Crisis Intervention With Mentally Ill Chemical Abusers: Application of Brief Solution-Focused Therapy and Strengths Perspective

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This article presents the application of Roberts’ seven-stage crisis intervention model in working with mentally ill chemical abusers. Roberts’ model will be combined with strengths perspective and brief solution-focused therapy to provide an effective framework for addressing the unique needs of mentally ill chemical abusers within a managed care treatment environment. This article will present three case examples and one impromptu intervention to demonstrate methods for clinicians to apply in addressing this challenging and complex population. [Brief Treatment and Crisis Intervention 2:197–216 (2002)]

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Kerry Kennedy begins her day as a social worker by completing assessments in an alcohol and drug treatment facility. Her first assessment is Ted, a 53-year-old African American male, dependent on alcohol and cocaine. Ted has previously been diagnosed with schizophrenia. While very well trained to address the issues of alcohol and cocaine dependence, Kerry is puzzled by what she describes as Ted’s “peculiar” affect and mannerisms. Taking a few additional minutes she completes a computer search on the patient to find that he has been treated at this facility three times in the past 18 months. On each occasion, by the third day of treatment, Ted has left the facility against medical advice (AMA). On the third occasion Ted became isolative and was quite agitated with one particular counselor who had insisted that he attend and actively participate in all treatment groups or that he would be thrown out of the program. Following a brief discussion with her medical director, Kerry concludes that Ted is not sufficiently motivated for treatment (based on his leaving treatment AMA) and that he would be a “risk to the treatment milieu” given his past disruptive behaviors. An appointment was set with the community mental health center to complete intake, within 1 week. Ted was also placed on the waiting list for a community based long-term alcohol and drug treatment facility; his initial appointment was tentatively scheduled for a Monday 8 months beyond this assessment.
Across town in the locked psychiatric unit a call for all available staff is made. Rick, a 44-year-old, has just broken a chair and is swinging one wooden leg of this chair attempting to hit the psychiatrist who had just told Rick he would not be discharged today.

Rick was admitted to this facility by a friend and local law enforcement agents who reports he was walking around his suburban neighborhood with a loaded shotgun, threatening to kill whoever placed the thoughts into his ex-wife’s head to leave him. He had done well with his treatment the first 2 days but has become increasingly agitated as time progressed. Rick was eventually taken down, medicated, and placed in seclusion. Further investigation indicates that Rick had been injured on the job 3 years ago and had been prescribed various pain medications. Prior to admission Rick was taking three times the prescribed dose of OxyContin. On admission he was prescribed only 10 mg of Valium to address his withdrawal symptoms. It was likely that the events of the third day of treatment were based on or certainly exacerbated by stage one opiate withdrawal.

Estimates of the Problem

Mental disorders are common in the United States. An estimated 22.1% of Americans ages 18 and older or approximately 1 in 5 adults suffer from a diagnosable mental disorder in a given year. When this information is taken into consideration as applied to the 1996 U.S. Census residential population estimates, it translates to 44.3 million people (Murray & Lopez, 1998). The Substance Abuse and Mental Health Services Administration is calling the nation’s attention to the emerging national problem of co-occurring substance-related and mental health disorders. The reason for this focus? The population of mentally ill chemical abusers and their families are among the highest users of expensive health care services. In addition it has been determined that their needs have not been addressed by the majority of the mental health and substance abuse treatment programs.

Individuals caught in the web of mental health and substance dependence treatment delivery systems find that either one or the other disorder is taking a secondary position in the treatment they receive. The end result? A cyclical process of active addiction, mental illness, treatment, and brief or sustained partial remission of symptoms followed by relapse and treatment. In the executive summary of the dual diagnosis conference report for the National Institute of Mental Health (NIMH), “the most common cause of psychiatric relapse today is the use of alcohol, marijuana, and cocaine.” Within the same summary you will find “the most common cause of relapse to substance use/abuse today is untreated psychiatric disorder” (Kessler, Nelson, & McGonagal, 1996, p. 18).

Beginning in 1990, Congress appropriated funds to the NIMH to survey the problem of co-occurring disorders of substance abuse/dependence and mental illness. The result was the National Co-morbidity Survey (NCS) which identified up to 10 million persons in the United States having at least one mental disorder and at least one substance-related disorder in any given year. The NCS study indicates that in the vast majority of individuals with co-occurring substance abuse and mental health disorders, the mental disorder develops first with the onset of mental illness frequently occurring in preteen years (Kessler et al., 1996). The substance abuse disorder develops a few years later on average. It is important to note that ages of onset may vary considerably by gender, geography, culture, and as yet undetermined factors (Kessler, 1995).
The Economics of Mental Health Treatment

The burden of mental illness on health and productivity in the United States and throughout the world has been underestimated in both prevalence and cost. Data presented by Regier, Farmer, and Rae (1990) through the Global Burden of Disease study estimates that over 15% of the burden of disease in established market economies is comprised of mental illness; this is greater than the disease burden created by all cancers. This study conducted by the World Health Organization, the World Bank, and Harvard University developed a single measure to permit comparison of the burden of disease across various disease conditions including death and disability. This measure was called Disability Adjusted Life Years (DALYs), which measures years of healthy life lost to premature death or disability. In this case the measure of disability caused by major depression was found to be equivalent to blindness or paraplegia whereas active psychosis was found to be equivalent to that of quadriplegia.

Though utilization of the DALYs measure major depression ranked second only to ischemic heart disease in magnitude of the burden of illness, projections show that with an aging population psychiatric and neurological conditions could increase their share of the total global burden of disease by nearly half from 10.5% to nearly 15%. In 1990, the estimated impact of the leading sources of diseases burden was estimated as indicated in Table 1.

