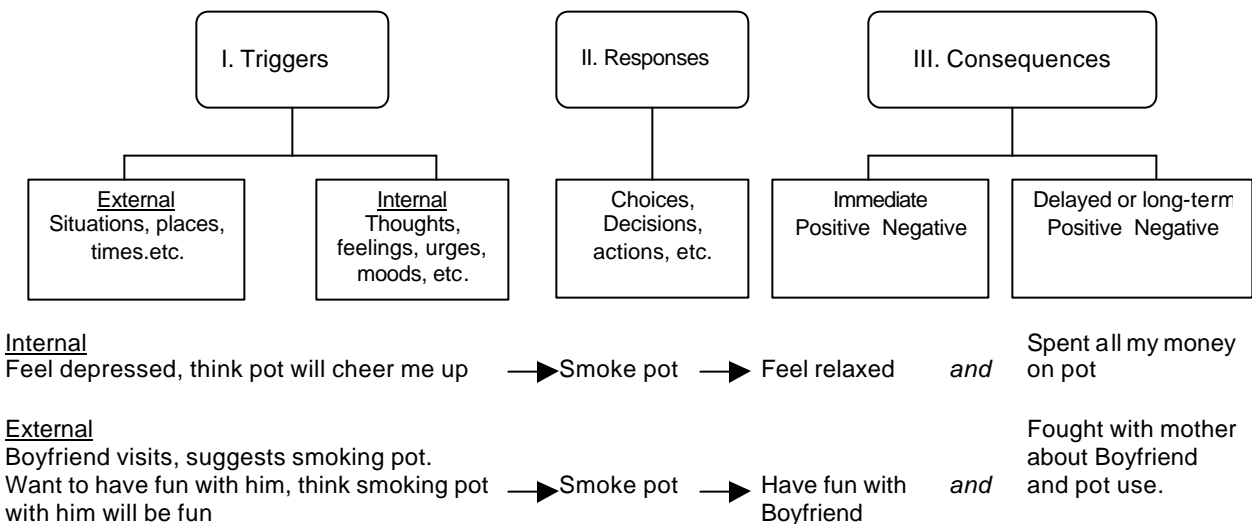
Table 4: What you need to know to do contextual analysis of substance use

- ☞☞ Expectations of use (e.g., relaxation, better social interactions, sleeping better, etc.)
- ☞☞ Internal triggers for use (e.g., emotions, thoughts, withdrawal, craving, etc.)
- ☞☞ External triggers for use (e.g., people, places, seeing needles, music, etc.)
- ☞☞ Immediate reinforcers (e.g., escaping or feeling relaxed or high)
- ☞☞ Positive aspects of use (e.g., make friends, be "cool", feel good, etc.)
- ☞☞ Negative aspects of use (e.g., expense, hangover, interpersonal problems, etc.)

Don't be discouraged if you are unable to obtain this information when you first meet a client. Like Marie, many clients with severe mental illness take weeks or months to trust a clinician enough to tell them about their substance use. When clients are in a crisis like Marie was, it is important to get information about the presence of use from other sources, such as family and urine drug and alcohol screens. However, to get the detailed information for a contextual assessment, a clinician will often have to spend more time with a client getting to know them. Getting this information can occur over time during the engagement and persuasion stages of treatment.

The information you gather about the context of substance use is used for the contextual analysis described below. We use the client's expectations, internal cues and external cues (or triggers) for using substances as well as the immediate reinforcers and longer term consequences to diagram, or analyze, the factors that are related to a client's substance use. In Figure 2, you can see an example of how a contextual analysis could be done for Marie. The figure diagrams out how Marie's depressed feelings lead to her thinking that smoking pot will cheer her up (expectancy). She smokes pot, and then feels relaxed (immediate reinforcer) but the next day is upset to realize that she spent all of her money on the pot (long term consequence). This kind of diagram will help you understand your client's substance use, plan interventions to help your client change their behavior, and talk with your clients about their substance use.

Figure 2: Contextual Analysis for Marie



Tables 5 and 6 show the criteria to diagnose a substance use disorder according to the Diagnostic and Statistical Manual (DSM), which is used by all mental health professionals in the United States (these are described in more detail in chapter 2). Getting information to clarify whether a client has symptoms that allow you to make a diagnosis is important. We recommend using the questions contained in the Structured Clinical Interview for DSM-IV as a standardized way of asking about symptoms that form the diagnostic criteria.

Some clients may use substances but do not have a substance use disorder. For example, some clients are able to drink socially without problems for a time, though we know that this rarely lasts. In fact, the overwhelming majority of clients with severe mental illness who use substances either opt for abstinence or develop symptoms of a substance use disorder. It may be important to recognize the category “use without impairment” so that these clients can be offered good information and advice before they develop problems.

Table 5. DSM Criteria for Substance Abuse

- ☞☞ Maladaptive pattern of use of a substance for 12 months or more
- ☞☞ Use of substance causes problems in at least one area of function (social, interpersonal, work, family, medical or legal)

Table 6. DSM Criteria for Substance Dependence

- ☞☞ Maladaptive pattern of use of a substance for 12 months or more
- ☞☞ Use of the substance causes 3 or more of the following:
 - Tolerance, withdrawal, uses more than planned or for more time than intended, desire to cut down, reduces other activities to use, uses despite problems (social, interpersonal, work, family, medical or legal).

Distinguishing between substance abuse and substance dependence is important because abuse implies that the psychological and physiological syndrome of dependence has not yet taken over the client’s life. *Substance abuse is a behavioral disorder in which a person makes poor choices around substance use, but is still more or less in control of those choices. In contrast, substance dependence is a more serious disorder in which a person loses the ability to control substance use and has powerful impulses to seek intoxication despite past negative consequences. All substance disorder assessments should specifically gather information that pertains to DSM criteria for abuse or dependence to make an accurate substance disorder diagnosis.*

In this vignette, Marie's boyfriend and parents gave information that suggested that for years she has used more cocaine than she had planned and continued to use cocaine despite multiple problems. If their information was correct, she could probably be diagnosed with cocaine dependence. Because the vignette did not give enough information about her use of alcohol and cannabis, we would want to get more information about whether she sees herself as in control of her use, or whether she has tried to stop but was unable to do so, and whether she had any subjective withdrawal symptoms. Without more information, we cannot determine for certain whether she has a cannabis or alcohol use disorder.

For clients with dual disorders, there is evidence that both substance abuse, the milder disorder, and substance dependence, the more severe disorder, lead to worsening of mental illness and to other negative outcomes like medical problems, financial problems, family problems, and homelessness over the life span. However, persons with dual disorders may require more intensive or different treatments than persons with single disorders.

STAGE OF
CHANGE/STAGE
OF TREATMENT

To develop an effective treatment plan, it is important to assess the person's stage of change and stage of treatment (see previous chapters). The stages are a way of describing a person's behavioral readiness for reducing or stopping substance use and their involvement in treatment. Because people often say what they think the clinician wants to hear or what they believe is socially acceptable, many report being more motivated to quit than they really feel. To avoid this problem, clinicians can ask about the client's attitudes regarding substance use and treatment but also observe behavior to understand the client's involvement in treatment, their understanding of the role alcohol and other drugs play in their lives, their current goals, and their current attempts to change substance use, including strategies, supports, and treatments. From these questions, it is possible to determine the stage of treatment and recovery as they are described in Table 3 on page 32.

Effective treatments are different at each stage. What helps in the early engagement phase is very different from what helps in the active treatment phase. In this vignette, the clinicians need to get more information to make an assessment of Marie's stage, but it appears that she is still in the engagement stage. By identifying the stage of treatment, clinicians can match treatments to the client's definition of the problem, her individualized goals, and her current readiness to consider change.

Recommended Reading

We recommend Assessment of Addictive Behaviors. Dennis D. Donovan and G. Alan Marlatt (Eds.) New York, Guilford Press, 1988. The introductory chapter on assessment of addictive behaviors is outstanding, and the book also contains many chapters on specific drugs and approaches that are quite good.

Treatment Planning

INTRODUCTION

Treatment planning is a collaborative process of working with a client and his family or support system to specify personal goals and the means by which treatment can help a client reach his or her goals. This chapter describes a man with schizophrenia and alcohol abuse and how his team helped him and his daughter to develop goals and to select treatments to address those goals. The discussion elaborates a six-step process to develop and follow up with integrated treatment plans for persons with substance abuse and mental illness.

VIGNETTE

Ferdinand is a 59 year-old, widowed, unemployed man with schizophrenia, alcohol abuse, and diabetes. He recently moved to New York from North Carolina to live with his daughter, who wants to help in caring for him. According to his daughter and medical records from North Carolina, Ferdinand spent the last 30 years living in a small apartment with his wife, until her death five years earlier. While she was alive, he took an antipsychotic medication and was able to take care of his basic needs. After his wife's death, however, he became quite isolated in his apartment, and his health rapidly deteriorated. He drank heavily in his early 20s but had no further history of alcohol problems.

According to his daughter, over the last year Ferdinand developed trouble with urinary incontinence and also appeared to be losing his memory. He was frequently angry and confused, and often talked to himself. The restaurant owners across the street where he ate most meals kicked him out and refused to serve him, and he lost weight rapidly. Soon thereafter, he was involuntarily hospitalized. On admission to the hospital, his blood alcohol level was above the state limit for intoxication, and his medication level was undetectable. His blood sugar was higher than normal, which led to a diagnosis of diabetes. He was started on intramuscular insulin, as well as an antipsychotic medication.

When his daughter brought him in to the mental health center in New York for treatment, he appeared disheveled, irritable, and distracted. He did not talk to himself, but admitted that he heard voices. His memory was poor. He was angry about the insulin shots, which he did not believe he needed. He was willing to take medication for his "nerves." He said he was grateful to his daughter for caring about him, but upset about moving. He denied drinking any alcohol and said that drinking had never been a problem for him. He said that the urine test

in the hospital must have been a mistake. When the clinician asked him what his goals for himself were, he said he “just wanted things to get back to normal” and wasn’t able to articulate any more specific goals.

Ferdinand’s daughter was concerned about his drinking: She had found numerous empty vodka bottles in his apartment in North Carolina, but she didn’t think he was drinking now that he was living with her. When asked about the bottles, Ferdinand became upset and said he didn’t remember any vodka bottles. His daughter was also concerned about his physical health and his incontinence, which was better than before but still an occasional problem at home.

At the end of two meetings, and after reviewing records from his previous treatment in North Carolina, Ferdinand, his daughter, his psychiatrist, and his case manager agreed on five treatment goals. First, Ferdinand wanted to be able to take care of himself at the house while his daughter was at work. Second, he wanted to stay physically healthy and find out more about his diabetes by seeing a doctor. Third, he wanted to work with the mental health team to “keep his nerves in check.” Fourth, he agreed to make his daughter happy by avoiding alcohol. Fifth, Ferdinand acknowledged that he was lonely without his wife and needed to meet some people in his new town. As the following figure shows, these goals led to specific action targets.

Figure 1. Treatment Plan for Ferdinand

Client name: Ferdinand

Mental Illness Diagnosis: Schizophrenia, probable alcohol abuse

Clinician Rating Scale Alcohol: Probable Alcohol Abuse

Substance Abuse Treatment Scale: Early persuasion stage

Problem #1: Hasn't been taking care of himself

Goal: Take care of himself while daughter is working

Targets: Get up, shower, eat breakfast and get dressed in clean clothes every day by 9:30; Make himself a sandwich or soup for lunch every day.

Intervention: Outreach to home by case manager; practice skills with case manager; set up cues in room to complete tasks. Make chart to check off meals.

Treatment modality: Case management, mental illness management

Responsible clinician: Joe (case manager)

Problem #2: Physical health including diabetes, incontinence, and memory problems

Goal: Stay physically healthy

Targets: Make and keep medical appointments; take meds prescribed by doctor

Intervention: Nursing assistance in setting up pill box, coordination with internist

Treatment modality: Mental illness management

Responsible clinician: Patricia (nurse)

Problem #3: "Nerves," auditory hallucinations, irritability

Goal: Keep nerves in check, i.e. reduce frequency of hallucinations, irritability

Targets: Keep appointment with psychiatrist; take prescribed medications; meet with case manager once a week

Treatment modality: Medication, case management

Responsible parties: Joe (case manager), Phil (psychiatrist)

Problem #4: Possible abuse of alcohol

Goal: Avoid alcohol use

Intervention: Meet with case manager weekly to learn about and discuss alcohol use; meet with case manager and daughter monthly to discuss her concerns

Treatment modality: Case management, education, family intervention

Responsible clinician: Joe (case manager)

Problem #5: Social isolation, loss of wife, move to new community

Goal: Establish social contacts

Intervention: Attend senior center three days a week, talk with members

Treatment modality: Case management, family intervention, social intervention
Responsible clinician: Joe (case manager)

TREATMENT
PLANNING
GUIDES
TREATMENT

Treatment planning is a collaborative process that guides treatment. It involves working with a client and his or her family (or other supporters) to consider the assessment information, to establish individual goals, and to specify the means by which treatment can help a client to reach those goals. Initial treatment planning occurs during the assessment and engagement processes, typically over weeks or months. The process results in a written document like the one in Figure 1. Remember that treatment and recovery must focus on the client's goals, which must be measurable and meaningful. For persons with dual disorders, the treatment plan will always address mental health and substance abuse, and will typically involve building both skills and supports for recovery goals. For Ferdinand, there are multiple areas of concern in addition to his mental health and his drinking: his physical health, his memory problems, the loss of his wife and home, the transition to a new community, and social isolation.

We assume that clinicians are already familiar with the general approach to treatment planning. This chapter focuses on treatment planning for substance abuse.

SIX STEPS FOR
SUBSTANCE
TREATMENT
PLANNING

Treatment planning involves six steps, which we will describe in detail below: (1) evaluating pressing needs, (2) determining the client's level of motivation to address substance use problems, (3) selecting target behaviors for change, (4) determining interventions for achieving desired goals, (5) choosing measures to evaluate the effects of the interventions, and (6) selecting follow-up times to review the implementation of treatment plans and their success.

1. Evaluating pressing needs. When clients are in crisis, such as in danger of hurting themselves or others, these issues need to be addressed first. Helping clients to develop safety and stability is usually a precondition to helping them move towards sobriety. In many cases, like Ferdinand's, the crisis situation cannot be resolved without addressing substance abuse, and the clinician must address both the pressing needs and the substance abuse.

Common pressing needs include dangerous behaviors, homelessness, victimization, violence, severe symptoms, medical problems, legal problems, and acute intoxication. For Ferdinand, his medical problems, weight loss, and confusion were pressing issues that endangered his life. His ability to take care of himself has been a serious problem, but he may be able to do much better with supports, medical attention, and

medications. Taking medications and avoiding alcohol may resolve his confusion.

2. Determining motivation to address substance use

problems. The level of a client's motivation to address substance abuse will determine the most appropriate interventions. The Substance Abuse Treatment Scale (SATS) (Figure 7 in the previous chapter) describes the different stages of treatment based on the client's substance use behavior and involvement in treatment. The team uses all available information in making this rating, using the most recent substance use and involvement in treatment over the past six months. In Ferdinand's case, his self-report, his daughter's report, the clinical records, and the team's observations suggested that he was in the early persuasion stage of treatment. He had regular contact with his team and was willing to discuss his drinking, though he denied that it had occurred. It was unclear whether he was drinking at present.

