

PART IV:
SRP for Clients
with Concurrent
Disorders

Adapting the SRP Approach

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Introduction

Client Profile: Steve

Steve is 32. He has a diagnosis of schizophrenia and is connected to the outpatient mental health program. He has a psychiatrist and a case manager, and medication is part of his treatment plan. Steve uses crack cocaine, typically in binges, particularly when his monthly disability cheque arrives. He also smokes marijuana and drinks alcohol. His substance use has had negative consequences for his mental health (it has produced psychotic symptoms), and also may jeopardize his housing situation (since substance use is not tolerated in the supportive housing where he lives). Steve calls crack “the Devil’s drug,” but feels he is hooked, and still values the escape and social enjoyment he gets from it. He says it is difficult for him to resist when drugs are offered to him, and he finds it hard to be assertive in refusing drugs if he is approached by dealers in his neighbourhood and has money in his pocket. He is open to receiving help to explore his use of crack, but does not see his marijuana and alcohol use as problematic.

This chapter addresses the issue of how we can work effectively with clients like Steve, who present with concurrent substance use and mental health issues. In what follows, we outline an adapted version of SRP for clients with concurrent disorders (CD). The first section of the chapter discusses the prevalence of concurrent disorders and summarizes some of the key research findings related to working with clients with concurrent disorders. It also

includes some tips for running SRP groups with this population. The following sections provide session outlines and clinical tools that have been adapted for use with clients with concurrent disorders.

Over the past decade, there has been an increasing appreciation of the needs of people with concurrent mental health and substance use issues. A variety of studies seeking to establish the prevalence rate of concurrent disorders have shown that *roughly half* of individuals with either a mental health or substance use disorder had concurrent disorders at some point in their life (Health Canada, 2002; Kessler et al., 1996; Regier et al., 1990). In an Ontario study of clients seeking treatment for substance use problems, 68 per cent had a concurrent mental health disorder (Ross et al., 1995). As expected, the study indicates that the prevalence rates are higher in agency and hospital populations than in the general population. However, the rates in clinical populations varies considerably, depending on the setting and the method of diagnosis.

What is clear is that this traditionally underserved (even, often, ignored) population comprises a high proportion of clients presenting for service in either specialized substance use or mental health settings, as well as other contexts (such as hostels and shelters, criminal justice and corrections systems, child protection and family services, employee assistance programs and primary care settings). The increasing recognition of the high co-prevalence rates has led clinicians to screen routinely for the presence of concurrent disorders. Ignoring or not properly recognizing concurrent disorders can affect clients' ability to recover successfully from both disorders, and negative effects can include:

- premature dropout from treatment
- higher risk of relapse
- risk of harmful interactions between drugs of abuse and psychiatric medications
- misinterpretation of symptoms (e.g., are they signs of a mental health problem, the effects of substance use or signs of withdrawal from substances?)
- likelihood of the client needing more expensive services in future.

However, a variety of factors, have made it difficult for agencies and health care organizations to respond adequately to the needs of people with concurrent disorders: lack of specialist knowledge and skills in substance use, mental health or both; limited access to specialist diagnostic and other treatment services and providers; agency exclusion criteria; problem complexity; and fragmented treatment systems. Nonetheless, people with concurrent disorders are often best served where they present; at the very least, they are best served within the context of an integrated treatment program or system (Health Canada, 2002).

Because research is still lacking in this area, our current understanding of best practices in screening, assessment and treatment of people with concurrent disorders must be seen as still in development. What we do have, though, is an emerging consensus regarding how best to design programs and systems to provide more seamless and integrated care, and how to respond clinically to clients with concurrent disorders. Integrated treatment for concurrent disorders started in the early 1980s as a solution to the difficulties and poor outcomes associated with “sequential” and “parallel” treatment systems that were not co-ordinated. Integrated treatment occurs when “mental health treatments and substance abuse treatments are brought together by the same clinicians/support workers, or team of clinicians/support workers, in the same program, to ensure that the individual receives a

consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers” (Health Canada, 2002, p. 15).

