

# SUBSTANCE MISUSE, MENTAL HEALTH, OFFENDING & TRAUMA

## (Part 2)

### **Considerations & Implications for Treatment**

This paper does not provide a review of treatment programmes, whether group or individual, nor does it compare the theoretical orientations of such interventions. The intended focus in this section is on the implementation of treatment needs emphasised in the previous section. It by no means covers the array of factors that require attention, but it does raise some relevant considerations and implications for treatment.

### **Integrated treatment: Need and reluctance**

Levenson, Greatley, and Robinson (2003) highlighted the high rate of dual diagnosis in London and drew attention to the challenges addressing such a diagnosis presents, especially within inpatient facilities. Considering the Department of Health (2002a) guidelines and the research evidence provided, the tripartite of mental health, offending and substance use requires attention and development with respect to service provision.

When dealing with dual diagnosis issues, integrated treatment programmes have been shown to be more effective than non-integrated programmes (Drake et al, 2001; RachBeisel, Scott, & Dixon, 1999), with high incidents of patient disengagement being associated with both serial and parallel models of treatment (Abou-Saleh, 2004). Drake et al (2001) outlined key components of integrated programmes, which include: staged interventions, assertive outreach, motivational interventions, counselling, social support interventions, long-term perspective, comprehensiveness, cultural sensitivity and competence.

Hipwell et al (2000) commented on American studies that suggest that integrated mental health and substance misuse approaches are more effective than non-integrated services. There is often ambiguity as to what came first, the substance misuse or the mental illness, thus emphasizing the importance of an approach (and in practice, a service) that incorporates the two (Walsh & Frankland, 2005), particularly as there is virtually no scientific support for utilising a primary / secondary distinction (Noordsy et al, 2003). The need for such services is clear and is illustrated by the fact that the number of people diagnosed with both a psychiatric and drug misuse disorder in England and Wales increased by 40% between 1993 and 1998 (Frischer et al, unpublished, as cited in Drugscope, 2001).

Kipping (2005) reported on a mapping exercise conducted in 2004 by The London Development Centre for Mental Health. Findings showed that few dual diagnosis strategies were actually in place within London boroughs. Abou-Saleh (2004) found that there is a general reluctance to treat psychiatric patients who misuse substances, and Hawkings (2005) observed that some mental health services still exclude individuals where substance misuse is their primary problem. More specifically, Hipwell et al (2000) commented that research findings generally agree that individuals with schizophrenia who misuse substances risk being lost between two services. Beck et al (2003) reported that with detained patients, forensic services traditionally consider mental health issues to have the biggest impact on risk of violence posed by a patient, which ignores literature commenting on the interactive effect of substance abuse / mental disorder and violence. Furthermore, they highlighted the difficulties when treating co-morbid substance abuse within forensic settings due to differing treatment philosophies between forensic and addiction services.

Importantly, several researchers have shown that the treatment of substance misuse offers positive outcomes with regard to a decrease in the use of drugs or abstinence, and a reduction of criminal behaviour (Hawkings, 2005). Furthermore, Scott, Whyte, Burnett, Hawley, and Maden's (2004) national study of medium security showed that there is a clear need to address dual diagnosis within forensic settings.

The National Treatment Agency for Substance Misuse ([NTA], 2002) provided guidance on the essentials of a substance misuse service, and emphasising the importance of links with health, social care and criminal justice agencies. Abou-Saleh (2004) commented on the need for referral pathways and protocols to be agreed between general, forensic and addiction services for the provision of treatment, training and support. In addition, Isherwood and Brooke (2001) highlighted the need for expertise within forensic psychiatric services when assessing drug related morbidity, and Wexler (2003) noted that treatment for those with dual diagnosis is an important factor in recidivism reduction. However, such treatments are still in their infancy.