3. Selecting target behaviors for change.

In making a treatment plan, the clinician asks, "What changes are necessary to decrease substance abuse or to minimize the chances of a relapse?" The client's stage of treatment is important to setting goals because it reflects the person's motivation to change his substance use behavior. The factors that maintain ongoing substance abuse or threaten a worsening or relapse of substance abuse should be the targets for change.

To identify suitable targets for intervention, the team should consider problems that are preventing the person from progressing to the next stage of treatment as well as factors that maintain ongoing substance use or threaten relapse. Once these are identified, concrete changes or goals that would address these factors are specified. Examples of common problems, target behaviors, and interventions for stage-wise treatment goals are listed in table 1.

Ferdinand's history, for example, suggests that he began drinking after losing his wife and that loneliness and isolation may have been the precipitants. The clinician should watch for signs of unresolved grief and depressive symptoms and consider with him the likely relationship between these moods and his drinking. To address the factors that led to relapse, the clinician should work towards increasing social support and daily activity for Ferdinand. To address the stage of treatment, persuasion, the team should help Ferdinand to learn how substance use interferes with personally valued goals, such as controlling diabetes and improving memory.

Table 1: Examples of common problems, target behaviors and interventions

<u>Stage</u>	<u>Problem</u>	<u>Target behavior</u>	<u>Intervention</u>
Engagement	??Lack of regular contact with dual diagnosis clinician	??Regular contact with clinician	??Assertive outreach ??Practical assistance(housing, entitlements, other) ??Family education
Persuasion	??Substance use interferes with personally valued goals	??Efforts to reduce substance use to make progress towards personal goals	??Motivational counseling ??Persuasion groups ??Basic social skills training ??Vocational supports
Active Treatment	??After abstinence achieved, craving to drink	??Use imagery to cope with craving ??Use self talk to cope ??Use distraction or replacement activity to cope	??Cognitive-behavioral counseling
Relapse Prevention	??Loneliness due to distance from substance-using friends	??Improved skills for making friends	??Social skills training ??Self help group referral

4. Determining interventions for achieving desired goals.

Different interventions are helpful at different stages of treatment. In early phases of treatment, clinical work does not focus on giving up substance use because clients are not yet interested and motivated to do so. Attempts to push a client to stop using a substance before he is ready are usually ineffective. However, once a client is interested in giving up a substance, interventions should be targeted at helping the client do so.

In Ferdinand's case, he is willing to discuss alcohol use, but isn't admitting it's a problem or even that he is using. Demanding that he attend AA at this point would not make sense. The team and his daughter are hoping, however, that his drinking was situational and that he will be able to stop with supports. They will continue to observe him for potential abuse, to educate him about the effects of alcohol on aspects of his life that matter to him, and develop a more specific treatment plan if the need arises.

5. Choose measures to evaluate the effects of the interventions.

When specific interventions have been selected to change the targets, progress must be measured. Assessment should be

simple, objective, easy to use, and clearly related to the target behavior. For example, if the target for Ferdinand is to avoid alcohol completely, his daughter and case manager can help to monitor his appearance, behavior, and house closely for two weeks. There should be no signs of alcohol use.

6. Select follow-up times to review the plan. Treatment plans are only useful when the team follows through with the proposed interventions. Monitoring will help the team be aware of any problems with the planned interventions early on, so that they can be resolved and the interventions can be delivered. Also important is that the planned interventions may not have the desired effects on the target behavior. For example, Ferdinand may relapse to drinking when he is alone at night. A new treatment plan would need to address that reality.

THE WORKING
ALLIANCE

A key to successful assessment and treatment planning with persons with dual disorders is a positive relationship, which is often called the working alliance. This is especially important in Ferdinand's case, because he does not have much insight into his drinking or his mental illness, in addition to being psychotic, angry, and confused. The clinician working with Ferdinand should convey genuine caring and respect. It would be important to find ways to build a relationship within which Ferdinand feels safe and valued, and senses that the clinician has his best interests in mind. Examples of such activities might include conversing with Ferdinand about topics in which he is interested and assisting him with his own self-determined priorities (e.g., helping him obtain new clothing or helping him get to a doctor's appointment).

The clinicians should continually assess whether Ferdinand feels threatened or alienated, and back away if necessary. Because Ferdinand actively denies any alcohol use, the appropriate intervention might be to make sure he gets education from the doctor and nurse about how alcohol might affect his mental illness, his diabetes, and his memory, and to watch for any clues of alcohol use. If at a later time he acknowledges use and expresses an interest in talking about drinking, the clinician could encourage the client to monitor himself for cravings, triggers, and drinking behavior.

In addition to asking about the drinking and other problems, it would also be important to talk with Ferdinand about positive aspects of his life, such as activities he enjoys, his hopes, and his goals. He may have lost sight of his own plans and hopes, and asking about these areas may be a first step toward helping him to recover a sense of possibility. Treatment should encourage and facilitate the client's aspirations and use individual strengths and resources to attain recovery goals.

TREATMENT
PLANNING IS
CONTINUOUS

Though this vignette describes the process of developing an initial treatment plan, remember that *treatment planning is an ongoing process*. The plans are adjusted as one develops a better understanding of the client and of which interventions are effective. Treatment plans also change over time because as people move through the different stages of treatment, different interventions are appropriate and effective.

COGNITIVE
PROBLEMS

Ferdinand's vignette illustrates numerous interesting problems, like the common problem of diabetes and the onset of alcohol abuse in older age, but we will address just one other aspect here, and that is his confusion. *Cognitive problems such as confusion or memory loss can be due to a variety of difficulties, e.g., old age, dementing illnesses like stroke, schizophrenia, antipsychotic medications, diabetes, or alcohol use.* Obviously, one or more of these might be relevant for Ferdinand. The most important point is that confusion and memory loss are often reversible and should be assessed thoroughly by a psychiatrist and an internist.

Intoxication with or withdrawal from alcohol and other substances cause reversible changes in memory and concentration during the time of use or withdrawal. Cognitive problems can persist for weeks or months and gradually clear up once a person stops using. Unfortunately, alcohol can also cause permanent changes in memory function, and the only way to know if the memory problem will get better is to observe the client carefully during prolonged abstinence. In Ferdinand's case, the team hopes that the recent history of alcohol abuse, medication non-adherence, uncontrolled medical problems, and situational stress are accounting for his cognitive problems. All of these factors should improve with good care, and Ferdinand should be able to function at a much higher level if he recovers his cognitive functioning.

When a dual diagnosis client has problems with memory and concentration, the first step is to measure the problems by using simple tests, such as the Folstein Mini-mental Status exam (see figure 2 below). If the problems are severe (score less than 20) or are moderate (score less than 25) and do not improve within a month of sobriety or improvement in physical illness, the client should be evaluated medically to assess other medical problems that could be causing the changes.

Recommended Reading

The textbook, Integrated treatment for dual disorders: Effective intervention for severe mental illness and substance abuse, has a chapter on treatment planning with many examples that you may find helpful. The book is by Kim Mueser, Douglas Noordsy, Robert Drake and Lindy Fox.

Another helpful book on treatment planning is Substance Abuse Treatment and the Stages of Change by Gerard Connors and others (Guilford, 2001).

Figure 2: ***Mini Mental Status Exam***:* *Instructions*: Each question is scored based on the number of items tested in that question. The highest possible score for each question is noted in italics in the column preceding the score boxes. The number of correct responses given by the client is recorded in the appropriate box. The number of points given for each question varies from 1-5 for a total possible score of 30. Question 9 asks the client to read a sentence and do what it says. Question 10 asks the client to write a sentence. Question 11 asks the client to copy a design. The sentence, a blank for question 10, and the design can be found on the next page of this manual. Read the following aloud to the client:

“I’d like to ask you some questions about to assess your memory. The questions may seem unusual, but they are routine questions we ask of everyone. Some of the questions are very easy and some are difficult, so don’t be surprised if you have trouble with some of them.”

Orientation	<i>Maximum Score</i>
1. “What is the (year) (season) (day) (date) (month)?”	5 _____
2. “What is your address? (state) (county) (town) (street) (number).”	5 _____

Registration	<i>Maximum Score</i>
3. “I am going to say three words. After I have said them, I want you to repeat them.”	
“APPLE TABLE PENNY”	
“Could you repeat the three words for me?”	
(NOTE: SCORE 1 POINT FOR EACH CORRECT REPETITION ON FIRST TRY. REPEAT WORDS UNTIL ALL ARE LEARNED. # of Trials _____)	3 _____
“Remember what they are, I am going to ask you to name them again in a few minutes.”	

Attention and Concentration	<i>Maximum Score</i>
4. Serial 7’s, backwards from 100. (93, 86, 79, 72, 65) Score 1 point for each correct.	
Stop after 5 answers. Alternatively, spell WORLD backwards.	5 _____

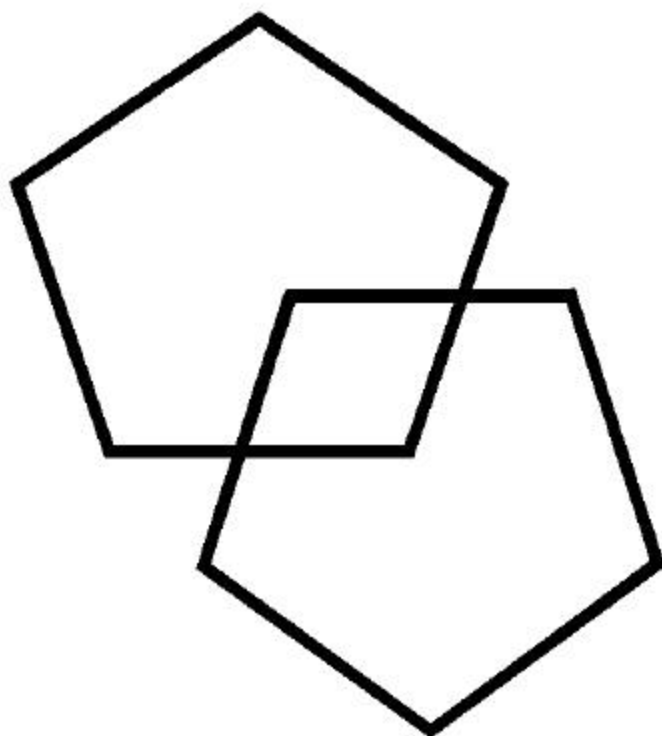
Recall	<i>Maximum Score</i>
5. Ask for the 3 words repeated above. Give 1 point for each correct.	3 _____

Language	<i>Maximum Score</i>
6. Point to, and ask to name: a pencil and a watch.	2 _____
7. Repeat the following “No ifs, ands, or buts”.	1 _____
8. Follow a 3-stage command:	
“Take a paper in your right hand, fold it in half, and put it on the floor”.	3 _____
9. “Read and obey the following”: CLOSE YOUR EYES (See next page)	1 _____
10. “Please write a sentence.” (See next page for blank space)	1 _____
11. “Please copy this design.” (See next page)	1 _____

Total Score:	(Total Possible=30)_____
>23 Normal	
18-23 Mild Cognitive Impairment	
<18 Moderate to Severe Cognitive Impairment	

*Questionnaire is the Mini Mental Status Exam, Folstein, 1975

CLOSE YOUR EYES



Engagement

INTRODUCTION

“Engagement” is the process of developing a trusting relationship, sometimes called a working alliance, with a client. Engagement is usually based on reaching out to the client, empathically understanding their situation and goals, offering practical assistance, and eventually helping them to understand that treatment can help him or her to reach those goals. Because many clients with dual disorders who have not yet engaged in treatment are in crisis, usually related to substance abuse and symptoms of mental illness, lack of psychosocial supports, and severe stress, developing a relationship that will foster recovery can be difficult and take time and creativity.

VIGNETTE

Sheryl is a 20-year-old woman with a diagnosis of schizophrenia. Her first contact with the mental health center was through a community outreach worker. Someone from the local shelter had called the mental health center because staff there were concerned about Sheryl’s behavior. She often stayed up half the night yelling back at voices that she said were calling her names. Even more worrisome, she often spent nights on the street prostituting for cocaine.

The outreach worker met Sheryl in the shelter. She was suspicious, fidgety, distracted, and had difficulty talking coherently. The only goal she could think of was to get her own apartment. The outreach worker said that that was something they could work on and asked Sheryl to come in to the mental health center to meet with a psychiatrist. Sheryl refused to come to the mental health center, but she did agree to meet with the outreach worker again. The next day the outreach worker picked Sheryl up and took her out for a cup of coffee and a sandwich. Sheryl reported feeling that she had no one to help her, that she was totally alone. She was angry with her mother, who had hit her and kicked her out when she was 16. Her father refused to talk with her. She didn’t know where her siblings were. She said she couldn’t trust anyone.

The outreach worker began to meet with Sheryl each morning before she left the shelter and gradually introduced her to other team members. A team member tried to meet daily with Sheryl at the shelter, the soup kitchen, or the local coffee shop. A team member accompanied Sheryl to the Social Security office and helped her sign up for disability benefits. Sheryl continued to insist that an

apartment was her only goal. After two months, the team agreed to help her find an apartment if she would meet with the team psychiatrist.

The psychiatrist diagnosed Sheryl with schizophrenia, alcohol dependence, and cocaine dependence; he prescribed an antipsychotic medication. Team members brought medications to Sheryl, and she agreed to take them knowing that the team would help her get money and an apartment. When she began receiving Supplemental Security Income benefits, the team helped Sheryl obtain an apartment and buy groceries. Within days, however, it became clear that Sheryl was prostituting and selling drugs in the apartment, and her landlord soon evicted her.

When Sheryl landed back in the shelter, the team offered again to help. Sheryl admitted that she had not been taking the medications, and she rejected suggestions regarding a payee and a group home. She wanted to control her money and to get another apartment.

For several weeks, Sheryl's behavior worsened with increasing paranoia, less predictable appearances in the shelter, and more frequent signs of physical abuse. At this point, she was arrested for breaking into her mother's home, stealing money, and assaulting her mother. Because of her psychotic appearance and behavior, she was diverted to a local psychiatric hospital. The team visited her regularly and worked with the hospital staff. As Sheryl took medications, got rest, and had a few weeks away from cocaine, she became clearer and more personable than the team had ever seen her. She expressed regrets about her life of addiction, prostitution, and victimization. She attended a group for women with dual diagnosis and another group for women with sexual abuse histories; she began to share her fears and anxieties with others. In anticipation of discharge, she agreed to allow the team to become her payee and to live in a supervised apartment. She expressed a strong interest in continuing with the groups.

Having been through the engagement process with several dual disorder clients like Sheryl, the team knew that she would probably continue to have crises and relapses. But they also knew that they were developing a relationship with her, that she liked and trusted some of them, and that the trusting relationship would eventually be her best chance of learning to participate in treatment, to control her illnesses, and pursue a different life.

HOW DOES
ENGAGEMENT
HAPPEN?

Engagement means developing regular contact and a helpful relationship that can foster recovery. Not all clients are as demoralized and distrustful as Sheryl, but it is common for people who are dominated by two untreated disorders to have difficulty entering into a treatment relationship. It often takes time, patience, an accepting attitude, a persistent approach, and being available when an opportunity appears. The outreach worker or counselor finds the client and tries to develop a relationship based on

acceptance, empathy, and helpfulness. Pushing treatment prematurely can interfere with the engagement process.

