



2003

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RUNNING HEAD: PREVOCATIONAL PROGRAMMING FOR A DUAL DIAGNOSIS

Prevocational Programming for a Dual Diagnosis Population

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CHAPTER 1

Introduction

Current research suggests that of individuals who have an addictive disorder, almost half have a co-occurring mental disorder (Watkins, Burman, Kung, & Paddock, 2001). The majority of individuals who suffer from dual diagnosis (DD) are not receiving effective treatment that addresses these compound issues (Woody, 1996). It is becoming apparent that treatment at the primary level of health care, i.e. inpatient hospitalization, is not a successful mean of intervention. Individuals with DD often cycle through the “revolving doors” of acute, inpatient hospital settings never gaining the skills necessary to lead a productive life in the community.

A major component of leading a productive life is gaining and maintaining employment. However, these individuals with DD often have difficulty pursuing employment due to their mental health, fear of failure, need for education and skills, impulse control, stigma, concerns about fitting in, and the need to stay in treatment. Work, primarily paid employment, can have a positive effect on mental health by providing opportunities for skill development, social contact, self-esteem, and income (Schied, 1993). Conversely, unemployment is a source of anxiety, stress, and depression.

An extensive literature review was conducted to investigate the nature of DD, the relevance of work to daily life, and successful components of comprehensive and/or pre-vocational programs for individuals with DD. A pre-vocational model of occupational therapy practice supported by current literature is proposed. This model is designed for use in a community-based setting and is tailored to meet the unique needs of the DD population.

CHAPTER 2

Literature Review

Dual Diagnosis

Dual diagnosis (DD) is the term used to describe the co-occurrence of a mental health disorder and a substance use disorder. It is a highly prevalent disorder; epidemiological data suggests that of individuals with a current addictive disorder, almost half have a co-occurring mental disorder (Watkins et al., 2001); as many as 40 percent of all patients in general hospitals are there because of complications to alcohol (Migdole, 2002). In addition, among individuals who have a mental health disorder, between 15 and 40 percent have a co-occurring addictive disorder (Watkins, et al, 2001).

The Diagnostic Statistical Manual of Mental Health Disorders (APA, 1994) defines both disorders. A mental disorder is a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with present distress or disability. Substance misuse is the maladaptive pattern of use not meeting the criteria for dependence that has persisted for at least one month or has occurred repeatedly over a long period of time. The dual diagnosis individual meets the criteria for both substance abuse or dependency and a co-existing psychiatric disorder (Gafoor, 1998).

Various factors have been hypothesized regarding the association between substance use and mental health disorders. Contributing factors of the presence of DD include: (1) the occurrence of both disorders simultaneously, (2) substance use causes certain psychiatric conditions or increases their severity, (3) psychiatric disorder causes substance use or increases its severity, (4) both disorders are caused separately by a third condition, such as Post Traumatic Stress Syndrome (Gafoor & Rassool, 1998), or (5) substance withdrawal produces symptoms that mimic those of an independent psychiatric disorder (Woody, 1996). Although the origin of the relationship between the disorders of DD is controversial, the presenting challenges produced

by this relationship are a profound danger to the affected population. As with any disorder/disease each individual will have a unique experience, it is, however, in the commonality of specific challenges that a problem base is found.

This co-existence of mental health and substance misuse inevitably creates complex problems and needs for individuals. This population of individuals presents with: (a) poor adherence to medication and treatment compliance, (b) increased propensity towards suicide and other self-destructive behaviors, (c) increased risk of HIV infection as well as generally poor physical health habits, (d) homelessness, (e) more contact with the criminal justice system, (f) increased burden on family/caregivers, (g) increased risk of homicidal behavior, (h) high levels of vulnerability, (i) few social supports or financial resources, and (j) exhibit the highest rates of expensive public psychiatric hospital admissions and criminal justice interventions (Rassool, 2002 and Johnson, 1999).

Bae, Brekke, Long, and Prindle (2001) found that individuals with schizophrenia living in the community have poor social functioning, multiple address changes, and few days of taking medication. These characteristics were found to be predictors of criminal charge for behavior such as traffic offenses, jaywalking, and police-assistance calls. More serious charges were the result of substance use and homelessness. In addition, individuals who have schizophrenia and are living in the community were found to have a victimization rate 65 to 130 percent higher than the general public; and a violent victimization rate 75 to 120 percent higher. Substance use often compounds this vulnerability by making the individuals less able to fend for themselves and increasing the likelihood of exploitation by others.

Research suggests that approximately fifty percent of persons suffering from schizophrenia also have a substance misuse disorder (Jackson-Koku, 2001). Individuals with

schizophrenia who abuse alcohol or other substances have more delusions, hallucinations, suicidal behavior, hostility, aggression, and homelessness than those who do not. This leads to poor outcomes on the measures of housing status, employment status, social functioning, and family relationships (Rassool, 2002). These outcomes, in turn, often lead to a cycled pattern of inpatient admissions and care (Jackson-Koku, 2001).

