Chapter 1

ISSUES IN WORKING WITH THOSE WITH COEXISTING SEVERE MENTAL HEALTH PROBLEMS WHO USE SUBSTANCES PROBLEMATICALLY

THE NATURE OF COEXISTING SEVERE MENTAL HEALTH AND ALCOHOL/DRUG PROBLEMS

Although there has been an increasing awareness of problem substance use in clients with severe mental health problems (that is, ''dual diagnosis''), it continues to be underrecognised in the psychiatric population. Even when treatment providers correctly identify substance misuse, the treatment response has often been inappropriate and ineffective. The result of inadequate assessment and ineffective treatment of these clients is a poor course of illness, including more frequent relapses and rehospitalisations, the increased costs of care and containment being borne by families, clinicians, law enforcement, society and the individual.

Effective treatment of this client group and improvement of their long-term prognosis rests with clinicians and treatment providers working in collaboration with clients and their carers. Clinicians thus need to be familiar with current knowledge about alcohol and drug use in the psychiatric population.

Prevalence of Problem Substance Use

The Epidemiologic Catchment Area (ECA) study of over 20 000 people in the USA found that 47 per cent of those with a diagnosis of schizophrenia and 60.7

per cent of those with bipolar disorder had substance use problems in their lifetime compared with 16.7 per cent in the general population (Reiger et al., 1990) found lifetime prevalence rates of alcohol use disorder of 43 per cent among clients with a diagnosis of schizophrenia, and higher rates for those with schizoaffective disorder (61 per cent), bipolar disorder (52 per cent) and major depression (48 per cent). Studies in treatment settings in the UK have tended to look at 1-year prevalence rates. For example, Graham et al. (2001) found that 24 per cent of clients with a severe mental health diagnosis were identified by their keyworkers as having used substances problematically in the past year. Menezes et al. (1996) identified a 1-year prevalence rate of 36.3 per cent among clients with a functional psychosis. Studies in the USA, have typically found recent rates of substance misuse in this population of 25–35 per cent.

Studies of the prevalence of substance use problems in people with severe mental health problems have shown significant variations. A number of contributory factors have been highlighted (Weiss, Mirin & Griffin, 1992; Warner et al., 1994). These include variations in the method used to assess substance use, the time period used (for example, problematic use in the past year versus problematic use over the course of the lifetime), diagnostic criteria for mental health and substance use problems, and the setting where substance use is assessed. Nonetheless, the studies all point to higher rates of problematic use of alcohol and drugs (abuse and dependent use) among those with mental health problems than the general population.

Types of Substances Used

The substances typically misused by people with severe mental health problems include alcohol, cannabis and stimulants (cocaine/crack and amphetamine). The question of whether people diagnosed with certain mental health problems are more prone to misusing particular types of substances has been the topic of much debate. Early reviews suggested that people with schizophrenia were more likely to use stimulants problematically than clients with other mental health problems (e.g., Schneier & Siris, 1987). However, more recent and larger studies of the prevalence of specific types of substance misuse in clients with a variety of severe mental health problems, including the ECA and the National Comorbidity Survey (NCS) (Kessler et al., 1996), have failed to replicate this finding (Kessler et al., 1996; Regier et al., 1990). The evidence suggests *availability* is the primary determinant of which specific substances are misused (Mueser et al., 1992), as opposed to the subjective effects. It is important not to overlook the fact that a very high proportion of clients with severe mental health problems smoke tobacco (de Leon et al., 1995; Hall et al., 1995; Hughes et al., 1986; Postma & Kumari, 2002). Due to the

limited information currently available about the use of tobacco in this population or its interaction with mental health problems, tobacco use will not be addressed in this manual.

Demographic and Clinical Correlates of Substance Use Problems

Understanding which clients with severe mental health problems are most likely to have problems with alcohol/drugs can facilitate the early recognition and treatment of these clients. A number of reviews of the demographic, clinical and historical factors associated with this client group have been carried out (e.g., Dixon, Goldman & Hirad, 1999; Drake & Brunette, 1998; Mueser et al., 1995). A number of demographic characteristics are correlated with substance misuse. In the main, the same characteristics that are related to problem substance use in the general population are also related to problem substance use in people with severe mental health problems. These include being male, young and single, and having lower levels of education. The clinical correlates include poor engagement and adherence with treatment. Additional correlates related to the personal history of individuals that have been identified include initial better pre-morbid social functioning, antisocial personality disorder (ASPD), family history of substance use problems, trauma and post-traumatic stress disorder.

