

Treatment program for dual-diagnosis substance abusers

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Summary

Dual-diagnosis mentally ill patients, i.e. those characterized with substance abuse problems combined with mental health problems, are a challenge both for systems treating substance abusers and for mental health services. These patients are not easily integrated in either of these health care systems and/or are treated only for one aspect of their problem by each of these systems.

For such patients, it is necessary to create a separate treatment model, combining care of the problem of substance abuse and attention to the patient's mental pathology, according to his individual personality traits.

For purposes of this program, a treatment setting operating on the model of a therapeutic community is proposed. This setting will open an affiliated treatment program for dual-diagnosed patients, which will not be part of the therapeutic community but will be affiliated with it.

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INTRODUCTION

Dual-diagnosis mentally ill patients, i.e. those characterized with substance abuse problems combined with mental health problems, are a challenge both for systems treating substance abusers and for mental health services. These patients are not easily integrated in either of these health care systems and/or are treated only for one aspect of their problem by each of these systems. A primary difficulty is that most of the professionals are proficient in only one field, either mental health or substance abuse. These patients receive care in the "revolving door" manner. They approach either the mental health care system or a substance abuse treatment program and then are referred to the other pro-

gram by the managing professionals. Sometimes each of these systems refuses to treat them due to the problems involved in treating such a combination of symptoms.

For such patients it is necessary to create a separate treatment model, combining care of the problem of substance abuse and attention to the patient's mental pathology, according to his individual personality traits. There is very little professional experience in this field, both in Israel and worldwide. Very few combined programs have been established (mainly in the U.S.) and even when they exist, very few studies have accompanied such professional work. Most of the research on the subject deals with experience accumulated while caring for this population within one of the existing systems. However, these studies do not present unequivocal conclusions for the following reasons:

- These patients did not remain in a therapeutic relationship within any of the health care systems when the system treated only one facet of the problem.

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- These patients were rejected by each of the health care systems.

Patients who were referred to the general health care system as substance abusers and who were also found to be suffering from a mental illness may have reached this condition as a result of:

- Mental disorders that resulted in substance abuse
- Mental disorders as a result of substance abuse
- A combination of these symptoms that reinforce each other where it is difficult to determine which was the initial cause

Many joint factors are related to the combination of substance abuse and mental health. The type of substance abused and its effect on the specific individual are significant, as are his personality traits and the nature of the mental illness. Substance abuse may have both a positive and a detrimental effect on the patient, since the substance may be a medication and medications may be abused. The effect on each patient may be varied at different moments in time. When interviewing and diagnosing the patient it is necessary to try and assess the mutual relationship between substance abuse and mental pathology. This assessment is problematic not only as a result of the practical difficulty of assessing whether the patient is an addict, but also due to the difficulty of assessing whether he is under the influence of a substance previously abused or whether he has already reached the end of the physical detoxification syndrome. There may be a situation in which the substance abuse has already caused irreversible mental damage. This issue must be addressed according to the various mental health categories.

DEPRESSION AND SUBSTANCE ABUSE

There is a positive correlation between emotional disorders and substance abuse. Initial findings in this field have been presented in alcoholism studies. A correlation has been found between alcohol abuse and the ranking of depression phenomena in MMPI tests. These findings have recently also been confirmed regarding heroin abusers.

In the past, psychiatrists distinguished between endogenous depression (introverted) and exoge-

nous depression (extroverted). Endogenous depression was defined as depression that cannot be related to a specific event and the patient's condition does not improve with the changing circumstances. This is a condition of depression that exists throughout the patient's life-span. Diagnosis of this depression is divided into two sub-groups:

- 1) Unipolar depression – a disorder expressed by a deep state of depression and melancholy
- 2) Bipolar depression – relates to manic-depressive conditions, switching from states of depression to states of euphoria.

Exogenous depression was defined as reactive depression, a reaction to various situations. These phenomena may be treated by a low dosage of antidepressants. This distinction between the two types of depression is no longer included in the DSMIII-R and the DSMIV. Today, the diagnostic criteria refer to a state of deep depression versus a state of superficial depression as symptoms of mental disorders.