The DD population presents many challenges for health and social care professionals, primarily due to their complex needs. Working with patients with DD can be demanding and stressful, as these patients tend to place a heavy demand on service provision and are associated with the stigma of poor outcomes. This, along with the fact that it is often difficult to distinguish between symptoms of substance misuse and those related to mental health, can lead to ineffective management and treatment. Furthermore, it is difficult to get a DD patient to adhere to treatment regimens and medications. There are also inherent treatment differences in the philosophies and goals of substance misuse services and mental health services; often they conflict (Rassool, 2002).

Work/Employment

Work is a major life role and a central aspect of human existence. It provides a valued social position and identity that affect self-concept and interpersonal relationships. As a primary life role, work is a major source of self-esteem and it helps us to structure how we define who we are (Scheid, 1993). Work has been identified as a positive treatment outcome and an indicator of recovery for substance-using clients as well as for clients with a mental health disorder. According to Knight, Laudet, Magura, and Vogel (2002), work in the form of paid employment has both economic and non-economic benefits for individuals with DD and contributes to higher-

level functioning. It has been associated with reduced substance use, decreased psychiatric symptoms and hospitalization, increased self-esteem, and improved quality of life.

For dually diagnosed individuals, employment can be beneficial in numerous ways. Work occupies time and provides structure for daily activities. These are two important issues for individuals with DD. Work also offers an opportunity for social connections and for socialization with non-substance users who can function as role models. Work can enhance the sense of personal mastery, self-esteem, and self-efficacy (Muesen, Becker, & Torrey, 1997); all are important benefits for DD individuals whose disorders are highly stigmatized. Work can strengthen one's commitment to recovery by providing something valued that can be lost to drug use or to hospitalization. Finally, work provides genuine income that can end or lessen dependence on disability benefits whose rules "enforce poverty" (Solomon & Draine, 1995). Therefore, work contributes to increasing the quality of life for many individuals.

The many benefits of employment are not available to most dually diagnosed individuals. This is evidenced by the fact that employment rates for this group are considerably lower than individuals in the general population. The aggregate employment rate for persons with mental illness is 10% - 15% and chronic unemployment is the norm (Knight, et al., 2002).

Among mental health clients, getting a job is often cited as an important self-reported goal and substance users express interest in training and employment. Recovering individuals, however, face many potential barriers to employment. At the societal level, the greatest barrier is stigma. The Surgeon General (2000) cited the stigma of mental illness as the primary barrier to services among nearly half of all Americans who have a severe mental illness and do not seek treatment. A national survey documented a bias among employers against hiring former substance users (Hazelden, 1999). For individuals with DD, the dual stigma may result in low

self-expectations, low self-efficacy, and low-self esteem so that challenges are ultimately avoided.

At the individual level, DD persons may face multiple obstacles in gaining and maintaining employment. First of all, the disorders themselves present a barrier to employment among individuals with DD. Symptoms and medication side-effects may cause cognitive impairments and physical distress that interfere with skill acquisition and job performance. DD persons also face many interrelated problems, some job-related and others not. Job-related obstacles to employment include lack of work experience, poor work history, low levels of marketable skills and pre-employment skills, inadequate work readiness, and poor social and work relations skills. Recovering individuals may also lack skills that are not directly job-related. These skills include personal habits, time management, impulse control, and self-presentation. Overall, for individuals with DD, gaining and maintaining employment are difficult tasks, especially for those who have lost or never gained the skills necessary to sustain employment (Knight et al., 2002).

The importance of providing employment and prevocational opportunities is increasingly being recognized by mental health professionals working with DD clients. The growing interest with employment is evident in the growth of psychosocial rehabilitation programs, clubhouses, and supported or transitional employment programs. Many psychiatric clients identify work as a goal to which they actively aspire. According to Leete (1989), one personal account illustrates a view of work as a means to mental health:

When one has a chaotic inner existence, the structure of a predictable daily schedule makes life easier...for me it is work-a paying job, the ultimate goal. It gives me something to look forward to everyday and a new skill to learn and

improve. As I work I become increasingly self-confident, and my self-image is bolstered. (p. 197)

Treatment Approaches for DD

There are three general approaches used to treat individuals with DD. They are sequential treatment, parallel treatment, and integrated treatment (Woody, 1996 & El-Mallakh, 1998).

In sequential treatment, the client receives treatment for one disorder then the other. For instance, a client would receive initial treatment towards the stabilization of either the addictive or mental disorder; once that disorder is considered stabilized, treatment would focus on the remaining disorder (El-Mallakh, 1998). The disadvantage of sequential treatment (Ries, 1993) is that “separation of addiction and mental health [treatment] does not require personnel to modify existing treatment skills or learn new skills.” Therefore, clinicians in one realm of treatment are not equipped to handle the stressors of the co-occurring disorder; clients feel as though they do not fit into either program’s focus.