The Impact of Substance Use Problems on Severe Mental Health Problems

It has been suggested that people with severe mental health problems who use substances problematically often experience greater adverse social, health, economic and psychological consequences than those who do not. These consequences are said to be exacerbated by the problematic use of substances (Drake & Brunette, 1998; Mueser et al., 1998a). Problematic substance use can lead to an increased risk of relapse and rehospitalisations (Hunt, Bergen & Bashir, 2002; Linszen et al., 1996; Swofford et al., 1996). The strongest evidence linking symptom severity and substance use is the effect of alcohol on worsening depression. The risk of suicide is significantly increased in persons with a primary substance use problem (Meyer, Babor & Hesselbrock, 1988), as well as in individuals with schizophrenia, bipolar disorder and major depression (Drake et al., 1985; Roy, 1986). This risk is compounded in persons who have severe mental health problems and use substances problematically (Bartels, Drake & McHugo, 1992; Torrey, Drake & Bartels, 1996).

Substance use problems among this population are associated with increased ''burden'' on family members, as well as interpersonal conflicts with relatives and friends (Dixon, McNary & Lehman, 1995; Kashner et al., 1991; Salyers & Mueser, 2001). Financial problems often accompany chronic substance use, as clients spend their money on drugs and alcohol rather than essentials such as food, clothing and rent. In addition, substances or craving for substances can contribute to disinhibitory effects that result in aggression and violence toward family, friends, treatment providers and strangers (Steadman et al., 1998; Swartz et al., 1998; Yesavage & Zarcone, 1983). The combined effect of problematic substance use on family burden, interpersonal conflict, financial problems, and aggression and violence often renders these clients highly vulnerable to housing instability, homelessness and exploitation (Drake, Wallach & Hoffman, 1989; Pickett-Schenk, Banghart & Cook, 2003). Furthermore, problematic substance use can result in illegal behaviours (such as possession of illegal drugs, disorderly conduct secondary to alcohol/drug use, or theft or assault resulting from efforts to obtain drugs), leading to high rates of incarceration (Mueser et al., 2001). In addition to the clinical, social and legal consequences of problem substance use, severe health consequences are also common. Substance misuse may contribute to risky behaviours, such as unprotected sex and sharing needles, that are associated with HIV and hepatitis infection (Cournos et al., 1991; Razzano, 2003; Rosenberg et al., 2001a,b).

MODELS OF COMORBIDITY

As we have previously mentioned, people with severe mental health problems are at much greater risk of developing problems with alcohol/drugs than people in the general population. What accounts for the higher rates? Understanding the factors that contribute to the high rate of comorbidity may provide clues useful in the treatment of this client group.

Kushner and Mueser (1993) have described four general models that might account for the high rate of comorbidity between substance use and severe mental heath problems. These models include the *common factor* model, the *secondary substance abuse* model, the *secondary psychopathology* model and the *bidirectional* model. These models are summarised in Figure 1.1. For a more in-depth review, see Mueser, Drake and Wallach (1998), and Phillips and Johnson (2001). For disorder-specific reviews, see Blanchard et al. (2000) on schizophrenia, Kushner, Abrams and Borchardt (2000) on anxiety disorders, Strakowski et al. (2000) on bipolar disorder, Swendsen and Merikangas (2000) on depression and Trull et al. (2000) on borderline personality disorder.

Common factor models propose that one or more factors independently increase the risk of both mental health and substance use problems. That is,

there are shared vulnerabilities to both disorders. Three potential common factors have been the focus of some research—familial (genetic) factors, ASPD and common neurobiological dysfunction—although many other factors are possible. If genetic factors, ASPD or some other factor was found

