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Article 15

Psychiatric Disabilities and Substance Abuse: Applications for Rehabilitation Professionals

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Roughly 1.7 to 4 million individuals have severe mental illness within the United States at any given time (Garske, 1999; Hilburger, 2000). Approximately 50% of these individuals have coexisting substance use disorders (Alverson, Alverson, & Drake, 2000; Chandras, Chandras, & DeLambo, 2007). Individuals with a psychiatric disability and a coexisting disability of substance abuse/addiction (i.e., dual-diagnosis) tend to have higher relapse and symptom exacerbation rates, poor treatment outcomes, less functional stability, limited social relationships, increased family stress, and premature death rates from either substance abuse, medical complications, or suicide (Ziedonis & Stern, 2001). In addition, they have an 85% unemployment rate (Garske, 1999; Hilburger, 2000). Rehabilitation professionals are likely to encounter unique challenges when working with dually diagnosed clients (Brown & Saura, 1996). Consequently, awareness of dual diagnosis as well as the various treatment modes and implications are vital for rehabilitation professionals.

Symptom Recognition

When working with dual-diagnosis individuals, the rehabilitation counselor must be able to differentiate between the symptoms of these coexisting disabilities (Benshoff & Janikowski, 2000; Brown & Saura, 1996). For example, a consumer with bipolar disorder may be displaying depressive symptoms arising primarily from the use of methamphetamine and depletion of neurotransmitters, rather than from the psychiatric disorder itself. Without recognizing the methamphetamine use, the rehabilitation counselor would address only the bipolar disorder, making successful outcomes (e.g., employment, symptom reduction, and independence, etc.) unlikely (Doweiko, 2006). In addition, the rehabilitation counselor needs to be aware of common characteristics of dual-diagnosed clients. These characteristics may include: marginal living quarters, drug-user social networks, depression, more binge/heavy drug use, difficulty with abstinence, symptom exacerbation (e.g., psychosis), relapse, self-medication, and poor work history, as well as hygiene issues (Gearon, Bellack, Rachbeisel, & Dixon, 2001). The rehabilitation counselor must be knowledgeable of these characteristics and address them in identifying appropriate interventions and in planning effective services.

Once coexisting disabilities and unique client characteristics are identified, the next step is choosing an appropriate treatment program (Inaba & Cohen, 2004). Some programs do not support the use of psychotropic medications; client participation in such a program could increase medication non-compliance, thus increasing psychiatric symptoms, such as depression, paranoia, and hallucinations. Once symptoms occur, a client may begin the self-medication cycle by using substances (e.g., cocaine, alcohol, methamphetamine, etc.) to offset psychiatric symptoms (Mueser, Bellack, & Blanchard, 1992). Rehabilitation plans that take these unique client needs into account follow the ethical code and tend to promote successful outcomes (Rubin & Roessler, 2001).

Treatment and Mental Illness

Counselor support, drug-free and safe housing, and sober social networks, as well as activities such as work all support recovery for persons with dual diagnosis (Alverson et al., 2000). Client substance addiction coupled with psychiatric disability lessens the chance that either the psychiatric disability or coexisting disability of substance abuse will go into remission (Doweiko, 2006). Furthermore, even if the client is willing to participate in a treatment program (i.e., substance abuse and/or mental health), not all groups/facilities have experience or knowledge in regard to dual diagnosis (Benshoff & Janikowski, 2000).

Some traditional Alcoholics Anonymous (AA) groups (Benshoff & Janikowski, 2000) follow strict adherence to a no psychoactive medication policy (including psychotropic medications). Programs that lack knowledge of dual-diagnosis may fail to recognize that what appears to be "denial" of the substance abuse problem on the client's part is actually due to lack of insight associated with the mental illness, rather than an attitudinal problem. Mueser et al. (1992) claimed that traditional AA approaches utilizing "confrontation" and "abstinence" for therapy may be counterproductive and unrealistic for individuals with dual-diagnosis. Abstinence should not be conditional for program entrance (NAMI, 2003); rather, health-protection procedures such as "reduced frequency" are more feasible (Craig, 2004). In addition, a more "soft" approach allowing individuals with dual-diagnosis to go through the system at their own pace is suggested. According to Inaba and Cohen (2004), traditional Mental Health Providers (MHP) and Substance Abuse Providers (SAP) tend to view treatment from a one-sided perspective, which can reduce program effectiveness for this population. For example, MHP and SAP believe that by addressing their area of focus, be it mental illness or substance abuse, the other problem will resolve on its own. Instead, simultaneous treatment of both disabilities is a preferred treatment mode (Inaba & Cohen, 2004) and more likely to be successful. According to NAMI (2003), effective treatments include the

following key factors: Treat in stages (e.g., build trust first); assertive outreach (intensive case management); motivational techniques; social support/network building; a comprehensive recovery philosophy involving a long-term and community-based approach; and cultural sensitivity/competence are vital. Fortunately, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2007), as well as NAMI (2007), have dual-diagnosis treatment facility locators to help identify appropriate programs.