Parallel treatment uses concurrent but separate treatment (El-Mallakh, 1998). Treatment is administered simultaneously, however separate treatment for each disorder occurs at a different facility. Therefore, mental health professionals treat the client’s psychiatric disorder and addiction professionals treat the client’s substance misuse/abuse (Woody, 1996). The disadvantage of parallel treatment lies within the concept itself. For parallel treatment to be effective both professional groups need to communicate and cooperate with one another; often they are reluctant to do so (El-Mallakh, 1998). This, ultimately, leaves the client responsible for coordinating services of care; when “the parallel model [of treatment], the burden of integrating

different philosophies falls on the patient; in other words, it rarely occurred (Drake, Mueser, Clark, & Wallach, 1996).”

Integrated treatment combines the elements of mental health and addictive services into one program (Woody, 1996). The advantages of integrated treatment compensate for the disadvantages of both sequential and parallel treatment. First, clinicians of this type of program are required to facilitate treatment that is compatible (El-Mallakh, 1998) to the presence of co-occurring disorders; both treatments are integrated into a program with a unified philosophy of recovery and rehabilitation. The responsibility of coordinating services of care shifts to the professionals of the program. Second, there is an emphasis on complimentary concepts unique to the DD population (El-Mallakh, 1998); clients feel as though they fit into the program’s focus and are more likely to actively participate in treatment.

Historically, the sequential model of treatment has been used in service programs for individuals with DD (Woody, 1996). Watkins et al. (2001) found that despite more effective approaches to treatment documented in recent literature, a majority of DD individuals (in the study) were not receiving care consistent with current recommendations. They stated only 8 percent of these individuals were receiving either parallel or integrated treatment. This lends to the conclusion that individuals with DD are receiving no treatment or sequential treatment.

The integrated model of treatment is the supported and recommended approach. While actual treatments used are generally the same as those used in the sequential model, integration ensures that services will be coordinated to provide the most efficient, well-rounded care (Woody, 1996). Saxon & Calsyn (1995) found evidence to support this idea. They compared dually diagnosed individuals receiving integrated care to individuals with a substance abuse only (SO) diagnosis receiving substance abuse only care. DD subjects in the study were able to

reduce their substance use to levels comparable to SO subjects. Furthermore, the DD subjects had better treatment retention than that of the SO subjects. This is evidence that DD subjects are able to exhibit success in a program that offers psychiatric care as well as substance abuse care within the same setting.

Moggi, Outimette, Finney, and Moos (1999) differentiated clients by the severity of mental illness. They found that DD clients, having either psychotic or nonpsychotic disorders, benefited from the integrated approach. Longer community tenure was cited as the primary benefit to clients.

Essential Elements of the Integrated Approach

Comprehensive treatment, while holistic in nature, can be broken down into essential elements used to guide the services provided to this unique population of dually diagnosed individuals.

Active participation.

Clients are required to be active participants in their program of care. The goal is to establish a trusting, supportive client-therapist relationship (El-Mallakh, 1998) within a program environment that has a desirable outcome for the client (Kofoed & Osher, 1989, El-Mallakh, 1998). The client should have the desire to participate in the program due to the very nature of the treatment. Helpful additives for success include effective relief from distress such as clothing, food, housing assistance, and access to recreation, socialization, or vocational rehabilitation. It is noteworthy that many clients with dual diagnosis will present with a unique combination of denial, disorganization, and loss of hope which prevents some individuals from responding to even the most positive offers of help. In such instances, clinicians must welcome opportunities for coercion (Kofoed, 1993).

Motivation.

Motivation, according to Kofoed & Osher (1989), can be viewed as a personal state of mind, rather than a personal trait. Clients have to, in some way, acknowledge their distress; this increases the likelihood the client will be abstinent throughout the duration of the program. This element can also be called the *persuasion* phase of programming. Clinicians may focus their attention to assessing and developing client readiness for the program. This is an important element as premature commitment to a program of this nature may lead to a sense of frustration or failure; this is detrimental to the goal of DD programming. For clients who commit to programming, it is essential to ensure ongoing support to the client (Kofoed & Osher, 1989); as well as perform a constant assessment of client's motivation. Persuasion involves convincing clients to accept ongoing rehabilitation treatment; the goal, therefore, is to move clients from depending on external motivations for recovery and assist them to feel the internal motivations that are necessary for success (Kofoed, 1993).

Internal motivation is a process that a clinician can assist the client in developing. Internal motivation for emotional stability and sobriety is dependent upon a conceptual understanding of and an emotional commitment to these goals (Kofoed, 1993). Kofoed describes the most important conceptualization as *control*. Clients with DD will greatly benefit from the conceptual differentiation of *reliable control* and *loss of control*; clients with DD often feel more in control of their behaviors than they ultimately are. This conceptualization is further critical as it will help the client to understand reasons for and benefits of complete abstinence. It is, therefore, paramount that clinicians' focus group discussions on individualized experiences of symptoms, consequences, and treatments. Groups of this nature will reduce client denial and

defensiveness, while evoking maximum intellectual and emotional impact. If persuasion is not effective, treatments shall be terminated (Kofoed, 1993).