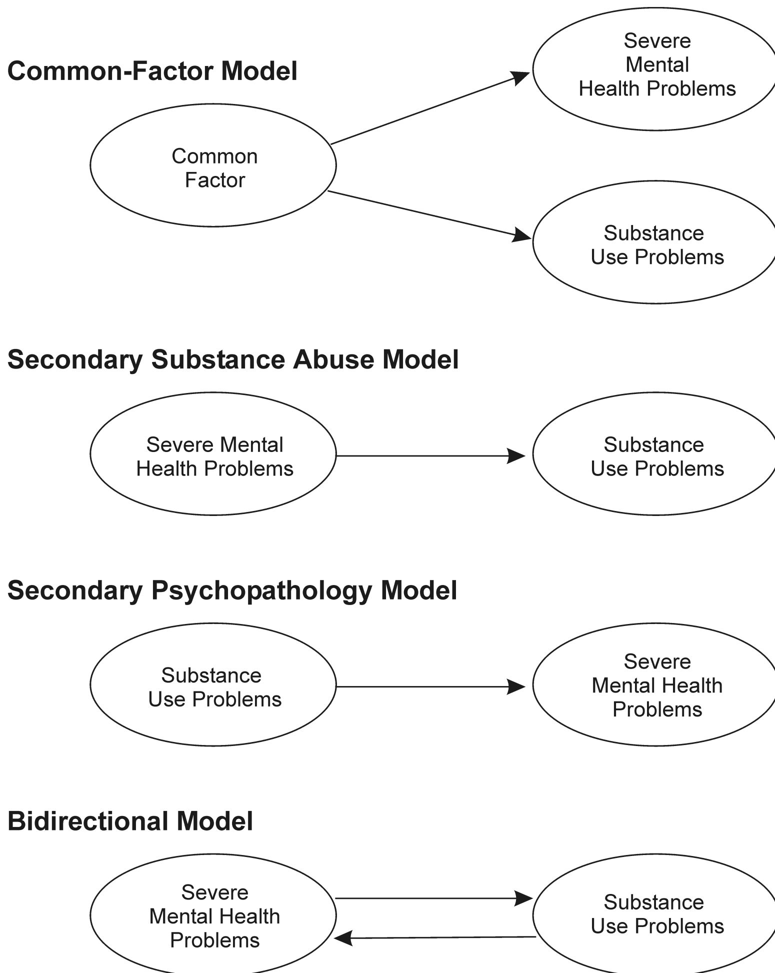

Figure 1.1 Models of comorbidity
From Mueser et al. (2003)

independently to increase the risk of both mental health and substance use problems, this would support the common factor model.

Secondary substance abuse models posit that high rates of comorbidity are the consequence of primary mental health problems leading to substance use problems. Within this general model, three different models have been suggested: *psychosocial risk factor* models (that is, clients use substances to ''feel better''; this includes the self-medication, the alleviation of dysphoria and the multiple risk factor models), the *supersensitivity model* (that is, psychological vulnerability to mental health problems results in sensitivity to small amounts of alcohol and drugs, leading to substance use problems) and *iatrogenic vulnerability to substance abuse*.

The secondary psychopathology model of comorbidity is the exact opposite of secondary substance abuse models. Secondary psychopathology models posit that substance use problems lead to or trigger a long-term psychiatric disturbance that would not otherwise have developed.

The bidirectional models propose that severe mental health and substance use problems interact to trigger and maintain each other. For example, substance use problems trigger severe mental health problems in a vulnerable individual. The severe mental health problems are then subsequently maintained by continued substance use due to socially learned cognitive factors such as beliefs, expectancies and motives for substance use (Mueser, Drake & Wallach, 1998).

The available research evidence suggests that there are many possible explanations for why clients with severe mental health problems are so vulnerable to substance use problems. No single model can explain this, and it is likely that multiple models contribute to the coexistence of these two problems, both within and across clients. Thus, in summary, different theories have been proposed to address the high rates of coexistence of severe mental health and substance use problems. Two models have the greatest empirical support: the supersensitivity model (that is, biological vulnerability to mental health problems lowers the threshold for experiencing negative consequences from relatively small quantities of substances) and the ASPD common factor model (that is, ASPD independently increases the risk of developing a severe mental health problem and a substance use problem). However, it is important to note that common social and personal factors (for example, socio-economic factors and deprivation) may also increase the likelihood of ASPD, thereby, in turn, increasing the likelihood of the development of coexisting mental health and substance use problems. The self-medication model (that is, high comorbidity is due to clients' attempts to treat their own symptoms with substances) does not appear to explain the high rate of substance misuse in clients with severe mental health problems, although there does appear to be an association between dysphoria and increased rates of substance use problems.