### **Adding the dynamic of trauma**

Research (Bartlett, 2002; Boles et al, 2005; Gearon et al, 2003; Yehuda et al, 1998) has indicated that there is a clear need to address the impact of trauma. The Department of Health's policy on the strategic development of mental health care for women (DH, 2002b) highlighted the importance of services addressing the issue of abuse, stating that 50% of women within mental health services have experienced violence and abuse. Roesler and Dafler (1993) suggested that substance misuse is a form of dissociation from childhood abuse issues, and thus exploring and coming to terms with such issues may reduce the need to misuse substances.

Unfortunately, Wadsworth, Spampneto, and Halbrook (1995) found that research into chemically dependent women and sexual trauma shows that mental health providers tend to almost exclusively focus on the substance misuse with there being a reluctance, or even resistance, to address issues of sexual abuse. Further, Hall (2000) states that survivors of childhood abuse report that mental health and substance misuse services are not sufficiently addressing the core issues pertaining to abuse. If the dynamics of mental illness and offending are added, then it is very likely that this issue drops down even further in the hierarchy, or at worst, is given little or no recognition. Zlotnick et al (2003) emphasised that with regard to incarcerated women, no treatments have been developed or systematically evaluated that address both PTSD and comorbid substance use disorder. This is all despite a growing awareness of the impact of childhood abuse on substance use (RachBeisel et al, 1999) and research that has reported, for example, that female survivors of childhood abuse are more likely to misuse substances in comparison to those who have not experienced such abuse (Alexander, 1996; Bartlett, 2002; Bennett & Kemper, 1994; Hall, 2000; Miller, Downs, & Testa, 1993). The SAMHSA/CSAT Tip 36 documentation states that further research is needed with regard to males and sexual abuse, as well as substance misuse.

### **Gender, cultural and societal considerations**

Gender differences also deserve consideration in relation to treatment. A report produced by the United States' Drug and Alcohol Services Information System ([DASIS], 2001) reported that between 1992 and 1998 women represented approximately 30% of substance abuse treatment admissions, and that in 1998, 23 men were admitted to such treatment for every 10 women. However, it has been suggested that women with dual diagnosis may attempt to hide their addiction due to social stigma and / or a fear of losing their children (DH, 2002b).

“There are distinct differences in social and offending profiles of women and men, their experience of mental ill health, patterns of behaviour, their care and treatment needs” (DH, 2002b, pg 16). This emphasises the necessity of developing gender sensitive services. The Department of Health’s strategy regarding mental health care for women reported that women-only services were experienced, by female service users, as safer, and more attuned and responsive to their needs. The basic components of programmes are similar, regardless of gender, but the work itself may require separate delivery in accordance with gender specific treatment requirements.

DASIS (2001) reported that in the US there are important gender differences regarding the primary substance of abuse, in that women were more likely than men to be in treatment for ‘hard’ drugs, such as cocaine and heroin, and less likely than men to be receiving treatment for alcohol abuse or marijuana use. Furthermore, women are more likely than men to use prescription drugs (DH, 2002b).

More men than women are admitted to substance use treatment, but the National Centre on Addiction and Substance Abuse (1996) reported that 70% of females receiving treatment for substance abuse have a history of sexual abuse, compared to 12% of males.

SAMHSA/CSAT Tip 36 (2000) advised that treatment groups structured specifically for women or men are beneficial, especially during the early stages of substance abuse treatment. They also stated that gender-specific groups are equally beneficial for abuse survivors in treatment. The Department of Health (2002b) highlighted the particular relevance of a safe environment for women who have experienced violence and abuse. Furthermore, women who have been sexually abused by a male perpetrator may find it difficult to discuss abuse in the presence of males (SAMHSA/CSAT Tip 36, 2000).