When treating dual-diagnosis substance abusers with depressive symptoms, latent mental pathology symptoms usually appear only at the end of the physical detoxification stage. At that point it is necessary to determine a treatment program that is based on information regarding the patient's ability of self-perception and insight, his ability to integrate personality elements, and his ability to function in the broad community social environment.

Regarding substance abusers, low-level symptoms of depression may be treated in a general treatment program, (whether in the community or in a therapeutic community) as many suffer from reactive depression symptoms as a result of the physical detoxification process. Deep depression symptoms combined with substance abuse must be treated in a special and separate treatment setting characterized by a medical-psychiatric orientation and combining specializations in mental health and substance abuse treatment. Treatment methods should be based on: adjusting medicinal maintenance dosages individually in order to balance the patient's mental and physical condition, the use of treatment methods on a behavioral level, therapeutic intervention on an emotional level, therapeutic intervention in a cognitive method based both on psychodynamic approaches, and on behavioral methods.

ANXIETY AND SUBSTANCE ABUSE

Symptomatic anxiety is often diagnosed among substance abusers. Anxiety may be the initial problem that caused the patient to begin abusing substances or it might be secondary as a result of the substance abuse. In many cases there are active mutual relations between these two phenomena – when a person abuses substances due to the feeling of anxiety and the substance abuse only increases the anxiety. The treatment approach to the co-morbidity of substance abuse and anxiety is very similar to the treatment of substance abuse combined with depression .

Before reaching a conclusive diagnosis followed by a treatment program, the substance abuser must complete the physical detoxification process. Low-level anxiety may be treated as part of the general treatment program for substance abusers, while pathological anxiety (a condition of psychoneurosis) accompanied by substance abuse must be treated in a combined professional setting specializing in substance abuse and mental healthcare. Evaluation of the patient's mental condition and of the level and characteristics of anxiety must be performed by a psychiatrist. The treatment methods applied must be determined by a multi-disciplinary healthcare staff with a joint specialization in treating substance abusers and states of mental pathology.

SOCIOPATHY AND SUBSTANCE ABUSE

It is extremely challenging to discuss the combination of these personality symptoms due to the difficulties in defining the essence of the sociopathic personality, or as it is also called, anti-social personality. The concept of psycho/sociopathy (used concurrently) was characterized as follows:

- 1) Superficial charm and good intelligence
- 2) Absence of irrational thought characteristics
- 3) Absence of neurotic or psycho-neurotic conditions
- 4) Inability to assume responsibility and lack of reliability
- 5) Lack of integrity and inability to form an interpersonal emotional relationship
- 6) Absence of conscience and shame

- 7) Deliberate anti-social behavior
- 8) Low self-judgment and inability to learn from life experiences
- 9) Pathological egocentricity and inability to form emotional relationships
- 10) Poor emotion-based relationships
- 11) Lack of self-insight
- 12) Inability to reach reciprocity in interpersonal relationships
- 13) Suicidal threats that are not carried out
- 14) Emotionally-lacking sex life
- 15) Lack of realistic long-term plans

The DSMIII and its successors did not include the category of sociopathy. It was replaced by the concept of anti-social personality which received 17 characteristics, three of which must appear before the age of 15. They are: frequent absence from school, not adapting to the study environment at school, delinquency, leaving home, lying, recurrent substance abuse, stealing, violent behavior, lack of achievement at school, vandalism, and tendency to get involved in arguments.

After age 18, a minimum of four of the following symptoms indicate a diagnosis of anti-social personality: inability to hold down a job, recurring criminal behavior, marriage failure, violent physical behavior, failure in managing finances, impulsiveness, negligent behavior accompanied by lying, persistence in these behaviors for over five years after the age of 15 and absence of mental retardation, schizophrenia, or other mental illnesses

The general tendency in defining psycho-sociopathy was to emphasize socialization problems. When substance abuse began appearing, an associative relationship was formed between anti-social sociopathic behavior and substance abuse. Significant psychopathic deviations (PD) were found in the ranking on MMPI tests given to substance abusers. A significant associative relationship was also found in those diagnosed as sociopathic cases, when criminal behavior accompanied the substance abuse. As the entire subject of substance abuse is an illegal act, it is only natural that substance abusers will be considered criminals, as their dependence on the substance that affects their mental condition urges them to illegal behavior.