Active treatment.

Treatment should focus on the acquisition of attitudes and skills necessary for wellness (El-Mallakh, 1998). According to Johnson (2000), active treatment interventions are often referred to as psychosocial services; they include: (a) training in basic living skills (ADLs), (b) activities to improve social skills, (c) education regarding how to manage symptoms and behaviors, (d) acquisition of basic skills for functioning in a normal work environment (prevocational), and (e) obtaining and maintaining paid work. A number of program models have embraced this idea, i.e., Assertive Community Treatment (ACT) (Dixon, 2000) and Step-Up (Talbot, 1992).

Treatment programs should be a place to learn and practice skills of everyday life; thus clients gain the ability and confidence to display appropriate behaviors and function within their environment. For example, the development and maturation of both coping and social skills is crucial for improvement among DD clients (Moggi et al., 1999). In agreement, ACT focuses on helping individuals with mental illnesses to develop skills for coping with problems of living in the community; active treatment in this instance consists of assistance in community daily living skills, such as laundry, shopping, eating in restaurants, grooming, budgeting, and using transportation. In addition, individuals in Step-up receive assistance finding a job, using leisure time constructively, developing socialization skills, and building meaningful relationships (Talbot, 1992). Clients were found to have dramatically reduced hospital stays and stabilized symptoms (Dixon, 2000).

Therapists need to be aware of the client's tolerance for interventions, such as the aforementioned skill building and education groups (El-Mallakh, 1998). Group therapies in which members are asked to talk may aggravate patterns of abnormal thought or exacerbate thought disorders in some clients; groups should be facilitated away from confrontational, stressful, and self-critical atmospheres (Johnson, 2000). Flexibility is paramount for therapists working with DD.

Relapse prevention/aftercare.

The goal of relapse prevention is to assist clients in recognizing the pattern of relapse, developing a plan of prevention, and reinforcing positive behavioral change (Osher, 1996). Relapse prevention involves three major factors: identifying risk factors for relapse, identifying early warning signs of an imminent relapse, and developing a specific plan to minimize the effects of a relapse (Kofoed, 1993). Relapse issues are inevitable for the DD client and it is in the best interest of both clinician and client to acknowledge the possibility of relapse. Kofoed (1993) states it should be clear to the client that relapse will not lead to rejection or punishment.

Aftercare is a form of maintenance programming for the DD client. Moggi et al., 1999, found that more participation in aftercare resulted in a greater likelihood for clients to maintain abstinence after one year; aftercare was also associated with longer community tenure. Aftercare can be administered one-on-one (healthcare provider and client) or in a group (i.e., DD support group facilitated by a health care provider). Maintenance requires an ongoing connection between health care providers and client; in this way health care providers can monitor the client for relapse behavior as well as making a learning experience of any relapses that do occur (Kofoed & Osher, 1989).

Train-Place-Train Model

There are numerous models of vocational programming available to serve individuals with chronic mental illness and/or persons with DD. To achieve positive outcomes in vocational programming, a partnership among clients, employers, and vocational and social services providers is pertinent. This appears to be best accomplished through a “place and train” model rather than the hierarchical “train and place” model (Scheinholz, 2001). The train and place model has been popular for decades in vocational rehabilitation. In this model, clients are evaluated, receive rehabilitation services, and then begin vocational training. Upon completion of training, the client is assisted with job placement, and services end when a job is obtained. This model has proved to be unsuccessful in helping individuals to maintain jobs once employment is found. Often, a client will lose his job or quit as a result of inadequate “on the job” training that addresses the specific work environment and job tasks (Scheinholz, 2001).

The place and train model, or the “choose, get, and keep” model as it is known in psychiatric rehabilitation is reversed. The client is evaluated, focusing on work history, skills and interests, and daily living skills. The client then selects an area of employment with the assistance of a vocational specialist. Once a job is obtained, a client’s skills and deficits related to that job and supportive living skills are assessed. Skills deficits are addressed via direct training and/or by modifying the work environment. The client then receives direct on the job training by the employer and his or her job coach (Scheinholz, 2001). This model has shown rapid gains in helping persons with DD to successfully gain and maintain employment because it prepares clients to work in a specific job environment and perform specific work-related tasks (Becker et al., 2001).

A variation of this model has been used by occupational therapists in community support programs. In these programs, a “train, place, train” model is used. Clients are typically involved

in a clubhouse day program and a supervised living program. They join the work adjustment training unit if they are interested in employment. In this unit, they undergo an evaluation process where they identify goals related to gaining employment. The initial “train” phase includes group and individual therapy sessions where work habits are being developed (Scheinholz, 2001).