Economists in 1990 speculated that in total, depression in the workplace costs the U.S. economy $43.7 billion, including $31.3 billion for indirect costs. By 1994 the estimated cost of untreated and mistreated mental illness and addictive disorders was $79 billion, according to a study by Dr. Dorothy P. Rice of the University of California, San Francisco and Leonard S. Miller of the University of California (2001).

In August 2001, Dr. Rice confirmed her concern; the escalating costs of mental illness and addictive disorders had in fact met the 1990 projections of a 50% increase in mental health treatment cost. The current estimated cost for these disorders in both the public and private sector in the U.S., according to the U.S. Department of Health and Human Services, is $205 billion. Less than half of that amount ($92 billion) is for the direct treatment of those suffering with mental illness or addictive disorders. The remainder, $113 billion, is accounted for through lost productivity, $105 billion, and crime and welfare costs $8 billion (Rice & Miller, 2001).

The U.S. National Comorbidity Survey in 1997 determined that within the civilian working population there was a total of 1 billion lost days of productivity as a result of mental illness (Narrow, 1998). According to the Mental Health & Wellness Survey in 2001, clinical depression emerged as one of the most common illnesses affecting 1 in 10 working age adults. The end result is an estimated 200 million working days each year.

These estimates were confirmed by the results of a survey published in May of 2001. This survey indicated that the unemployment rate among adult age mentally ill persons is 23% compared to 6% within the general population. Specifically, among men ages 21 to 49 with a depressive disorder the unemployment rate is 30% or four times greater than the national average for the nondepressed members of the same age group (Gruss, Schlesinger, & Allen, 2001).

State and federal governments spend roughly $20 billion per year on case transfers to poor nonelderly persons. Approximately the same amount is spent for food stamps for families in distress. A conservative estimate is that 25% of people on welfare are depressed. It is estimated that successful treatment of one half of this population would result in an 8% reduction or approximately $3.5 billion in welfare costs (U.S. Department of Health and Human Services, 2001).
The cost-benefit ratios for early treatment and prevention programs range from 1:2 to 1:10, meaning that a $1 investment yields a $2 to $10 savings. A population that would most benefit from early prevention, treatment, and support is the at-risk youth population. Providing community based treatment, prevention, and support programs targeting mental illness and substance abuse/dependence would yield between $1.7 to $2.3 billion in savings. The return on early treatment, prevention, and support programming would yield more than five times the estimated costs of traditional treatment approaches. The NIMH estimates a 5% increase in the $92 billion currently spent on direct mental health treatment within both the public and private sector would result in a $10 billion to $56 billion return on this investment.

Unfortunately, mental health and substance dependence treatment has not been made a priority. Despite increased data to support the effectiveness of treatment, a growing number of Americans remain undertreated, mistreated, or untreated. The disturbing truth is that from 1987 to 1997, according to the U.S. Department of Health and Human Services, mental health treatment’s portion of federal health care expenditures has decreased from 8.8 to 7.8%. The share of mental health care spending has decreased by 13% at the state level (U.S. Department of Health and Human Services, 1999).

### Challenges Within the Treatment Process

Questions relating to addressing both substance abuse and mental illness are complex. They challenge the therapist to implement all of his or her therapeutic skills in development and implementation of a recovery plan that is not only effective and agreed upon by both therapist and client, but also that identifies the essence of the client’s personality, environment, and spiritual strengths. Therapists are challenged to enter into a working agreement with the client that will work toward a previously established solution that capitalizes on the individual strengths of the client and restores the client’s natural dignity and self-respect.

In the complexities of today’s treatment setting practitioners frequently find themselves addressing cases of mentally ill chemical abusers who present following a crisis or possibly a series of crises, which they have been unsuccessful in attempting to resolve. Psychiatrists, psychologists, and social workers, functioning within a managed care environment are consistently
challenged to demonstrate positive outcomes with an acute focus on cost containment within the least restrictive environment. Professionals providing direct care are finding the combinations of crisis intervention with brief solution-focused approaches are effective strategies in meeting the rigorous demands of managed care.

There have been remarkable shifts from inpatient to outpatient therapy approaches over the past decade. Cost savings attained in the private sector have led to the consideration or application of a managed care approach within the public sector (Gartner & Mee-Lee, 1995; McLellan, Beldaing, & McKay, 1997; Schmidt & Weisner, 1999). At least 40 states currently have implemented some form of a managed care approach in addressing mental illness and substance dependence. And five other states are developing programming in this direction (Croze, 1999; Schmidt & Weisner, 1999).

This approach has not been met with acceptance by all; a great many authors have expressed concerns regarding the consequences of the managed care approach. Etheridge, Craddock, Dunteman, and Hubbard (1995) documented substantial declines in treatment services provided over the past decade. The findings are inclusive of considerable increases in clients reporting unmet service needs. Additional review of public managed care programs have called into question the severity of clients presenting for services possibly as the end result of a managed care treatment delivery system (Akiskal, 1996; Beinecke, Callahan, Shepard, Cavanaugh, & Larson, 1997; Schmidt & Weisner, 1999). Others continue to question the viability of a managed care approach in meeting the complex needs of mentally ill chemical abusers. However, despite these concerns program administrators continue to mold programming in a fashion to meet the demands of a managed care environment, providing care within the least intensive environment in an effort to sustain cost curtailling efforts (Kuttner, 1998; Rivers, 1998). Roberts’ seven-stage crisis intervention model when combined with the strengths perspective provides a viable framework for approaching the unique needs of the mentally ill chemical abuser (Roberts, 2000).