Outreach is often necessary, particularly when clients are overwhelmed and unable to muster the courage and hopefulness that are necessary to pursue recovery. The outreach worker expresses empathic friendship by accepting the client as she is and using a technique called reflective listening. This means that the counselor listens carefully to the client's view of the situation and reflects this understanding back to the client to make sure it is correct, without attempting to interpret the situation, offer advice, or correct the client's misperceptions. Reflective listening does not mean accepting the client's view as correct; rather, it ensures that the counselor understands the client's view, the client's language, and the client's attempts to cope. Using this technique is non-threatening and begins the process of building a trusting relationship. (Please see the next chapter on Motivational Interviewing for more details on this approach.)

As part of establishing a relationship, the counselor asks about the client's goals. He then helps clients plan small realistic steps towards the goals, and offers assistance in pursuing goals that are healthy. For example, clients often need assistance in obtaining financial support, clothing, housing, employment, or a better relationship with their families. The client may not know how to pursue these goals effectively, but the counselor can help break the goals down into realistic steps.

Note that the counselor does not help to pursue self-destructive goals like obtaining an apartment when the client acknowledges that he will sell drugs from his apartment. In such a situation, the two attempt to find another goal that they can agree on. At the same time, the counselor does not confront the client about substance abuse while establishing a relationship. This is sometimes difficult for counselors to remember.

Working with a dual-disorder client can easily become derailed by the client's illnesses, crises, or attempts to cope with a bad situation. The counselor must remain positive and optimistic, avoid confrontation, and emphasize hope, self-efficacy, and the client's strengths. As they develop a relationship through working together, the client discovers that substance use and psychiatric symptoms are barriers to accomplishing his or her goals. At this point, the counselor suggests treatment possibilities, sets up an appropriate appointment, and, if the client wishes, accompanies the client to the appointment. The counselor is careful to stay on the client's side and to facilitate but not insist on entering treatment and adhering to treatment recommendations. Over a few months the relationship and the support will enable most clients to connect successfully with treatment.

Despite heroic efforts to help, some clients, like Sheryl, will continue to experience wild fluctuations or to spiral downhill. Their lives are so dominated by illness, trauma, addiction, and instability that they don't see the need to master their illnesses and don't even hope for a better life, even with a counselor to help in the process. Sheryl's behavior indicates that she is severely addicted to crack cocaine, which has severely worsened her schizophrenia, caused her to lose her supports, and made it difficult for others to maintain a relationship with her. She needed respite, safety, and protection to recover her ability to see her situation rationally and to make good decisions for herself. Hospitalization and protected housing are often critical steps, but they may not be acceptable to the client.

As with Sheryl, the opportunity to turn the situation around often comes with a crisis. The client may experience a shocking realization, often during enforced sobriety, that he or she needs to get off the path of self-destruction and to do something different. Having a relationship with someone who can help at this point is critically important.

The approach to engagement we have described here is commonly used and is quite effective. In the substance abuse literature, it is called motivational counseling, and in the mental health literature, it is known as strengths case management. The approach has been widely used with homeless clients and other extremely demoralized people who are difficult to engage in treatment. With such people, it can be a protracted process. With clients who are more intact, who have a helpful support network and a safe place to live, the process often goes much faster. Once clients are engaged in the relationship and begin to see that treatment might be helpful in reaching their goals, a variety of interventions for substance abuse and mental health problems can be used, but engagement nearly always precedes involvement in treatment.

✍ We strongly recommend the following book, which describes the engagement process and is extremely helpful for anyone attempting to engage dual-disorder clients in a treatment relationship.

Rapp, Charles. The Strengths Model. New York: Oxford Press 1998.

Motivational Counseling

INTRODUCTION

Motivation refers to a state of readiness to change. Clients in the engagement and persuasion stages of treatment are not yet ready, or motivated, to change their substance use, even though clinicians might think that they could benefit from change. In the early stages of treatment, the counselor can help increase the client's readiness to reduce substance use by using the skills described in this chapter, which are called motivational counseling, or motivational interviewing. This chapter presents a man with post-traumatic stress disorder and alcohol dependence. The vignette is used to introduce five basic principles of motivational interviewing and how to use them to help your clients become interested in reducing substance use.

VIGNETTE

Kevin is a 57-year-old Irish-American, unemployed, divorced father of five grown children. He was diagnosed with post-traumatic stress disorder, psychotic disorder not otherwise specified, and alcohol dependence. He has been living at the homeless shelter and receiving outreach services from the assertive community treatment team.

Kevin worked as a heavy equipment operator until five years ago. Since his discharge from the Marines 20 years ago, he has experienced symptoms of racing thoughts, flashbacks, anxiety, and social avoidance. He has used alcohol and marijuana since adolescence. As his use of alcohol and marijuana has increased over time, he has become more and more paranoid. Kevin has been arrested a number of times for criminal threatening and assault.

Five years ago, Kevin was in an automobile accident and sustained a brain injury. He was charged with driving while intoxicated, lost his driver's license, and lost his job as a heavy equipment operator. Since then, he has not had stable housing, has not worked, and has experienced poor memory and concentration in addition to his other symptoms. He refused treatment at the local Veterans Administration Hospital and at the local mental health center, but was willing to meet with team members at the homeless shelter.

Kevin's behavior at the shelter has been paranoid and aggressive. His case manager went with Kevin to his last court hearing and was told by the judge: "This man needs mental health treatment. See that he gets treatment and is not a

threat to the community.” The judge wrote a court order requiring Kevin to participate in treatment at the mental health center.

Kevin’s case manager began meeting with Kevin at the homeless shelter every day. They usually went for a walk and had coffee. Over the next month, they had many conversations. The case manager started by asking Kevin what he thought about the judge’s order. Kevin thought “he has it in for me” and refused to go to the mental health center. The case manager offered to meet with him at the shelter or a coffee shop, and Kevin agreed. Asked about the good things in his life right now, Kevin identified having a warm, dry place to sleep, his five children, his drinking buddies, and a good disability income check from the VA. The case manager then asked Kevin what was “not so good” in his life right now. Kevin listed the judge’s order requiring him to be in treatment, living with the “crazy” people in the shelter, and running out of money during the month. The case manager asked Kevin to tell him more about his concern about living with the “crazy” people and running out of money during the month. He learned that Kevin wanted to have his own place, but that his confidence in being able to keep housing was low. With his case manager’s help, Kevin listed the following pros and cons of having his own apartment.

<u>Pros</u>	<u>Cons</u>
Privacy	Trouble managing his money
Nothing gets stolen	Isolation and loneliness
Control of when to sleep, eat etc.	Drinks more
Something that is his	Friends want to move in
	No money for furnishings
	Not eligible for housing supplement

After looking over the list, Kevin began to talk more about his use of substances and how much he has lost because of drinking. When he was taking medication, he was able to concentrate better and felt more hopeful about life. Kevin’s case manager said that Kevin was presenting an interesting picture and wondered if Kevin would like feedback on his impressions, noting that the feedback could be taken or thrown out. Kevin agreed to hear the feedback. The case manager suggested that there could be a connection between Kevin’s use of substances, taking medication, and his capacity to live on his own. The case manager also wondered if Kevin’s desire to be in control has actually left him out of control in most areas of his life. He then asked for Kevin’s reaction to the feedback. Kevin agreed he wanted control of his life and that until recently he believed he was in control.

Kevin’s case manager asked him what he wanted to do next. Kevin decided to begin working on a plan that included reducing his drinking to every other day, attending a money management group once, and thinking about opening a bank account to work on saving money for housing.

After four months, Kevin was taking medication. After two more months, he decided to apply for and got into a residential treatment setting where he was able to stop substance use, take some classes, and become involved in Alcoholics Anonymous. He stayed there for two years and then transitioned into his own apartment. He had reconnected with one of his children, and was proud to be involved with her family.

WHAT IS
MOTIVATIONAL
INTERVIEWING?

Motivational interviewing is an approach to counseling that helps clients to enhance their motivation to reduce substance use or to become abstinent in order to reach their personal goals. These techniques can also be used to help clients to become motivated for mental health treatment, or to make other changes in their lives. This client-centered counseling approach aims to help clients who aren’t yet ready to change. In the past, these clients were seen as “resistant” or “in denial” of their substance abuse or of their need for mental health treatment. Motivational interviewing, on the other hand, assumes that clinicians can help clients to increase their readiness to change behavior by helping them to focus on their own goals.

Using stage-wise integrated dual disorders treatment that includes the techniques described in this chapter results in remission of substance abuse for the majority of clients who receive the treatment. Even clients such as Kevin, who are often seen as difficult to treat because of severe symptoms, threatening behavior, or difficulties processing information, tend to respond well to this approach.

STAGE OF
TREATMENT

Motivational interviewing techniques are important to use when working with clients in the engagement and persuasion stages of treatment. For example, Kevin is initially in the engagement stage for substance abuse and mental health treatment. Therefore, his counselor concentrates on developing trust and building motivation. The counselor explores Kevin’s mixed feelings about his substance use and about treatment for his mental illness without passing judgment, giving advice, or being coercive in any sense. He helps Kevin to set goals and to recognize that using substances gets in the way of reaching his goals.

PRINCIPLES
OF
MOTIVATIONAL
INTERVIEWING

Motivational interviewing uses five principles, which are listed in Table 1. Counselors should keep these principles in mind during interactions with their clients during the persuasion stage.

Table 1. Principles of Motivation Interviewing

1. Express empathy
2. Develop discrepancy
3. Avoid argumentation
4. Roll with resistance
5. Support self-efficacy

EXPRESSING EMPATHY

To express empathy, the counselor begins by actively listening to the client without offering judgment, criticism, or advice. The goal is to understand fully the client's situation and perspective. This requires active listening, where the counselor uses body language to show the client he is interested. He faces the client and uses frequent eye contact. He reflects back what he hears the client say. He asks for more information and more details to clarify the client's view of the world. He does not to give advice, reframe the client's views, make interpretations, or attempt to persuade the client of anything. The goals of reflective listening are to understand the world through the client's eyes and to build trust by being a good listener and demonstrating that understanding.

Early in treatment, the client is often not interested in treatment. Pushing for change at this time only turns the client off and increases resistance to change. Thus, initially the focus is on building trust and supporting the client instead of suggesting change. In Kevin's vignette, the case manager wisely attempts to form a relationship, to listen carefully, and to assure Kevin that change is up to him.

DEVELOPING DISCREPANCY

One of the goals of motivational interviewing is to identify and amplify discrepancy between behavior and goals in the client's mind. This is done in two steps. First, the clinician helps the client to clarify what her goals are. It is critical to identify the client's goals, not the family's, the clinician's, or anyone else's. The clinician does, however, help the client to focus on goals that are feasible and healthy. Together they look carefully at steps needed to reach the goals. Second, when the topic of substance use arises, the clinician helps the client to explore the pros and cons of continued use, especially how the substance use impacts the steps she wants to take towards reaching her goals. This approach assumes that almost everyone who abuses substances is ambivalent about continuing to use. When the client lists pros and cons of substance use and considers them in depth, she will often make her own argument for changing. The clinician then highlights the discrepancy between the goal and the substance use by repeating back to the client her recognition that substance use interferes with her goals. In this process the client may make a statement about concern over her drinking or wanting to change. When this happens, the clinician reflects the statement back.

In Kevin's case, the case manager helped him with what is called a

decisional balance exercise. This exercise is often useful for clients with mental illness. They can be done on simple, structured worksheets that can be used to guide the discussion. The worksheets also serve as visual prompts to focus attention.

In doing this exercise, Kevin identified the “good things” in his life as well as the “not so good” things. The clinician learned that Kevin wished to have his own home rather than live in the shelter, and that he strongly wished to reconnect with his children. He explores in the decision balance some of the steps necessary to getting housing. It might be helpful for the clinician to point out, using Kevin’s own words, the discrepancy between Kevin’s current behavior and his goals. The clinician should emphasize the ways in which Kevin’s use of alcohol and marijuana may be preventing him from living the way he desires. In addition to discussing housing, the counselor might ask Kevin if his use of substances has affected his relationship with his children. Repairing relationships with family can be an important motivator to reduce substance use. However, take care not to overwhelm clients with early discussions of too many areas of behavior change.

Where do you start? When clinicians work with persons with dual disorders, the multitude of problems may seem overwhelming. Some clinicians prefer to focus on the area in which the client is most ready to change; others begin by targeting behaviors that pose the greatest threat to the client’s well-being. In either case, remember that the client is ambivalent. Decisional balance statements should reflect that genuine ambivalence: for example, “I hear you saying that you really enjoy drinking, but that it also keeps you broke and apart from your children.”

AVOIDING
ARGUMENTS

Many people reject being labeled with a mental illness or addiction diagnosis. Motivational interviewing differs from other approaches to treating substance abuse in that it avoids confrontation, especially around diagnostic labels. *The principle is to avoid arguments in general, with the assumption that arguments simply strengthen people’s beliefs, rather than helping them change their beliefs.* While making a diagnosis is necessary to help clinicians target treatment to mental illness, it may not be helpful to the client. As a general rule, the counselor emphasizes the clients’ perceptions of the consequences of their behaviors rather than the clinician’s model of its causes.

In motivational interviewing, whenever the clinician senses disagreement, it is time to change strategies rather than getting into an argument. The focus should be on discrepancy, or ambivalence, within the client’s thinking, not on discrepancy between the client and the counselor. This is an important principle behind the success of these techniques. Most people do not want to change if they feel they have to defend themselves and that the clinician is unsupportive. The clinician working with Kevin has

appropriately focused on Kevin’s life context (homelessness) and behavior (drinking) rather than labeling Kevin as alcoholic or mentally ill. Also of note, Kevin’s case manager did not argue with him about the judge’s pronouncement; rather he offered an empathetic ear to his concerns and an acceptable way for them to meet on Kevin’s own turf.

ROLLING WITH
RESISTANCE

If a client doesn’t want to go in a certain direction (“*resistance*”), it is important to let him express his opinions, or to “roll with it” instead of trying to fight it. It is helpful for the counselor to encourage the client to explore all the possible answers to his own questions and concerns. By doing this, the client becomes the source of answers, does not feel defeated in sharing his concerns, and is able to risk expressing true feelings. For example, helping Kevin to develop a pros and cons list about having his own place to live helped him think about the impact of his drinking on housing.

Clinicians also need to be ready to roll with unusual behavior, such as clients’ restlessness, disorganized behavior, and inappropriate speech. The clinician can handle this behavior in a matter-of-fact way, rather than interpreting it as a sign that the client is unmotivated or too ill to participate. In Kevin’s case, since he refuses to go to the mental health center, the case manager has begun meeting with him at the homeless shelter. This is a good example of “rolling with resistance.” It is likely that as Kevin develops further trust in his counselor, they can explore together Kevin’s concerns about going to the mental health center.

The principle of rolling with resistance is simple if one thinks back to the treatment plan. There are always several possible areas to work on, and rather than getting into a struggle, it’s always better to find an area where the client is ready to do some work. For example, if the client begins to express resistance related to discussing medications or drinking, the counselor can move quickly to ask about finances, housing, family, work, or other areas of concern that the client has previously identified.