Job Preferences

For the general population, vocational preferences have been shown to be an important factor in a person’s ability to successfully maintain a job. However, mental health practitioners frequently report that individuals with severe mental disorders have unrealistic work expectations and undeveloped vocational goals. Practitioners think that severe mental illness often impedes vocational development and results in individuals lacking the knowledge or experiences needed to make choices about work. The result is that traditional vocational programs do not emphasize the importance of client preferences in job selection. However, research has consistently shown that clients who obtain jobs in areas of interest have better outcomes for maintaining employment over longer periods of time (Becker, Bond, Drake & Farabaugh, 1996).

In a study by Becker et al. (1996), job preferences of adults with severe mental illness who were participating in supported employment programs were examined. Data were collected from 135 adults in the areas of job preferences, attainment of competitive employment, job satisfaction, and job tenure. Eighty-one percent of the participants expressed job preferences that tended to be realistic and stable. People who obtained employment in preferred areas were more satisfied with their jobs and remained in their jobs twice as long as those who worked in non-preferred areas.

A study by Gervy and Kowal (1994), reported comparable results. They also found that people with severe mental illness who obtain jobs that are consistent with their job preferences have job tenure that is twice that of those who do not obtain jobs in areas of preference.

Coping Skills

Individuals with DD commonly lack the ability to successfully cope with their lives. An individual's perception of his illness is directly related to how he carries out symptom management strategies, general life-tasks, and work-related tasks. Brockmeier, Cunningham, and Wolbert (2000), conducted a study to examine the factors associated with the ability of individuals with chronic mental illness to successfully gain and maintain employment. Experiences were compared among individuals who have been successful gaining and maintaining employment, with those who have been successful gaining but not maintaining work, and those who have been unsuccessful gaining employment. The three groups seemed to differ in three significant ways: (1) in the ways the individuals talked about their illness, (2) in the ways the individuals talked about work, and (3) in the strategies they described for coping with bad days. In each of these areas, individuals' awareness of and attitude toward their illness was significant. In comparing the three groups, a clear pattern emerges in terms of these two factors. Those individuals who are most successful at gaining and maintaining employment tend to have a clear perspective on their illness and have the ability to see their illness as just a piece of who they are. Those in the middle group have a clear perspective on their illness and a solid set of strategies for managing it, but have a lesser sense of their illness as just a piece of who they are. Those in the least successful group express minimal insight into their illness and describe illness management strategies that tend either to cover up the illness or push it aside.

The research also suggests that strategies that help individuals to manage their life are more useful, at least in the area of employment, than those focused on helping people to manage their illness. This suggests that practical coping skills related to everyday life tasks and roles are most effective in helping individuals to successfully gain and maintain employment.

Prevocational Skills

The focus of prevocational programming is to assist clients in building skills necessary for obtaining and maintaining a meaningful work experience. Through the promotion of skilled behaviors and developmental areas, professionals can provide care that is holistic as well as occupation-based and client-centered. This includes assisting clients to develop: job objective behaviors related to career/vocational exploration and goal setting; job-getting behaviors related to interviewing and job seeking; job-keeping behaviors related to attendance, punctuality, decision-making, productivity, and interpersonal relations; social-living and recreational behaviors related to solitary and group activities; and personal and community-living behaviors related to self-care, independent living, and community mobility (Reynolds-Lynch, 1985).

Lloyd and Bassett (1997) outlined key areas that are necessary for a successful, comprehensive, prevocational programs such as the one described by Lynch (1985). These key areas are personal development and work experience (see Table 1).

Occupational Therapy Perspective

Moyers (1997) described substance use as an occupation because there are significant activities and tasks associated with using directed toward the goal of achieving a substance-induced state. Furthermore, these activities have meaning for the user and gradually become

Table 1

| Personal Development Objectives | Work Experience Objectives |
|---|---|
| <ul style="list-style-type: none"> • develop a rapport with each client to understand their specific needs, interests, and goals for their future • provide opportunities for the client to discuss their mental health and its impact on lifestyle and life experiences • promote decision making and responsibility • encourage clients to increase awareness of support services in the community • empower clients to set goals and plan for the future • empower clients to identify their contribution to the people around them • promote independence in the community | <ul style="list-style-type: none"> • provide a practical environment where vocational skills can be assessed • enhance client's feelings related to self-esteem and self-confidence by providing just-right challenges that can be successfully completed • provide a relaxed environment where clients can develop social, interpersonal, and vocational skills • provide positive and alternative experiences of work |

(Lloyd & Bassett, 1997)

organized habits. Occupational therapists, therefore, are uniquely able to view the dually diagnosed individual as a client in need of occupational intervention in relation to overall role performance.

Therapeutic interventions employed by occupational therapists, according to Moyer and Stoffel (2001), are used as a way for the individual to reinvent him/herself through an approach referred to as lifestyle redesign. Occupations of "using" can be replaced with occupations of sobriety, leading to successful occupational performance overall. In order for this modification of engagement in life to take place, therapeutic interventions focus on the individual reinventing him/herself as abstinent with rationales for being sober as well as the development habits of sobriety. Daily occupations related to basic habits, such as eating balanced meals, keeping the body neat and clean, and participation in follow-up care are all necessary occupations for maintaining abstinence (Moyers & Stoffel, 2001).