**Application of Roberts’ Seven-Stage Crisis Intervention Model**

Kerry Kennedy’s second patient of the day is Tom, a 44-year-old with a history of bipolar disorder and alcohol dependence. Tom presents following a remarkable argument with his wife. Tom reports that he has been involved in numerous extramarital affairs. He indicates that this is not the first time he has been caught in this situation, indicating that he has experienced similar difficulties throughout his 18-year marriage. Tom indicates that his children are now older and understand the reasons for the arguments between him and his wife and that it is becoming increasingly difficult to hide the truth from them, as they are able to “add it all up.” Tom’s wife indicates that if he doesn’t seek professional assistance she will have no choice but to take action in the form of legal separation followed by divorce proceedings. Tom is extremely successful. He is an investor and is well respected within the banking industry.

Tom indicates that while he is aware that his bipolar disorder causes some problems in his life, he is also acutely aware that there have also been remarkable contributions to his success. He specifically identified his ability to work long hours and to see projects to their end. Tom reports that he has always utilized alcohol and marijuana to self medicate his bipolar disorder, and over the past 5 years he has found cocaine to be extremely helpful in medicating his depressions.

He indicates that the cocaine began when he became involved with a woman from his office, stating, “Sex and cocaine seemed to go together.
very well.” It seemed to diminish the depressive symptoms he experienced initially. He also adds that he struggled to deal with the guilt associated with his extramarital affairs, that he eventually broke off this relationship, as he felt he was becoming emotionally connected with this woman. Tom quietly states, “I didn’t want to cheat on my wife.” He rationalized that if he was not emotionally involved then he wasn’t cheating, it was only sex. Therefore he began having sex with very young prostitutes, most of whom were underage runaways. Tom reports that he really found these young women fascinating, that they “responded to the simple things . . . the way that I spoke with them, held them, and made them feel safe.” Tom felt that they were better off with him because “it’s not like they’re with some sort of a pervert, they and I knew they would not be hurt; in fact, that they would be treated to a great time, with a great guy.”

Now Tom feels that if he isn’t able to address his bipolar disorder and substance abuse he will lose everything that is important to him. Tom reports no suicidal ideation, and feels that he would be able to function on an outpatient basis.

Tom is not alone in his diagnosis. Bipolar disorder appears in approximately 1.3% of the population. Bipolar I disorder occurs equally in men and women; however, bipolar II appears to be more common in women (American Psychiatric Association, 2001; Schatzberg, 1998; Sonne, Brady, & Morton, 1993). Individuals who abuse substances such as alcohol, marijuana, and cocaine experience earlier onset of bipolar disorder, frequently, several years earlier than in those who are not substance abusers. Patients presenting with comorbid bipolar disorder and substance dependence are often hospitalized for greater periods of time than their counterparts with a single diagnosis, and require longer hospital stays to stabilize prior to transition to outpatient treatment (Strakowski et al., 1998).

The treatment of substance dependence and bipolar disorder raises difficult treatment issues when they present separately. However, when there are co-occurring situations, treatment issues become more complex. Understanding and treating bipolar disorder when it co-occurs with substance dependence is one of the more difficult clinical situations a clinician can face.

The Epidemologic Catchment Area Study reports a lifetime prevalence of a substance use disorder for persons with a coexisting substance disorder was 56.1%. While it is not understood why persons with bipolar disorders have a high rate of substance dependence, there are numerous theories that exist (Regier et al., 1990). The first theory, as in the case of Tom, is that patients with bipolar disorder use alcohol and drugs to self medicate their affective symptoms (Kanthzian, 1997; Weiss, Griffin, & Mirin, 1992). That is, substance abuse occurs at the same time or shortly after the onset of bipolar disorder.

Others believe that substance abuse is a symptom of bipolar disorder; the manic’s tendency to excess includes alcohol and drug use. Third, is the perception that substance dependence/abuse can trigger affective illness. Since most mood-altering substances create affective symptoms, it may be possible that the same substances can create bipolar disorder in persons vulnerable to this disorder. A fourth and final possibility is that bipolar disorder and substance dependence have common risk factors. It may be that there are similar or same gene contributors. Furthermore, aspects of neurophysiologic adaptation may account for the occurrence of both disorders (First, Spitzer, Gibbon, & Williams, 1995; Strakowski & DelBello, 2000; Winokur et al., 1995).

In the 1997 executive summary for Improving Services for Individuals at Risk of, or with, Co-Occurring Substance-Related and Mental Health Disorders, it is indicated: “The most common cause of psychiatric relapse today is
the use of alcohol, marijuana, and cocaine.” Also, “[t]he most common cause of relapse to substance use/abuse today is an untreated psychiatric disorder” (U.S. Department of Health and Human Services, 1999, p. 288). The co-occurrence of bipolar disorder and substance abuse/dependence results in a negative impact of both the course of the disorders and the outcome of treatment. As previously indicated patients with bipolar disorder who also have a substance use disorder have an earlier onset of mood disorders. There is also a greater chance of a co-occurring Axis I disorder such as an anxiety disorder, and a greater likelihood of more frequent requirement for hospitalization for stabilization of the individual’s disorders. In addition substance abusing bipolar disordered individuals demonstrate a poorer response to treatment and significantly less success in their clinical outcomes (Strakowski et al., 1998). Furthermore, treatment of substance disorders is frequently less effective in the presence of psychiatric illness and the efficacy of substance dependence treatment worsens with severity of mental illness. There is indication that when patients suffering from bipolar disorder begin to stabilize, the active abuse of mood altering substances appears to diminish and stabilize. Therefore there appears to be justification for concurrent treatment of the mentally ill chemical abuser; however, there is no consensus within the treatment community of an effective integrated therapeutic framework to be applied to this population.

This case will be used to demonstrate how Roberts’ model of crisis intervention (see Figure 1) can be utilized in combination with strengths perspective and solution-focused therapy. The theories will be used to assist mentally ill chemical abusers define processes of recovery that incorporate the naturally occurring supports within their recovery environment in combination with an agreed-upon plan of action designed to maximize the individual’s strengths in his or her recovery.

