Managing Comorbidity in the Therapeutic Community:

Managing the Unmanageable

Julie Fox
Director of Clinical Services
Gold Coast Drug Council Inc.

The therapeutic community:

The key distinction being the use of community as a method to promote the health, welfare and growth of the individual. The TC uses community as a method to help individuals change themselves. Its structure (social organisation), its people (staff and residents), and its daily regimen of activities (groups, meetings, work, recreation) are designed to facilitate healing, learning, and change in the individual.

(De Leon 2000).

Why Modify What Works?

- High rate of comorbid presentations
- Lack of services willing to accept clients with a comorbid disorder
- Adopt a ‘no wrong door’ policy
- Comorbidity always been in existence, just not recognised or identified as such
- Best Practice Recommendations include an integrated approach to treatment (Canada Health, 2002)

The Modified Therapeutic Community

- Developed in early and mid 1990's as a treatment model and approach for those whose substance use disorders co-occurred with mental disorders
- Based on the theoretical framework of the standard TC model

Sacks, Banks, McKendrick & Sacks (2008)

Core Principles & Methods of modified/comorbid TC:

- Providing a highly structured daily regimen
- Fostering personal responsibility
- Self-help in managing life difficulties
- Using peers as role models and guides
- Community as method

Sacks et al, 2008

Key modifications for comorbidity in the Therapeutic Community

- Flexibility
- Less intense
- More individualized

Sacks et al, 2008

“Mirikai”
A Modified Therapeutic Community

- 40 Bed Residential Therapeutic Community program for young people aged 17–29 years
- Includes 8 beds for clients on Intensive Drug Rehabilitation Orders (IDRO’s)
- Integration of programs across the service
- Majority of clients are comorbid

Typical Presentations

- Client 1 – 23 year old male
- Witness to excessive physical,verbal and emotional abuse from birth onwards
- Bullied at school
- Reported hearing voices at age 10
- Exposed to hard core porn at 12 years
- Lived with older male from 14 years; male used to bring underage girls home and rape them in front of client 1
- Started using cannabis at 13 years, amphetamines and ICE at 16 years
- Sustained brain injury in car accident and severe bashing at 17 years
- Current presentation: masturbating excessively every day, reporting obsessions around sexual activity, counting and checking behaviour, increased levels of anxiety

Typical Presentations Cont.

- Case 2 – 20 year old female
- Mother alcoholic (previous client of Mirikai)
- Client witnessed violence from birth
- Erratic lifestyle because of mother's alcoholism
- Raped at 9 years, started drinking at that time
- First pregnancy at 10 years
- Witnessed best friend killed by a car as she crossed the road at 11 years
- Never commenced secondary school
- First child at 14 years, second at 18 years
- Alcohol primary, commenced amphetamines at 18 years (IV)
- Prostitution to support habit
- Children removed from her care
- Currently 20 weeks pregnant

Typical Presentations Cont.

- Client 3 -27 year old female on IDRO
- Parents chronic alcoholics; mother deceased when client 12 years of age – left 10 children all placed in foster care
- Started drinking at age 10
- Amphetamines at 13 years
- Physically & Sexually abused in foster care (Forde Inquiry)
- Substantial history of crime and jail time
- Currently has 5 children all in care
- Lots of impulsive behaviour
- Difficulty with identity
- Increased anxiety and Panic Disorder

“Mirikai” cont..

- Treatment plans (prior and post admission)*
- Structured Days
- Complex Case Panel
- Dual Diagnosis Team
- Psychiatric Assessment
- Funky Monkey’s
- Step Up – Step Down System
- Transition to Half-way Houses (Clarity & Commitment)
- MOU’s with Mental Health (ACTT/ACCESS)
- Co-Case manage with Mental Health
- Exclusion as a strategy

- Contingency Plan
- *Must be completed at Clinical Review Meeting*

- Case Manager
- Date of Plan:
- Proposed Admission Date:
- Provisional Diagnosis
- _____
_____
- Significant Issues (i.e. previous diagnosis, legal issues etc)
- _____
_____
_____
_____
_____
_____
- Possible issues that may arise on admission and while in Assessment Phase (i.e. anger, anxiety etc)
- _____
_____
_____
_____
_____
_____
- Strategies to help client manage (include those that have worked previously):
- _____
_____
_____
_____
_____
_____
- _____
_____
_____
_____
_____
_____