Minkoff (2001) has articulated the following key principles of integrated treatment for concurrent disorders:

- comprehensive programs and services designed to respond to the substance use, mental health and other issues with which clients present
- continuity of treatment over time, as many clients with concurrent disorders require long-term follow-up, aftercare and community support
- accessibility in the location of services; flexibility in hours and service delivery
- acceptance by practitioners of both mental health issues and substance use issues
- a sense of optimism about the possibility of recovery, even for clients with very severe or complex problems
- treatment that is tailored to individual needs
- culturally competent treatment.

The end result of a fully integrated approach is essentially a “no wrong door” response for individuals with concurrent disorders. Within this approach, new clients presenting to either a mental health or a substance use facility receive screening, assessment and treatment services both for substance use and for mental health problems.

Screening and Assessment

While there is no consensus about the best screening and assessment tools for people with concurrent disorders, the components of an integrated treatment process are addressed by Health Canada’s (2002) *Best Practices* document:

- identifying potential substance use and/or mental health problems by properly screening clients
- for those who screen positive, conducting a comprehensive assessment to investigate the nature and severity of the substance use and mental health problems, and exploring their interrelations
- for those who have been diagnosed as having concurrent substance use and mental health problems, providing treatment and support.

With respect to screening to identify people with potential concurrent disorders, the principles of best practice suggest “level 1 screening procedures,” where all people presenting in mental health services are screened for concurrent substance use problems (Health Canada, 2002). Level 1 screening procedures include asking a few key questions regarding substance use, being alert to social and clinical indicators that raise the clinician’s index of suspicion, and drawing on the judgment and experience of a case manager. These procedures are summarized below.

ASKING A FEW KEY QUESTIONS

By asking a few key questions regarding, for example, a client’s perception that others are concerned about his or her substance use, you can make better decisions about whether or not the client requires more intensive assessment of a potential concurrent substance use

disorder. A Yes response to any one of the three following questions suggests that further investigation into the possibility of concurrent disorders is warranted:

- Have you ever had any problems related to your use of alcohol or other drugs?
- Has a relative, friend, doctor or other health worker been concerned about your drinking or other drug use, or suggested you cut down?
- Have you ever said to another person, “No, I don’t have an alcohol (or other drug) problem,” when, around the same time, you questioned yourself and felt, “Maybe I do have a problem”?

Do not rely only on client self-disclosure, because clients may minimize their problems. For this reason, additional screening procedures may be helpful.

INDEX OF SUSPICION AND CLINICAL CORRELATES

If it is not possible to ask questions, or if the quality of a self-report is in question, a number of behavioural, clinical and social indicators and consequences (the “index of suspicion”), can be considered; the presence of a number of items from this index may give cause for suspecting possible concurrent substance use difficulties. The index includes:

- new or unexplained mental health symptom relapses
- history of substance use
- unstable housing
- budgeting difficulties
- treatment compliance issues
- sexual acting out
- social isolation or difficulties
- violence or threats
- suicidal thoughts or attempts
- self-harm
- hygiene or health concerns
- legal problems
- cognitive impairments
- avoidance of disclosing mental health or substance use issues.

Along with the items above, be alert to what Mueser et al. (1992), in their work with clients with severe mental illness, have identified as various “clinical correlates” of substance use disorders:

- cigarette smoking (people who smoke are three to four times more likely to misuse substances)
- male
- younger
- lower education
- single or never married
- good premorbid social functioning
- family history of substance use problems
- history of childhood conduct disorder
- antisocial personality disorder
- higher affective symptoms (e.g., depression or suicidality)
- relationship problems

- job problems
- disrupted housing or other instability
- disruptive behaviour or violence
- non-compliance with treatment (e.g., medication not taken, missed appointments)
- legal problems
- physical symptoms (e.g., dilated pupils, sweats, shakes, smell)
- physical diagnoses (e.g., liver problems).

Given the high prevalence of comorbidity, you should make screening efforts routine, and “view concurrent disorders as the *norm*, NOT the *exception*” (Mueser et al., 1992). Accordingly, the use of an index of suspicion, and bringing this lens to interactions with clients, represents good clinical practice in both substance use and mental health settings.