SUPPORT
SELF-
EFFICACY

Self-efficacy is the belief that one can succeed at change. The final principle in motivational interviewing is to *support the client’s self-efficacy*. This is particularly critical for people who are demoralized, depressed, or hopeless. Dually diagnosed clients are often reluctant to attempt to change because they have a long history of failing to achieve their goals. The clinician demonstrates optimism and belief in the client’s ability to change by interest, attitude, comments, and behavior.

Self-efficacy can be enhanced by achieving success on small, realistic goals and undermined if the client focuses on unrealistic goals. For dually diagnosed clients, a reduction in dangerous behavior or substance use may be a more realistic early goal than complete abstinence. Remember that success breeds greater self-efficacy and further success.

One strategy for increasing self-efficacy is to discuss examples of positive changes the client accomplished in the past. In Kevin's case, his former job as a heavy equipment operator seems to be a particular source of pride. The counselor may wish to raise the issue of this past success and explore a time in Kevin's life when things were going well for him as a way of rekindling optimism, self-efficacy, and remembrance of important goals.

HOMELESSNESS
AND DUAL
DIAGNOSIS
TREATMENT

Many clients with dual disorders become homeless over the course of their lives because substance abuse consistently worsens life problems as well as mental illness. When people with mental illness use substances, they often behave in ways that cause problems with relationships, finances, housing, and self-care. They often lose their housing as a result of those problems. Many dual disorder clients therefore end up in shelters. Offering treatment for clients in these settings that includes motivational interviewing is critical to helping them to attain stable housing as well as sobriety.

RECOVERY-
GETTING BACK
TO LIFE

People with mental illness, substance abuse, or dual disorders are usually motivated by a desire to pursue recovery, which means attaining personally satisfying and meaningful life goals. They have often become discouraged, lost hope, and given up on their goals. The crux of motivational interviewing is to help the client to identify those goals, to break them down into realistic steps, and to figure out that managing one's illnesses is part of achieving one's goals.

People with dual disorders have the same goals as everyone else. They want to have meaningful activities, friendships, and family members in their lives. For example, most people with dual disorders are parents. Many have had problems in their role as parents, and they may have lost custody of their children, but they still strongly wish to be good parents and to have contact with their children. Similarly, most people with dual disorders, even those who are homeless and unemployed for many years, want to work. These normal wishes for normal adult roles can be strong motivators to become engaged in treatment to attain sobriety and control of mental illness symptoms. Kevin exemplifies these issues.

The treatment team can instill new hope that life will get better by providing practical and intensive supports, by helping the client recognize the costs they are incurring through their substance use, and by helping to identify small steps toward large goals. This support can help clients achieve some success and thereby to find optimism, confidence, and meaning in their lives. This is what recovery is all about.

Recommended Reading

There are now many good books, treatment manuals, and articles on motivational counseling. We strongly recommend Principles of Motivational Interviewing by William Miller and Stephen Rollnick (New York, Guilford Press, 1991). It is an excellent introduction to the principles and techniques, and it offers a wealth of practical examples.

Substance Abuse Counseling for Persons with SMI

INTRODUCTION

For clients who are ready to stop using substances, substance abuse counseling helps them to develop the skills and supports they need to live a satisfying life without substances. This chapter describes a young woman with polysubstance abuse and an acute anxiety disorder. Counseling during the active stage of treatment helps clients to identify thoughts, emotions, behaviors, and situations that lead to substance use, and to change these patterns in order to avoid substance use.

VIGNETTE

Susan is an attractive 18-year old, single student. After an episode of intoxication at the local emergency room a week earlier, her mother brought her in for treatment at the mental health center.

The counselor met with Susan alone first and then was joined by her mother. During the intake, Susan appeared disheveled, tremulous, and distracted. Her eye contact was poor. She described increasing substance use, depression and anxiety over several months with the following symptoms: insomnia, rapid changes in mood, difficulty concentrating in class and doing homework, and feeling tense and worried most of the time. She gave the following history of substance use: she first drank alcohol at age 14 and for the past 6 months has been drinking up to 6 drinks a night on weekends (with friends and at parties); she first used ecstasy at age 17 and now uses it once or twice per month; she first used cocaine 6 months ago and now uses every weekend at parties; and she tried heroin last week at a party prior to going to the emergency room. She said that when she starts drinking at parties she drinks more mixed drinks or wine than she plans to, but that all her friends “get wasted” like that.

Susan reported several problems. She had been struggling to do her work in high school. She recently quit working on the school paper. She also revealed that she often “hooks up” with guys at parties and doesn’t use any birth control or other protection. She is concerned about the possibility of being pregnant. The counselor asked her if she had ever been sexually touched when she didn’t want to be. After a lengthy pause, Susan revealed that she had been raped six months earlier after an all-night party, a “Rave.” She had been afraid to tell her parents or anyone.

Susan was tearful and tremulous talking about the rape. The clinician asked her about post-traumatic stress disorder (PTSD) symptoms. She reported intrusive memories, occasional nightmares, and that she always felt “on the edge” and extremely alert. She felt nervous and cried when she thought about what happened. The memories bothered her all the time. She avoided situations that reminded her of what happened, including the young man, and when she saw him she experienced feelings of panic. Sometimes she wished she were dead, but she had not made plans to harm herself because she wouldn’t shame her family that way.

The clinician asked her whether these feelings led her to want to drink or use drugs. Susan said that when she experienced intrusive memories of her assault and when she had trouble sleeping at night, she thought about drinking, but that she only drank when she went out with friends. Whenever she was on a date or at a party, she couldn’t wait to have a drink. She always used drugs at parties when she was offered, but she didn’t think she had the urge to use in other situations. She couldn’t remember actually saying “no” when offered a substance and didn’t know if she could.

Susan’s mother reported a strong family history of anxiety, depression, and substance abuse in several family members. She was shocked and angry with Susan for using substances, but wanted to help her address her problems.

The counselor empathized with the symptoms and problems that Susan was experiencing. She suggested that the problems might be made worse by using substances. She asked for Susan’s input about the effect of using substances on her current situation. Susan wasn’t sure, but thought if she felt better she might not feel like using substances so much. The counselor suggested that they try an experiment. Susan was to keep a journal for a week. She would write down every time she used substances, what was happening and what she was thinking and feeling before using, and also what she experienced during and after using. The counselor gave her a worksheet to use for this assignment.

At the end of the evaluation, Susan agreed she wanted to work on feeling better, even if it meant changing her substance use. She agreed to come weekly to therapy, but she did not want to see a doctor for a psychiatric or for a physical evaluation. Her mother agreed to keep an eye on Susan and to restrict her from dates and parties until they met again and developed a plan of action.

When Susan and her counselor met the next week, they looked at the journal and worksheets together and talked more. Susan had not used any substances because her mother “barely let me out of the house!” Susan was able to identify thoughts, feelings, and situations in the past that led to using drugs and alcohol that allowed them to complete a contextual assessment of her use of alcohol, cocaine, and ecstasy. Key triggers for wanting to use alcohol were memories of being raped and the anxiety she felt around boys, dating, and parties. Key situations leading to other substance use were being at a party where others were

using and offering substances to her. She and her counselor began to look at other ways to handle these situations without using substances. During this meeting, the counselor talked with Susan about alcohol and other substances, giving her information about how they affected her body and her mood. She also gave her information about post-traumatic stress disorder, which helped Susan to understand most of her symptoms. They agreed to talk more about what to do next the following week. She agreed to continue to write in her journal and to stay at home.

At the next meeting, they came up with an action plan. They also met with Susan's mother, and Susan revealed more about her problems with substances and shared the plan with her. Susan asked her mother to help by doing one fun thing with her on Saturdays. Her mother agreed. They also agreed on a 10 p.m. curfew and a one-week grounding if it was broken.

ACTION PLAN

Name: Susan

Start date: 1/1/01

Action goal: Avoid use of all street drugs and reduce alcohol to no more than two drinks in one week

Detox plan: none

Cues or triggers: peer pressure, anxiety around boys, feeling anxious and overwhelmed by memories of rape, being at a party or other place where substances are being used

Consequences or reinforcers: perceived peer acceptance, perceived reduction in anxiety

Action plan for sobriety: avoid use of street drugs and reduce alcohol use to two drinks or less/week

1. Susan will learn how to refuse substances and to avoid social situations (including parties) where there is potential for substance use

- ~~///~~ practice saying no and suggesting other activities with counselor by Jan 15
- ~~///~~ say no and suggest another activity if close friend suggests attending party (movie, take a walk, go shopping or to mall, get ice cream, etc) by Feb 1

2. Susan will make friends who don't use substances

- ~~///~~ practice conversation skills with counselor by Feb 1
- ~~///~~ try out conversation skills with one person at school every day in Feb
- ~~///~~ invite one person who does not do drugs to an activity by March 1

3. Susan will learn how to cope with depression and anxiety better

- ~~///~~ participate in relaxation training with counselor by Feb 1
 - o practice relaxation exercise or other relaxation activity daily 7 times a week
- ~~///~~ learn other ways to cope with anxiety on dates and in other social situations
 - o positive self talk for dates and other social situations by Mar 1
 - o learn and practice conversation and assertiveness skills: how to say no, to agree, and to disagree with someone
- ~~///~~ consider meeting with doctor to discuss medication by April 1

4. Susan will fill her time with healthy and fun activities

- ~~///~~ attend school and homework club daily
- ~~///~~ attend karate class weekly (chosen by Susan as new 'fun' activity)
- ~~///~~ do one enjoyable activity a day (from list of 15 things generated by Susan) alone, with mother, or with a friend.

5. Susan will learn about rape, how to avoid being a victim and how to cope with the symptoms related to rape

- ~~///~~ read handout from counselor
- ~~///~~ consider attending group for rape survivors by listing pros and cons by feb 1

Susan and her counselor met weekly for a year. In the first four months they focused mostly on helping Susan learn and practice relaxation skills and the

social and assertiveness skills to stay away from parties and to say no when substances were offered. The counselor and Susan's mother also encouraged her to engage in other fun activities, which helped Susan's mood. After a few months, she agreed to see a psychiatrist for a medication evaluation and decided to try an antidepressant medication. She also agreed to get a medical evaluation and testing for infectious diseases. She stopped using substances but then had three different one-night lapses of heavy alcohol use, which she reported were related to going on a date and being offered alcohol. By the third month of treatment, the memories of the rape and anxiety related to them were less bothersome, but her social anxiety was not.

Susan, her mother, and the counselor reviewed her action plan at this point. In the next six months she and her counselor worked on reducing her social anxiety and developing more positive self-esteem by improving her conversation and assertiveness skills. In this context, she talked in more detail about how she was raped and her shame around this event. Her counselor suggested an AA group for young people and a rape survivors group to give her a place to make new friends and get further support, but Susan adamantly stated she would have nothing to do with groups. She did make a new friend at the afternoon homework club and started dating a boy from her Karate class. Neither one used drugs. She remained substance free for six months and stopped seeing the counselor when she entered college.

DIAGNOSIS
AND
COMPREHENSIVE
ASSESSMENT

This vignette is simplified for the sake of being brief, but it illustrates that clinicians have to clarify the psychiatric diagnosis and the extent of the substance abuse problems, as well as complete a contextual assessment of the substance abuse to be able to do effective substance abuse counseling. Susan's diagnoses were PTSD and polysubstance abuse (not dependence). She became aware that substance use worsened her problems in many ways and quickly became committed to giving up substance abuse. She was fully in the active treatment stage by the third meeting with her counselor.

COGNITIVE
BEHAVIOR
COUNSELING
AND STAGES
OF TREATMENT

Substance abuse counseling aims to help clients recover from substance use disorders. What the clinician does depends on the client's stage of treatment. During the engagement stage, the clinician focuses on establishing a trusting relationship in which substance use and other personal issues can be discussed openly. During the persuasion stage, clinicians focus on helping the client to develop motivation to change substance-abusing behaviors. These skills are described in the chapters on engagement and persuasion. *Cognitive behavioral counseling skills are particularly important when the client is actively trying to reduce or eliminate substance use in the active treatment stage or when the client is abstinent and attempting to maintain abstinence in the relapse prevention stage.*

THE ACTION
PLAN

Substance abuse counseling is based on an action plan that outlines a roadmap for how the client can get the needed skills and supports to reduce use of substances, obtain abstinence, or manage her illness better. The plan is based on a detailed analysis of the emotions, thoughts, behaviors, and circumstances before, during and after substance use. This information is gathered during the engagement and persuasion stages of treatment as the counselor gets to know the client's world through the client's eyes, learns about the details of the client's substance use, and helps the client to develop motivation for pursuing life goals. Individual targets of the plan can include biological, psychological, cognitive, interpersonal, and environmental antecedents or consequences to substance abuse. An action plan is always developed with the client. If the client is part of the process of developing the plan, she is more likely to understand it fully and to be confident in the plan. It also makes it clear that the client is a responsible participant in carrying out the plan.

The action plan includes the specific strategies, timelines, and responsibility for addressing each of the targets that can be clarified in the analysis of substance use. Cognitive behavioral counseling was used to help Susan learn to avoid or cope with internal cues and external situations that lead to substance abuse. Before a plan can be specified, however, the counselor needs to know about withdrawal, craving, triggers to use, expectations of use, and what reinforces use for the client.

CUES THAT
LEAD TO
SUBSTANCE
USE

Clients face many situations, emotions, and thoughts that lead to substance use (see the discussion in the chapter on assessment). Situations may be external cues to use substances. For example, being offered substances at a party was an external cue to use for Susan. Clinicians can help clients consider ways to avoid or cope with external cues. This is discussed in more depth in the next chapter on relapse prevention, though these clinicians will often help clients cope with external cues during the active treatment stage.

Many clients have difficulty managing emotions, which then lead to substance use. Emotions can be internal cues to use substances. Common emotions that precede substance use are anger, anxiety, depression, and loneliness, though people who have substance abuse problems report that almost any uncomfortable emotion can lead them to use substances. Helping clients manage uncomfortable emotions is a central part of substance abuse counseling.

Unpleasant emotions often are accompanied by negative or self-defeating thoughts, which can also be internal cues to use. For example, anger at a spouse might lead to these thoughts: "I hate him; I'm miserable in my marriage; it's all hopeless. I might as well drink." Or in Susan's case, anxiety in social situations led to two scenarios in her head: "I'm not popular enough; no guy will ever really love me for who I am; I just need a

drink to get rid of how bad I feel.” Or “I’m so anxious I can’t stand it; people are noticing how stupid I look; I need to drink to relax and fit in.”

Thoughts, emotions, and behaviors directly impact and change each other. By changing one of these three, usually the other two will change too. Events outside ourselves over which we have no control may trigger a thought, feeling or behavior that then leads to urges to drink. If clients can learn to monitor the thoughts, feelings, and behaviors that lead to urges to drink before they drink, and then modify them, they can avoid the drinking. Figure 1 describes the process of identifying the negative thought, emotion or behavior that leads to urges to drink, stopping the thought, and replacing the old response of using a substance with a positive thought or a coping behavior.