The skills necessary for maintaining abstinence are the same skills necessary for obtaining and maintaining meaningful employment situations. This is another example of how occupational therapy can make a unique contribution to prevocational programming for dually diagnosed clients. While occupational therapists can skillfully focus on teaching work skills, they are also qualified to cover a wide-range of basic living skills (Lloyd & Bassett, 1997). Basic living skills are paramount to long-term success in occupational performance related to overall life roles, including work.

Basic living skills and occupational substitution, however, do not define the contribution of an occupational therapist to prevocational programs. Intervention plans may also focus on strategies that improve skills related to time-management, assertiveness, anger-management, learning, and socialization. For example, coping skills training involves relaxation techniques, meditation strategies, control skills, drug refusal skills, emotional self-monitoring, and positive thinking (Moyers & Stoffel, 2001).

Occupational therapists are also experts of environmental modification and adaptation. Moyers and Stoffel (2001) describe the need for intervention to incorporate methods to remove environmental cues as well as decrease the strength of cue reactivity in relation to treating persons with substance-use disorder. For individuals with dual diagnosis, this means removing/modifying triggers for relapsive behavior related to substance use, as well as mental health, that are environmental; such as availability of drug of choice, transportation routes (avoidance of going past a familiar bar or site of emotional trauma), unsupportive friends, etc. To decrease cue reactivity, an occupational therapist can coach the individual to produce adaptive responses in relation to situations that would likely trigger relapsive behaviors (Moyers & Stoffel, 2001); this can, again, be considered in relation to substance abuse and mental health.

For example, coping skills that are client-centered are necessary for an adaptive response to high-stress situations; high-stress situations are unique to each individual, such as family conflict, cravings to use, increased frustration/anger, etc.

Occupational therapists are qualified in a way that no other profession can match. Simply put, professionals of occupational therapy can provide a comprehensive service to individuals with dual diagnosis. Evaluation of occupational performance related to roles of daily life, acquisition of basic living skills, healthy occupational substitution, development of skills necessary for occupational success, emphasis on role of work and related skills, and environmental modification are components that characterize occupational therapy. These components also outline an appropriate program to meet the needs of individuals with dual diagnosis.

CHAPTER 3

Methods

Data Collection

The information for this study was drawn from 39 references. These publications were collected on the data variables of dual diagnosis, mental illness, substance abuse/dependency, work, prevocational/vocational assessment and intervention, and current programming focused on dually diagnosed individuals. This combination of literature content was effective in presenting the researchers with information that was comprehensive in nature. Due to the wide range of subject material, the researchers were able to discover unique needs associated with individuals with dual diagnosis as well as programming needs related to prevocation.

Procedure

The extensive literature review was conducted to ensure validity and reliability of findings. The researchers studied and evaluated sources for content, applicability, relevance, and credibility. The reviewed material was then separated according to the strength of the contribution it provided.. *Psychiatric Services, 46, 353-58.*

OT Implications

Of the 39 references used, 2% were obtained from occupational therapy publications. The intent of the literature review was to investigate how current literature supports a pre-vocational model of occupational therapy practice. This percentage establishes the idea that this area of practice is emerging and in need of professional development in the field of occupational therapy.

CHAPTER 4

Product

Treatment protocols have been established for occupational therapists working with dually diagnosed clients in a community-based setting. The literature supports these treatment groups as an appropriate way to address the unique needs of the DD population. The groups that will be included in occupational therapy programming are as follows. They are intended to be facilitated by a registered occupational therapist; it would also be appropriate to utilize an experienced, certified occupational therapy assistant as a co-facilitator in facilities that serve larger numbers of DD clientele or at the discretion of the OTR.

Clients will attend each of these one-hour groups five times per week in intense programming facilities, which is the recommended means of service delivery. It would be appropriate for less intense programming to utilize these groups as treatment protocol to promote health and well-being. The duration of programming will differ depending upon individual progress; a referral will be made upon discharge towards job placement.

Upon initiation into prevocational programming, clients will be assessed by the occupational therapist via several measures. It will be at the therapist's discretion to determine the appropriate assessments for each client. Assessments may include, but are not limited to, The Canadian Occupational Performance Measure (COPM) (Baptiste & Rochon, 1999), The Occupational Performance History Interview (OPHI-II) (Henry & Mallinson, 1999), The Role Checklist (Dickerson, 1999), The Worker Role Interview (WRI) (Velozo, Kielhofner, & Fisher, 1990), The Allen Cognitive Level Screen (ACL) (Allen, Kehrberg, Burns, 1992), and the Strong-Campbell Vocational Interest Inventory (Strong & Campbell, 1981).

Treatment will take place in a medium sized room conducive to group process and education purposes. The Community Living Group may take place within appropriate places in the community, such as the bus station, library, support group sites, restaurants, etc. Group size

will be dependent upon the number of facilitators, the topic to be discussed, and the functional acuity of the clientele. Approximate group size will be 6 clients per therapist.