CASE MANAGER JUDGEMENT

Also useful is a case manager’s opinion and concern about the possibility of a substance use problem, since the case manager often has the benefit of a long-standing relationship with the client. Seeking this opinion can be as simple as asking the case manager, “Do you think the client has ever had a drinking or other drug problem? Would you say definitely, probably or not at all?”

MOVING FROM SCREENING TO ASSESSMENT

If the result of the screening procedures outlined above suggests concurrent disorders, you may find it helpful to complete a brief screening tool. The Dartmouth Assessment of Lifestyle Instrument (DALI) (Rosenberg et al., 1998) is the only tool that was explicitly developed as a screen for substance use disorders among people with severe mental illness (see www.dartmouth.edu/~psychrc/pdf_files/DALI.pdf).

With respect to diagnostic assessment, the most comprehensive option for such clients is a complete assessment for psychiatric and substance use disorders, per the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (American Psychiatric Association, 1994). However, several barriers may preclude a complete psychiatric and substance use assessment, including limited resources, long waiting lists for treatment and limited CD-specialized programs and services. For a more complete review of CD screening and assessment considerations, issues and instruments, see Juan Negrete’s chapter, “Screening and Assessing for Concurrent Disorders” in Skinner (2005).

Treatment

Harm reduction (see Skinner & Carver, 2004) is seen as the most desirable treatment philosophy in working with a population that may not be willing or able to accept abstinence-based goals. Despite the recognition among health care professionals that abstinence is an ideal goal for people with concurrent substance use and psychiatric disorders, most experts in the field acknowledge that returns to substance use (i.e., relapses), are a reality of working with this client population. A harm reduction approach brings with it an understanding of the need to continue to work with these clients even (and especially) when they are not abstinent.

Further clinical challenges include compliance issues with taking prescribed psychiatric medication and ambivalence about changing or stopping substance use. The recommended response is to set small, incremental goals. Keeping clients engaged in treatment is preferable to mandating abstinence, as treatment engagement increases opportunities to continue to facilitate and support positive change. Finally, treatment outcomes can be measured by more than just adherence to substance use goals or medication compliance. It is important to also assess a client's overall level of functioning, use of coping strategies and support systems, community integration, vocational rehabilitation, social and interpersonal functioning, and other target areas as evidence of good treatment outcomes.

MODIFICATIONS TO COUNSELLING PROCEDURES AND CLINICAL TOOLS

Research in Motivational Interviewing approaches suggests that clinical tools and techniques developed for people with substance use problems need some adaptation when they are used with clients who have concurrent disorders (Martino et. al., 2002; Graeber et. al., 2003; Steinberg et al., 2004). Given the motivational orientation of SRP, it is not surprising that the SRP treatment sessions and clinical tools require some modification for use with this population.

This section outlines such an adapted version of SRP for use with clients with concurrent disorders. While not as rigorously evaluated as the “generic” version of SRP, the CD-adapted protocols and tools were developed in collaboration with a group of inpatient-based and community-based clients with concurrent disorders, and reviewed and revised in light of responses by a cross-disciplinary mix of clinicians working in both substance use and mental health specialties.

Although further research is needed to establish the efficacy and effectiveness of SRP with clients who have concurrent disorders, the goal of sharing our understanding and experience is to allow others to take advantage of the gains that we have made, and to join us in pursuing further knowledge in this area. Therefore, we suggest that you let your clients be your guide in implementing these tools: they are the most expert in the treatment structure, format and content that will best fit their needs.

The revisions needed for running an SRP group for clients with concurrent disorders include:

- shortening group duration (90 minutes, as opposed to two hours in the “substance-use-only” SRP group)
- using fewer clinical tools per treatment session (we found that even one or two paper-and-pencil tools could be overwhelming for some clients with concurrent disorders)
- modifying clinical tools to incorporate CD-specific treatment goals (such as taking prescribed medications, or coping with the symptoms of mental illness and/or the side-effects of prescribed medications)
- spending more time in the group processing discussion around access to services, and navigating the mental health and substance use treatment system
- making the clinical tools easier to complete.
- including a follow-up SRP group three to four months after the last weekly session, in order to review ongoing or emergent treatment needs, to help clients progress toward their goals and to identify next steps.

