

# Co-occurring Mental and Substance Related Disorders

## Contents and Brief Summary

**Assessment** This section covers co-occurring diagnostic and assessment issues that commonly arise for the patient with both a psychiatric and a substance abuse disorder. This section would apply to individual and facility providers, and for in-patient, outpatient, and alternative levels of care settings.

- All admissions or potential admissions for either a psychiatric diagnosis or a substance abuse diagnosis should be screened for a co-occurring disorder.
- Screening should include information from collateral sources, primary health care providers, laboratory reports, and self-reports. The screening may also include self-report instruments.
- The assessment should address issues of safety, psychosocial support, potential for sexually transmitted diseases, and other medical conditions associated with substance abuse.
- Particular attention should be paid to the patient's culture and special issues of adolescents and women.

**Treatment Issues** This section covers the individual individualized elements of patient of care.

- Treatment should be based on the patient's readiness to change (i.e., motivational stage)
- Treatment should be flexible enough to allow for continued engagement despite relapse
- Emphasize behaviorally based, learnable skills
- Use modified twelve-step approaches for support, or, alternatively, Rational Recovery approaches.
- Engage the patient's support systems into treatment
- Address psychosocial needs

**Program Issues** This section covers elements of care for a treatment program and thus affects many patients at the same time. This section applies to all levels of care.

- Treatment should be integrated in a program that addresses both psychiatric and substance abuse treatment at the same time, and delivered by the same staff.
- Such programs can be characterized either as "Dual Diagnosis Capable Programs", treating patients with stable or moderately severe psychiatric disorders, or "Dual Diagnosis Enhanced Programs", designed for

Group treatment of patients led by a professional with advanced training in areas of both mental health and substance abuse treatment is a preferred treatment modality. The groups should be specifically for dual diagnosis patients, and should take into account the needs of the seriously mentally ill population as well as any cognitive deficits found in the seriously mentally ill population.

- Staff should be cross-trained in both mental health and substance abuse.

**Medication Issues** This section covers medication issues specific to the patient with co-occurring psychiatric and substance abuse diagnoses. It applies to all levels of treatment.

- Careful consideration should be given to the use of medications in this population due to the complexity of the diagnoses, drug-drug interactions, and the potential for abuse of some of the routinely prescribed psychopharmacological agents.
- Special attention should be given to education and training of treatment teams in pharmacological treatment.
- Consider proactively addressing barriers to adherence through patient and family education, simplified medication regimes, and other strategies.
- Medications with addictive potential should be used very cautiously with this population, with appropriate monitoring of response and a careful assessment of the potential benefits and risks of using the medication.

# Co-occurring Mental and Substance Related Disorders

## DSM-IV Diagnostic Codes:

This guideline covers co-occurring psychiatric and substance use disorders, concentrating on the combinations of disorders from list 1 and list 2 below:

<u>List One: Psychiatric Diagnoses</u>	<u>List Two: Substance Abuse Diagnoses</u>
296.xx Major Depression	292.xx Psychoactive Substance Intoxification or Withdrawal
296.xx Bipolar Disorder	292.xx Psychoactive Substance Induced Disorders
295.xx Schizophrenia	303.00 Alcohol Intoxication
295.7 Schizoaffective Disorder	304.xx Psychoactive Substance Dependence
298.9 Psychotic Disorder NOS	305.xx Psychoactive Substance Abuse
311 Depressive Disorder NOS	

The following guidelines are to be considered and rendered within the context of the patient's cultural, ethnic, and spiritual values in order to maximize the accuracy of the diagnosis, the effectiveness of the treatment, and the best possible outcomes for the patient and the family.

## Diagnostic Guidelines:

### Need for Complete Assessment

All admissions or potential admissions for either a psychiatric diagnosis or a substance abuse diagnosis should be screened for a co-occurring disorder. This is particularly important for facilities that have traditionally served only one of these populations. The rate of lifetime substance abuse disorders in the psychiatric population is about 50%, with about 25-33% active substance abuse (Mueser et. al. 1998; Goldsmith, 1999). Even small amounts of substance use can lead to negative outcomes for the seriously mentally ill population (RachBeisel et.al., 1999).

The assessment should include a thorough history, including the history of psychiatric symptoms, substance use, treatment attempts and strategies, periods of sobriety and/or periods where the patient was symptom free.