Figure 1: Using positive thoughts, emotions, or coping behaviors to stop substance use

Old pattern:

Event ➔ negative thought/emotion/behavior ➔ urge to use ➔ use substance

New Pattern:

Event ➔ negative thought/emotion/behavior ➔ STOP ➔ Positive thought/emotion

OR

Event ➔ negative thought/emotion/behavior ➔ STOP ➔ Coping behavior

COGNITIVE INTERVENTIONS

When you examine how clients come to use substances, *usually particular thoughts and feelings come before the urge to use, which is then followed by the substance use behavior.* One way to help clients to change their substance use behavior is to help them identify the thought or feeling, to stop, and then to change the preceding thought or feeling. Being able to manage negative thoughts and negative feelings can dramatically improve a client’s ability to stay away from substances. Figure 1 summarizes the important skills in this area, which include observing and identifying one’s thoughts and feelings, stopping the negative thoughts, and replacing them with positive thoughts.

Table 1: Cognitive skills

- ☞☞ Identify negative thoughts
- ☞☞ Categorize negative thoughts

☞☞ Stop negative thoughts

☞☞ Replace negative thoughts with positive thoughts

In Susan's case, the clinician helped her understand how her thoughts were linked to her feelings and behavior. Susan did this by keeping a journal of thoughts, feelings and behaviors, and by talking about situations in detail with her counselor. First, they looked at how social situations brought on anxiety for her. When in a dating or group situation, Susan worried about what others thought of her. The clinician taught her about different kinds of negative thoughts (see Table 2). The clinician helped her identify the thoughts she had in these situations, such as making an assumption and then leaping to an overgeneralization, like "he doesn't like me, he thinks I'm ugly, everyone must hate me," which led to negative self-statements, such as "I'm pathetic." These thoughts always made her feel anxious or depressed and led her to want to drink to get rid of her feelings and to forget her memories.

Table 2: Categorizing Negative thoughts

Unrealistic goals (perfectionism): "I must do everything right" or "Other people should always be friendly."

Imagining catastrophe: "If things don't work out exactly the way I expect, then it's useless, terrible, the end of the world."

Overgeneralization: "I am never on time" or "I will always feel this bad"

Expecting the worst: "Nobody will ever like me" or "My marriage is doomed"

Putting herself down: "My mother always said I was stupid" or "I'm weak"

Black and white thinking: "If that person doesn't like me, they must hate me" or "If I'm not perfect, I must be a complete failure."

The counselor helped her come up with different thoughts to use when she found her mind going in this direction (which she used in addition to a quick relaxation technique, as described below). What worked for Susan was to repeat a positive slogan she learned in Karate. Other clients may want to develop their own personal affirmation statement, such as “I can do it without alcohol” or “I have faith in myself.” Some clients find AA slogans helpful and use them to replace negative thoughts that lead to drinking. Other ways to reduce negative thinking are listed in Table 3.

Table 3: Ways to reduce negative thinking:

- ☞☞ Recall the good things in life and about yourself
- ☞☞ Challenge and refute irrational beliefs
- ☞☞ Avoid assuming catastrophe
- ☞☞ Re-label the distress
- ☞☞ Make a hopeful statement about yourself
- ☞☞ Blame the event, not yourself
- ☞☞ Remind yourself to stay on task
- ☞☞ Pat yourself on the back.

BEHAVIORAL INTERVENTIONS

Behavioral interventions to reduce or stop using substances include helping clients to improve conversation and assertiveness skills, to learn relaxation skills, and to increase pleasant activities to replace the substance use activities and to manage mood problems. These skills are also discussed in the next chapter on relapse prevention.

Table 1: Behavioral interventions to reduce substance use

- ☞☞ Conversation skills
- ☞☞ Assertiveness skills
- ☞☞ Relaxation skills
- ☞☞ Leisure skills

Susan experienced anxiety related to PTSD symptoms and social situations, which led her to crave alcohol. Therefore, the clinician worked with her on skills to manage the anxiety without alcohol. She focused on relaxation training, which includes helping the client develop awareness of body cues for anxiety and training her how to breathe and relax her body. The clinician helps the client practice this and then to use a quick deep breath and relaxing thought when in social situations that bring on anxiety.

Many clients with dual diagnoses lack social skills, including conversation skills and assertiveness skills. Since interpersonal problems often lead to substance abuse, most people benefit from improving their ability to interact socially with others. The skills that usually help people cope with interpersonal issues include how to: start and continue a conversation, listen, assert an opinion, make a request, refuse a request, give and receive criticism, and refuse an offer to use a substance. Susan had problems with both conversation skills and assertiveness skills. She used alcohol to help relax in social situations. Even though she didn't want to use drugs, she had no idea how to refuse. Learning these skills continues in the relapse prevention stage of treatment.

Another important behavioral intervention is to help clients start new enjoyable activities that reduce anxiety and depression, increase enjoyment, and replace the substance-using activities. Engaging the family to help reinforce the new activities can be helpful, as it was with Susan.

REVIEWING
THE ACTION
PLAN

One key aspect of an action plan is that it should be reviewed at a specified time point or earlier if something unexpected occurs. Reviewing the plan helps the clinician and the client see how they are doing and whether they are on track with learning new skills and attaining sobriety. It also allows for changing the plan if it is ineffective. When Susan relapsed on dates with boys, she and her clinician looked at the events and saw that early on she was unable to get her worries about the boy out of her mind and became overwhelmed by anxiety. She then ended up at a party and drank.

The counselor refocused their work by helping her understand that parties where alcohol and drugs were present were a bad idea, practicing skills for saying no to going to parties, and using affirmation and assertiveness skills to say no to boys who she thought were probably not going to be respectful to her.

DUAL
DIAGNOSIS
AND TRAUMA

The majority of persons with dual diagnosis have experienced traumatic events during their lives, and many have post-traumatic stress disorder. It is important to ask clients about trauma and to screen for PTSD. Effective interventions for clients who have experienced trauma include education, support groups, and cognitive behavioral therapy designed to directly

address symptoms of PTSD (for more information on how to help clients with these problems, see the reference at the end of the chapter.).

Many teenagers who will develop dual disorders present for treatment in emergency rooms. Unlike Susan, they usually do not show up for follow-up appointments. *Teens need close follow-up and assertive outreach to engage them into treatment early on in their illness.* They need to be offered information and a menu of treatment options. When engaged into treatment early, we believe there is a good chance of greatly reducing or preventing the problems persons with dual disorders experience.

It is essential to involve family members in the treatment of teenagers. Family therapy may be appropriate as the main form of treatment for dually diagnosed teenagers. Because Susan's drinking was triggered by anxiety problems, her treatment providers chose individual treatment, but the counselor also engaged the mother by providing education and enlisting her to provide structure and limits that reduced Susan's access to substances, and to provide support for increasing other fun activities.

Recommended Reading

There are many excellent books on cognitive-behavioral treatment of substance abuse. We recommend Treating Alcohol Dependence: A Coping Skills Training Guide, by Peter Monti, David Abrams, Ronald Kadden, and Ned Cooney (New York, Guilford Press, 1989). It offers a simple introduction to basic techniques that are effective with dual disorder clients in the active treatment stage.

Relapse Prevention

INTRODUCTION

During the relapse prevention stage of treatment, clients are in stable remission (not abusing substances), but they are still vulnerable to returning to substance abuse. Avoiding or reducing the impact of relapse, returning to work, improving social relationships, and getting more involved in recreational activities are important goals for the client in this stage of treatment.

This chapter presents a client who has stopped using substances and how his clinician helped him to maintain abstinence. Relapse prevention fosters the development of skills and activities to avoid alcohol and drugs and also to enhance life, for example, in the social, leisure, and vocational arenas.

VIGNETTE

Mark is a 35-year-old single man diagnosed with schizophrenia and alcohol dependence who lives alone in an apartment. He occasionally sees his brother, who is a drug dealer, and his sister, who is a secretary and doesn't use substances. Mark has been coming to the mental health center for the past 15 years. Three years ago he was referred to an assertive community treatment team for his dual disorders. After progressing through the stages of treatment, he has been sober for the last six months.

Mark and his counselor had developed a relapse prevention plan based on watching for early warning signs for relapse of substance abuse or mental illness. Hanging out with his old drinking buddies, driving by the liquor store, or being anywhere where drinking occurred, including bars or bowling alleys, were external cues, or early warning signs for his alcohol use; and not sleeping and feeling paranoid about police were early warning signs for his schizophrenia. Once these were identified, Mark and his counselor wrote down a relapse prevention plan that specified steps to take if he experienced any of these cues or high-risk situations. The plan also addressed what to do if he did relapse in order to minimize the length and severity of relapse. In Mark's case, the plan included immediate calls to his sister and to his counselor.

Since it was clear that spending time with old drinking buddies wasn't a good idea, Mark wanted to find new friends. He first renewed relationships with family. Mark enjoyed being around his sister again, went fishing with his

brother-in law, and had weekly dinners with his sister's family. His counselor helped him work on social skills to use in making new sober friends. He attended one meeting of Alcoholics Anonymous, but felt uncomfortable and didn't return. He did, however, join a local church and met several people by attending regularly.

In addition, Mark began to expand his recovery to other areas of his life. Although he had been working part-time as a janitor for the mental health center, he was dissatisfied with this job. An employment specialist helped him to find a new job working in the stock room of a local retail store, a job that he really enjoyed.

Two years later, Mark was still not drinking, though he had experienced one brief relapse after running into an old drinking buddy at the grocery store. He was able to call his sister the next day, and she helped him get back on track by calling his case manager, renewing his goal to be sober, and developing a plan for what to do if the old friend called him.. He was still working part-time, enjoying a positive relationship with his sister, and attending church. He said, "Some days I still wish I could drink, but I know I just can't go back." Despite encouragement and support, he did not return to Alcoholic's Anonymous. He did continue to meet with his case manager regularly to review his relapse prevention plan.

HOW TO HELP
CLIENTS WHO
ARE IN THE
RELAPSE
PREVENTION
STAGE OF
TREATMENT

Mark is in the early relapse prevention stage of treatment, where the main goal is to maintain his sobriety and expand his recovery to other areas of his life. His case management team, including his counselor, has taken five important steps to help him remain stable and sober, but also to help him expand his recovery. The first step is to make a relapse prevention plan that will enable Mark to prevent a relapse or to stop a relapse at the earliest possible point if it occurs. The next step is to develop better social skills to establish friendships with sober friends as well as to get along with family, roommates, and coworkers. A third important goal is to develop (or renew) social and leisure activities as alternative outlets from using alcohol and drugs. A fourth step is to explore new job possibilities that Mark finds more interesting than his current job. The last important step is to participate in self-help groups to maintain motivation and social support for sobriety.

These steps do not need to be accomplished in any particular order. Some clients will focus on a few but not all of the steps. Many clients will begin to work on some of these steps during earlier stages of treatment. Also notice that client preferences and choices are important. Mark did not want to use Alcoholics Anonymous but found that church was a consistent support system for him.

Table 1. Relapse Prevention Interventions

- ☞☞ Make a relapse prevention plan
- ☞☞ Support and reinforce previously learned skills for sobriety
- ☞☞ Facilitate social skills to make sober friends
- ☞☞ Facilitate social and leisure activities
- ☞☞ Explore job opportunities
- ☞☞ Encourage and facilitate participation in self help groups

MAINTAINING AWARENESS

Many of the skills and techniques used during active substance abuse counseling are still relevant in the relapse prevention stage of treatment. The clinician and client need to remember the client's specific cues or triggers for substance use. Though high-risk situations will be unique to each client, there are some cues or triggers that are common to many people. Common external cues include being with people or in situations where the client previously used substances, experiencing interpersonal stress (such as a disagreement with a family member or a breakup with a girlfriend), experiencing loss (losing a job or a case manager), and experiencing a relapse of mental illness symptoms.

The client then needs to learn to use strategies to avoid substance use when faced with an external cue. This may involve working with his clinician, treatment group, or self-help group to develop specific skills to carry out these strategies. They will include refusing substance use, leaving a stressful situation, and using distractions or other alternative behaviors, such as listening to relaxing music, instead of using the substance. Finally, identifying a supportive contact person who can be called for direction and support when the client feels he is at risk for using substances is vital.

Mark's main cues to drink involved being around people who drink or in places where drinking occurs. To address the cue of people who drink, the clinician can help him come up with ideas. Possible plans could include: (1) how to avoid these people, (2) finding different people to be with, (3) refusing a drink if he is with those people and is offered one, (4) calling a support person before taking a drink, and (5) staying busy with a particular activity or job to help him stay away from the old drinking friends.

SOCIAL SKILLS

Mental illness often interferes with relationships, and people with severe mental illness often have problems communicating effectively. They may

then use substances with others as a way of joining a social group and finding acceptance from others. That is, many dually diagnosed persons rely on substance use for social contact. With ineffective social skills, they are unable to refuse offers to use substances from old peers and are unable to develop new friendships with sober peers. Thus, developing good social skills is key to maintaining sobriety.

People use three types of skills to communicate with another person: social perception, problem solving, and behavioral skills. A person must be able to accurately perceive relevant social information in the situation, such as the other person's affect and whether the situation is public or private. After the person has sized up the situation, he needs to be able to decide on a communication goal, to identify options for achieving that goal, and to select one with a high chance of success. This involves solving problems. Once a response to the person has been selected, behavioral skills are needed to put it in action. These include non-verbal behaviors, such as how close to stand to another, and verbal behaviors, such as loudness and choice of words. Social skills training programs are available in user-friendly manuals (see Recommended Readings below).

Table 2. Communication Skills

- ☞☞ Social perception
- ☞☞ Problem solving
- ☞☞ Communication behavior skills

Groups or individual counseling can be used to teach social skills. The five basic skills important as a foundation for more complex skills include: (1) listening to others, (2) making requests, (3) expressing positive feelings, (4) expressing unpleasant feelings, and (5) refusing an unreasonable request. Clinicians can explain the behavior and its specific components, show the client the specific skills, and help the client to practice the skills with the clinician or with other clients in a group. Clients need feedback and practice to be able to use these skills in real life.

Table 2: Basic Social Skills.

Listening to others

- ☞☞ Maintain eye contact
- ☞☞ Nod your head
- ☞☞ Say "OK or uh-huh"
- ☞☞ Repeat what the other person said.

Making requests

- ☞☞ Look at the person
- ☞☞ Say exactly what you would like the person to do.
- ☞☞ Tell the person how it would make you feel.

Expressing positive feelings

- ☞☞ Look at the person
- ☞☞ Tell them exactly what it was that pleased you.
- ☞☞ Tell the person how it made you feel.

Expressing negative feelings

- ☞☞ Look at the person. Speak calmly and firmly.
- ☞☞ Say exactly what the person did that upset you.
- ☞☞ Tell the person how it made you feel.

Refusing an unreasonable request

- ☞☞ Look at the person. Speak calmly and firmly.
- ☞☞ Tell the person that you are sorry but you are unable to do what they asked.

When a client has a substance use disorder, using substances typically becomes a preoccupation so that other enjoyable activities and relationships are given up. Often clients with dual disorders can't remember how they used to have fun. If the only rewarding activity in a person's life is using alcohol, he is unlikely to give it up unless he has learned other ways to have fun. People with dual disorders often need to relearn ways to relax and pursue enjoyment. Clinicians should ask clients what they enjoy doing. Sometimes you will have to help the client remember what he did as a child to help him remember what he used to

like to do for fun. Ask about all kinds of recreation: hobbies, crafts, sports, social activities, clubs, classes, art, household activities, yardwork, and volunteer work.