Double-Trouble in Recovery

Double Trouble in Recovery (DTR, 1997), a 12-step program, is aimed specifically at this population. This fellowship of dually diagnosed members share experiences, hope, and strength to assist with recovery from substances as well as psychiatric symptoms. DTR's philosophy is that the individual walks a "long and narrow path." When substances are abused or psychiatric regimens (medication compliance and counseling) are not followed, control of substance use is compromised and the path becomes "dark." This program emphasizes that there is "Double Trouble" in recovery because of the two disabilities. Empathic understanding among members is a core condition. Fortunately, approaches such as Double Trouble in Recovery (DTR) exist for this population and have shown positive outcomes. The success of Double Trouble's self-help approach can be attributed to:

1. *A social network of persons with dual diagnosis share common experiences* (e.g., discrimination). Universality is felt from the stigma of mental illness and substance abuse. The social network is a driving force for growth and awareness.
2. *The self-help approach moves the client from the victim to the helper role.* This can increase self-esteem because the helper is "valued" in society. In fact, this role can buffer unwanted anxiety at later points as well as other crises.
3. *Role models can demonstrate successful coping techniques based on their many experiences.* Group members can model effective coping strategies.

4. *The members provide a meaningful structure to process the issues of dual diagnosis.* The group's structure is not imposed by outside forces. Members run the group without the constraints of the human service system. Self-efficacy can be strengthened from this model.

A separate 12-Step program for dual-diagnosis individuals is preferred because of the need to focus on both diseases (mental health and addiction), the stigma associated with dual-diagnosis, and the importance of psychotropic medications. In addition, some group members in traditional 12-Step programs have provided harmful information in regard to psychiatric disability and the use of medication (Doweiko, 2006; Inaba & Cohen, 2004). Even the concept of "character flaw" has been projected upon clients. As a consequence, some dual-diagnosis clients in these programs have reportedly ceased their medication, leading to psychiatric relapses (DTR, 1997). When helping a client select a specific treatment program, the rehabilitation professional should thoroughly understand the client's unique situation as well as the aim of the treatment program; otherwise, harm (e.g., relapse) could come to the client (Roessler & Rubin, 2006; Rubin & Roessler, 2001).

The Role of Work

Work is regarded as a common therapy for persons with severe mental illness (Spaniol, Wewiorski, Gagne, & Anthony, 2002). A number of effective job placement strategies are utilized with persons with mental illness: Post Employment Support (PES), natural supports, job clubs, supported employment, transitional employment (TE), and Choose-Get-Keep procedures (McGurrin, 1994). These strategies have successfully placed individuals with mental illness into employment positions. The psychological benefits of work accomplishments include enhanced self-concept and self-esteem and a sense of connection with society. In addition, work provides beneficial structure to people's lives (Benshoff & Janikowski, 2000).

Work and Sobriety

Work can be a powerful tool to assist with sobriety as well as disease stabilization for persons with mental illness. Employment can positively affect the individual's self-efficacy, self-esteem, social status, social interactions, relapse rate, and skill development, as well as providing a structured environment that is not conducive to drug use (Blankertz, McKay, & Robinson, 1998; Chandras et al., 2007). Rehabilitation professionals are in key positions to influence the employment process (Rubin & Roessler, 2001). A strong working alliance between the counselor and client is central to both client life satisfaction as well as employment outcome. Research on this working alliance found that employed clients gave higher ratings to both the working alliance and job satisfaction as compared to those who were unemployed (Donnell, Lustig, & Strauser, 2004). The counselor-client relationship is vital to this "working relationship" (Raskin & Rogers, 1995). Consequently, through this joint venture, the client and counselor work in partnership to identify an appropriate job position that will promote both sobriety and relapse prevention.