### Assessment Strategies

Screening should include information from collateral sources such as family, friends, significant others, workplace contacts, etc. (as allowed by release of information and

federal and state laws). Screening should also include information from primary health care, laboratory reports, and self-reports (RachBeisel et.al., 1999).

Screening can include self-report instruments. Some of the more commonly used self-report screens include the Drug Abuse Screening Test, Michigan Alcoholism Screening Test, CAGE, Dartmouth Assessment of Life Style Instrument, and Addiction Severity Index.

During history taking and assessment sessions, persons may overemphasize or underemphasize their psychiatric symptoms, for a variety of reasons. These reasons include attempts to normalize symptoms, feeling deserving of being depressed, excessive feelings of guilt, or confusion and memory lapses.

### Other Assessment Issues

All five Axes of DSM-IV should be part of the diagnostic assessment. ValueOptions also uses American Society of Addiction Medicine PPC 2R, 2001 (ASAM, 2001) criteria for placement. ASAM Criteria are ranked in the following domains, each of which should be assessed:

Dimension One	Acute intoxication and/or medical dangerousness of withdrawal
Dimension Two	Biomedical conditions and complications
Dimension Three	Emotional/behavioral conditions and complications
Dimension Four	Treatment acceptance/resistance/readiness to change
Dimension Five	Relapse/Continued Problem/Use potential
Dimension Six	Recovery Environment

Attention should be paid to issues of safety

Assess **danger to self**. Suicidality may be an issue. Because of grandiosity, manic patients may become a danger due to impulsivity, irritability, and poor judgment.

Screening should include **potential for violence** (RachBeisel, et.al., 1999).

Substance abuse and mental illness are strong risk factors for violence. About 1/3 of persons with co-occurring disorders commit violence, as opposed to about 2% of the general population. Most (86%) violence by former psychiatric patients occurred against family and friends (RachBeisel et al, 1999). Warning signs of violent potential include increased hostility, noncompliance with treatment, negative attitudes toward treatment, history of past violence, and history of contact with the legal system. Depending on state and federal laws, there may be a duty to warn if there are specific threats of violence.

Screening also includes those issues commonly found in the co-occurring disorders population that could potentially affect the patient.

Consider contribution of **psychosocial stressors**, both long term and acute. Examples include: the availability of appropriate support systems, death of a loved one, marital conflict, lack of housing, job loss/stressors, interpersonal conflict. Also consider how these issues may impact treatment. For example, marital conflict may be a contributing factor to a client's illness, and marital treatment may then be indicated.

Screening should include risk for and presence of **HIV virus and other Sexually Transmitted Diseases**, which occur at a far higher rate in this population than the general population (RachBeisel, et.al., 1999). This is especially true for women, who are at greater risk for sexual violence, and childhood physical or sexual abuse (Bellack & DiClemente, 1999).

Assessment should screen for **medical conditions**, particularly the following (SAMHSA, 1994):

- Diabetes, hypoglycemia, endocrine disorders
- Infections, pneumonia, AIDS-related complications
- Neurological disorders (stroke, hemorrhage, and seizures)
- Liver disorders including hepatitis
- Withdrawal symptoms, delirium tremens, delirium.

**Other high risk indicators** for co-occurring disorders include: homelessness; incarceration or criminal history; persons assessed in an emergency or an acute care setting; male, young, single, less educated; depressed, suicidal; and a family history of substance abuse (Mueser et. al. 1998; Drake et.al. 1998).

### Differential Diagnosis

To make a definitive psychiatric diagnosis by history, the psychiatric symptoms must have occurred during drug-free periods. A definitive diagnosis may have to be postponed until the clinician can observe the patient for a significant time drug-free – a shorter time for objective, psychotic symptoms; a longer time for subjective, affective symptoms (Mee-Lee, 2000). The time length needed without substance use to definitively determine if an independent psychiatric diagnosis is also present may vary depending upon the substance, patterns of abuse, and psychiatric history (Goldsmith, 1999; SAMHSA, 1994). This time length may be several days to several months.

All psychoactive drugs cause alterations in normal mood. The severity and manner of these alterations are regulated by preexisting mood states, type and amount of drug used, chronicity of drug use, route of drug administration, current psychiatric status, and history of mood disorders (SAMHSA, 1994).

Acute manic symptoms may be induced or mimicked by stimulants, steroids, hallucinogens, polydrug combinations or withdrawal from alcohol (SAMHSA, 1994).