Wadsworth et al (1995) drew together several research findings on the treatment of substance misuse with sexually abused clients. These studies demonstrated that traditional intervention is typically aimed at males and is confrontational, and that the focus of intervention seemed to be on substance misuse, with sexual trauma being an issue of secondary concern. They report that, when working with sexual abuse victims, a confrontational approach may leave individuals feeling as though they have been further violated and thus increase their resistance to intervention. Their paper focuses specifically on the effect of sexual trauma on chemically dependent women, and note that many authors stress the need for an approach that is encouraging, supportive and empowering when treating such a cohort. They also refer to the work of Evans and Schafer (1987, as cited in Wadsworth et al, 1995) wherein the importance of appropriate therapeutic boundaries, in reference to individuals with a history of sexual abuse, is emphasised: such individuals tend to have poor boundary-setting skills as a consequence of their own boundaries being violated at such young ages, often before ego formation has occurred.

In addition, Drake et al (2001) note that cultural sensitivity should be considered when planning treatment for dual diagnosis. Key issues influencing all individuals, and thus needing consideration in any service, include: gender, race, sexuality, class, disability and age (DH, 2002b).

Hawkings (2005) found that social needs such as housing, employment and the availability of social networks, are often overlooked when an individual with dual diagnosis is being assessed, due to a concentration on clinical needs. This lack of focus on social needs will inevitably impact on both the presenting problem and consequent approach to treatment. Brooke, Taylor, Gunn, and Maden (2000) compared men remanded in custody with substance misuse problems and men who did not misuse substances, and they found that the former group were more likely to face social difficulties,

which included housing difficulties, more unemployment and to have gained fewer qualifications than the latter group. In contrast, Loughran and King (2004) conducted a needs analysis of female prisoners, which demonstrated that as well as an interplay of needs including mental health, offending behaviour and substance abuse, social needs were also identified.

### **The demands of implementing treatment**

Substance misuse is a complex and multi-dimensional problem that has its roots in physiological, psychological and social areas, all of which are then affected by the problematic use of substances. Professionals who work in the field are acutely aware of the demands required in such work. Slow, gentle, non-confrontational and persistent interventions are required over a prolonged period of time. Short, sharp, and confrontational methods only serve to reinforce the users' defences and alienate them from engaging in services (Ghodse, 2002; Miller & Rollnick, 1991).

A disproportionate amount of individual work is required, particularly in the early stage of intervention leading to motivation to change (Miller & Rollnick, 1991). Such work, by virtue of its nature, needs to take place over a long period of time with repetition being required at various stages. Women's increased incidence of trauma-related issues that precede, but promote and maintain substance misuse, often require interventions to take place on a 1:1 basis over a prolonged period of time (as may be the case with male victims of abuse). Loughran & King (2004) identified a number of drawbacks when using group work for female prisoners, which included low recruitment rates, a concern by the women regarding confidentiality, and the possibility of disclosed information being used for bullying.

A powerful factor relating to substance misuse is the level of resistance from the substance abuser in addressing the problem, which may be partly due to the pervasive quality of its impact. It is only in more recent years that the healthcare and prison systems have begun to both recognise this pervasive quality and, as discussed earlier, to address it as a key element that requires dedicated and well-formulated interventions within both these systems. Miller and Rollnick (1991) stated that resistance may be a result of a failure to match the treatment approach to the stage of the client, or that the approach is too confrontational.

### **Staffing**

While it is important to integrate such input into services, it is essential that it be provided by those with specialist knowledge, as it requires a complex set of skills (DH, 2002a; Drake et al, 2001). Ridgely and Jerrell (1996) commented that with regard to dual diagnosis treatment, it is necessary that staff have the time and motivation to work with individuals who are likely to have frequent relapses and a strong denial of their diagnosis over long term treatment. This view is an accepted one by the Department of Health (2002a) and professionals within the field, as is the view that staff training, support and close supervision are essential in order to prevent rapid burn-out rates and clinical difficulties that are frequently encountered in this field of work. Jerrell and Ridgely (1999) highlighted the importance of good supervision when working with individuals with a dual diagnosis, in ensuring that staff morale and enthusiasm remain high. Furthermore, Levenson et al (2003) found that staff stress and turnover is associated with the demands placed on individuals working with people with a dual diagnosis, and Kipping (2005) reported that staff recruitment and retention could be hindered by the complexities encountered as a dual diagnosis practitioner.

