Mixing Substance Abuse and Mental Health Disorders

By Rich Bayer, Ph.D.

In the spring of 2002, Jenny found herself in the hospital. She had just attempted suicide. For a few months prior to her hospitalization, she had felt deeply depressed and had been drinking excessively.

She was in need of treatment.

From the hospital, she was referred to a local counseling agency for outpatient psychotherapy. When she started at the agency, she was diagnosed with bipolar disorder (manic-depression) and alcohol dependence. She had what is called "co-occurring disorders," a mental health disorder combined with a substance use disorder.
Jenny worked hard to improve. She kept frequent appointments for individual therapy and soon also began attending a day program designed specifically to help clients with co-occurring disorders.

Within a couple months, she started doing better. Her depression began to lift. In addition, she gained some control over her addiction as she began staying sober for longer and longer periods of time.

Jenny felt that the therapy and day programming turned things around for her. She came to understand how her mental health symptoms interacted with her substance abuse. She identified an emotional cycle common to most people with co-occurring disorders. When her mental health symptoms increased so did her desire to drink. But if she drank, her mental health symptoms became more uncontrollable. She improved emotionally by learning some non-drinking ways to reduce her stress and minimize her mood swings.

Overall, she has been consistent with treatment and made slow but steady progress. At this point she has been sober since December 2002 and she manages her moods more effectively than ever. She continues with psychotherapy and attends a local support group. She also attends Cecil Community College where she's studying to become a counselor.

This case history was provided by Becky Raughley, LCSW-C, CCDC, a Cecil County expert in co-occuring disorders. "Jenny experienced a positive, successful outcome," Raughley says, "an outcome that was enhanced by the type of treatment she received. It has been shown in study after study that clients with co-occurring disorders fare better in programs which provide integrated treatments for both the mental health and the substance abuse disorders."

Raughley has been specifically trained in treating clients with co-occurring disorders. She is a licensed clinical social worker and a certified chemical dependency counselor who has worked in this field for more than a dozen years. Recently she has been appointed the Coordinator of Co-Occurring Services at Upper Bay Counseling and Support Services, Inc.

Facts about Co-Occurring Disorders
As just mentioned, people with co-occurring disorders have a mental health diagnosis as well as a substance use diagnosis. Previously this problem was known as "dual diagnosis."

Raughley reports that some of the typical mental health conditions common in co-occurring disorders include depression, bipolar disorder, schizophrenia, and anxiety disorders including post-traumatic stress disorder (PTSD). The substance use disorders include “substance abuse” or “substance dependence,” depending on the severity, and usually identify the substance or substances the person is addicted to.

It’s also interesting to note how common the co-occurring disorders really are. This has been studied extensively and the results are consistent. Among people who have a mental health diagnosis, 50% also have a substance use disorder. Among those who have a substance use disorder, 30% have a co-occurring mental health diagnosis.

A Better Treatment Model

For years, researchers such as Kenneth Minkoff, M.D., of Harvard Medical School, and Fred Osher, M.D., of University of Maryland, have studied individuals with co-occurring disorders and they have come to the same conclusions. People with co-occurring disorders are best treated in clinical settings that provide therapy for both disorders.

They call it “integrated treatment.”

They learned what works partly by observing what doesn’t work. Traditionally, substance abuse clinics are separate from mental health clinics. They each hire different types of professionals and offer different types of treatment.

But in a system like this, what happens to clients with co-occurring disorders? Typically, they bounce back and forth from one treatment setting to the other and get only partial help in each setting. Even worse, they often hear treatment recommendations at one that are at odds with what they hear at the other.

For example, according to Raughley, substance abuse clinics typically under-diagnose mental health disorders. Also they may be quick to call a client “in denial” who is temporarily struggling with mental health symptoms.

On the other hand, therapists at mental health clinics have been seen as “too soft” on substance abuse, as not holding their clients accountable enough. In addition, in the mental health setting, clients have traditionally found it easier to misrepresent the extent of their substance use.

These are just a few reasons why it makes sense to treat clients with co-occurring disorders in a single, integrated setting. It ensures that clients will be properly diagnosed, that they won’t get mixed messages, and that they’ll be able to establish a therapeutic relationship with a professional who has been cross-trained in treating addictive and mental health disorders.

There’s one other reason too. Based on outcome measures, integrated treatment works better for clients with co-occurring disorders than does treatment at separate mental health and substance abuse clinics.

I wonder how many people in our community would benefit from a program providing integrated treatment?

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