Depressive symptoms can result from intoxication or withdrawal from sedative-hypnotics, stimulants.

### Special Populations

1. *Adolescents*--The literature does not have information about co-occurring disorders among adolescents that is as clear and definitive as among adults. This is partly due to the differences in diagnostic understanding of psychiatric disorders and mental illness in adult versus adolescent age groups. The diagnoses of schizophrenia and bipolar disorder are not as readily attached to adolescents as they are to adults. However, the research appears to be indicating that adolescents with substance abuse have as high a risk for co-occurring psychiatric disorders as do adults. One study found that three times as many adolescents with substance abuse as those without substance abuse have another co-occurring current psychiatric disorder, such as anxiety, mood, or disruptive behavior disorders (Kandel et al, 1999).

2. *Women*--Alcoholism is four times as prevalent among men as among women, although drug abuse is only about twice as great among men as women (Goldsmith, 1999). However, depressive, bipolar and anxiety disorders are three times more prevalent among women than men. Schizophrenia is about equal in prevalence (Goldsmith, 1999).

Women admitted to substance abuse treatment programs tend to have more severe symptoms than do males who are admitted to such programs. This is possibly due to the fact that women with co-occurring disorders tend to be admitted to the mental health treatment system, whereas men with co-occurring disorders tend to utilize the substance abuse treatment system (Moore et al, 1989). Women more frequently report entering treatment due to mental/physical health or family problems (Goldsmith, 1999).

Risk of HIV infection is about 3.8 times greater among women than men in this population. About 20% of persons with co-occurring disorders are HIV positive, compared to about 0.4% of the general population (RachBeisel et al, 1999).

Treatment components that appear more critical for women with co-occurring disorders include identifying accompanying medical problems and education on sexuality, pregnancy prevention, safety and empowerment. This is due to issues that these women frequently encounter around victimization, homelessness, childcare, sexual abuse, domestic violence, and poverty (RachBeisel et al, 1999).

## **Treatment Guidelines:**

### **Treatment Planning / Treatment Elements**

Because of the unique needs of patients with co-occurring psychiatric and substance abuse diagnoses, the traditional substance abuse treatment model of confrontation and breaking through denial has to be modified. In general, treatment for co-occurring psychiatric and substance abuse patients is characterized by:

- Focus on preventing increased anxiety rather than on breaking through denial
- Emphasis on trust, understanding and learning rather than confrontation
- Slow pace and long term perspective rather than rapid one time intervention
- Treating clients at their level of readiness rather than waiting for them to hit “rock bottom”

(adapted from Drake, Mercer-McFadden, Mueser et al. 1998)

### **Stage based treatment**

There is an increasing amount of evidence to show that treatment based on readiness of a client to change has improved outcomes over treatment as usual (Prochaska et.al., 1994, Osher & Kofoed, 1989). These models of stage-based treatment emphasize matching treatment approaches to a client’s readiness for change. There are several stage models, the most popular being Prochaska and Diclimente’s trans-theoretical model (Prochaska et.al., 1994) and Osher and Kofoed’s stage model (Osher & Kofoed, 1989). The stages, goals, and interventions appropriate for each stage of the latter model can be found in the Table 1.

**Table 1: Osher and Kofed’s Stage Model**  
(After Meuser, Drake, Noordsky 1998; Carey, 1996)

<u>Stage</u>	<u>Definition</u>	<u>Goal</u>	<u>Interventions</u>
Engagement	Patient does not have regular contact with dual diagnosis clinician (sporadic attendance in outpatient clinics; leveraged into in-patient	To establish a working alliance with the patient so that the patient views the treater as having something to offer him or her; to assess patient’s use, needs filled by substance use, attempts to stop, motivation and	<ul style="list-style-type: none"><li>• Outreach</li><li>• Practical assistance (housing, benefits etc.)</li><li>• Crisis Intervention</li><li>• Support to social networks</li><li>• Stabilization of Psychiatric symptoms</li></ul>