In utilizing Roberts’ crisis intervention model as applied to mentally ill chemical abusers, the social worker should be acutely aware of the need to maintain the balance between stabilization and removal of the individual’s motivation for seeking assistance. Within the process of crisis intervention social workers must be aware of the mentally ill chemical abuser’s unique issues of active defense structures, cravings, traps, trigger issues of vertical splits, and potential for self harm, which can present as remarkable barriers to treatment (Yeager & Gregoire, 2000).

It is important to note the differences in working with mentally ill chemical abusers and the general population. Roberts’ initial seven-stage model indicated establishment of rapport as the first stage. However, consideration of the mentally ill chemical abuser population and other at-risk populations has indicated a shift in the initial thinking. Roberts’ subsequent publications recommend shifting assessment of lethality with establishment of rapport depending on the presenting problem of the population being seen. In the case of mentally ill chemical abusers, it is recommended that the assessment of lethality always be the first consideration (Roberts, 2000).

This will be particularly true of mentally ill chemical abusers. As in the case of Tom, the bipolar cocaine-abusing client, there is the potential to experience extremely intense crisis within a very short period of time. In such cases it is important to continue to assess the patient’s progress in therapy as well as abstinence. There will be times that chemical abusing mental-health patients will consider progress in one area an indication that safe use of chemical substances will again be an option (Yeager, 2000).

In this case, Tom does not indicate significant suicidal or homicidal risk. His situation has the potential to be extremely volatile, as actions while experiencing a manic episode in combina-
tion with cocaine use may lead to a crisis situation. In such cases initial assessment of the individual’s condition at the time of initial contact is recommended. Understanding this, the clinician is able to apply Roberts’ second stage of crisis intervention by establishing rapport and rapidly establishing a working relationship with the patient. This is accomplished simply by indicating a genuine interest and concern for the problems that the patient brings to the session. As is the case with many mentally ill chemical abusers, Tom has no problem sharing the issues that he brings to the initial session. Giving Tom the opportunity to vent the issues that are bringing...
him to treatment is helpful in building the therapeutic relationship. Attentiveness on the part of the therapist offers assurance to Tom that he is in the right place to have his issues examined and addressed. Any lack of attentiveness on the part of the therapist could provide Tom with sufficient rationalizations not to return to treatment. Similar rationalizations and justifications can be if he felt that the therapy session adopted the flavor of moral underpinnings, rather than acceptance of the story provided. While it is important for Tom to hear that his problems are not unique, this did not appear to bring him into contact with what was pressuring him to seek assistance (Khantzian, 1985; Yeager & Gregoire, 2000).

Often in the session(s) the factual presentation of information proves helpful in addressing concerns of the patient. In Tom’s case, an unasked question emerged as Tom paused, looking to the therapist for an indication of if he was the only person to find himself in this type of predicament. The answer, of course, was no; the therapist assured Tom that many individuals who use cocaine have experienced sexual issues, and that this is not uncommon with bipolar disorder (Hser et al., 1999). However, assurance that this was not uncommon in no way suggested that this behavior would help Tom to move forward in his goal of stabilizing his marital issues and enhancing his productivity in the work place. Tom agreed that he was responsible for working within the sessions to move toward established treatment goals.

This brings Tom and the therapist to the third step in crisis intervention as outlined by Roberts, which is, “identifying major problems, including the ‘last straw’ or crisis precipitants.” Having agreed on the need to examine the problem further the therapist is able to ask pointed questions about Tom’s presenting problem (Roberts, 2000).

Q: Tom, you stated that you and your wife had a fight that brought you here today. Would you be willing to tell me more of what led to this argument?

A: Well, this had been coming on for some time now. Debbie knew I had stopped taking my medication some time ago. She’s always on my case about that. She harps on me day in and day out to take that stuff. . . . Even though a part of me knows she’s right, there is another opposing part that argues I simply don’t think I need all that. Deb was on me for not coming home until late and questioning if I was really working all of that time. The truth is sometimes I was, and sometimes I wasn’t. Anyway, last Thursday was a big day. The market was hot and I was able to make some really big moves. I decided to reward myself with a drink before heading home. The next thing I know I’m waking up 10:00 Friday morning in a hotel room with a young prostitute in bed with me. I called the office, saying I was ill. After an awkward silence, my secretary said, “Tom, your wife has been calling all morning looking for you. I don’t know what’s going on but you might want to head home.”

So I did, and when I got there all hell broke loose, screaming, yelling, accusations. . . . Finally she said it, she said I hope you enjoyed your whore. I was just about to explode when I turned around to see Katie, my daughter standing in the hall. The look on her face was unbelievable. It was like she was torn between being my daughter and seeing someone she didn’t know or understand . . . I spun around and lashed out at Deb saying, “That’s great . . . that’s just great, now you’ve destroyed our daughter too.” Hell, I knew who created the problem. . . . It was me. God, I hate myself for that.

The answer provided much more information for building the treatment plan. This account provides a greater understanding of the impact of Tom’s actions on his wife and daughter. Furthermore, Debbie’s willingness to set and main-
tain boundaries becomes clear. There is also a greater understanding of the impact of Tom's actions on his daughter Katie. Tom indicated the last thing that he wanted to happen was to hurt his wife and daughter. He added, "The pain isn't over yet, I'm sure there will be another argument when she [Debbie] figures out this little fling cost over $3,500." Tom states, "While I know what I'm supposed to do I can't ever seem to do it." This is representative of the mentally ill chemical abuser's estrangement between knowing and doing. While Tom is clearly aware of the pain created by his actions, he was unable to master the urge that led to his eventual consequences (Saleebey, 1992).