In some cases, it is helpful to give clients a list of fun activities and ask them what they used to do for fun and what they'd like to do now for fun (see Table 3). The list reminds people about which activities can be fun. Help the client set a goal for specific activities they'd like to complete in the next week and help them fulfill the goal.

Table 3. Fun Activities

Listening to music	Playing the piano
Playing the guitar	Reading a magazine
Reading a newspaper	Watching a sports game
Playing tennis	Playing basketball
Riding a bike	Taking a walk
Watching a sunset	Swimming in a pool
Going to a beach	Eating an ice cream cone
Eating a piece of pizza	Going out for coffee
Doing a crossword puzzle	Playing cards
Volunteering at a hospital	Writing a letter
Mowing the lawn	Raking the leaves
Planting flowers	Watering plants
Organizing your closet	Buying a new shirt or dress
Window shopping	Giving a gift to a friend
Calling a friend	Calling a family member
Taking care of a pet	Writing a story
Taking a class	Writing a letter to the editor of the paper
Doing your hair in a new way	Painting your fingernails
Making a shelf	Sewing a tablecloth
Knitting a scarf	Painting your room
Collecting stamps	Baking a cake
Learning a new hobby	Learning a new sport

Work is a critical part of recovery for many clients. Having a daily activity like work is a major predictor of staying sober. Aside from the financial rewards, work is reinforcing in many ways that help people stay sober. Going to work helps people feel normal. It gives people a sense of purpose in life and helps them feel they are contributing to the world. It provides a place to make friends with other sober people. It provides structure in the day.

Surprisingly, people with dual disorders can hold down jobs as well as people who have severe mental illness who don't have substance use problems. Furthermore, many report that working was a key step in the recovery process. Encourage your clients to work. The vocational services described in the vocational toolkit are effective for people with dual disorders.

Episodes of mental illness can lead to relapses in substance use. Thus, it's important to encourage your clients to use medications, manage stress management, get adequate sleep, use social support, engage in enjoyable activities, and use recovery strategies to avoid or minimize symptoms of mental illness as well as to avoid abusing substances. Rather than badgering your client to take medication, you can help the person to develop an overall plan for achieving and maintaining wellness. This plan usually involves learning how to use medications effectively as well as many other strategies.

Recommended Reading

Social Skills Training for Schizophrenia: A Step-by-step Guide, by Bellack, Mueser, Gingerich and Agresta (Guilford, 1997).

Relapse Prevention, Maintenance Strategies in the Treatment of Addiction edited by Alan Marlatt.

Group Treatment for Dual Disorders

INTRODUCTION

Group treatment for substance abuse problems is often highly effective. In a group setting, people with dual disorders can learn from and be supported by others who have had experiences similar to their own. A peer network develops that can increase social support and enhance the recovery process. Many types of groups can be helpful for persons with mental illness and substance use disorders. This chapter presents a woman with bipolar disorder and alcohol abuse who used a group to learn more about how alcohol was affecting her life and to develop motivation to stop using. Groups can be helpful both for people who are in the persuasion phase of treatment and for those who are in the action phase of treatment.

VIGNETTE

Vicky is a 23-year-old African-American woman who has been diagnosed with bipolar disorder and alcohol dependence. Vicky has shown symptoms of bipolar disorder since she was 17 years old and reports that she started drinking alcohol around the same time. She had a full-blown manic episode at age 21, when she stayed awake for several days studying for courses she was taking in college. She became convinced she was teaching the courses and acted this way in class, resulting in her dismissal. After two months of hospitalization and medication, she did not return to college.

Vicky worked at a series of jobs. She started drinking alcohol daily, however, and her moods became unpredictable with wild ups and downs. She was often unable to work and lost several jobs. She experienced another manic episode and was hospitalized again. When she was able to think clearly, she realized that her landlord had given her notice of eviction because she hadn't paid her rent. She had no way to pay the hospital either. The hospital social worker referred her to the mental health center.

For the next 12 months, the assertive community treatment team worked with Vicky to engage her into treatment, to stabilize her living situation, and to help her stay on medication. After they developed a good relationship with her, they began talking with her about how alcohol seemed to be interfering with her personal goal of holding down a steady job and returning to college some day. Vicky was in the persuasion stage, and the team felt it would be appropriate for

Vicky to attend the team's dual diagnosis group. They suggested that she could meet people struggling with issues similar to hers.

At first Vicky was reluctant to attend the group. She wasn't sure she would fit in and she didn't want strangers knowing about her troubles. She was afraid she would be the only African American person in the group. Vicky did come into the mental health center once a week, so the team suggested she give the group a try for a month because she was already at the center, and she could meet with her case manager after the group. Her case manager let her know that there were other people of color in the group, and that one of the leaders was African American.

Vicky agreed to try it for one month. She was surprised to see that popcorn and soda were served and that people seemed pretty nice. At first when people were talking about their substance use, she felt nervous and passed when it was her turn. She was shocked at how bad some of the other people's problems were. The group leader let Vicky's case manager know that she wasn't talking in the group, and her case manager then talked with her about her fears of "people knowing my business." The group members reviewed the policy of confidentiality. After the third week, she began to talk about how much she enjoyed drinking alcohol. She also talked some about how much her father used to drink, and how badly he acted when he was "really bad drunk." She heard about how other people had parents who abused substances, and how substance use disorders are biological diseases that can run in families. She was impressed when another group member announced that she was planning to start attending AA with her brother, who had stopped drinking a year ago, and that that group member was going to stop drinking. She told her case manager that she felt she might have something in common with some of the people in the group. She really liked one of the group leaders, and would stay after the group to talk with her.

During the group there were many discussions about how substance use interacted with mental illness. Another person in the group had bipolar disorder. Vicky learned from the discussions about how she and the others were more sensitive to the effects of alcohol than someone without a mental illness, and how drinking can worsen mania or depression. As people talked about their substance use, the group facilitators would start a discussion about the similarities for group members and help people examine some of the negative consequences of their use. Vicky talked about how alcohol helped her feel better when she was feeling like a failure in her life. This led to a discussion with her doctor about depression and whether alcohol prevented her medications from helping as much as they could.

Over time Vicky began to see that her daily alcohol use was interfering with her ability to keep a job. With the help of the group, she decided to try a period of drinking only on nights when she didn't have to work the next day. Group members helped her come up with ideas about what to do on the nights she didn't

drink. A few of them offered to get together with her to watch TV or play cards. Vicky stuck with this plan for several months and remained in her job for over a year. She eventually chose to stop drinking completely.

GROUP
INTERVENTIONS

Groups can be a powerful way for clients to learn about themselves, to learn new skills, to find models of recovery, to develop new values, to develop social supports, and to have the experience of helping others. Feedback from peers is often more valued than the opinions of treatment providers. Groups are also a cost-effective way of providing education and treatment to several people (usually 6-12) at the same time.

Many types of groups are used for clients with dual disorders. Self-help groups like Alcoholics Anonymous and Narcotics Anonymous are described in the next chapter. Skills training groups can help people learn particular skills, such as social skills or work skills. Educational groups usually focus on a specific topic, such as the effects of substance use. Stage-wise treatment groups focus on helping people who are in the same stage of treatment to move toward recovery from their substance use disorder. Persuasion groups are for clients who do not yet see that their substance use is a problem; they are in the late engagement and persuasion stages of treatment. Active treatment groups are for clients who have decided that substance use is a problem they want to change. Active treatment groups are for people in the active treatment and relapse prevention stages of treatment.

PERSUASION
GROUPS

Persuasion groups are supportive, educational groups for people in the early stages of substance abuse treatment. Participants are encouraged to explore how their substance use affects their lives, with the goal of helping them to see how substance use interferes with reaching their own goals. Like Vicky, most clients are anxious about attending a group for the first time. Case managers or therapists need to explain that the purpose of the group is NOT for the client to give up using substances, but is just to learn about substances in a supportive environment with other people like themselves. Case managers should help people start the group by asking them just to attend for a short time to see what it is like. Group leaders need to be in contact with team members so that individual and group treatment can be coordinated.

Persuasion groups are long-term and have group members coming and going all the time. They may be co-led by an addiction professional and a mental health professional, and often one or both leaders are recovering persons. Consumers in recovery may be very helpful co-facilitators. The groups meet weekly and last forty-five minutes or an hour. They often have a break in the middle for snacks and socializing to keep people's attention up.

Table 1. Characteristics of persuasion treatment groups

- ☞☞ Supportive
- ☞☞ Non-judgmental
- ☞☞ Facilitate peer interaction
- ☞☞ Provide education
- ☞☞ Use motivation interviewing techniques
- ☞☞ Long-term
- ☞☞ Support attendance

Leaders of persuasion groups expect that group members are currently abusing substances. They offer an open, non-judgmental opportunity for people to talk about how they use substances and how their lives are going. Each group begins with everyone sharing how their week went and what their substance use was like. The leaders use this information to begin a discussion about common problems people are having and to encourage peer-to-peer interaction. Motivational interviewing techniques are also used to point out how people's substance use is interfering with taking steps towards their goals. Vicky was able to learn from others in the group, and was able to get help from them when she was ready to consider cutting back on her alcohol use. Like many clients, she trusted the opinions of her peers because she believed they knew what living with dual disorders is really like.

Many clients are initially resistant to participating in groups but subsequently become very attached to the group. Leaders try to maintain attendance by making the group low-key, supportive, and fun. They make sure that every client feels valued by checking in with each person. They do not confront people about their substance abuse, and they keep the group safe and positive for everyone. Refreshments are usually served. Some groups will have a weekly drawing for a prize, such as tickets to the movies. Sometimes groups will have structured activities or group outings that help keep clients interested in attending the group. One often hears that helping people to connect with the group initially is the most difficult step. Once they become a regular member and feel part of the group, almost everyone benefits. Excellent programs are able to engage about two-thirds of their clients with dual disorders in group interventions.

Table 2. Characteristics of active treatment groups

- ☞☞ Supportive
- ☞☞ Educational
- ☞☞ Skills building
- ☞☞ Skills to cut down on substances or to maintain abstinence
- ☞☞ Identifying triggers for substance use
- ☞☞ Social skills
- ☞☞ Coping skills
- ☞☞ Self-care skills
- ☞☞ Long-term
- ☞☞ Expect sobriety

When consumers make a decision to reduce their substance use or try a period of abstinence, they are ready for active treatment groups. Vicky was ready for an active treatment group at the end of the vignette. The goal of active treatment groups is to help people stop using substances and to learn new skills to maintain abstinence. These weekly groups are also co-led by a substance abuse specialist and a mental health specialist who encourage peer-to-peer interactions and support. They last 60-90 minutes, in addition to a break in the middle. Because clients in this stage are motivated to stop all substance abuse, the expectation is that clients will attend regularly without group leaders needing to use engagement activities.

Active treatment groups are offered on a long-term basis, with people participating for as long as they feel they need for support. People further along in recovery act as role models for people still trying to achieve abstinence. When a person in the group relapses, members help them get back on track. Group leaders help the group use the relapse as a learning experience. If a client is unable to stop using substances within a few weeks after relapse, they may need to return to a persuasion group. When people are ready to graduate from active treatment groups, they may want to go on with a self-help group to continue to get social support for sobriety.

In active treatment groups, leaders provide education about how to reduce and stop using substances. They provide training for skills that will help people achieve their goals for recovery. These skills include being able to

recognize high risk situations as well as internal and external cues that lead to substance use. Leaders help people learn and practice communication skills for assertiveness and for refusing substances. Group leaders also help clients explore new ways of coping with stress. They might teach clients stress management skills such as relaxation techniques or imagery to deal with cravings. Self-help materials are often used, and participants are encouraged to try self-help groups in the community.

Active treatment groups usually start with clients taking turns describing how their week went and any challenges they faced in staying sober. Group leaders decide which problems may be relevant to focus on that week and encourage group members to become involved in offering concrete suggestions and participating in role plays that permit practicing a particular skill or confronting a particular situation. Clients give feedback and support to those who do a role play.

C O M B I N E D
G R O U P S

In many treatment settings, clients in the persuasion and active treatment stages are invited to participate in one combined substance abuse treatment group. Mental health centers may choose to run a single substance abuse group when they feel there are not enough clients to attend two separate groups. The challenge in running a combined group is meeting the varied needs of all group members. Clients in the persuasion stage of treatment need to explore the effects of substance use on their lives, while those in the active treatment stage need to learn new skills to stop using substances, to remain abstinent, and to go on with their lives. The advantage of a combined group is the opportunity for clients in the engagement stage to have peer role models that are abstinent. The disadvantage of combined groups is that issues relevant for clients in the persuasion stage may not be relevant for active treatment, so some active treatment clients lose interest and drop out. Ideally, groups for both stages should be offered.

Recommended Reading

Many books and articles discuss specific types of groups. We recommend the following chapter, which describes different types of groups: Mueser, K.T., & Noordsy, D.L. Group treatment for dually diagnosed clients. In R.E. Drake & K.T. Mueser (Eds.), Dual Diagnosis of Major Mental Illness and Substance Abuse Disorder II: Recent Research and Clinical Implications (pp.33-51). San Francisco: Jossey-Bass, 1996.

For Social Skills Training, see Social Skills Training for Schizophrenia, A Step by Step Guide by Alan Bellack and others (Guilford, 1997).

Self-help

INTRODUCTION

Self-help is a recovery-oriented process where peers share their experiences, strengths and hope to help others overcome a variety of illnesses and behaviors. A variety of peer-support organizations exist for people who are working toward recovery or who are in recovery from problems related to substance use disorders: Alcoholics Anonymous (AA), Cocaine Anonymous, Narcotics Anonymous, Rational Recovery, Double Trouble and Dual Recovery Anonymous (specifically for people with dual disorders), and others. This chapter describes a woman with bipolar disorder, alcohol dependence, and cocaine dependence who begins to use AA. This chapter covers how self-help groups work, how to help your clients use them, and what to expect when your clients go to them.

VIGNETTE

Joanne is a 30-year old woman with bipolar disorder, alcohol dependence, and cocaine dependence. She has been going to the local mental health center for treatment for ten years and attended treatment groups for the past two years without making much progress. About a year ago, she had a manic episode during which she was charged with driving while intoxicated. She felt unjustly charged, and discussed the issue with her counselor and her peers in the group. After some months of discussion, she accepted that she would have to follow the judge's recommendation to do something about her substance use.

In the last six months, Joanne tried to avoid drugs, but whenever she went out with friends, she couldn't resist the temptation to get high with cocaine. Her case manager pointed out that after the high, she seemed to be more depressed for several days. Joanne became discouraged about quitting because she didn't want to stay away from her friends who were using. Joanne's case manager asked her if she had ever tried a self-help group like AA to stay sober and as a way to meet sober people. Joanne replied she had gone to one meeting several years ago, but she didn't like it. She didn't feel like she fit in and she didn't want to have to talk in front of a big group of people that she didn't know. The case manager explained that there are many different AA meetings and encouraged Joanne to try several, suggesting that maybe she could find a group where she felt more comfortable. They obtained a meeting list and picked out a few meetings that were close by at times that were good for Joanne. The case manager offered to attend a few meetings with Joanne so she wouldn't have to go by herself. They

picked open speaker meetings in which Joanne would not have to speak. The two attended the meetings and then talked about how it felt on the drive home. Joanne said she felt nervous, but also relieved that she was not alone in her attempt to get sober.