	treatment)	attitudes.	
Persuasion	Patient has regular contact with a dual diagnosis clinician, but does not want to reduce substance use	To develop awareness that the negative effects/ cost of substance use outweigh the positive effects / benefits; to increase awareness of complications of substance in patient's life; to increase patient's awareness of vulnerability to negative consequences of use; to increase patient's sense of ability to stop use; to create the motivation to change	<ul style="list-style-type: none"> <li>• Persuasion groups where peers relate experiences with use</li> <li>• Individual and Family Education, single or group format</li> <li>• Motivational Interviewing</li> <li>• Social skills training addressing situations related to substance abuse</li> <li>• Structured activity, as patient may not have the skills to self-structure activity without resorting to substance use.</li> <li>• Psychological preparation for lifestyle changes necessary to achieve remission</li> <li>• Select medications to treat psychiatric illness that may have a secondary effect on craving/addiction</li> </ul>
Active Treatment	Patient is motivated to reduce substance use	To help patient reduce substance use and achieve abstinence; to individualize goals for changes in use pattern; to build an environment supportive of abstinence	<ul style="list-style-type: none"> <li>• Family Problem Solving</li> <li>• Peer groups</li> <li>• Social Skills training to address substance related situations</li> <li>• Self-help groups (AA, NA etc.)</li> <li>• Cognitive Behavioral Counseling</li> <li>• Substituting activities (e.g. work, sports)</li> <li>• Contingency management</li> </ul>
Relapse Prevention	Patient no longer experiences problems related to substance use	To maintain awareness that relapse could happen; to anticipate and cope with crisis, and to extend recovery to other areas of life.	<ul style="list-style-type: none"> <li>• Supported or Independent employment</li> <li>• Peer Groups</li> <li>• Self-help groups</li> <li>• Social Skills training</li> <li>• Life style improvement (smoking cessation, healthy diet, stress management)</li> </ul>

## Motivational Interviewing

Often, stage-based treatment is combined with an interviewing strategy called Motivational Interviewing. Motivational interviewing acknowledges that often the patient is ambivalent about changing their substance use behavior. Motivational interviewing suggests ways of working with, rather than fighting against, this ambivalence. Motivation Interviewing techniques include this listed below in Table 2:

**Table 2: Motivation Interviewing Techniques**

- Empathize with the client's ambivalence about use and change
- Discuss the pros and the cons of both using (pro: getting high, friends, good times etc.; con: social, familial, legal consequences etc.) and of changing (pro: elimination of negative consequences, establishment of a more beneficial lifestyle etc.; con: losing friends, feeling of getting high etc.)
- Encourage and reinforce clients when they make self motivating statements, no matter how tentative, such as "Maybe I should quit".
- Provide feedback on information learned and decision making process to help a client's sense that he or she can change

Further information on this approach can be found in Ziedonis & Fisher (1995), Miller and Rollnick (1991), in the NIAAA Project MATCH Motivational Enhancement Therapy Manual, and in "Enhancing Motivation for Change in Substance Abuse Treatment", Treatment Improvement Protocol Series No. 35 (1999), available from the National Clearinghouse on Alcohol and Drug Information (800) 729-6686.

## Flexibility

In contrast to programs that would discharge a patient because his or her substance use indicates that he or she has not reached "rock bottom", integrated and stage-based treatment emphasize that the program must work from whatever level the patient is

functioning and toward goals for which the patient is motivated. A patient may relapse one or more times before sustained sobriety is reached. Ongoing treatment planning should address problem behaviors (Swindle et. al., 1995) and use flexibility to maintain the patient in the program (Drake et. al. 1998; Swindle et. al., 1995)

Behavioral/skill-based treatment

Traditionally, substance abuse treatment has focused on confrontation and twelve-step work. (see Modified 12 Step Groups below) However, because of their historical focus on twelve-step work, facilities that traditionally have served the substance abuse population may have to adapt their content areas and presentation approaches to accommodate those shown in psychosocial rehabilitation literature to be efficacious with the Seriously Mentally Ill (SMI) population. Skill-building, behavioral oriented treatment has been shown in a few studies to have better outcomes than 12 step-oriented treatment alone (Bradizza & Stasiewicz, 1997; RachBeisel, et.al., 1999; Jerrell, 1996 , Jerrell & Ridgely, 1995).

Behaviorally oriented treatment is treatment characterized by:

- A behavioral analysis of substance abuse, including precursors, triggers, use behaviors and consequences of use (Carey, 1996).
- Emphasis on behavioral skills, rather than on processing of emotions
- Education on specific skill sets that can intervene in the substance abuse pattern and/or substitute for that pattern.
- Education on skill sets that aid the patient in developing a sober lifestyle.
- Practice and incorporation of skill sets into the patient’s behavioral repertoire.
- Feedback and contingency planning from the patient’s trials at skill set behaviors.