The closer examination of the issues at hand facilitates a transition into Roberts' third stage of the seven-stage crisis model dealing with the feelings and emotions. It is not unusual for mentally ill chemical abusers to experience difficulty with this stage. Frequently, this stage evokes feelings of helplessness and hopelessness. In this case the therapist works with Tom using guided imagery as a powerful tool that he can practice and place juxtapose to cravings for cocaine use or sexual acting out as the cravings occur. In this case the feelings associated with the problem are turned to the form of a strength as a tool to work against his craving. Tom indicates feeling this is important as the majority of his problems stem from impulsive actions that lead to behaviors that have, in Tom's words, "caused me all of the pain that is present in my life today."

Clinical Issues and Special Considerations

Tom was no stranger to the therapist client relationship. Tom has been in and out of treatment since age 18 when his problems first began to emerge. In this case assessing past coping mechanisms, Roberts' fifth stage, became a homework assignment. Tom was given the assignment to create a list of the times that he had been in therapy previously. To accomplish this task Tom was given a roll of paper and a set of markers. Once each treatment had been listed Tom was then asked to assess the actions that were helpful in treating his illness in the past.

Tom came up with a list of five actions he was willing to take. First was achieving and maintaining abstinence or at least a willingness to work toward total abstinence. Tom notes that this is a slippery slope for him and that in the past all of his relapses had begun with "just one beer.” Second was stabilizing the acute psychiatric symptoms. Tom was challenged as to why this wasn’t the first step. He responded that he was aware that alcohol presented a problem with the effectiveness of his medications. Tom agreed to see the psychiatrist for medication evaluation and stabilization. Tom’s third step was working to resolve or reduce problems improving physical, emotional, social, family, interpersonal occupational, spiritual, and financial issues. When asked to provide specifics Tom offered the following with regard to his daughter Katie as an example:

- Involving Katie in my counseling so she can develop a greater understanding that I am ill and that she isn’t responsible for my actions and problems and those between her mother and me.
- Providing a stable home environment. By that I mean keeping involved in treatment, being home when I need to be home, being at work when I am supposed to be at work. Being open and honest about the past and what I’m doing to secure the future.
- Letting my family know that I love them ... not through my words or by buying them things. But for real being there, not just being in the same house. Being there for my family.
• Showing interest in the lives of those I love, Katie’s schoolwork and Debbie’s day, Kyle’s sports and his progress toward his academic goals.
• Building strong relationships with friends of ours and working to maintain those friendships.
• Developing family interests, hearing what my family wants to do and being there to be a part of the family.
• And, incorporating help from outside of the family to improve the home environment. Thus far, I’ve tried to do this all on my own; that didn’t work. If they’ll participate I would like to have some professional counseling for my family.

**Special Considerations and Treatment Planning**

Tom was asked to develop similar planning as he did with his plans to bolster his family relationships. The plan was simple and to the point, beginning with maintaining all of his appointments with his social worker and his psychiatrist. Tom agreed to restart his medications as prescribed and to maintain them at whatever level his physician recommended. For Tom there was a large issue with deciding to discontinue his medications. The plan was to contact his social worker to discuss any such plans. In addition Tom, Debbie, Katie, and Kyle agreed to meet weekly as a family and to discuss the family schedule, as well as Tom and Debbie reviewing his medications.

Tom agreed to enter outpatient group therapy three evenings per week for a period of 6 weeks. Tom will be attending one session per week with his social worker, and there will be three family therapy sessions over the 6-week period of time. Within the individual sessions Tom and the social worker will be addressing the issue(s) of “vertical splits.” Simply put, these issues resemble the scenario of Dr. Jekyll and Mr. Hyde. Initially Tom would like to have dismissed or denied the somewhat unwholesome areas of his life. At times in his therapy Tom indicated that he couldn’t understand why he acts out sexually. It would be all too easy to assume these behaviors would dissipate once Tom had established abstinence and engaged in the therapeutic process. On the other hand social workers frequently condemn the behaviors of delinquent, criminal, or immoral behavior in persons who are otherwise considered moral and even at times admirable contributors to the community. Frequently, mentally ill chemical abusers present with severe and striking split in their personalities: a vertical split in the individual that seems to represent two personalities standing side by side within one person (Goldberg, 1999). In most cases the division is not neat, and the portions of the individual splits are seldom even, with regard to emergence, duration of episode, or frequency of occurrence. Nevertheless, the experience for the individual is a baffling separation of the self into concurrent existing dimensions of the self.

The focus of individual treatment will be to address the vertical split, examining an extensive range of behavior issues. The primary focus will be the elements of the offensive or forbidden actions that coexist alongside the normal personality. Once the therapy process begins the focus is on the now and how rather than the then and why. Tom will be required to focus on the establishment of concrete plans to address behaviors associated with the maladaptive split (Goldberg, 1999). This approach is different from previous methods of addressing environmental traps, addressing high-risk situations and triggers, which focus on issues that trigger cravings in traditional addiction treatment. The concept of vertical splits in dealing with mentally ill chemical abusers, specifically cocaine-abusing bipolar disordered individu-
als, provide the opportunity to focus on a grouping of consistent treatment defeating behaviors. In the case of Tom, this approach addresses circumscribed dissociation, that is the seeming separation of self from the actions and potential consequences of the chemical abuse and sexual acting out. A second area of focus will be addressing Tom’s narcissistic characteristics, grandiosity, and concurrent narcissistic behavior.

In this case the exception question of solution-focused therapy can be applied to assist Tom in examining times where he had the desire to act out either through cocaine and alcohol abuse or sexually, but did not. In response to this Tom indicated that he has been able to sustain his focus and “do the right thing” but he quickly adds that this was usually followed by an episode of acting out within a 1-week period of time (Miller & Berg, 1995). In addition, Tom was instructed to examine areas in which he felt his attempts to stay on track were supportive and areas where he needed to develop supports. As in many cases Tom experienced an initial burst of energy as recovery supportive activities, opportunities seemed to appear everywhere. However, as time progressed Tom settled into a more realistic and perhaps painful reality of reflection into the full impact of his disorders. Overall, Tom’s progress was very good. Within a 6-week period he had successfully completed all of his goal assignments. He and his family were actively engaged in therapy. He was attending 12-step meetings and had maintained total abstinence for a period of 5 of the 6 weeks. There were no episodes of sexual acting out and Tom was working with his dual diagnosis (double trouble) support group and A.A. sponsor, actively addressing his vertical splits. Tom states he would rather use the A.A. terminology of “character defects,” which he felt was more acceptable to his newfound support group.