### **Theoretical underpinnings**

“As more research literature is developed on the mental health treatment of offenders, it is apparent.

that approaches need to be explored that synthesize strategies and interventions from the fields of biology, psychology, and sociology” (Cellini, 2002, pg 78)

Physical tolerance and withdrawal, and the implications of these, are only one aspect of substance misuse. They do not take into account the dynamics, thinking patterns or substance-seeking behaviours that promote and maintain substance misuse problems. The model of treatment that approaches the problem from a multi-dimensional perspective appears to be the one that allows for the widest range of interventions. Engel’s (1977) biopsychosocial model, Liberman’s psychosocial model (Adams, 2000; Liberman, Massell, Mosk, & Wong, 1985; Liberman et al, 1993), and the Minnesota Model (Ghodse, 2002) are some of the influential treatment models that have been utilised over the years to inform a broader and deeper model of care that addresses substance misuse from three primary angles, namely, the biological/physiological area of tolerance, dependence and withdrawal, the psychological arena of underlying psychodynamics, coping strategies and behaviours, and the social dimensions of relationships, peer groups, subcultures and social interactions. More recently, other models have drawn upon aspects of these models and developed more specific interventions, such as cognitive behavioural (Graham et al, 2003a; Graham et al, 2003b; Marlatt & Gordon, 1985) or Dialectical Behavioural Therapy (DBT) which has been adapted (with limited success, Verheul, 2001) for use with individuals with borderline personality disorder and drug dependence (e.g. Linehan et al, 1999). Of great importance is the vast amount of neuroscience research that investigates the effects of trauma on individuals (e.g. Yehuda et al, 1998, Bremner, 1999; Kendall-Tackett 2000; Perry, 1976; van der Kolk et al, 1996; Rezek, 2003 unpublished) and which should certainly be considered when developing treatment interventions.

Edens, Peters, and Hills (1997) reviewed prison programmes aimed at dual diagnosis. Treatments included therapeutic communities, peer support, 12-step programmes, cognitive behavioural or skills building approaches, relapse prevention and case management. Wexler (2003) has commented on the ‘San Carlos’ programme, which has applied the principles of a therapeutic community to a cognitive-behavioural programme, focussing on substance abuse, mental illness and criminal thinking. Early results show evidence of effectiveness (i.e. better outcomes on self-reported crime and arrest) whilst highlighting the needs for community aftercare. There appears to be little research available on treatment interventions in this area, whether group or individual, from a psychodynamic perspective.

Most models of intervention are underpinned by the aim of preventing relapse, not only of the use of substances but by linking the individual’s psychological and social drives as precursors to seeking out and using substances, and the consequences thereafter. Such models are well placed for use within forensic settings, as each dimension allows for exploration and intervention in order to address the complexities of the domains of mental health, substance misuse, trauma and offending behaviour.

### **Factors affecting treatment outcomes**

Mental health factors that can affect substance use treatments include the type and severity of psychiatric disorder, early onset of illness and the level of cognitive impairment (Montoya, 2006). More specifically, Noordsy et al (2003) commented that difficulties with treatment engagement can be attributed to both negative and positive symptoms of schizophrenia, which include cognitive limitations, poor insight, and daily symptom variation. Also requiring consideration is the nature and severity of substance use. With regard to the former, McCaul, Svikis, and Moore (2001) studied an outpatient substance abuse treatment clinic and concluded that there is a significantly higher retention rate for alcohol-only patients, in comparison to those with a history of drug-only or combined use.