Suggestions or standards may include the presence of certain subjects (such as relapse prevention) or certain topic groups (such as interpersonal relationships) from Table 3 (adapted from Mueser & Noordsy 1996; Bradizza & Stasiewicz, 1997; Bellack & DiClemente, 1999; Mowbray et. al., 1995; Ziedonis & Fisher, 1994; Nikkel, 1994).

**Table 3: Subject Content for Behavioral/Skill-Based Treatment**

<u>Focus</u>	<u>Topics</u>
Interpersonal	Interpersonal relationships Being assertive, not passive or aggressive Problem-solving Communication with medical staff
Personal	Managing leisure time Dealing with stress Sleep hygiene Self-care

	Money management Transportation
Cognitive Behavioral	Managing thoughts/cravings that lead to substance abuse Developing constructive substitutes for substance use
Cognitive Behavioral Relating to Affect	How feelings motivate behavior Identifying when you are angry Dealing with anger
Relapse Prevention	Drink and drug refusal skills Preventing relapse Trigger situations Peer support skills
Other	Physiological effects of drug use Reasons for substance use, including habits, triggers and craving Role of substances in your life Particular dangers of substance use for people with schizophrenia HIV/AIDS prevention

### Modified 12-Step Groups

Although 12-step groups are common in substance abuse treatment, there have been some concerns raised about the use of these groups with the dual diagnosis population. Concerns raised include (Mowbray et.al. 1995):

- Dual-diagnosis patients may feel rejected by other members of a support group
- Non-psychiatrically diagnosed members of a support group may not understand symptomatic behaviors such as shorter attention span, or medication side effects such as akathisia.
- Non-psychiatrically diagnosed members may perceive dually diagnosed members as disruptive and therefore feel that their own experience of being helped is affected.
- Non-psychiatrically diagnosed members may perceive mental illness as non-manageable and therefore dissimilar to substance abuse.
- Dual-diagnosed members may perceive substance abuse as a moral issue.
- Non-psychiatrically diagnosed members may counsel dually diagnosed members against taking medications.
- The concept of needing to ‘hit bottom’ may produce severe symptoms that delay recovery.

Most articles agree that modified 12-step groups can provide social support that dual-diagnosis patients need for sobriety. However, due to interpersonal deficits and anxieties, some care should be used with patients dealing with both psychiatric and substance abuse issues. Initially, self-help groups should be voluntary rather than mandated (Drake et. al. 1998; Mowbray et.al. 1995). In addition, an orientation to self-help groups may be helpful to problem solve anticipated issues (Bradizza & Stasiewicz, 1997, Mowbray et.al. 1995)

Patients with severe mental illness may have difficulty initiating conversations necessary for 12-step group function. Suggestions from the literature to address this issue include (from Mowbray et.al. 1995; Ziedonis & Trudeau, 1997):

- In-house dual recovery groups
- “Panel meetings” where people from outside the group give talks about their recovery experiences (rather than rely on attendees talking to fill out meeting time).
- Partnering with established groups and providing them education about mental illness.
- Use of staff who are single or dually recovering to lead groups.

### Enlisting support systems

A sober support network and inclusion of natural supports (family, etc.) is important to any recovering patient, and particularly important for the patient with co-occurring psychiatric and substance abuse issues. Social support systems should be involved as early in treatment and as much as possible unless doing so is not clinically advisable. Discharge plans should include social support networks when possible.

### Case management to address common psychosocial needs

The patient with co-occurring psychiatric and substance abuse issues often has other issues as well, including medical issues, social support issues, housing issues, vocational and educational issues, legal issues, and parenting or custody issues. Historically excessive boundaries, exclusion, and territoriality between mental health, substance abuse, and other community services (such as those that serve the needs listed above) have made it difficult for the patient with co-occurring illness to access these services. A combination of difficulty initiating (due to the psychiatric illness), denial of need (due to the substance abuse illness) and discouragement (due to bureaucratic barriers) often means that the patient does not access needed services, and thus relapses or experiences a recurrence of symptoms and return to the hospital. It is helpful for a provider to address these issues, in either a linkage or a treatment manner.

## Follow up after discharge

Dual-diagnosis treatment is best conceptualized from a long-term perspective (Drake et. al. 1998). Rather than a one-time chance for immediate abstinence, the ideal goal is continuous attempts at engagement and harm reduction that eventually lead to a long-term abstinence that includes psychiatric stability and social support. Achieving this goal requires a continuum of linked, wrap-around services to engage the patient at different entry points and to support the patient towards greater autonomy with necessary supports.