So remember,

- the prevalence of substance abuse/dependence is higher in clients with severe mental health problems than in the general population
- alcohol is typically the most commonly misused substance, followed by cannabis and cocaine/crack, although drug misuse may be more common in some urban areas
- diagnostic groups do not tend to differ in their preference for one type of substance over another; availability is the most important determinant of which substances are used problematically
- higher rates of substance abuse tend to be found in clients who are male, young, poorly educated and single
- substance use problems are associated with a wide range of negative outcomes, including relapses and rehospitalisations, violence, suicide, interpersonal problems, legal repercussions, health consequences and higher treatment costs
- two of the models proposed to address the high rate of coexistence of severe mental health and substance use problems have the greatest empirical support: the supersensitivity model and the common-factor model; the self-medication model does not have great support.

OBSTACLES TO TREATMENT AND BEHAVIOUR CHANGE

When clinicians attempt to engage and offer treatment to clients with severe mental health problems who use alcohol/drugs problematically, they often encounter a number of obstacles to change. Some of these may be due to motivation, cognitive deficits and social factors that are directly related to experiencing severe mental health problems (Bellack & Gearon, 1998; Drake et al., 2001). In working with this population, it is important to take these factors into consideration.

Motivation

People in the general population who use substances problematically often experience fluctuating motivation to change. However, among those with severe mental health problems, motivation is often confounded by a number of additional factors. These include low self-efficacy, primary negative symptoms of severe mental health problems, such as loss of motivation, energy and drive, apathy and difficulty in experiencing interest or pleasure, and secondary negative symptoms, such as depression and the side effects of

medication. Such factors serve generally to reduce motivation among people with severe mental health problems; however, the presence of substance use problems often exacerbates this. Clients may minimise problems related to substance use and focus solely on the perceived positive benefits associated with using substances in the absence of other positive, powerful reinforcers. Thus, motivation often waxes and wanes.

Cognitive

Cognitive functioning is important in making and sustaining changes in behaviour, particularly substance use. People with severe mental health problems, notably schizophrenia, experience significant cognitive impairment (Bellack & Gearon, 1998), some of which may be due in part to the side effects of medication. Specific deficits in the areas of attention, memory, complex cognitive processes and ability for self-reflection are likely to impair utilisation of the standard cognitive and behavioural skills to change alcohol/drug use (Bellack & DiClemente, 1999; Bellack & Gearon, 1998).

Social

The experience of severe mental health problems is often associated with significant feelings of loss. People often lose a social role, and they can be excluded from the normative routes of gaining pleasure and social contact due to the associated stigma of mental health problems. Poor skills and confidence in social situations, school and vocational failure, poverty, lack of adult role responsibilities, lack of structured and meaningful daily activities, and living in neighbourhoods with high rates of drug availability and deviant subgroups may increase exposure to substance-using social networks (Dusenbury, Botvin & James-Ortiz, 1989; Pandina et al., 1990), and substance use may facilitate social interactions with peers (Drake, Brunette & Mueser, 1998; Salyers & Mueser, 2001). The combined effect of severe mental health problems and problematic substance use on interpersonal conflict and financial problems often renders these clients highly vulnerable socially to exploitation by drug dealers and involvement in illegal behaviours (Mueser et al., 2001).

All of these factors can present as obstacles to engaging clients in treatment and behaviour change. However, awareness of these factors can signal the specific treatment needs of this population and guide the treatment-planning process.

TREATMENT NEEDS

The C-BIT approach is based on the principles of integrated treatment (Drake et al., 2001; Graham et al., 2003; Mueser, Drake & Noordsy, 1998a; Mueser

et al., 2003), which are driven by the specific treatment needs of people with severe mental health problems who use alcohol/drugs problematically. These include the following principles.