With Joanne's consent, her case manager approached another recovering client about helping Joanne to find meetings that she liked. The case manager introduced Joanne to this person and Joanne agreed to attend more meetings with her. Joanne finally found two women's meetings in which she felt comfortable and began attending them regularly on her own. After a few months of attending, she met a woman she liked and trusted, and asked the woman to be her sponsor. She and Joanne began talking and attending meetings regularly.

INTRODUCTION
TO SELF-HELP

The term self help refers to a process of working towards recovery from mental illness or substance abuse with a group of people who share the same problem. The most widely used form of self-help for drinking problems, Alcoholics Anonymous (AA) is an organization of people who use mutual support groups, sponsorship, the 12 Steps, and the 12 Traditions to recover from substance use disorders. AA was founded in 1935 and has millions of active members in over 100 countries.

AA is an invaluable but free resource that enables many people to attain and sustain recovery. Though AA is often referred to as a support system or an adjunct to treatment, it is actually a remarkable organization that offers people with substance use disorders virtually everything known to be helpful in recovery. AA offers a regular activity, a new way of seeing the world, sober friends and supports, hope, role models, spirituality, cognitive-behavioral strategies for change, emergency help, a way of making amends for past mistakes, and an opportunity to help other people. Many other successful approaches to self-help have been modeled on AA.

SELF-HELP
AND THE 12
STEPS

AA is based on the 12 steps to recovery, the 12 traditions, and mutual responsibility. AA is the model upon which many other self-help groups are based, including Narcotics Anonymous, Cocaine Anonymous, and Dual Recovery Anonymous (specifically for dually diagnosed people). 12 step meetings are self-help groups run by non-professional people who are themselves working on recovering from addictive disorders. Clinicians who refer clients to 12-step meetings should attend some open meetings to see what they are like. They should understand the meaning of sponsorship and of AA's concept of a higher power (discussed later in this chapter). They should be familiar with local meetings, including self-help groups that understand and accept people who are taking medicine, as these groups will be the most accepting of people with dual disorders.

Table 1: The 12 steps to recovery

Step One: We admitted we were powerless over alcohol—that our lives have become unmanageable.

Step Two: We came to believe that a Power greater than ourselves could restore us to sanity.

Step Three: We made a decision to turn our will and lives over to the care of God as we understood him.

Step Four: We made a searching and fearless moral inventory of ourselves.

Step Five: We admitted to God, to ourselves and another human being the exact nature of our wrongs.

Step Six: We were entirely ready to have God remove all these defects of character.

Step Seven: We humbly asked him to remove our shortcomings.

Step Eight: We made a list of all persons we harmed, and became willing to make amends to them all.

Step Nine: We made direct amends to such people wherever possible, except when to do so would injure them or others.

Step Ten: We continued to take personal inventory and when we were wrong promptly admitted it.

Step Eleven: We sought through prayer and meditation to improve our conscious contact with God as we understood him, praying only for knowledge of His will for us and the power to carry that out.

Step Twelve: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

The 12 steps are guidelines to recovery (See Table 1). The founders of AA believed there was a process that people went through to achieve sobriety. They wrote this process down in a step-by-step way for others to follow. The process of working on the 12 steps in a peer-group setting with a sponsor helps people to stop using alcohol and drugs and to stay sober by helping them develop skills and supports.

People learn by reading from self help literature, by observing the unsuccessful and successful coping strategies of others in groups, and by being coached by their sponsor and peers in the groups (see below.) The AA model of self-help works in many ways, and numerous books have been written about recovery through 12-step programs. For example, psychologists have pointed out that 12-step programs help people learn to manage their feelings, to reduce their use of avoidant and destructive coping strategies, and to increase their use of healthy cognitive and behavioral coping strategies.

AA is not a religious organization, but it does have a spiritual component. The steps talk about a higher power. In 12-step meetings, people are encouraged to believe that a higher power can be anything outside of themselves that can help them to change their addictive behavior, though many people do think of a higher power as God. To participate in AA, it is not necessary to believe in a higher power, but it does play a role in many meetings. Some meetings open or close with the Serenity Prayer or the Lord's prayer. Rational Recovery is a self-help organization that uses principles of AA without the emphasis on religion or higher power.

DIFFERENT
TYPES OF 12-
STEP
MEETINGS

In the vignette, the clinician attended an open speaker meeting with Joanne. The difference between open and closed meetings is that anyone interested may attend an open meeting. Closed meetings are just for people who admit to having a problem. There are many types of AA meetings. In speaker meetings, someone tells the story of his or her illness and recovery. Discussion meetings involve open discussion, and people bring up problems they are having with their addiction. In step meetings, one of the steps is read aloud and discussed. In Big Book meetings, a chapter in the Big Book of Alcoholics Anonymous is read, and people discuss it. Clinicians should help clients choose which meetings they would feel most comfortable at. People never have to speak at a meeting other than to say they pass, but a discussion meeting is not a good place to start for someone who feels uncomfortable speaking in a group. Mental health clinicians who refer clients to 12-step meetings need to understand AA and types of meetings; they should definitely attend some open meetings to see what they are like.

SPONSORSHIP

In the vignette, Joanne finds a sponsor. A sponsor is someone with stable (usually 4 or more years) sobriety. Sponsors often talk to people they sponsor daily, go to meetings with them, and socialize with them. Sponsors guide a person through the steps of the program and help when a person has an urge to use substances. Many sponsors make themselves available day or night. People are encouraged to get a sponsor of the same sex. Persons who are willing to be sponsors usually raise their hands at meetings. When your client is looking for a sponsor, they need to pick someone they like and trust, as this is important to developing close relationship with them. Often groups will have a list of

temporary sponsors, who agree to take phone calls or give rides to meetings to support someone until they find the “right” sponsor for them.

WHO SHOULD
GO TO 12-STEP
MEETINGS?

Who should go to self-help meetings? The meetings are helpful for persons who want to go, for persons who have no sober support network, and for persons who like the idea of peer support rather than or in addition to professional supports. Since AA and other self help groups are so widely available, affordable (free), and offer so many different tools and supports for recovery, everyone should be encouraged to try them. Participation in 12-step groups for people with dual disorders can be a very positive experience even if the person does not have the cognitive ability to embrace the 12 steps and traditions. When a dually disordered person finds a “home” group, he often experiences a sense of acceptance and community that was previously missing from his life.

Many 12-step meetings rely on the concept of accepting that one is an “addict” and using this self-identification to accept help from others and to avoid substance use. Some dually diagnosed people with psychotic disorders have difficulty tolerating this type of self-concept, which is experienced as a threat to self-esteem. Clients who are clear that they do not want to attend and clients who are very angry should not be pushed to attend 12-step groups. However, they may find AA more congenial at a later stage of their recovery process. Sometimes people have difficulty with accepting the concepts of powerlessness and character defects. Additional readings or reinterpreting the steps with more empowering concepts can be useful.

Table 2 outlines the steps the case manager took to help Joanne get involved with self-help groups. In the vignette, the clinician had a meeting list, so it was an easy task to sit down with Joanne and pick out some meetings. If you don’t have a meeting list, you can always look AA up in the yellow pages. People with severe mental illnesses who are symptomatic often need more help than Joanne did to use 12-step groups. They may need an introduction to the ideas used in these groups. They may need explicit coaching about what to wear, how to act, and what to say. A case manager or counselor may need to go to meetings with a client for a longer period of time. Some clients will need social skills training to learn the skills to interact appropriately at 12-step meetings before they are ready to attend. While at meetings, clinicians can greet people and shake hands to model social skills. It often helps to discuss the meeting afterward to clear up any misunderstandings. If meetings for people with dual disorders, such as Double Trouble or Dual Recovery Anonymous, are available, many of these difficulties are eliminated.

Clients should be instructed about some of the unwritten “etiquette” expected at self-help meetings. For example, remind your client that what he sees and what he hears at the meeting is confidential, that is the

“Anonymous” part of the program. When someone is talking, you remain in your seat. If coffee and/or food is provided, you might provide a donation and only take one helping. If the meeting is non-smoking, you can’t smoke. For people with dual disorders, this type of orientation will help them be accepted by the group.

Table 2: How to help your client attend self help groups

- ☞☞ Talk with your client about self help groups, the pros and the cons.
- ☞☞ If your client agrees to try one meeting, pick a meeting appropriate for your client.
- ☞☞ Talk about what expect, what to do, and how to act at the meeting.
- ☞☞ Go to the meeting with your client.
- ☞☞ After the meeting, ask client how it went and give feedback on your perspective of how it went.
- ☞☞ Tell the client at least one positive behavior he used during the meeting.
- ☞☞ Choose another meeting, attend with your client, and discuss how it went.
- ☞☞ If the client is willing to continue to attend meetings, link him with another recovering person who will go to meetings with him.

OPTIONS IN SELF HELP

Many self-help options are available. In the vignette, Joanne was able to successfully use AA as a support system. Initially, she had some ambivalence because she had tried it once and didn’t feel like she fit in. Many dual disordered clients feel this way. There are different reasons for these feelings. Some people are uncomfortable with the spiritual aspect of the program. An alternative might be Rational Recovery where spirituality is not a part of the program. Another reason dual disordered people feel uncomfortable is that their mental illness makes them feel like they don’t belong. A Dual Recovery Anonymous group might help solve that problem. If Joanne had not succeeded in AA, her clinician might have encouraged her to try Narcotics Anonymous or Cocaine Anonymous, which directly addresses addiction to substances other than alcohol. If a dual disordered person tries and really dislikes 12-step programs, a clinician should look for alternative ways to support that person’s recovery.

Recommended Reading

We strongly recommend *The Dual Disorder Recovery Book* (Hazelden, Center City, Minnesota, 1993) for a discussion of self-help and recovery for persons with dual disorders. Additionally, George Vaillant's book, *The Natural History of Alcoholism* (Cambridge, MA, Harvard University Press, 1995) offers a brilliant analysis of natural pathways to recovery and explains how self-help and treatment can enhance the process.

To learn more about 12-step programs, consider reading *The Big Book* by Alcoholics Anonymous World Services, Inc. Staff and *Rational Recovery* by Jack Trimpey (Pocket Books, 1996).

Family Treatment

INTRODUCTION

Because families can be such a strong source of support for clients with dual disorders, it is important to include them in treatment. This chapter presents a young man with schizophrenia and alcohol abuse whose family played a critical role in his recovery. The clinical team can involve the family in different ways at each stage of treatment.

VIGNETTE

Jack is a 26-year-old, unemployed man diagnosed with schizophrenia and alcohol abuse. When he drank, his symptoms of schizophrenia seemed to worsen, including delusions of reference, poor attention, and disorganization. Jack had been hospitalized three times and had not worked in several years. He argued frequently with his mother and stepfather, with whom he lived. Though he wanted friends, he had difficulty meeting people.

One day Jack's mother called his case manager, furious because she had found a bag of what appeared to be marijuana in his bedroom. She demanded to meet with Jack's treatment team. When Jack's case manager mentioned this to Jack, he agreed that his substance use was causing problems with his parents and that they should all meet.

In a long family meeting, the treatment team tried to understand each person's view of the current situation and what each was hoping could happen. They offered Jack and his family several options. First, there was a monthly educational group at the mental health center. Second, the National Alliance for the Mentally Ill (NAMI) also held a monthly meeting of families who were trying to help a family member with mental illness. Third, they could work with a therapist to get family therapy. After explaining each of these options, they agreed that Jack's parents would attend a NAMI meeting and that the family would discuss the options and call the case manager about what they would like to do next.

Two weeks later, Jack's parents called again with the news that Jack had come in "stumbling drunk" and that a huge fight had ensued. They all returned to the mental health center and quickly decided to try family therapy.

The therapist met with each family member to understand their view of the problem and their situation. Jack expressed an interest in making some friends,

and in having a girlfriend. He recognized that his drinking was a problem and said that he wanted to cut down. Jack's mother expressed extreme anxiety over his mental illness and the effects of alcohol. She felt that Jack was unable to take care of himself and that she needed to monitor him daily. Jack resented what he perceived to be his mother's over-involvement in his life, which led to conflict between them. Despite these problems, they both enjoyed being together. Jack's mother wanted to spend less time managing Jack's illness and more on herself (e.g., taking an exercise class) and with her husband. Jack's stepfather was supportive of his wife's concern for Jack, but he tended to be highly critical, which often inflamed difficult situations. He didn't understand schizophrenia, but was interested in learning more. He wanted Jack to live more independently so that he and his wife could travel more.

The family treatment began with weekly educational sessions. Jack talked openly about his symptoms and his stepfather began to see what the experience was like for Jack. During the educational sessions on substance use, Jack gained a better understanding of how he used substances to escape from feelings of failure but how using actually made things much worse. Jack's mother contacted the local NAMI group and began to attend a group, which she found quite helpful.

In several months, the family was introduced to problem-solving exercises. They worked on several problems in succession over the next eight months. First was getting Jack involved in activities and meeting potential friends. He enrolled in a course at a local community college within a few months. Social skills training with his case manager helped him to make a friend at the college, and he met several sober friends in a dual disorders group.

The second goal was to increase Jack's independence. After several discussions, Jack moved into supervised housing, and several months later he got his own apartment. The family members agreed on how much support the mental health team would provide and on how often Jack's mother would check on him in the new apartment.

The third issue was Jack's drinking, which the family chose not to address until Jack relapsed after a few months of sobriety. Several sessions addressed treatment planning, Jack's involvement in a dual disorders treatment group, understanding the course of recovery, and the family's role in encouraging sobriety without reacting strongly to drinking. Jack again- became committed to reducing his drinking, and the family learned more about accepting his need to learn to control his own behavior. He reduced his drinking dramatically. The parents were extremely proud of the progress that Jack made and were able to understand brief setbacks as part of recovery.

After one year, the family sessions ended. Jack and his parents continued to be regular participants at the monthly multiple-family group meetings. Jack's parents appreciate the support from other families and continue to learn more

about dual disorders from other families. They are also helpful to other families that are feeling helpless about their relatives' drinking.

Jack has found a couple of non-drinking friends and a part-time job. He has succeeded in dramatically decreasing his drinking; he currently drinks one or two beers on occasion and has long periods of abstinence. He has been abstinent from marijuana use since beginning the family sessions. Jack's mental illness has been stable for almost two years, and he has not been hospitalized since the beginning of family work. His current goals are to find a better job and a girlfriend. Jack's parents have achieved their goal of having more time for themselves, and have taken several vacations on their own.

THE
IMPORTANCE
OF FAMILY
INTERVENTIONS

Working with the families of dually diagnosed clients is extremely important. Clients often have few friends, small social networks, or drug-abusing friends who encourage self-destructive behaviors. Family members can be their most important social supports. However, these clients and their families typically experience serious tension and conflict around substance abuse, difficult behavior, and symptoms of mental illness. Families may not understand the interactions between substance use, severe mental illness, and behavior. They need practical information about dual disorders and help in developing strategies to meet family goals. Family treatment can reduce stress in the family, increase the family's ability to offer positive supports, and focus everyone on the same goals.