Case Autopsy Follow-Up

Tom transitioned into weekly sessions with his social worker for a 2-month period of time then to biweekly sessions for 2 months. Finally, Tom attended monthly sessions, completing a total of 35 outpatient sessions. Tom’s major struggle came approximately 180 days into his treatment when he decided he no longer required medication. Within a 2-week period of time Tom was acting out sexually and drinking heavily. Tom’s wife and family maintained the boundaries set in therapy stating that Tom must leave the home until he was able to reestablish his recovery program. Tom agreed to do so. Knowing that setting and sticking by limits was important, Tom’s family did not bend. Tom was not permitted to return home until he had established 1 month of abstinence combined with taking his medication. During this time Tom reported living with his sponsor and actively participating in the 12-step fellowship of A.A. During Tom’s relapse, he reworked Roberts’ stages of crisis intervention, specifically steps two through six. Tom reports being aware of his responsibility to seek out the strengths and support within his recovery environment and to focus on concrete solutions rather than waiting for “things to fall into place.” Tom indicates, “Things are far from perfect . . . but I feel like I’m able to say who I am and what I’m doing to treat my illness. I have choices today. That’s something I never knew I had before this treatment.”

The Case of Rick R.: Agitated Depression and Opiate Dependence

As previously discussed, Rick R. presented to a hospital facility. Shortly after admission Rick appeared to decompensate. Examination by staff identified a history of opiate dependence that had been underestimated at the time of admission.
Rick reports that he had begun drinking beer at age 16 with his friends. He reports that while in school he frequently drank to the point of intoxication. However, he has suffered no consequences as a result of his drinking. Rick has never experienced a blackout, nor has his tolerance increased remarkably since his college years. Rick states he has always been able to drink large amounts of alcohol without becoming ill. Rick married at age 22, but divorced at age 27, after a tumultuous relationship. There was a positive history of physical and emotional abuse. In the initial assess Rick reported hitting his ex-wife, stating, “She always egged it on.” Rick is employed as a production supervisor at an auto manufacturing facility. Three years ago Rick was involved in an industrial accident. Rick reports he was crossing an elevated walkway when a forklift struck it. The impact resulted in Rick falling 12 feet to the cement floor below. The resulting injury was three compressed disks in his lower back L-3,4,5.

Rick underwent surgery 2 1/2 years ago, which appears to have provided only partial relief. Rick reports chronic lower back, leg, and foot pain. As a result of his injuries Rick was placed on full disability. Rick lost structure in his life and was diagnosed with depression 2 years ago. At this time Rick began antidepressant medications. He took them for a brief time but indicated that he did not like the “side effects.” Rick has been off and on medication since that time. When he is not taking the medication he consistently abuses alcohol and his pain pills. Eight months ago Rick was prescribed OxyContin for his pain. He reports feeling this was a miracle drug; he reported that not only was his pain managed, but also he was not depressed.

Following Rick’s episode of acting out he was placed in a seclusion room. Once Rick was safe in seclusion the physician, nurse manager, and social workers began to piece the case together. Telephone calls were placed to his pharmacy and his insurance carrier. The social worker was surprised to find that Rick had been taking a combination of Vicodan, OxyContin, and codeine. Examination of Rick’s prescription bottles indicated that he had been visiting three pharmacies. Thinking this was unusual, the nurse manager contacted the pharmacies indicating her concern. While specifics were not provided, there was indication that Rick was receiving prescriptions for Vicodin, OxyContin, and codeine from each pharmacy. Contact with the insurance carrier provided remarkable information as, following review of the case, Rick’s insurer faxed a seven-sheet record of prescription drug utilization by Rick over the past 2 years. Clearly, Rick was experiencing opiate withdrawal in conjunction with his depressive disorder and psychosis.

Rick’s problem is one of growing concern in the United States; one study indicated that 28% of a pain clinic’s patients treated for chronic pain met three or more criteria for substance abuse (Chabal, Erjavec, Jacobson, Mariano, & Chaney, 1997). In addition, according to a study by Gruss, Schlesinger, and Allen (2001), clinical depression in the United States “has become one of the most common illnesses, affecting one in ten working age adults each year” (p. 733). The total impact is a loss of 200 million working days each year. In this case, the therapist was able to assure Rick that his pain issues as well as his withdrawal symptoms could be managed. At the same time the therapist was required to advise Rick of the potential legal issues associated with selecting several physicians to prescribe medications for the same symptoms. Given this information Rick was advised that while staff could not assure there would be no legal backlash of his actions, the current action of seeking treatment would function as the foundation against placing himself at further risks for legal, health, and emotional crisis.

This case will demonstrate the effectiveness of combining both Roberts’ crisis intervention
model and the strengths perspective approach. In working with Rick the rapid establishment of psychological contact was postponed as his emergent withdrawal and subsequent decompensation into a withdrawal induced violent attack. Once Rick was stabilized, psychological contact could proceed taking the form of medical and psychiatric stabilization. Even in the worst case as Rick required seclusion, it is important to note that the seclusion occurred initially in a closed-door seclusion for approximately 30 minutes, with one-to-one staff observation through a window in the door. The seclusion then transitioned to open door seclusion with one-to-one staff observation. During the period of seclusion staff spoke with Rick when he was able to tolerate conversation. During this time Rick became willing to discuss the extent and severity of his drug abuse. He was able to share that he had been “doctor shopping” with a total of five physicians. He had presented with similar symptoms to each physician knowing that he would be prescribed certain medications when he presented certain symptoms. Knowing the results of previous physician appointments, Rick was able to direct the conversation to points where he was able to ask for specific pain medications. Rick said the process was very easy to replicate. He added that he was now concerned that he has taken himself to a point from which he feels he will need medical assistance to return. The establishment of rapport provided staff information that would enable them to more effectively address the withdrawal symptoms exacerbating his depressive disorder (Miller & Berg, 1995; Saleebey, 1996; Sullivan & Rapp, 1991).