This section includes CD-adapted Therapist Checklists for each session, as well as revised versions of the relevant clinical tools from parts II and III of the manual.

NOTE: We have indicated the tools that have been altered for clients with concurrent disorders by appending the notation “CD Adapted.” Any tools listed that are not identified as “CD Adapted” are identical to the non-adapted versions, which can be found earlier in this book.

Other Issues with CD-Adapted SRP

CO-FACILITATION

There is no research examining whether or not CD-adapted SRP groups should be co-facilitated. In fact, the overall composition of CD-adapted SRP groups is an area we hope will be the focus of further research (e.g., should groups be composed of people with similar or with differing psychiatric diagnoses?). In our clinical practice, co-facilitation has been the model for several reasons, as discussed below.

Safety

It is not uncommon when working with people who have concurrent disorders for a group member to arrive acutely psychotic, acutely suicidal, intoxicated or acting out. When a situation like this occurs, one therapist is typically required, for safety reasons, to intervene directly with the person outside of the group. It is therefore helpful to have a second therapist who can be free to stay with the group and carry on with the session.

Avoidance of Burnout

One therapist “going it alone” in running a CD group can find the work to be emotionally draining. In a co-facilitation situation, the two therapists can support each other, plan for the group together and work together to manage challenging clinical group issues that inevitably arise. Within this model, therapists are less likely to feel isolated in this challenging clinical work, and to potentially burn out.

Professional Development

Co-facilitation allows the therapists to brief for the group before the group session, and to de-brief together after the session is over. This kind of clinical exchange stimulates analysis of the CD-adapted SRP approach and related group developments, and provides a forum for peer support. Also, exposure to a co-therapist’s insights can enhance professional development and skills.

Opportunities for Training and Supervision

We also believe there is value in having one seasoned, experienced therapist co-facilitating a CD-adapted SRP group along with a less experienced clinician or a student. This combination can provide a valuable real-life learning process and an ideal opportunity for close supervision.

Opportunity for Mutual CD Capacity-Building

A co-facilitation model comprised of one clinician with a substance use background and another with solid mental health preparation allows for mutual professional development, with a view toward building capacity in the area of concurrent disorders.

DETERMINING THE SUITABILITY OF SRP FOR A GIVEN CLIENT

Once the presence of concurrent substance use and mental health problems has been established, several factors contribute to determining whether SRP, among the range of other treatment options, would best fit a client’s needs.

Although SRP employs written feedback, exercises and forms, the ability to complete written exercises is not essential. Where written exercises are not appropriate, we have substituted discussion and role-playing exercises (or individual therapy).

If SRP is being delivered as part of an inpatient, hospital-based program, the major criteria for SRP treatment is the client’s ability to attend and participate in the group or individual sessions.

However, before considering SRP on an outpatient basis, consider the factors listed in the table below. If any of the following are present, we suggest a more intensive treatment program (such as day or residential treatment), as SRP may not be the most appropriate treatment at that juncture.

Presentation	Suggestion
Poor outcome of previous brief treatment episodes	Suggest a “stepped care” approach, where the least intrusive treatment options are attempted and, if they are unsuccessful, “stepping up” to a more intensive level of care.
Multiple concurrent problems (e.g., substance use <i>and</i> mental illness <i>and</i> housing instability <i>and</i> medication non-compliance; active symptoms <i>and</i> cognitive impairment; etc.) Severe substance use problems (i.e., DSM-IV criteria are met for substance dependence)	Suggest day treatment or residential options, which, research suggests, are better suited to these clients.
Acute or recurrent suicidality	Suggest hospitalization for stabilization.
Acute psychosis	Suggest hospitalization for stabilization.
Acute intoxication or withdrawal	Suggest withdrawal management.
Cognitive impairment (e.g., poor concentration, memory, inability to focus)	Suggest a review of medications and an inquiry into whether a cognitive impairment exists in addition to mental health and substance use issues. Use SRP tools on an ad hoc basis.
Long-term history of relapse following multiple unsuccessful treatment episodes	Suggest more intensive treatment.
Serious consequences to relapse	Suggest more intensive treatment.