Even though the preferred point of entry into treatment is an outpatient evaluation, in many environments the entry point into treatment is the inpatient unit. Often there are few post-discharge dual-diagnosis programs or services. Patients may be motivated to continue treatment after discharge, but due to a system delay of several weeks, they may lose their treatment gains (Mowbray et.al. 1995). Some research has demonstrated effective use of integrated treatment teams or ACT teams (Wingerson & Ries, 1999; Clark et.al, 1998; 23). However, those services are not available in all communities. Therefore the following recommendations are made:

- Contact should occur as soon as possible after admission and prior to discharge with resources that existed prior to the patient's entry into services, such as external case management (external to hospital) (Jerrell & Ridgely, 1995; Segal et.al., 1995; Mowbray et.al. 1995), professionals treating the patient's psychiatric problems((Bradizza & Stasiewicz, 1997, Swindle et. al., 1995), and professionals treating the patient's medical issues (such as HIV, cirrhosis, diabetes, ulcers, respiratory problems) (Mowbray et.al. 1995).
- Discharge plans should include follow-up with other community services as appropriate (Bradizza & Stasiewicz, 1997), with professionals treating psychiatric issues (Bradizza & Stasiewicz, 1997, Swindle et. al., 1995), with professionals and/or support groups addressing substance abuse issues (Bradizza & Stasiewicz, 1997), and with professionals treating medical issues (Mowbray et.al. 1995).
- Follow up should be scheduled and occur within a seven day time frame (Swindle et. al., 1995).

Because relapse in either disease can occur, other recommendations include:

- Holding aftercare groups at the facility
- Training of community mental health center staff to engage dual diagnosis patients
- Re-assessing the patient for relapse every six months (Jerrell, 1996)

## **Program Elements**

### **Integrated treatment**

Historically, attempts to treat dual-diagnosis patients within (or as an attachment to) a substance abuse or psychiatric treatment program have not been as successful as an integrated treatment approach that addresses both disorders simultaneously. Instead of regarding one disorder as primary and another as secondary, integrated treatment assumes that both the psychiatric and the substance abuse diagnoses are primary disorders, each persistent and recurrent, that are best treated in a model that addresses the treatment requirements of each disorder. Standards to insure that a treatment program is integrated include:

- Dual-diagnosis people should have separate group treatment designed for this population's needs, apart from single disorder clients (those who have only a psychiatric diagnosis or only a substance abuse diagnosis).
- There should be a description of a specific treatment track for dual diagnosis, including its own groups.

The description of a specific treatment track for dual diagnosis should address both psychiatric and substance abuse treatment in the same program at the same time (RachBeisel, et.al., 1999; Drake et. al. 1998; Jerrell, 1996). Treatment for both SMI and SA should be delivered by the same staff (RachBeisel, et.al., 1999; Drake et. al. 1998).

There are some considerations for treating patients with co-occurring psychiatric and substance abuse problems in treatment centers that traditionally treat only one disorder. Patients with stable psychiatric symptoms whose primary problem is getting sober may receive a greater degree of addiction intervention in a substance abuse program. Likewise, the patient with severe minimally treated psychiatric disorder who only uses substances episodically, and has developed dependence of compulsive use may not fit well with more highly addicted patients and might be served better within a relapse prevention education model within standard psychiatric care (Psychiatric Clinics March 1993 on alcohol abuse). However, the vast majority of patients with co-occurring psychiatric and substance abuse diagnoses are best treated in an integrated program.

### **Group Treatment**

Treatment performed in a group modality allows for feedback from peers with similar experiences, creates an analogous situation to substance abuse, which often occurs in social settings, and allows for modeling and vicarious learning. Training is best done in a small-group format, with six to eight participants (Bellack & DiClemente, 1999). A professional should lead the groups, and there should be no use of patient led treatment groups (Swindle et. al., 1995).

The groups should specifically be for dual-diagnosis patients and tailored to the needs of the seriously mentally ill population. Groups including the SMI population can be problematic if the patient is not properly screened for their ability to tolerate interaction with people, to maintain sufficient self-control, to not be a danger to self or others, and possess the ability to allocate sufficient attention to external stimuli (Bradizza & Stasiewicz, 1997).