STAGES OF
TREATMENT
FOR FAMILIES

The concept of stages of treatment described in the previous chapters can also be useful for working with families. At the beginning of treatment, during the engagement stage, the clinician can reach out to families, provide them with practical assistance, and give them information about mental illness and substance abuse to establish a working relationship. This does not appear to have happened with Jack's family because the family initiated contact with the team.

As the family enters the persuasion stage, the clinician provides education about the effects of substances on the course of mental illness and about treatment. Education helps the family become interested in addressing the substance abuse. If needed, clinicians can use motivational interviewing to help family members recognize the impact of substance abuse. Families need to see substance abuse as a barrier to their family member's goals. In Jack's case, the clinician helped the family focus on Jack's goals as well as his parents' goals.

When family members are committed to the same goals of reducing substance use, they enter the active treatment stage. Many different methods can be used to help the client learn to manage his illnesses and

pursue goals, depending on the client's motivation to change, the circumstances of the client's substance abuse, and the family's communication and problem-solving skills. When the client has reduced substance use, family work in the relapse prevention stage aims at minimizing vulnerability to relapses of substance abuse and expanding recovery to other areas of functioning. Jack's family was able to make progress in many different areas.

FAMILY
INTERVENTIONS

Family interventions for persons with dual disorders can include education, involvement in an individual's treatment plan, family therapy, family support groups, and involvement with organizations that support families such as the Alliance for the Mentally Ill (See Table 1). Families can participate in any or all of these options. Combinations of treatment and support groups can be especially helpful.

Table 1: Family Interventions

- ☞☞ Education
- ☞☞ Involvement in treatment planning
- ☞☞ Family Therapy
- ☞☞ Family Support Groups
- ☞☞ Organizations such as the National Alliance for the Mentally Ill

When trying to decide which intervention will be most helpful for a family, assess the family member's areas of interest and motivation for involvement. Try to get families involved in at least one of the interventions listed in Table 1. Any interaction with family is better than none. As with clients, it is critical to treat families with dignity and respect. They have a wealth of knowledge and experience with your client that is invaluable.

EDUCATION

The primary goal of education is to help the family understand the nature of the psychiatric illness and its interactions with substance use. Most families know little about mental illness and even less about substance abuse. Though they want to help their family member, they may not understand the recovery process or know how to nurture recovery. Helping families understand the situation from the client's perspective is a powerful way to enlist their support. Their new understanding helps them learn to work together on shared goals.

Education can be provided verbally, with pamphlets, with books, with videos, and in support groups with speakers. Education alone is helpful for many families, but by itself is not a treatment for a client with dual disorders.

Family education typically covers eight topics: 1) psychiatric diagnosis; 2) medications; 3) the stress-vulnerability model; 4) the role of the family; 5) basic facts about substances of abuse; 6) cues and triggers for and consequences of substance use; 7) treatment of dual disorders; and 8) good communication. Other topics of interest to families include dealing with cravings; managing stress; dealing with high-risk situations; coping with depression; self-help groups (e.g., AA); finding and improving relationships; resolving conflicts; recreational and leisure activities; work; planning for the future; new advances in medication treatment; and money management.

Table 2: Educational Topics for Families

- ☞☞ Psychiatric diagnoses
- ☞☞ Medications
- ☞☞ Stress-vulnerability model
- ☞☞ The role of the family
- ☞☞ Basic facts about alcohol and drugs
- ☞☞ Cues or triggers for and consequences of substance use
- ☞☞ Treatment of dual disorders
- ☞☞ Good communication

FAMILY THERAPY

Family therapy involves outreach and engagement of the family, education about mental illness and substance abuse, and training in problem-solving techniques for addressing the dual disorders and their impact on the family. An immediate goal of family therapy is to maintain family involvement and to reduce the stress of substance use on them. A long-term goal is to decrease the client's substance abuse, and to help everyone make progress towards personal and shared goals. Jack's story illustrates typical goals.

The focus of problem-solving training is to teach families how to address problems on their own. Family members are taught the following sequence for solving problems: 1) define the problem to everyone's

satisfaction; 2) generate possible solutions; 3) evaluate advantages and disadvantages of solutions; 4) select the best solution; 5) plan to implement the selected solution; and 6) meet at a later time to review progress.

When families are still in the persuasion stage, problem-solving is aimed at developing motivation to address substance abuse or to reduce its effects on the family. The clinician looks for ways to prompt family members to consider whether the client's substance use interferes with achieving the goal. Developing a discrepancy between substance use and a desired goal can help a family become motivated to address the problem of substance abuse. For example, a client who wants to work, but does not view his alcohol use as a problem, may experience problems on the job on the day after drinking. Family problem-solving that is focused on improving the client's job performance or getting a better job may lead to a decision to reduce drinking on certain days or to stop drinking altogether.

When families are in the active treatment stage, the problem-solving focuses directly on reducing substance use. This may include anticipating high-risk situations for continued abuse or relapse as well as developing skills and supports for getting needs met without using substances (e.g., finding places to meet people who are not substance users). In relapse prevention, the focus of problem-solving often shifts to other areas that further recovery, such as work, independent living, taking care of health, and developing close relationships.

FAMILY
SUPPORT
GROUPS

Ongoing multiple-family support groups can be useful for families. Group meetings are led by a clinician that brings in speakers and facilitates family participation. The meetings focus on providing ongoing education to families about dual disorders, facilitating a free exchange that validates others' experiences, motivating families to address the dual disorders, and sharing successful coping strategies. Potential speakers to provide education to a support group include, for example, a doctor from the mental health center to talk about new medications, someone from the social security agency to discuss rules about benefits, an addiction specialist to discuss various aspects of addiction, or a mental health consumer to discuss the concept of recovery.

Al-Anon is a self-help group for family members and support persons of people who have substance use disorders. Families can get information, support, and skills for coping with their relative's substance use problems by attending Al-Anon. To learn more about self-help, see chapter 14.

FAMILY
ORGANIZATIONS

The National Alliance for the Mentally Ill (NAMI) is a grassroots coalition of people and their families coping with mental illness. The organization supports families and advocates for non-discriminatory and equitable

funding and policies. The organization supports research into the causes, symptoms, and treatments of mental illness, and public education to eliminate stigma.

In most areas, there is a state NAMI group that sponsors monthly family meetings to provide an opportunity for clients and their families to meet each other and to learn from each other's experience. Usually there are regular educational meetings. The national organization (NAMI) provides numerous educational materials that are extremely helpful to families. The state NAMI groups sponsor family support programs, opportunities for advocacy, and education regarding local issues.

Recommended Reading

Among many helpful books on family interventions, we recommend one book that is written for families: Coping with Schizophrenia: A Guide for Families by Kim Mueser and Susan Gingerich (Oakland, New Harbinger Publications, 1994); and a second for clinicians: Behavioral Family Therapy for Psychiatric Disorders by Kim Mueser and Shirley Glynn (Boston, MA, Allyn & Bacon, 1995).

To learn more about Problem Solving Therapy, read Problem Solving Therapy by Thomas D'Zurilla and Arthur Nezu (Springer, 1999).

Infectious Diseases

INTRODUCTION

Hepatitis B, hepatitis C, and the Human Immunodeficiency (HIV) viruses are germs that cause illnesses and that can easily be spread from one person to another. This chapter describes three common but dangerous infectious diseases that are caused by viruses: the *hepatitis B virus*, the *hepatitis C virus*, and the *Human Immunodeficiency virus (HIV)*. These diseases are spread by contact with contaminated blood or other body fluids. Each of these diseases is serious, and can harm a person's health and well-being and result in life-threatening illness. This chapter can be used to educate yourself and your clients. It explains:

- ☞ how these viruses infect people
- ☞ whether a person should be tested for the diseases
- ☞ the treatment options for the diseases
- ☞ how to protect oneself from these viruses
- ☞ if someone has a disease, how to avoid spreading it to others

HOW COMMON ARE INFECTIOUS DISEASES?

Infectious diseases are more common in some places than others, and in some years compared to others. As of the year 2001 in the United States, about 1 person in 20 (5%) is infected with hepatitis B virus, and about 1 person in 50 (2%) has hepatitis C virus. HIV is less common, about 1 person in 200 (.5%) is infected with the virus.

People with dual disorders are considerably more likely to have an infectious disease than people who have no disorder or one disorder. Among people who have both disorders, almost 1 in 4 (25 %) has hepatitis B virus, about 1 in 5 (20%) has hepatitis C virus, and about 1 in 25 (4%) has HIV.

WHAT IS HEPATITIS?

Hepatitis is a disease of the liver, which is part of the digestive tract. The liver helps filter out toxic materials, builds proteins for the body, and stores vitamins, minerals, and carbohydrates. A person needs a functioning liver to stay alive.

When a person has hepatitis, the liver becomes sick or inflamed because it has been infected with a virus. Though it can take many years to happen, this sickness can cause more serious liver problems and death. The problems can include:

- ☞☞ *cirrhosis* (permanent scarring of the liver that reduces blood flow),
- ☞☞ *liver failure* (the liver is unable to function)
- ☞☞ *liver cancer* (cancer cells attack the liver)

There are many kinds of hepatitis viruses, but the most serious ones are hepatitis B and hepatitis C. Preventing infection with hepatitis B and hepatitis C, or taking care of oneself if one has the infection, is important to prevent liver damage and death.

WHAT ARE HIV
AND AIDS?

HIV is a virus that attacks and destroys special white blood cells in the body called T-helper or CD4 cells. These T-helper cells are a part of the immune system, which helps the body fight infection and stay healthy. When HIV destroys these cells, the immune system breaks down and is unable to fight infections. Infections that are normally mild can then become serious, causing the person to get very sick and even to die. Acquired Immunodeficiency Syndrome (AIDS) is the disease someone gets after the HIV virus has destroyed the immune system and the body cannot fight infections.

HOW DO
HEPATITIS
VIRUSES AND
HIV SPREAD?

These viruses pass from one person to another through exposure to infected blood and body fluids. A person gets infected when the blood of an infected person enters the blood stream of an uninfected person. The HIV and hepatitis B viruses can also be passed by the sex fluids (such as semen or vaginal secretions) of an infected person to an uninfected person when they have unprotected sex. Hepatitis C is much less likely to be passed to another person by sex fluids, but it can be in some cases.

Some of the ways people get exposed to the contaminated blood of other people and get infectious diseases are listed in Table 1. You can review this list with your clients and have them check off the ones that apply to them.

Table 1: Risk factors for getting infectious diseases

- ☞☞ sharing injection needles with other people
- ☞☞ sharing a straw for snorting cocaine, amphetamine, or heroin with others
- ☞☞ having unprotected sex (without a condom) with many partners or people they do not know well
- ☞☞ having had a blood transfusion, hemodialysis, or organ transplant from an infected source before 1992 (for hepatitis B virus or hepatitis C virus) or before 1985 (for HIV)
- ☞☞ having a body piercing or tattoo from improperly sterilized needles
- ☞☞ using personal articles such as a razor, toothbrush, nail file, or nail clippers from someone else with the infection
- ☞☞ being born to a mother with the infection

Hepatitis B, hepatitis C, and HIV cannot be spread through insect bites, kissing, hugging, or using public toilet seats, unless there is direct contact with other people's body fluids.

TESTS FOR HEPATITIS B, HEPATITIS C AND HIV

Most people who have these viruses do not have symptoms until long after they get the virus, and they might not have any symptoms at all. Therefore, people need to get blood tests to tell if they are infected with hepatitis B, hepatitis C, or HIV. A person should get tested if he or she has had any of the risk factors listed in Table 1. Since people with dual disorders are at such high risk to be exposed to these viruses, they should all be offered a blood test to see if they are infected. If your client was tested in the past and the results were negative, but they have since been involved in risk behaviors, they should be re-tested every six months.

TREATMENT

Treatments are helpful for hepatitis B and C and HIV, but a vaccine can prevent only one of the viruses, hepatitis B virus, if the person gets the vaccine before he or she is exposed to the virus. This vaccine is safe and available. To get protection against hepatitis B, a person needs 3 vaccine shots over a period of months. Since persons with dual disorders are at such high risk for being exposed to hepatitis B, they should all be offered the vaccine.

Most people who get hepatitis B virus recover on their own. However, about 1 in 10 people get a chronic illness after years of having the virus. People who have chronic hepatitis B virus may improve from treatment with medicines that boost the body's ability to fight the infection. These medicines are given in a series of injections into the muscle over a 16-week period and in pills that are taken daily.

People who have chronic hepatitis B illness who get infected with a different virus, hepatitis A, can then get sick with *fulminant hepatitis*. Fulminant hepatitis is a very serious disease that can cause death. To prevent this, people with hepatitis B virus need to get hepatitis A vaccine shots. All children are currently vaccinated against hepatitis A and B.

Unlike hepatitis B, there is no vaccine that protects a person from getting hepatitis C virus. Also unlike hepatitis B virus, *most people (85%) with hepatitis C virus carry the virus for life unless they are treated*. This is called chronic hepatitis C infection, and can cause very serious illness over a period of years.

Several medications help people with hepatitis C. They are given by weekly injections into the muscle and daily by mouth for up to a year. These treatments completely get rid of hepatitis C virus from the body for many people who complete the treatment. Because treatments for hepatitis C virus can cause serious side effects, such as experiencing flu-like symptoms or depression, doctors decide to treat people with hepatitis C depending on how sick a person's liver is.

Similar to hepatitis B virus, people with hepatitis C virus who are then infected with the hepatitis A virus can develop *fulminant hepatitis*, a deadly disease. This can be prevented by taking a vaccine for hepatitis A. People who have chronic hepatitis C should get the hepatitis A vaccine.

No vaccine or cure exists for HIV or AIDS. However, medications can slow down the illness. In addition, new medications are being developed and tested for HIV and AIDS that may help more in the future.

TAKING CARE
OF ONESELF

When your client has one of these viruses, it's important to encourage him to take care of himself. Since hepatitis harms the liver, and alcohol is toxic to the liver, people infected with hepatitis B virus and hepatitis C virus need to avoid drinking alcohol. There are other steps people with hepatitis B, hepatitis C, and HIV can take to help themselves. First, clients need to get a medical provider (such as a nurse or doctor) who can monitor health and discuss treatment options. They need to take medication as prescribed, get enough rest, and eat healthy foods.

To avoid getting or spreading these infectious diseases, people need to avoid contact with infected body fluids. Table 2 presents a list of ways people can avoid contact with body fluids.

Table 2: How to avoid getting or spreading Hepatitis & HIV

- ☞☞ Don't use intravenous drugs
- ☞☞ If you can't stop using drugs, don't share needles with other people
- ☞☞ Don't have sex unless you are sure your partner has been tested and doesn't have any infectious diseases
- ☞☞ Always use a latex condom when having sexual relations
- ☞☞ Don't share personal items such as a razor, toothbrush, nail file, or nail clippers with others

Because most of the behaviors associated with spreading infectious disease occur in the context of substance use, effective dual disorder treatment will help reduce the spread of these deadly diseases. Offering your clients testing, immunization, and risk reduction counseling is important to include in dual disorder treatment.

Recommended Reading

There are many books about coping with HIV and Hepatitis that you and your clients and their families may find helpful. Here are two to start with: Guide to Living with HIV Infection by John Bartlett and others (Johns Hopkins U. Press, 1998) and Living with Hepatitis C by Gregory Eversen and Hedy Weinberg (Hatherleigh, 1999).