Rick responded quickly once provided medication to counteract the emergent withdrawal symptomology. The ongoing withdrawal management included utilization of Clonidine patches in combination with a tapering order for Ultram. Rick was also prescribed a selective serotonin reuptake inhibitor (SSRI), which had proven effective previously prior to his decision to discontinue medication following a time of stability.

In this case the focus moves very quickly away from the problem into current functional coping skills. Rather than asking questions that focus on the consequences of the concurrent depressive symptoms and issues of self medication to address both depression and chronic pain, the focus becomes one of: How have you been able to cope under such difficult circumstances? What have you done that has helped you to function up until this point? Once the recovery supportive and sustaining actions have been identified staff are then able to focus on moving the process forward. The therapeutic focus with Rick is now able to capitalize on the newfound insight. The focus becomes one of what a depression-free and pain-free life will be like. This is combined with questions and assignments designed to identify specific actions will be required to move the patient in a direction that capitalizes on inherent strengths (Yeager, 2000).

Providing the client with the opportunity to explore positive coping skills and supports that exist in their recovery environment is a natural extension of the strengths perspective. This integrates very well with Roberts’ second and fourth stages of crisis intervention. The goal is to capture the client’s view of their problem in a framework that provides them with the awareness that their illness is one that is medical, and thus can be managed medically. In doing so, resistance to the recovery process is minimized. The new focus becomes one of working toward an agreed-upon plan that minimizes, but does not eliminate pain. And that incorporates participation in a combination of pharmacotherapy, group therapy, and individual actions to address symptoms of pain and depression (Roberts, 2000).

The establishment of clear criteria for administration of medication is required at this point.
The importance of moving the client away from seeking medication for perceived pain to providing medication only for identifiable symptoms of withdrawal minimizes “drug-seeking behavior” on the part of the patient. Reasons for providing withdrawal medication are to be concrete, measured in quantifiable elements such as: elevated blood pressure, temperature, and elevated pulse. Medications for pain should be scheduled and given as scheduled with behavioral actions utilized to address pain rather than PRN, medication of pain symptoms. Clients should be encouraged to utilize solution-focused/strengths-based approaches combined with a self-developed and implemented recovery plan. This plan was inclusive of alternative solutions to pain management that focused on anything but seeking a pill to fix the pain. The development of a self-directed plan of recovery incorporates Roberts’ third, fifth, and sixth stages of crisis intervention. In this case Rick was encouraged to build his recovery plan based on his new understanding of actions that led to his crisis. In doing so he was encouraged to generate and explore alternatives to pain and feelings of helplessness and hopelessness. Finally, Rick was encouraged to formulate an action plan to address the symptoms identified.

Staff is encouraged to remind the patient of their self-directed recovery plan and to assist in any way possible in the implementation of the self directed plan of care. For example, providing hydrotherapy in the middle of the night is an additional burden to staff; however, there is awareness on the part of staff that pain symptoms are worse in the evening and night. Rather than seeking the “quick” pain medication solution staff encourage long warm baths in the whirlpool. In addition, whenever possible the client should be encouraged to collaborate with persons within the recovery environment. Rick identified a group of three peers who he felt had a good understanding of the issues he was addressing. He frequently spoke with them when making decisions of how to proceed in his treatment. The importance of this type of support cannot be underestimated as the most important treatment decisions are not made in the treatment team, rather they occur when one patient says to another:

Q: Are you going to take that medication after you leave?
A: Yep, because when I didn’t all hell broke loose and I ended up back in the hospital. You know, if I had only stuck with my plan I think I might have been able to avoid having the current problems I’m working on today.

Utilizing the plan Rick developed with the treatment team he was able to put into place (a) a daily plan for recovery, (b) a list of actions that he intended to take on a daily basis to support his recovery, (c) a medical management plan developed in collaboration with a single primary care physician, psychiatrist, physical therapist, and social worker, and (d) a plan for ongoing treatment to sustain this plan including participation in partial hospitalization to be decreased to intensive outpatient group and finally followed by outpatient therapy and aftercare group sessions. The plan as developed was presented to Rick’s managed care gatekeeper. There were additional recommendations, for example, Rick’s progress was to be monitored through utilization of standardized depression and helplessness scales to document progress, and that any utilization of care providers and/or prescription utilization other than those discussed within the recovery plan would be shared with the primary care providers. Rick agreed to this plan and provided signatures on the appropriate release of information forms, indicating approval of this conversation. Eighteen additional outpatient sessions with biweekly updates inclusive of scaling results to track progress were approved. The gatekeeper indicated that further sessions would be approved as needed.
With this plan in place, and demonstration of medical/psychiatric stability, Rick was discharged from the inpatient psychiatric unit within a 7-day period of time. Rick received a prescription for decreasing amounts of detoxification medication in combination with a prescription for SSRIs. Rick agreed that he would participate as directed in partial hospitalization and intensive outpatient therapy as agreed upon.

