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On Co-Occurring Mental Health and Substance Abuse Disorders

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THE TREATMENT OF CO-OCCURING DISORDERS IN ADOLESCENTS

By George Michael Kolarik, DCSW

Over the past decade, experts in the field of treating adolescent drug abusers have frequently encountered adolescents with co-occurring disorders or the "dually diagnosed." [1] Consequently, it has been recognized that there is a critical need for specialized skills and knowledge to effectively treat this difficult and complicated population. A realistic, logical and coherent treatment philosophy is necessary in treating the dually diagnosed. This clinical picture of dual diagnosis has brought together two historically separate disciplines – Addictions Treatment and Mental Health services – into a much-needed partnership. Effective treatment providers incorporate the knowledge base of addiction counselors (i.e. pharmacology and chemical dependency, levels of care, use of support groups) with that of a mental health professional (i.e. human development, diagnostic skills, and family therapy expertise). This interdisciplinary approach increases the possibility of successfully planning the interventions needed to serve these adolescents, and in many instances, their family members. In addition, a competent counselor is able to simultaneously build trust and rapport with both the adolescent and his family. This ability to convey expertise, as well as care, is an essential building block to the therapeutic relationship with the adolescent and his family. [2]

One of the major challenges in assessing the dually diagnosed adolescent is in determining the etiology of the addiction disorder and concomitant mental health disturbances. One of the fundamentals of effective Adolescent Outpatient Treatment Programs is to address substance abuse as the *primary presenting problem*. [3] Clinicians can no longer treat chemical abuse as a secondary or tertiary symptom of some other deeper psychological issue. Despite the fact that adolescents suffer from a myriad of psychological problems, it has never been shown that adolescents quit using drugs because they have developed a clear understanding of "why" they use drugs. Insight oriented therapy, a recognized effective mental health technique used with adults, is not an appropriate

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A MESSAGE FROM THE COMMITTEE

In September 2002, the Associated Press cited a report by the National Council on Disability. This report states that the mental health system in the United States is unable to provide the most basic services to people with psychiatric disabilities. They also note that the large shift in prescribing medication as the primary means of treatment has led to a system that focuses solely on treating symptoms while ignoring other possible mitigating circumstances that the client may be experiencing. The system needs to become more holistic and less "symptom-oriented". In addition, the mental health system must include services that help individuals to lead productive lives by providing counseling, peer support, respite care, supportive housing, and job training. The members of the Metropolitan Washington Council of Governments' Dual Diagnosis Committee agree with this report.

The dilemma now is to secure resources to overhaul the system so that it can provide this vast array of services. The cost that Medicaid currently covers is inadequate to support agencies and practitioners who provide these services. We are seeing a decrease in the availability of these necessary services due to the costs associated with obtaining new medications and hiring knowledgeable staff coupled

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MEETING THE 2010 HEALTH TARGET LEVELS

By Edward Hendrickson

Healthy People 2010 includes 14 health indicators that are related to substance abuse and mental health. According to the COG report, *Community Health Indicators for the Washington Metropolitan Region* [1], of the 14 indicators, the COG region has so far met the target in only one area – adult binge drinking. The COG report, which parallels the federal report *Healthy People 2010*, presented data on 29 health indicators for the nine counties included in this region. Six of the 29 indicators directly measured substance abuse and/or mental health symptoms, and nine other indicators measured health problems that are correlates to substance abuse and mental health disorders. *Healthy People 2010* is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats – the prevention agenda for the nation.

The substance abuse and mental health measures used in this study were adult binge drinking, drug-induced death rates, adult smoking and lung cancer death rates, suicide rates and percentage of adults reporting (8 or more days of) "not good" mental health during the last month. Fortunately for the Washington Metropolitan area, five of the six substance abuse and mental health indicators and four of the ten health-related indicators, had lower rates than the national average. One additional indicator, mental health level. The target measure for reduction of lung cancer appears reachable with minimum additional planning, because there are established interventions already funded through federal and state tobacco cessation programs.

Unfortunately, reaching the 2010 target levels for many of the other indicators would require significant financial and programmatic activities to achieve incident reductions of 33% to over 300%. Obviously, these reduction rates would require enormous amounts of planned interventions.