If SRP is the best treatment option, it is important to give clients with concurrent disorders a thorough orientation to the format and content of the treatment sessions. In addition, for clients involved in the forensic system, there should be a discussion about how disclosures of substance use episodes, cravings and triggers, and exposure to risk situations, will be documented, as there may be legal implications for clients. The CD-adapted Therapist Checklist for the Assessment phase (page 136) notes some of these group process issues, as well as listing relevant clinical tools.

HANDLING RELAPSES

Relapse is often a part of recovery from mental health and substance use problems. Clients should be encouraged to view lapses and relapse as temporary setbacks.

Relapse to Substance Use

When clients relapse to substance use, we are careful to correct the interpretation that relapse means failure in recovery. On an emotional level, for some people, the perception that relapse equals failure often creates a significant experience of shame, pessimism about the ability to change and even self-loathing because they have continued to repeat old patterns. In settings where relapse is not normalized, clients have reported dropping out prematurely because they could not imagine returning to and facing the group. Within a CD-adapted SRP approach, we reframe experiences of relapse as an opportunity for learning and for problem solving. Relapse is also seen as an opportunity for clients to reaffirm their substance use goals and shore up their levels of motivation and commitment.

The hope is that within a harm reduction approach, clients will feel comfortable disclosing relapses—should they occur—without fearing they will be asked to withdraw from the program. Permission to be honest about a relapse in the treatment process, especially if the relapse is already over, helps to normalize it as an occurrence, and helps to prevent the client feeling he or she cannot be genuine in therapy. It is also helpful for clients to explore the trigger(s) that led to the slip, and to discuss more adaptive coping responses that could prove useful for any similar situations in the future.

Relapse of Mental Health Problems

When working with a population that has concurrent disorders, it is also important to note clinically that relapse is a common occurrence with mental health problems such as depression and psychosis. However, in our experience, clients tend not to feel the same guilt and shame with a mental health relapse as they do with a relapse to substance use. The underlying belief for many clients seems to be that the use of substances is essentially their fault, but that a relapse to psychiatric symptoms is largely beyond their control. Nevertheless, relapsing mental health symptoms are associated with a feeling of disappointment and learned helplessness, and a profoundly demoralizing sense that the psychiatric condition will be a continuing struggle, possibly for a lifetime. This is a common reaction in clients with chronic depression or bipolar disorder.

To foster a better, more helpful mindset for managing relapse, we normalize the idea that relapses occur in both domains, and then attempt to help clients identify personalized early warning signs that their mental health is deteriorating. Such signs in depression,

for example, might include sensing a tendency to withdraw socially, beginning to lose interest in activities previously enjoyed and experiencing an increase in negative or pessimistic thinking.

Once the client becomes aware of these early warning signs or “red flags,” he or she can develop strategies for coping and intervening early in the cycle. Such interventions might include relaying symptoms to a caregiver, implementing personal coping strategies such as good self-care and seeking social support, with the overall goal of circumventing a full relapse.

The SRP approach helps a client to anticipate substance use triggers for the coming week and identify and commit to a plan of action. Within the CD-adapted SRP approach, relapse prevention goals include, but are not limited to:

- working on a substance use goal of abstinence or reduction
- within an abstinence-based goal, having fewer and shorter-lasting slips
- using less (if any) of the problem substance, and having fewer negative consequences associated with substance use
- recognizing the impact of substance use on mental health
- learning and recognizing early warning signs for mental health relapse
- developing an action recovery plan and putting it into practice in the “real world,” in between SRP sessions, which aim to support the maintenance of change.

THE SUPERSENSITIVITY HYPOTHESIS

Mueser and colleagues argue that people with severe mental illness are more sensitive to the effects of alcohol and other drugs, due to an increased biological vulnerability (Mueser et al., 1998). As a result, people with concurrent disorders may experience increased negative consequences from relatively small amounts of substance use. Thus, in someone with schizophrenia, relatively moderate use (e.g., two beers three times per week, or \$20 worth of crack cocaine used once every few weeks) may result in negative consequences (such as increased psychotic symptoms), or may dramatically increase the risk of more severe substance use. A key message with respect to the supersensitivity hypothesis is that, when working with people with serious and persistent mental illness, the *quantity* of the substance use is less important than the *consequences*.

REFERENCES

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