Analysis or Risk and Protective Factors

In assessment of Rick’s case it is important to note the presence of physical dependence and tolerance as an expected component of his long-term utilization of opiate mediation for pain. Seas and Clark (1993) noted that determining the existence of dysfunctional behavior is the salient point for the diagnosis of addiction. However, this case demonstrates a concurrent need for pain medication occurring independently of the physical health problem. Ultimately Rick discovered that much of the pain experienced was actually the result of pending withdrawal symptoms, unrelated to his long-standing injury. Once stabilization of his depression and management of the addictive component of his illness occurred, the requirement for opiate medication was nonexistent as his pain was effectively managed with nonsteroidal anti-inflammatory medications such as Motrin.

In assessing the protective factors in the case of Rick it is important to note the friendships and decision making that occurred during his inpatient stay. It is particularly important to establish this trust as many persons suffering from depression and opiate dependence tend toward isolative patterns. Many authors have empirically demonstrated the important role social support plays in maintaining the benefits of therapeutic interactions (Bell, Richard, & Feltz, 1996; Havassey et al., 1991). Subsequent to the violent episode Rick took important steps to the establishment of trust with another individual.

A strengths-based approach facilitated the establishment of such an interaction presenting the opportunity to apply an effective mechanism for overcoming the initial denial that may have impeded Rick’s engagement in the treatment process. Human interactions—one person to another—laid the foundation of collaborative relationships. Miller (1995) indicated that the establishment of collaborative relationships is much more important than a focus on self-labeling that has historically existed in traditional chemical dependency treatment. The goal is to “create a salient dissonance or discrepancy between the person’s current behavior and important personal goals” (Miller, 1995, p. 95).

Case Autopsy: Follow-up

Following discharge Rick maintained weekly outpatient appointments for approximately 8 weeks. He then began biweekly therapy sessions for a 3-month period of time. Finally, he concluded the rest of the year by attending monthly sessions. He has maintained his antidepressant medication throughout this time period. Rick states that this time he plans to take this as long as it is recommended. Rick continually reports amazement with the relatively pain-free life that he is now leading. He reports he is maintaining compliance with the recommendations of his treatment team, not out of fear of the consequences of failing to do so, but rather because of the benefits he has experienced thus far in his recovery. Rick has entered a vocational rehabilitation program and is actively seeking a degree in computer engineering. Rick reports his mind is clearer now than he has ever experienced and states with pride that he has maintained a 3.8 grade point average in his course.
work, stating, “It’s not perfect, but it’s better than I have ever done before.”

**Treatment in Fast Food Restaurants**

At the beginning of this article, Kerry Kennedy’s first patient of the day was Ted, a schizophrenic who abused alcohol and cocaine. A few weeks following his assessment this writer ran into Ted in a fast food restaurant. Ted was engaged in a heated discussion with the manager of this restaurant. Ted was living in the alley behind this restaurant. However, this was not the problem; the argument centered on the pants Ted had recently acquired. The pants were quite large on Ted. He did not have a belt nor was he wearing any underpants. Ted was doing his best by holding the pants up with his hands in the front pockets, unfortunately this led to a rather deep droop in the back, exposing Ted’s backside. Rather than permitting this to accelerate to the point of Ted’s arrest, I suggested there might be a reasonable compromise. Applying Roberts’ second step of establishing rapport and third step, the major problem was identified (Ted’s lack of a belt). The restaurant’s manager was asked if he had any string. He indicated that he did and returned with a ball of twine. Applying Roberts’ fifth step the three of us generated alternative solutions. As a result, Ted, the restaurant manager, and I were able to fashion a belt and suspenders. Applying the sixth step of Roberts’ crisis intervention model, I created an action plan on a restaurant napkin that read, “Ted, if you keep your pants up with this belt and suspenders, you will receive a free coffee refill whenever you buy a cup of coffee. This will happen as long as your behaviors are not disruptive to others in the restaurant.” Ted, the restaurant manager, and I were all in agreement with this strengths approach and the established plan of action.

Five months later I ran into Ted who was sitting drinking coffee in the same fast food restaurant. Ted still had the belt on we had fashioned 5 months earlier, but the suspenders were not present. Wanting to see how things were going I approached Ted. From his pocket Ted pulled what was left of the napkin action plan, and asked if I would buy him a cup of coffee. That morning we had breakfast together.

**Conclusion**

Challenges facing social workers today go far beyond the obvious struggles to maintaining the delicate balance between cost and quality of care. An entirely new dimension of practice is emerging, one that requires rapid interaction based in crisis interventions designed to stabilize patients as quickly and effectively as possible (Edmunds et al., 1997). Roberts’ crisis intervention model combined with strengths perspective provides a remarkable framework for addressing the needs of the mentally ill chemical abuser. The established practice within Roberts’ crisis intervention approach facilitates the development of self-directed and maintained processes that leads to crisis stabilization and normalization (Roberts, 2000).

In each case links between the crisis and the client’s life history were identified and examined in a manner that supported the patient’s historical and existential continuity. Focusing on people within their recovery environment provides patients with the opportunity to reframe what was previously familiar to them as a using environment or of one that sustained and exacerbated their mental illness. This process permits patients to examine their functioning within this environment while building on the identified strengths they bring to the treatment process. In doing so the treatment process becomes one that enables recovery within the least restrictive environment while permitting indi-
individuals to maintain their dignity, sense of strength, pride, trust, spirituality, and personal identity.

In closing, Roberts’ model has the potential to meet not only the needs of mentally ill chemical-abusing consumers, but also the goals of payers and system administrators within both public and private sectors. Application of Roberts’ model in combination with strengths perspective appears to meet the challenges of today’s treatment environment by reducing hospital days, reducing emergency services, and increasing utilization of community support, hence reducing relapse potential.

This article is not intended to present Roberts’ seven-stage model as a replacement for traditional approaches to mental illness, substance dependence, or a combination of the two. It was the intention of this writer to provide an alternative framework that when applied to the mentally ill chemical-abusing population provides a viable alternative to be considered for development, refinement, and potentially effective approach to the treatment of mentally ill chemical abusers.

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