Snowden (2001) reported that treatment outcomes are found to be worse in individuals with dual diagnosis compared to individuals with psychotic illness alone. Hipwell et al (2000) identified that clients with a psychotic illness and a substance misuse problem were more likely to miss appointments at a day service facility than individuals who had a psychotic illness but did not use substances, and that those using substances were also poorer at complying with medication. Furthermore, patients with a dual diagnosis and a personality disorder were significantly less likely to attend an initial after-care appointment than patients with a dual diagnosis alone (Ross, Dermatis, Levounis, & Galanter, 2003). Relapse rates for people with schizophrenia were found to be higher for those with a history of substance use (Swofford, Kasckow, Scheller-Gilkey, and Inderbitzin, 1996), and individuals with a dual diagnosis were more likely to abstain from substance use if they were part of a long-term residential treatment, as opposed to a short-term residential programme (Brunette, Drake, Woods, and Hartnett, 2001).

Boles et al (2005) reported on treatment outcomes amongst adults in drug abuse treatment and found that a lower likelihood of post-treatment abstinence is related to a history of sexual abuse. Rohsenow, Corbett, and Devine (1988) reported on a chemical dependency treatment program and suggested that sexual trauma seemed to be an indicator of susceptibility to relapse into substance abuse. They also concluded that of the individuals in their sample who relapsed, 90% had been sexually abused. Wadsworth et al (1995), with reference to other research findings, suggested that perceived helplessness, which is common in those who have experienced sexual abuse, may contribute to this risk of relapse. Another indicator of a higher relapse risk may be a lack of social support (Daley, 1989), which may be a result of abused individuals believing that they cannot trust those around them.

Lehmann (2005) reported on preliminary findings released by SAMHSA from a five-year study of women with mental illness disorders and a history of trauma. The 'Women, Co-Occurring Disorders, and Violence Study' is believed to be the first large, US national treatment study of women with mental health and substance abuse disorders and a history of violence-induced trauma. The study focuses on nine treatment sites throughout the US and enrolled 2,729 adult women. Treatment either comprised of typical community counselling or a more integrated approach that combined the treatment of co-occurring disorders and trauma. Results at six months show that of the 2,006 women still enrolled in the study, women in the more comprehensive, integrated treatment group, as opposed to women receiving usual care, exhibited fewer symptoms of mental illness, alcohol use, and drug use.

In 2003, The Department of Health provided national guidance on the treatment of personality disorders, advocating a number of approaches. However, it raised the issue that in general, treatments have not yet been thoroughly evaluated in those with co-morbid substance misuse. Verheul's (2001) research questions the notion of excluding individuals with personality disorders, with regard to 'mainstream' psychological substance misuse treatments, concluding that the amount of improvement achieved in treatment by individuals with a personality disorder and substance misuse does not differ significantly from those without a personality disorder (although those with a personality disorder may have greater pre and post-treatment severity than individuals without a personality disorder). However, there appears to be a higher vulnerability to relapse for individuals with both a personality disorder and substance misuse in comparison to those without a personality disorder (Welch, 2003).

In a survey of psychiatrists, Herbeck et al (2005) found that treatment compliance problems were prevalent in 40.5% of their sample, which consisted of patients with a substance use disorder. Among other factors, these patients were more likely to have personality disorders in comparison to those

without compliance issues. Marlowe, Kirby, Festinger, Husband, and Platt (1997) stated that results regarding treatment compliance for co-morbid personality disorder and substance use disorder are inconsistent, although borderline and antisocial personality disorders have been reported to predict lower treatment retention rates.

## **Conclusion**

Clinical experience acted as a catalyst for the writing of this paper as it has shown that there is a strong link between all four domains: mental health, substance misuse, offending and trauma. However, research has tended to focus on pairs or triads of the four areas, and this was evidenced by the dearth of research available covering all four. This combination of factors is prevalent in forensic mental health and prison settings, whether for males or females, and yet it has not received the level of attention that would be beneficial to the treatment of this population. The extent of the impact of traumatic experiences, at a psychological and physiological level, and on mental health, substance misuse and offending is of such significance to any forensic, or even general, unit, that it can no longer be ignored. The implications for failing to recognise this powerful link will impact upon both assessment and treatment. The authors hope to raise the profile of this largely unrecognised and unmet treatment domain within all services, as there is a pronounced need for more integrated and accessible treatment interventions, particularly when developing treatment services for such a complex and challenging population.

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