Funky Monkeys

- Client outings
- Music & art therapy
- Mental health education & management
- Relapse prevention
- Life skills
- Basic group processes

Managing Complex Clients: Exclusion as possible strategy

- Step 1: Handover from residents suggest client's behaviour is extreme (details below)
- Step 2: Staff investigate to validate claims (details below including staff members involved) - Discussed/engaged with community?
- Step 3: Claims unvalidated OR claims substantiated (circle one)
- Step 4: Exclusion raised as an intervention yes/no (circle)
- Step 5: What is client's diagnosis? Have they been seen by psychiatrist/Dual Diagnosis Team? Have the Psychiatrist/DD team been consulted in this process? If not, why?
- Step 6: Is their behaviour a result of their diagnosis?
- Step 7: What else could explain their behaviour?
- Step 8: What are the risks for excluding this client?
- Step 9: What other supports does the client have in place (i.e. family, other agencies etc)
- Step 10: What are the risks associated in keeping this client in program?
- Step 11: What identified supports are in place within the program?
- Step 12: What other options are there for managing this client apart from exclusion?
- Step 13: What is the best course of action recommended by staff involved?

Case Study

- Client contacts service for assessment – 26 year old female
- Thorough assessment
- First used alcohol at 9 years, speed at 17 years
- Numerous detox attempts
- Three admissions to psych. Unit
- Self harm history
- Unstable relationship with mother
- Reviewed by team – accepted and contingency plan developed

- Contingency Plan
  - *Must be completed at Clinical Review Meeting*
- Case Manager: Vicky R
- Date of Plan: 15/8/2007
- Proposed Admission Date: 21/8/2007
- Provisional Diagnosis:
  - Substance Use Disorder; Major Depression; psychotic episodes; Panic Disorder without Agoraphobia

- Significant Issues (i.e. previous diagnosis, legal issues etc)
  - No legal issues; significant mental health issues may/may not be related to substance use

Possible issues that may arise on admission and while in Assessment Phase (i.e. anger, anxiety etc)

Increased anxiety, psychosis, difficulty settling

- Strategies to help client manage (include those that have worked previously):
  - Involve grandmother in treatment; appointment with psychiatrist; appointment with dual diagnosis team; choose 1 (possibly 2) buddy(s) from TC who will be able to manage and support client; regular monitoring by senior residents; encourage client to seek support when required

Case Study Cont:

- Client is admitted into program
- Settles well initially
- Referred to Funky Monkey's
- Participates in program
- Finds responsibility overwhelming at times
- Presented at Complex Case Panel
- Recommendations include: flexibility within program responsibilities/support from other residents, increase time out, case management with client to determine capabilities at present

Case Study Cont:

- Recommendations implemented
- Some improvement in clients coping
- Client continues to participate in program, sees dual diagnosis psychologist fortnightly and reviewed by psychiatrist as needed
- As client comes towards end of stage 1 of program (approximately 14 weeks in the program), she begins to demonstrate signs to suggest she is not coping i.e. increased anxiety, some suggestion of psychotic episode, paranoia
- Team meeting (with input of residents) suggest stepping client down to help reduce stress

Case Study Cont.

- Client placed in well monitored and supported half way house (Clarity)
- Client improves and is stepped back into program
- Completes stage 2 and graduates to halfway house
- Increased anxiety at move to halfway – longer transition
- After 6 weeks, client deteriorates and has psychotic episode
- Mental Health Service contacted
- Client admitted for four weeks to P1
- Discharged to our care with Case Manager from Mental Health
- Client is able to attend groups that are appropriate (i.e. funky monkey's, anxiety group) at Mirikai, still remain in supported accommodation, continue to see psychologist/psychiatrist, volunteer, participate in groups

In summary…

- The complexities are great
- The clients numerous
- Incorporating modifications into an existing model has produced many positive outcomes for clients