Group 1: Life Skills

The focus of this group is to promote functional independence in activities of daily living. Basic self-care skills may be addressed if appropriate, i.e., grooming and hygiene. Basic self-care skills are prerequisites for proper presentation of self in the workplace. Proper presentation of self, in turn, promotes a positive self-esteem and social interaction in the workplace. Instrumental daily living skills (IADL) may be addressed in relation to the needs for the clients, i.e., financial management, health maintenance, and home management. IADL skills are co-requisites for functional productivity in the workplace because both require a person to be responsible for him/herself, demonstrate the ability to appropriately solve problems, make decisions independently, and maintain a healthful living/work environment. It is the responsibility of the facilitator to assist clients in identifying their main areas of need related to life skills.

Sample Life Skills groups may include, but are not limited to:

- Learning to utilize an ADL checklist as a visual cue for an appropriate self-care routine
- Identifying and caring for appropriate attire associated with different jobs
- Creating a budget to help manage finances
- Creating a routine associated with self/home management to ensure a healthful balance

Clients will discharge from this group upon completion of the personal goals established within the client-therapist relationship; goals will be client-centered and unique to each individual. The client will be required to perform his/her agreed upon self-care duties

consistently in daily life. It is the responsibility of the therapist to perform skilled observation and informal interview to assess the client's status in relation to successfully meeting the goals of this group.

Group 2: Job Exploration

The focus of this group is to assist in career/vocational exploration. Interests and values of the client will be addressed in relation to performing the life role and occupational area of work/volunteer. It is necessary to direct clients toward a vocational placement that is meaningful and intrinsically motivating for them, as this will promote success and longevity of the work role.

Many individuals with DD have a poor work history or have had limited opportunities for growth in this area; facilitation in an educational manner with material regarding realistic employment options is appropriate. It is also necessary to provide opportunities for clients to experience carrying-out tasks related to employment interests. This will ensure clients are able to perform the chosen duties, as well as provide the opportunity for client and therapist to evaluate the client's level of satisfaction. Satisfaction related to self and employment duty/task is necessary to promote the intrinsic and extrinsic motivation required for new behaviors to become habits of an adaptive work role.

Sample Job Exploration groups may include, but are not limited to:

- Identifying areas of interest and/or talent related to vocation
- Learning how to find employment options, i.e., newspaper, Internet, Job Service
- Learning how to fill out applications for employment
- Creating opportunities to visit/tour the site of a possible placement option
- Creating opportunities to experiment with duties associated with a chose interest

Goal setting will also be addressed in this group. Clients will contribute to treatment planning by establishing a target date for short-term goals, as well as for the long-term goal of

being placed in an employment situation. The importance of utilizing healthy goals as a way to assess progress and promote continued health in the work role will be emphasized. Personal accomplishments become concrete examples of success through the goal setting process; this promotes the self-esteem and confidence required for overall health.

Discharge from this group will take place when the client is able to identify an area of personal interest and has met 3-5 short-term goals related to job placement in that area. The therapist will initiate the short-term goals, however they will be chosen by the client. It is the responsibility of the therapist to use professional judgment related to the creation of short-term goals, as well as the guidelines for meeting those goals.

Group 3: Job Skills

The focus of this group is to address skills related to acquiring employment as well as maintaining employment. Groups will process and practice areas of skill related to job seeking and interviewing to promote acquisition of employment as well as increase the likelihood of a successful experience. Insight into this process is necessary for the client to appropriately assess self, regardless of the outcome of the attempt to gain employment.

Skills required to maintain employment that will be addressed are as follows:

- Attendance
- Punctuality
- Decision-making
- Productivity/Time management
- Interpersonal relations
- Anger management
- Assertiveness
- Coping

These areas will be addressed according to the needs of the individuals in the group; it is the responsibility of the therapist to assist clients to determine their main areas of concern in relation to job skills. It is necessary to prepare clients for difficulties they will inevitably encounter in the workplace setting, such as interpersonal conflict, feelings related to productivity (i.e., overwhelmed), and time management responsibilities. It is further necessary to prepare clients for what will be expected of them in the workplace; this includes rationale as to why these

expectations are important. For example, regular attendance can be linked to trust between the employer and the employee.

Sample Job Skills groups may include, but are not limited to:

- Role-playing with another group member or therapist
 - Practicing the interview process
 - Practicing assertive behaviors/statements
- Distribution and processing of educational materials
 - Learning to utilize coping skills
 - Learning to utilize anger management techniques

Upon discharge, the client will be better able to cope with the stressors of employment, manage time more effectively, demonstrate appropriate self-control in the areas of anger and assertion, and execute appropriate decisions for the workplace. It is the responsibility of the therapist to evaluate the utilization of these skills through informal interview, group process, and skilled observation. It is necessary for the client to verbally assess him/herself in relation to these skills as well. It is important to emphasize self-evaluation of these skills as a life-long process.