Treatment programs for the psychopathic/anti-social substance abusing personality must

include both attention to the phenomenon of physical and mental addiction to the chemical substance and attention to the anti-social life patterns and manner of behavior. Substance abusers with an anti-social personality characteristic may be treated in a general setting for substance abusers (in the community or in an inclusive residential environment). The treatment model characteristic of this type of personality is the therapeutic community model, where treatment emphasizes the normative socialization process and gradually returns the patient to the community at the re-entry stage. Treatment of cases of sociopathy combined with substance abuse requires stricter supervision and control. It is based on the patient's responsibility for himself, assumed upon his signing a therapeutic contract in which rules of behavior are determined when entering the treatment program. A therapeutic contract with such a patient must include clear conditions that determine: his rights and responsibilities as a patient, setting a daily routine that requires active participation, determining the treatment stages (including the stage of rehabilitation), urine drug tests, and rejecting violent behavior.

When discussing this type of patient, the concept of reconciliation (renewed integration in normative social life) is mentioned. As it becomes clear that the patients had engaged in anti-social behavior since childhood, in most cases they must undergo a process of basic socialization. These programs can also be implemented within a prison environment.

SCHIZOPHRENIA AND SUBSTANCE ABUSE

Schizophrenia includes a group of pathological mental disorders that disrupt cognitive processes, and causes personality disintegration and separation from the social system. Symptoms of schizophrenia include states of psychosis that involve a decline in the ability to organize mental faculties. In the active state of the illness the patient loses contact with reality and might suffer from auditory and visual hallucinations. Thought and speech disturbances are evident. In time, there is a deterioration of the ability to function at work and in interpersonal relationships, and the patient neglects his self-care

and hygiene. This condition can last weeks and even months.

Research of Alerman and Erdlen (1970) confirms that frequent abuse of alcohol and drugs is related to schizophrenia. The percentage of these dual-diagnosis cases, i.e. substance abuse and schizophrenia, is estimated at 10%–15% of all psychiatric cases. There is not enough research about this phenomenon to provide guidance on improving the mental and physical condition of these patients.

Dual-diagnosis patients require the treatment of a special and separate professional-therapeutic setting combining mental health services with treatment of the substance abuse problem. Treatment of these cases lasts longer and includes a physical detoxification stage with careful medical-professional supervision and control. In fact, with these cases it is impossible to reach a situation of full physical detoxification as the patients need medication in order to reach a situation of mental balance. In many cases the patient medicates himself by adding street drugs to the medication he receives by medical prescription.

Cases of schizophrenic patients with substance abuse are characterized by lack of perseverance in the treatment program and inability to benefit from the psychotherapeutic relationship. It is very difficult for the caregiver to follow the patient and form a stable caregiver-patient relationship, and thus the condition of these patients is usually more deficient than that of other psychiatric patients who are not substance abusers. This population is rejected by the mental health services due to the difficulties involved in maintaining regular supervision of their mental condition. When they resume the substance abuse their mental condition also deteriorates, requiring renewed restricted hospitalization and purging of the drugs, with an attempt to reach renewed stability based only on medication, in itself a repetitive process. This population does not receive care by the community social services due to its attribution to the mental health system and thus the patients "fall between the cracks".

For such cases it is necessary to create a separate health care system, combining mental health services and treatment for the substance abuse with a treatment program that will deal not only

with the medical aspect, but also with rehabilitative and social aspects.

THEORETICAL TREATMENT MODEL FOR SUBSTANCE ABUSERS – DUAL – DIAGNOSIS CASES

There are a number of treatment models that serve as the basis for treatment programs that were designed specifically for the population of dual-diagnosis cases – a combination of psychiatric problems with substance abuse. A diagnostic procedure for identifying such cases has not yet been designed and developed, since diagnosticians in the field of psychiatry or those within the field of substance abuse are often unable to receive authentic information from the patient confirming the presence of an additional diagnosis. In the initial interviewing process it is difficult to identify active mental symptoms, since the clinical expression of drug addiction symptoms is very similar to those present in the active stage of mental disorder. A single examination is insufficient to determine the presence of dual-diagnosis. It is necessary to receive the patient's history from sources within additional professional treatment settings in which he was treated in the past. Therefore, the diagnostic process should include a number of sessions as well as information additional to that received from the patient.

