

CHAPTER VII

CO-OCCURRING DISORDERS

“If we had no winter, the spring would not be so pleasant; if we did not sometimes taste of adversity, prosperity would not be so welcome.”

— ANNE BRADSTREET

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FOUR QUADRANT MODEL

“The four quadrant model is a viable mechanism for categorizing individuals with co-occurring disorders for purpose of service planning and system responsibility.” Christie A. Cline, M.D.

This paradigm identifies sub-groups with coexisting disorders.

Less severe mental disorder Less severe substance abuse disorder QUADRANT I	Less severe mental disorder More severe substance abuse disorder QUADRANT III
More severe mental disorder Less severe substance abuse disorder QUADRANT II	More severe mental disorder More severe substance abuse disorder QUADRANT IV

The population of youth with both a high mental health and high substance dependence in Quadrant IV is at high risk and is the target population for the Transition Age Youth (TAY) Resource Guide. This is the quadrant that requires cross-training between mental health and alcohol and drug program practitioners, as well as the support of family members and other individuals in the TAY’s social network in order to provide integrated treatment.

When working with transition age youth, it is important to recognize that the systems of care within a county are often fragmented and driven by funding, rather than the actual needs of the youth. Services to transition age youth are exceedingly difficult to provide effectively due to perceived adult status of the youth and high degree of mobility and independence of youth.

“Treatment success derives from the implementation of an empathic, hopeful, continuous treatment relationship, which provides integrated treatment and coordination of care through the course of multiple treatment episodes.”

“When substance disorder and psychiatric disorders co-exist, each disorder should be considered primary, and integrated dual primary treatment is recommended, where each disorder receives appropriately intensive diagnosis-specific treatment.”

—Christie A. Cline M.D.

PREVALENCE

The United States Household Survey on Drug Abuse for 2002 indicates that among all persons aged 18 through 25 years of age who responded to the survey, 13.2% had a Serious Mental Illness (SMI). By gender, 16.3% of the populations within the TAY age group were males and 10% were females who experienced SMI. In that same age range, 21.7% experienced an alcohol or other drug dependence or abuse disorder.

The Substance Abuse and Mental Health Services Administration Report to Congress on Co-occurring Disorders provided explanations for high prevalence rates of substance abuse disorders among individuals with mental disorders, but the etiology is not yet clear. Dr. Marc Schuckit (NASMHPD/NASADAD, 1999) outlined three ways in which substance abuse disorders and mental disorders may relate to one another:

- The disorders may occur independent of each other;
- The mental disorder may place an individual at greater risk for substance abuse disorders (e.g., schizophrenia and anti-social personality disorder); and
- Drug abuse intoxication or withdrawal may result in temporary mental disorder syndromes.

Mueser et al. (1998) reviewed two decades of etiological theories related to co-occurring substance abuse disorders and mental disorders. Based on that analysis, they offered four general models that synthesize current thinking in the field regarding the etiology of co-occurring substance abuse disorders and mental disorders (Anthony, 1991; Kosten and Ziedonis, 1997; Kushner and Mueser, 1993; Lehman et al., 1989; Meyer, 1986; Weiss and Collins, 1992):

- ***Common factor models*** — High rates of co-morbidity are the result of risk factors shared across both severe mental illness and substance abuse disorders.
- ***Secondary substance abuse disorder models*** — Severe mental illness increases a person's chances of developing a substance abuse disorder.
- ***Secondary mental/psychiatric disorder model*** — Substance abuse precipitates severe mental illness in people who would not otherwise develop a severe mental illness.
- ***Bi-directional models*** — Either severe mental illness or substance abuse disorders can increase a person's vulnerability to developing the other disorder.

TRANSITION AGE YOUTH (TAY)

It is accepted knowledge that all youth, who have the developmental task of leaving home as a goal, will have to meet significant challenges in their individuation. This task of “leaving home” can be difficult to address when the youth suffers from a mental illness and a substance related disorder. Even youth who are blessed with good health and who are free of disabilities can find this transition bewildering. However, youth who have co-occurring psychiatric and substance-related disorders can encounter major barriers to continued emotional and physical health because

of inadequate communication and coordination of services. TAY youth who lack housing, transportation, and other supports are especially at risk of not reaching this developmental task. Youth who have a co-occurring disorder and are also involved in the child welfare system are triply-challenged by the additional task of negotiating emancipation and achieving independence with limited supports.

Youth with co-occurring disorders are going to need resources to overcome each of their disorders. Some resource-building treatment strategies include:

- There should be no wrong door as an entryway to treatment. Whatever agency the youth uses to request help must ensure that the youth has access to services from partner agencies. These services may include mental health and substance-related treatment as well as housing, training, rehabilitation resources, and therapeutic courts. This is critical because when the youth needs help, it must happen in the moment or the opportunity may be lost. With the youth's permission, there should be collaboration and coordination of the youth's treatment plan. Substance abuse programs, from the continuum of abstinence to harm reduction, recognize that recovery is incremental and the road to recovery has its ups and downs. Providers should strive to reduce barriers to the provision of appropriate, coordinated, and integrated services for TAY youth, which include different funding streams, philosophical differences, lack of cooperation and collaboration, and the lack of cross training.
- Once the youth acknowledges the substance use problem, and agrees to receive support, all significant social supports of the TAY youth should be involved in the treatment planning process including the youth, his or her family, school, social services or probation, mental health, and Alcohol and Other Drug (AOD) providers as well as other members of the youth's support network. Providers must acknowledge that the youth is the holder of the privilege, and thus he or she must agree to how the treatment is organized. In the event the youth does not acknowledge the need for services, all providers and members of the support system should continue to encourage the individual until engagement and maintenance in treatment occurs.
- Youth who are homeless or otherwise without stable living conditions will find it difficult to embrace recovery from substance use. Therefore, ensuring that basic needs are met is a critical step in providing care to these youth. This is especially true for TAY with a background in the foster care system whose priorities may be focused on obtaining the basic necessities of living.
- Because of TAY's age-appropriate need for independence, providers should work to balance client-driven treatment planning with a solid supportive structure to prevent the individual from becoming "lost" in the process of recovery.
- Foster youth are most vulnerable to treatment failure because they may not have the financial and emotional resources to support them in recovery. The youth who suffered trauma from growing up in a domestically violent or an abusive or negligent home is especially vulnerable. If appropriate, family support services can strengthen the youth and the entire family system. By building on the strengths of the youth, his or her family, and his or her support system, counselors can draw on the resources that each participating party brings to the intervention. Using a strength-based approach, the treatment team can develop and implement a realistic, attainable plan for recovery that improves the functioning of each participant.

TREATMENT STRATEGIES

- Place a strong emphasis on family involvement. Youth need to feel secure and feel the support of his or her immediate family members and broader social network. No matter what the circumstances of the relationships within the family are, the youth and the family should be engaged in securing solutions to a better relationship. For a variety of reasons, some youth have disengaged from their families and/or support groups and will not have functioning social networks. In these situations, efforts should be made to help the youth build natural supports as part of the treatment process.
- Develop an individualistic case plan. Each client has unique circumstances with individualized sets of goals and objectives. A “cookie cutter” or “one size fits all” approach will not be effective. As Dr. Pablo Stewart has noted, there are instances where the substance use is a manner of self-medicating for long standing untreated mental illnesses. It is for this reason that MH and AOD staff need to work closely together and use a universal chart where entries from both Departments are available to the other and to additional participants of the treatment team.
- Explore the strengths of the youth. Recovery based goals will be founded upon the youth’s vision of his or her future. The treatment planning team will need to focus the discussion in a hopeful and supportive manner.
- Providers need to consider that what is happening for the youth may in fact be a “system issue,” meaning that the youth may be acting out symptoms for other family members or for a significant other. By including the whole family group and/or the significant other, there is a greater likelihood that a true solution will be found. A youth’s crisis is an opportunity for the family constellation to enhance communication and improve functioning for the future.
- Woman and girls with co-occurring disorders often come from a background of family violence, and the sequelae of trauma endured may be what is driving the mental illness or substance involvement.

The special needs of girls are described by the National Mental Health Association:

“The forces that pre-dispose adolescent girls towards delinquency are believed to be different than those that pre-dispose adolescent boys. In fact, some studies show that mild to moderate depression in girls may put them at greater risk for antisocial behavior and delinquency. Women and girls with co-occurring disorders also have substantially different treatment needs than men and boys. Females with co-occurring disorders may engage in high-risk sexual behavior, have more complicated health conditions, and have histories of exposure to physical and sexual violence. In fact, there is growing evidence that women with co-occurring disorders are more likely to have experienced childhood physical and sexual abuse than severely mentally ill women without substance use problems.”

- There are distinct differences in the prevalence of co-occurring disorders related to gender, socioeconomic status, and ethnicity that require specific attention. With the influx of many immigrant families into California, the therapeutic team must be cognizant of the role of immigration, of women in their countries of origin, and the potential isolation of men and/or women here due to lack of language facility, potential acculturation opportunities and difficulties, socioeconomic status, and expectations of both parents and children as they transition from one culture to another. In addition to cross training, cultural competency is a critical subject to providers who render services to those individuals with co-occurring mental and substance-related disorders.

APPENDIX

1. Action for Mental Health and Substance-Related Disorders: Improving Services for Individuals at Risk of, or with, Co-Occurring Substance Related and Mental Health Disorders. SAMHSA (1998)
2. Cross-Training for Dual Disorders: A Comprehensive Guide to Co-Occurring Substance Use and Psychiatric Disorders. Burton, Donna L. (2001)
3. Dual Diagnosis: Counseling the Mentally Ill Substance Abuser. Katie Evans, and J. Michael Sullivan (c2001)
4. Dual Diagnosis: An Integrated Approach to Treatment. Watkins, Ted R. (c2001)
5. Dual Diagnosis of Major Mental Illness and Substance Disorder. Edited by Kenneth Minkoff and Robert E. Drake (1991)
6. Dual Diagnosis, Substance Misuse and Psychiatric Disorders: An Inter-professional Approach. Edited by G. Haussein Rassool (2001)
7. Dual Disorders: Essentials for Assessment and Treatment. David F. O'Connell (1998)
8. Improving Treatment Compliance: Counseling and Systems Strategies for Substance Abuse and Dual Disorders. Dennis C. Daley and Allan Zuckoff (c1999)
9. Integrated Treatment for Dual Disorders: A Guide to Effective Practice. Kim T. Mueser (2003)
10. Managing the Dually Diagnosed Patient: Current Issues and Clinical Approaches. Edited by David F. O'Connell and Eileen P. Beyer (c2002)
11. Mental Health Assessment and Diagnosis of Substance Abusers. NIDA (1994)
12. Strategies for Developing Treatment Programs: For People With Co-Occurring Substance Abuse and Mental Disorders. SAMHSA (2003)