Integration of Mental Health and Substance Misuse Treatments

Treatment programmes that fully integrate the treatment of substance use problems into mental health treatment can overcome many of the disadvantages of traditional sequential or parallel approaches to the treatment of this client group. First, organisational and administrative lapses are effectively eliminated with integrated treatment because limited coordination between different service providers is required: in the main, both mental health and substance misuse services are provided by the same team/clinician. Second, clinical problems related to treating one problem first and the other disorder second are avoided with integrated treatment, as both problems are viewed as ''primary'' and are targeted for concurrent treatment. Third, conflict between the different philosophical perspectives of mental health and substance misuse professionals on treating combined problems is minimised when the clinicians work side-by-side, and, preferably, for the same agency. In addition, an integrated approach to the treatment of this client group enables the dynamics and interrelationships between the problems the clients present with to be identified, explored and addressed in a systematic and holistic manner.

Assertive Outreach

An *assertive* approach to treatment recognises that clinicians cannot passively wait for clients to demonstrate the initiative and motivation to seek out treatment for their substance use or mental health problems on their own. However, it is important to recognise and be aware that an assertive approach can at times be experienced by clients and their families as intrusive. Thus, although clinicians must make every effort possible to engage reluctant clients actively in treatment, this needs to be done in a sensitive and collaborative way, connecting with clients in their natural environments and providing practical assistance with immediate goals defined by clients (such as housing, medical care, crisis management and obtaining legal aid). Hence, assertive outreach becomes a means of developing trust and a working alliance between the clinician and the client, not only improving medication adherence and monitoring but also enhancing quality of life and the recovery process.

Collaborative Relationship Between the Client and the Clinician

Integrated treatment is based on a collaborative relationship, where the client works in collaboration with the clinician to tackle the problems he/she is

experiencing. A positive working alliance becomes a way of engaging clients in the treatment process and providing support for change.

Stage-Wise Approach to Treatment

It is often tempting to run ahead and set idealistic goals of detoxification and abstinence for this client group. However, these goals are often not based on the current engagement and motivation of the client, and thus attempts to implement such interventions result in perceptions of ''failure'', frustration and disengagement. Thus, a key principle of integrated treatment is to set realistic goals and interventions that are matched to the phase of engagement and stage motivation.

Comprehensive Services

Individuals with severe mental health problems who problematically use alcohol/drugs typically have a wide range of needs, such as finding work or other meaningful activity; improving the quality of family and social relationships; developing a capacity for independent living, leisure and recreation; and developing skills for managing anxiety, depression and other negative moods. Integrated treatment programmes need to be *comprehensive* because the recovery process occurs longitudinally in the context of making many life changes. In addition, even before clients have acknowledged the problems associated with their substance use or have developed motivation to reduce alcohol and drug use, they can make progress by improving their skills and supports. These improvements can increase clients' hopefulness about making positive changes and facilitate their subsequent efforts to change their destructive involvement with substances.

Optimism About the Long-Term Effects of Treatment

Research suggests that integrated-treatment programmes do not produce dramatic changes in most clients over short periods of time; rather, clients gradually improve over time, with approximately 10–20 per cent achieving stable remission of their substance use problems per year. As clinicians, we can at times become disheartened when clients make significant strides forward and successfully change their substance use, only to slip back. However, reflection on how many times we have tried to change a given behaviour/habit and found ourselves slipping back gives some idea of how difficult behaviour change is. Bellack and Gearon (1998) summarise the consensus view on a long-term and optimistic treatment approach quite aptly. They suggest, ''There is also general agreement that treatment must be conceptualized as an ongoing process in which motivation to reduce substance use waxes and wanes. They need the ongoing support provided by programs

that extend over time and are tolerant of patients dropping in and out, sometimes trying to quit and sometimes not, abstaining for a while only to relapse'' (page 750).

Optimal Prescribing of Medication for Both Mental Health and Substance Use Problems

Reasons for using substances or substance-related beliefs can often be associated with the negative effects of medication, psychiatric symptoms and withdrawal effects. Optimal prescribing of medication often stabilises psychiatric symptoms and reduces withdrawal effects, and can reduce cravings and urges to use substances (Day, Georgiou & Chrome, 2003).

So remember,

- potential obstacles to engage clients in treatment and changing their substance-using behaviours include fluctuating motivation, cognitive deficits and social factors
- the treatment of people with severe mental health problems who use alcohol/drugs problematically needs to include integration, assertive approaches, collaboration and stage-wise interventions. It must address a range of needs over the long term, and clinicians will need to remain optimistic
- optimal medication may increase engagement and reduce cravings to use alcohol or drugs.