Treatment programs for cases of dual-diagnosis require the creation of a protocol that combines professional elements and knowledge from the fields of both substance abuse and mental health. The basic tenets of this program should include:

- 1) A restricted residential inpatient unit connected to the services of an ambulatory supervisory clinic in the community. This program can be established as a special and separate program associated with a psychiatric hospital.
- 2) A therapeutic program flexible in its professional manner of operation.
- 3) Professional staff operating this unit, proficient in psychiatric knowledge and knowledge of treating problems of substance abuse.
- 4) An individual evaluation and a personal treatment program adapted to the needs of each patient.

5) Consideration of possible suicidal attempts during the treatment period. Studies report that 50% of all such cases attempted suicide while in a therapeutic environment.

6) The provision and supervision of supportive dosages of psychiatric medication.

It is vital to determine the goals of the therapeutic program for these patients, but the expectations should be very limited. It is unrealistic to expect complete recovery from these disorders (substance abuse and mental illness). The results of the treatment program and its success should be measured in terms of a lower and less serious frequency of substance abuse, longer periods without substance abuse, the patient's cooperation with the treatment program which balances and supervises the provision of psychoactive medication, and a decline in the number of recurring hospitalizations in the restricted residential inpatient unit.

The treatment program model will formulate a therapeutic contract in which expectations will be determined and coordinated in cooperation with the patient. The contract must outline: instructions concerning obeying the psychiatrist's directions to take the prescribed dosage, behaving in accordance with the therapeutic environment (personally and in group therapy), avoiding alcohol and/or drug abuse, honesty and reliability in the therapeutic relationship, avoiding the use of (verbal and physical) violence, retaining confidentiality, and cooperating in order to achieve the social and rehabilitative goals determined in the patient's individual program.

TREATMENT PROGRAM FOR DUAL-DIAGNOSIS CASES: SUBSTANCE ABUSE AND MENTAL ILLNESS

The treatment program for this population must be based on the patient's specific symptoms and individually adapted to the patient. Expectations cannot be similar to those of general treatment programs for substance abusers. When mental pathology is combined with substance abuse, the individual displays a very low level of functioning, with an inability to organize mental and functional faculties as well as behavioral instability in mental situations. The patients perceive the drug as medication and increasing consumption of the prescribed medication at his/her own ini-

tiative fulfills the need for self-drugging. These individuals usually request help in situations of stress, when they are unable to find drugs. At this stage pathological symptoms of the mental illness may appear. Patients with dual diagnosis are a great burden to their families due to their dysfunctional behavior, helplessness, and their state of constant addiction, causing them to sever themselves from relationships and daily functioning.

Treatment stages:

- 1) Interview and diagnosis: Following referral for therapeutic care, whether by the patient or by relatives, the person is invited for an interview and diagnosis. Due to diagnosis difficulties, if this is a case of dual-diagnosis, the community caregiver (if approached first) will ask for a medical opinion and refer the patient to the regional dual-diagnosis mental health clinic. There the patient will be examined by a psychiatrist. If dual-diagnosis is confirmed, the regional clinic will refer the patient to the national inpatient ward. The staff of the ward will summon the patient for a more intensive process of diagnosis, performed by the unit physician and its professional staff, and if this professional examination indicates his need for inpatient care he will be admitted for hospitalization.
- 2) Admission and detoxification: Upon admission, the psychiatrist will determine the patient's detoxification program. This is actually the most acute stage of the treatment – the stage at which the patient decreases his use of drugs and balances his psychiatric medication. At this stage, the medical staff is dominant and the patient can be contacted only on a very low level, as his mental pathology is very active. He requires maximal medical supervision. It is impossible to define the length of this stage, since the rate of physical detoxification and stabilization is individually adapted to each patient according to his progress.
- 3) Determining the treatment program and its application: Upon ending the physical detoxification stage and stabilizing the medication, each patient's personal treatment program will be decided. The program will include individual and group therapy sessions, as well as occupational therapy activities. At this stage, the patient is more communicative and able to cooperate in organizing his daily routine on a basic level. This is actually the stage at which the patient grows stronger, stabilizes, and organizes his mental faculties in order to function as well as possible. The length of this stage also varies individually.
- 4) Stabilization of the mental and physical condition: This is the most advanced inpatient stage. The patient is capable of a conversational relationship and is able to start working and functioning according to his abilities. At this stage, he begins coping with behavioral requirements for self-responsibility. The customary therapeutic method at this stage is based mainly on behavioral approaches, with reinforcement and support of positive behavior. Rehabilitative plans aimed at reintroducing the patient into the community are initiated, and therefore, at this stage it is important to contact the supervisory clinic that will continue treatment in order to form a sequence of treatment programs.
- 5) Release from hospitalization – Transferring treatment to the ambulatory clinic at the mental health center: The patient ends his hospitalization and returns to live in the community, usually returning to his family, as assisted living settings for dual-morbidity substance abusers are not readily available. The clinic must supervise the patient through therapeutic sessions (at least once a week), follow his medication, assist him with rehabilitative care, and hold joint discussions with family members. The clinic must continue performing urine tests in order to follow the patient's use of substances and medicines, as the recurrent use of drugs indicates deterioration. The clinic caregiver must use rehabilitation services operated in the community for the rehabilitation of mentally ill patients. The dual-diagnosis patient is capable of becoming integrated on this level of jobs or studies. Also at this stage, the program will be individual and adapted to the patient's ability and capabilities. In situations of regression and recurring substance abuse followed by a deterioration of the patient's mental state, he may be re-

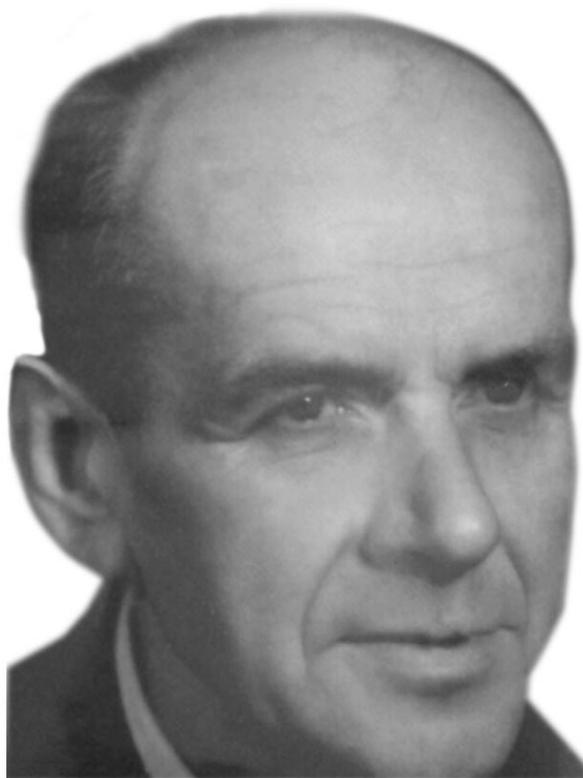
turned to the national inpatient unit and the treatment renewed.

CONCLUSION

For purposes of this program, a treatment setting operating on the model of a therapeutic community is proposed. This setting will open an affiliated treatment program for dual-diagnosed patients, which will not be part of the therapeutic community but will be affiliated with it, and will accept dual-diagnosis patients that are at the end of stage 3 (physical detoxification and basic physical and mental balancing). This will be a residential setting that will use the principles of the therapeutic community, adjusted for the abilities of this population to accept conditions of discipline and functioning. This program, operating in a restricted environment, will be able to provide stabilization in a more lengthy and basic process in an atmosphere that is not part of the mental health field and is separated from psychiatric patients. The two settings that are willing to accept this program as affiliated with them perceive it as a mutually beneficial process, in which dual-diagnosis patients will achieve a feeling of normalcy and the therapeutic community patients will provide them with support and assistance.

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