Group 4: DD Education

The focus of this group is to provide clients with a well-rounded picture of what it means to have DD and knowledge of how to apply this wisdom to daily life roles and tasks. Essential elements of this psycho-educational group include:

- Defining DD
- Complex needs and problems associated with DD
- Effects of substance misuse on mental health
- Effects of mental health issues on substance-use disorder
- Attitudes and stigma toward individuals with DD

It is essential that individuals with DD understand the unique challenges associated with this diagnosis. It is also imperative that they understand the dynamics between the co-existing disorders of mental illness and substance misuse.

Motivation is also a key component of the DD education group. Therapists can help facilitate the shift from dependency on external motivation for recovery to the internal motivations necessary for client success. Internal motivation for emotional stability and sobriety is dependent upon a conceptual understanding of and an emotional commitment to these goals.

Another important element of the DD educational group is the development and utilization of effective coping skills. Clients will engage in the process of redefining both self and identity. Individuals will gain coping skills that focus on awareness of and attitude toward their illness. Emphasis will be placed on the development of strategies that help individuals gain perspective on their illness, rather than focusing on controlling the level of symptom acuity. Clients will also

gain skills that help them to manage their daily life in terms of roles and responsibilities. These skills are:

- Routine development
- Time management
- Life balance
- Relapse prevention
- Identification of internal and external supports

Clients will discharge from this group when he/she is able to verbalize acceptance of DD as his/her diagnosis. This includes identifying and taking responsibility for the negative effects DD has had on daily life in the past and present, as well as verbalizing a healthful plan for the future. Clients will also be required to demonstrate an understanding of personal relapse triggers related to both mental health and substance use, complete with coping skills for each trigger.

Upon discharge, clients will be encouraged to personally initiate follow-up care by attending community support groups for mental health, substance use, and/or DD. Dealing with issues presented by the co-existence of mental health issues and substances misuse issues will be an ongoing process for the individual. Completion of this group will provide the individual with knowledge and skills; however coping with difficulties will be a life-long process for which the individual will likely need support.

Group 5: Community Living

The focus of this group is to instruct clients on the elements of successful community living. This is an important aspect of treatment, as the client will inevitably be required to use community resources to support the healthy and productive lifestyle needed to maintain employment.

This group may take place within an actual community site; it will differ in time and location per group topic. For example, this group may focus on community transportation options; the appropriate place to learn and practice use of community transportation may be the bus station and/or train station. This group will also focus on the use of community resources, such as the library, support group sites, restaurants, etc. The focus will be on the application of skills in these and other community settings. For example, skills required for utilization of a community library, support group, or restaurant would be determining appropriate means and time of arrival/departure, effective communication with persons in the environment, and other practical skills specific to an area, i.e., cash machine utilization, computer skills, or ordering from a menu and paying a bill. It is appropriate for the therapist to collaborate with the client to determine client needs in this area.

Sample Community Living groups may include, but are not limited to:

- Identifying sites/situations in the community where skill development is needed
- Verbally processing areas of concern and identifying ways to cope and/or adapt
- Visiting/touring the an identified site
- Practicing skills in a safe, simulated environment or in the actual environment

CHAPTER 5

Summary

Individuals with DD are not receiving effective treatment to meet their unique needs. Integrated treatment appears to be the most effective form of treatment for these individuals; this requires programming to focus on mental health and substance misuse issues at the same time. The occupational therapy treatment protocols presented reflect this idea.

Work is found to have a positive effect on mental health by providing opportunities for skill development, social interaction, self-esteem, and income. Work, however, is often an underdeveloped area of life for persons with DD secondary to decreased opportunity for skill development, social stigma, symptomology, and lack of effective personal coping skills and community supports.

Positive outcomes related to successfully gaining and maintaining employment appear to be best accomplished through the train-place-train model. The focus of the protocols is that of the initial “train” component, which is, essentially, prevocation. Occupational therapists are uniquely qualified to address the prevocational needs of the DD population found within the literature.

Five treatment protocols are presented that reflect the unique needs of the DD population. The protocols combine education on DD, education on and application of life skills necessary to function within a work-related role, exploration of job preferences and personal skills, education on job skills such as effective communication and the application/interview process, and the application of the skills necessary to live and work in the community.

There are limitations to the presented treatment protocols. These protocols rely on the expertise of a committed, creative, flexible, and experienced occupational therapist. It is impossible to predict the unique situations an occupational therapist working with the DD

population will encounter. The efficacy and applicability of these protocols will depend largely on the occupational therapist utilizing them. Furthermore, these protocols were established for persons whose substance misuse co-exists with mental disorders related to mood and mild psychosis. Persons with severe schizophrenia and related disorders may not benefit from the services outlined within the protocols.

Future research is needed to establish the relationship between prevocational programming and individuals with DD. This includes information regarding specific mental health diagnoses, therapist education requirements, and appropriate intensity of follow-up care. Outcome studies of occupational therapy prevocational programs regarding long-term implications and benefits will enhance this area of study, as well.

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