Work Environment

A work environment that fosters recovery and discourages drug-use is crucial to the recovery process. "Wet" environments (i.e., where drug use is supported) can be detrimental to recovery (Blankertz et al., 1998). In addition, environmental cues, such as the place (e.g., warehouse, parking lot), people (coworkers and friends), and things (e.g., anything the individual associates with substance use, such as a song or particular smell) can all affect substance use behaviors based on Classical Conditioning (Craig, 2004). For example, the client may enter a work site where prior substance abuse conditioning has occurred. Friday night drinking with coworkers and marijuana use on lunch breaks can be stimuli which set the abuse in motion. Such cues can trigger physiological responses (e.g., increased blood pressure and heart rate) and/or craving. Thus, the work environment is a location where abuse can be initiated based on these "triggers" or "discriminative stimuli" that can set the occasion

for drug use (Inaba & Cohen, 2004). The rehabilitation professional, through networking and experience, must determine if the site will support recovery.

Job Accommodation Network and Dual Diagnosis

A thorough intake interview will assist the rehabilitation counselor in developing a client profile that delineates major assets (e.g., coping mechanisms and support systems), limitations (e.g., level of social skills, coping skills, and assertiveness) and preferences (e.g., career choice; Rubin & Roessler, 2001). Once this client profile is developed, the counselor can match the consumer with appropriate employment. The Job Accommodation Network (JAN) is an important resource on the World-Wide Web to help counselors identify appropriate job accommodations for persons with disabilities (Rubin & Roessler, 2001). Rehabilitation professionals can obtain assistance from JAN professionals via telephone or by interactive web site (JAN, 2007a; JAN, 2007b).

Psychiatric accommodation categories include:

1. Maintaining Stamina (e.g., flexible work schedule);
2. Maintaining Concentration (e.g., reduce distractions in work area);
3. Difficulty Staying Organized and Meeting Deadlines (e.g., remind employee of important deadlines);
4. Memory Deficits (e.g., tape record meetings);
5. Working Effectively with Supervisors (e.g., develop strategies to address problems before they arise);
6. Interacting with Coworkers (e.g., provide disability sensitivity education);
7. Difficulty Handling Stress and Emotions (e.g., provide rest breaks);
8. Attendance (e.g., permission to work from home); and
9. Handling Changes in the Workplace (e.g., transition new supervisor within department).

The following are job accommodations categories specifically pertaining to employees with drug abuse issues (JAN, 2007b):

1. Treatment Needs (e.g., provide flexible scheduling for support group attendance);
2. Difficulty Handling Stress (e.g., provide self-paced work schedules);
3. Fatigue (e.g., provide rest breaks);
4. Maintaining Concentration (e.g., reduce workplace distractions); and
5. Exposure to Drugs in the Workplace (e.g., reassign to position where no drugs are present).

The rehabilitation professional, with the use of JAN, can modify the work environment in a manner that will decrease the probability of client drug use. These suggestions are a few that are available to facilitate client adjustment to the work environment (JAN, 2007a) and to assist with curbing substance abuse behaviors (Doweiko, 2006).

Supported Employment

Supported employment is another method known to promote client success. Research has demonstrated that supported employment geared specifically for consumers with dual diagnoses is a vital contributor to recovery (Becker, Drake, & Naughton, 2005; Drake, Becker, Bond, & Mueser, 2003). The rehabilitation professional can form a multidisciplinary team of professionals to assist with the process. The team may include a number of members, including the supported employment specialist, rehabilitation counselor, mental health counselor, substance abuse counselor, and social worker. The team must recognize the negative impact both addiction and psychiatric disability can have on employment (Becker et al., 2005) and take into account both disabilities in planning services. The team can develop a "vocational profile" which identifies client strengths, skills, and specific substance abuse issues (e.g., stage of recovery, triggers for substance abuse, social support system, coping techniques, and money management issues). This

profile can be used as a guide to identify jobs, work settings, and supports that promote recovery (Becker et al., 2005; Doweiko, 2006). In identifying appropriate jobs and settings, the team must realize that certain jobs can be "breeding grounds" for substance abuse, while others can be therapeutic tools for recovery. This integrated, team approach format should greatly benefit the rehabilitation counselor to assist client recovery (Becker et al., 2005).

Conclusion

Individuals with severe mental illness have a significantly high rate of coexisting substance abuse. Rehabilitation professionals are in a particularly key position to address client sobriety as well as psychiatric symptoms. This can be accomplished by matching the client with appropriate dual diagnosis treatment modalities, such as Double Trouble in Recovery, and by locating and modifying work positions/environments to match the client's vocational and substance abuse profile. Work can be a powerful tool within the recovery process. Rehabilitation professionals who understand the implications of dual diagnosis as well as the various vocational issues are much more likely to have successful outcomes.

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