The health indicator measures that have direct links with substance abuse and mental health problems were the incidence of AIDS, gonorrhea, tuberculosis, low-birth weight and infant mortality, and death rates from coronary heart disease, diabetes, motor vehicles and firearms. Death rates from coronary heart disease, diabetes, and motor vehicles were below the national average, whereas only the death rate from coronary heart disease met the 2010 level. Of those health indicators remaining, only motor vehicle death rates appear reachable with minimum intervention requiring an 8% reduction. However, during the last year, the number of deaths resulting from alcohol-related automobile accidents increased significantly in the Northern Virginia portion of this region and many other issues complicate what appear to be attainable goals. Overall, in order to meet the 2010 target levels for all of the other health indicators, it would require reductions in rates ranging from 40% to 3,600%. Individuals with co-occurring substance abuse and mental health problems are not specifically identified in this study; however, some assumptions about their general health can be made. The National Institute of Mental Health's Epidemiologic Catchment Area Study [2] reported in 1990 that about 6% of the general population had a lifetime prevalence of co-occurring substance abuse and mental health disorders. In 1996, the National Comorbidity Study [3] noted an increasingly higher prevalence of mental health and substance abuse and higher rates of co-occurrence disorders. Therefore, a conservative estimate would be that more than 200,000 persons living in this region experience co-occurring substance abuse and mental illness sometime in their life.

We know that individuals with co-occurring disorders who do not receive integrated treatment have a greater risk of being unemployed, experiencing homelessness, and receiving inadequate health care. Lack of treatment combined with behavioral risk-taking from substance use and mental health disorders place these persons at a greater risk for having a multitude of health-related problems.

It is predicted that individuals in the Washington Metropolitan region with co-occurring disorders have higher incidence rates for many of the previously noted health indicators. Should we have any chance of meeting the national mental health goals set for 2010, it will be necessary to insure

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initial intervention when treating adolescent substance abusers.

By definition, the adolescent is living through a stage of life where biopsychosocial needs, cognitive skills, and emotional intelligence are in maturational development. Psychologically, drug use retards the development of complex coping mechanisms necessary to deal with the frustration, pain, and grief of adolescence. Typically, the adolescent drug abuser creates a distorted perception about the source of these discomforts and often blames others. These emotional challenges are not "worked through", and a feeling of intense anger may manifest itself through a variety of maladaptive behaviors. As such, when an adolescent chooses chemical dependency, it becomes near impossible to develop the necessary honesty and insight that are essential for self-appraisal. In fact, an adolescent's drug consumption often becomes a psychological barrier and interferes with diagnostic assessment and treatment planning. Notwithstanding, it is imperative to remember that chemical use by the adolescent is a primary presenting problem and not a symptom of another condition. In most cases, the substance abuse adolescent and his family are brought into the treatment milieu because drug consumption causes situational problems and an impairment of functions.

Until the adolescent is able to achieve a sustained period of sobriety, he will not be able to fully engage in a therapeutic relationship and counseling interventions. Treating the drug abuse first does not mean that all of the adolescent problems stem from their chemical dependency, nor does this imply that there are no primary developmental problems. However, the adolescent, his family, and the treatment provider are better able to achieve success when the drug addiction is strategically managed.

It is recommended that the successful treatment of the dually diagnosed adolescent and his family require a hybrid-trained counselor skilled in both addictions and mental health techniques. Empowered with this knowledge, a counselor is able to effectively convey a professional competence and concern to the wary and frightened client and family. By emphasizing the fact that the first step towards recovery lies in the attainment of abstinence, the counselor will more likely succeed in this complex and challenging task.

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with the financial problems that states and local jurisdictions are experiencing. There are waiting lists to obtain any number of services that, at times, are over a year long. When individuals can no longer wait for these services, they end up in shelters, hospitals, jails, or even morgues.

Moreover, we are experiencing a lack of qualified mental health professionals to meet the large demand for these essential services. The reasons as follows:

- Public and private agencies are unable to offer competitive salaries to attract and retain qualified individuals;
- Insurance companies are not paying adequately so that private providers can maintain their practices;
- When providers apply to participate on provider panels, they are rejected due to filled quotas of providers instituted by the insurance companies;
- Insurance companies are requiring voluminous plans of care which cause providers to spend hours writing (for which they are not being compensated) instead of providing treatment to patients; and
- Insurance reimbursement rates have not changed in many years even though treatment costs have risen dramatically.

In the 1960's, there was a commitment to community mental health. The resources were established to see that people could obtain the services they needed. Over the years, various forces have eroded that commitment. There have been great strides in this field, however there has not been the same commitment to ensuring that people who need treatment are able to access and utilize it. Today, we need to recommit ourselves to seeing that mental health and substance abuse treatment remain viable along the whole continuum of care.

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that adequate integrated co-occurring treatment services is available throughout all jurisdictions in this region.

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