The presentation of group content can be structured in a manner that takes into account the cognitive deficits found in the seriously mentally ill population. Recommendations from psychosocial rehabilitation literature for structuring group content to be more useful for serious mentally ill patients include the following (Bellack & DiClemente, 1999):

- Sessions are highly structured, and there is a strong emphasis on behavioral rehearsal.
- The didactic material is broken down into small units. Complex social repertoires, such as making friends and refusing substances, are divided into component elements, such as maintaining eye contact and being able to say no. Patients are first taught to perform the elements, and then gradually learn to combine them.
- The intervention emphasizes overlearning of a few specific and relatively narrow skills that can be used automatically, thereby minimizing the cognitive load for decision making during stressful interactions.
- Extensive use is made of learning aids, including handouts and flip charts, to reduce the requirements on memory and attention.
- There is extensive repetition of material within and across sessions.
- There is the possibility of using personalized reminder cards that patients carry with them, covering what to do in common high risk situations.
- Schizophrenics have difficulty with abstract concepts and in generalizing principles of action across situations. Focus on specific skills that are effective for handling a few key specific high-risk situations.
- At times, the abstract concept or theory can be downplayed or omitted almost entirely. For example, the management of negative affect and interpersonal distress can be addressed concretely using scenarios provided by the patient to practice alternate responses and highlight behaviors that could evoke more satisfying interactions.
- As an accommodation to the disorganization typical of Seriously Mentally Ill patients, make-up sessions for group topics should be offered as needed.

### Staff Training

There are also issues involving professionals who have traditionally served only psychiatric or only substance abuse populations. A treating professional with a substance abuse background may have to work on helping the patient manage anxiety, rather than on provoking anxiety through confrontation of denial (Drake et. al. 1998). On the other hand, a treating professional with a psychiatric background may be discouraged and become punitive when faced with a dually-diagnosed patient's frequent relapses

(Mowbray et.al. 1995). Therefore, cross training of all staff in both mental health and substance abuse is very important. (Drake et. al. 1998).

Other recommendations for staff training for this population are designed to address administrative concerns of a unit changing from a single disorder focus to a dual disorder focus, or for a dual diagnosis unit housed with single disorder units. These recommendations include individualized supervision, quality assurance, regular in-service training, and team-building activities. (Mowbray et.al. 1995)

### **Medications:**

Careful consideration should be given to the use of medications in this population due to the complexity of the diagnoses, drug-drug interactions, and the potential for abuse of some of the routinely prescribed psychopharmacological agents. The specific medications for treatment of the mental disorders in this group are beyond the scope of this guideline and should be consistent with the APA Guidelines for those specific disorders.

For the treatment of the substance abuse conditions, medications may be beneficial in:

- States of intoxication and withdrawal;
- Blocking or reduction of reinforcing effects of abused substances;
- Induction of unpleasant consequences of substance use;
- Agonist treatment; and
- Treatment of comorbid mental disorders.

Given the often seen disparity in attitudes toward medications between substance abuse and mental health providers, special attention should be given in the education and training of the treatment team to the appropriate pharmacological treatment of both the substance use disorders and the mental disorders. The timing of prescribing for this population should also be carefully considered based on:

- The need for a variable observation drug-free time depending on the nature of the symptom presentation and acuity level;
- The vigorous treatment of the diagnosis of which the clinician is reasonably sure;
- The motivational level and ability of the patient to accept the diagnosis and treatment plan including pharmacological treatment; and
- The treatment setting.

### **Medication Adherence**

Adherence (e.g.,: “How likely is client to take medication as prescribed?”) is a major factor in successful medication treatment of the dual-diagnosed patient. In evaluating

adherence issues, the following should be considered:

- factors such as avolition and denial inherent to substance abuse and serious mental illness
- medication-related factors
- available or absent social support
- quality of therapeutic alliance
- patient's acceptance of illness
- prescribing medications with side effects in mind

Methods to proactively address potential non-adherence include patient education. This can occur in both a structured group format, as well as through a careful individual explanation by the physician of expected medication effects, side effects and duration of treatment. Ideally, education should be given to the family as well.

A simplified medication regime and methods to remind patients to take medications (such as visual cues, enlisting the aid of family members, or associating medication ingestion with activities that occur at the same time on a daily basis) may also be considered.

Because of varying responses to medications, cultural, ethnic, and age considerations must be part of all prescribing decisions.

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