

UNDERSTANDING THE ADOLESCENT WITH CO-OCCURRING DISORDERS & DEVELOPING BEST PRACTICE MODELS

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OVERVIEW

This presentation focused on co-occurring disorders in adolescents, looking at an overview of the problem and the principles for successful treatment intervention in the context of an integrated model of service delivery that utilizes a common language and philosophy and makes sense from the perspective of both the mental health and the substance system. These concepts are seen as an emerging national best practice design for individualized clinical treatment intervention for individuals and families with co-occurring disorders, as well as a model for designing systems of integrated, comprehensive and continuous systems of care at the state, region wide or system wide level.

NATIONAL STANDARDS

Recently these concepts have been organized into a set of national standards for the treatment of people with co-occurring disorders. Although these standards were developed with more of an adult focus in mind they are applicable also for the treatment of adolescents and their families. The Federal government, through The Managed Care Initiative with the Center for Mental Health Services (“CMHS”) in 1996, brought together experts and through a consensus process developed standards for the treatment of the various populations affected by managed care, being either the use of managed care organizations or through the use of internal managed care systems within agencies or public sector systems. The co-occurring disorder panel was chaired by myself, Kenneth Minkoff, M.D., and included people from both mental health and substance backgrounds, families and consumers from all over the country. The annotated bibliography (1997) and subsequent report, entitled *Individuals with Co-Occurring Psychiatric and Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Work Force Competencies and Training Curricula (1998)*, can be obtained through the CMH Policy and Services Research web site, www.med.upenn.edu/cmhpsr or by phone order: 215-622-2886.

COMPONENTS OF THE CO-OCCURRING MANAGED CARE REPORT

The managed care report is divided into 5 parts. The first part is dedicated to the idea that if we are designing systems of care then they should be oriented to the needs of the consumers and families who are using them. It identifies the key principles of the system of care; welcoming, accessible, integrated, continuous and comprehensive.

The second part of the report is standards for designing systems to meet the needs of consumers and families. These include things like a mission statement, a philosophy, a set of principles and a structure for overseeing the system. It speaks of the need for an array of programs within the system that has standards or competencies for each program. In addition, it says that the system needs to develop other sets of materials for helping the system to establish that kind of welcoming accessible integrated continuous comprehensive model.

The third part of the report is practice guidelines for clinicians to follow that include assessment, treatment, rehabilitation, and psychopharmacology, for clinicians to follow to meet the standards of the system and to meet the needs of the consumers and families.

The fourth part of the report is provider competencies that include attitudes and values as well as knowledge and skills for clinicians to acquire to implement the practice guidelines, to meet the standards of the system, and to meet the needs of the consumers and families.

The fifth part is a training curricula that includes both models for designing competency-based curricula as well as about a half dozen sample curricula that were found around the country to train clinicians.

RELEVANCE OF THE MANAGED CARE REPORT

The report establishes real material for real systems to use even in the event that they had no additional resources for moving forward in the creation of more successful system level interventions. The intent was that this report could be used at any level of system organization. It can be used at a state level, a regional level, a network program level, an individual agency or a program within an agency.

Since the report was issued, a growing number of states and other systems are using this material to facilitate or catalyze system level change initiatives. States such as Pennsylvania, New Mexico, Massachusetts, Arizona, Louisiana, and Illinois to a certain extent are restructuring their services. Aspects of this system change also can be found in Washington, Oregon, New York, Florida, Texas, Michigan, and so on.

TRENDS IN CO-OCCURRING DISORDERS

These changes are being fueled by the emerging consciousness over the last several decades of the problems of co-occurring disorders in both the adult and the adolescent children's families service systems. First, to some extent this relates to pressures for deinstitutionalization. Even among younger children there is less likelihood that people will be maintained in sustained institutional environments.

Second, people are more likely to be retained in community based settings in which individuals have more access to and for people with emotional disturbances, a high likelihood of using, abusing and frequently becoming dependant on psycho-active substances. People have access increasingly to substance use at earlier ages and greater varieties and combinations and use of substances that is more psycho-pathologically dangerous in its ability to either initiate or exacerbate psychiatric symptoms and syndromes.

Third, another trend that is contributing to the awareness of dual diagnosis is a change in our understanding of the nature of psychiatric illness in general. During the past decade, the decade of the brain, there has been an explosion of research. A wide range of biologically based brain disorders, not just the most serious mental illnesses but an assortment of affective anxiety and trauma related cognitive impairment, have been identified. Behavioral disorders that we used to term personality disorders are all being recognized as having varying degrees of biologic impairment with them. Consequently there is also a wider array of psychopharmacologic agents to treat these disorders.

There is an increased awareness that these disorders are very common in the general population and 2 to 3 times more common in populations of adolescents with substance use disorders. People's symptoms and syndromes that once were attributed only to substance use disorders are now increasingly more likely to be recognized as representing distinct psychiatric disorders that require distinct treatment.

CHARACTERISTICS OF POPULATION

The population of people with co-occurring disorders, both adolescents and adults, present with many difficulties. One of the ways in which they are difficult is that they do worse. People with more than one problem do worse than people do with only one problem. We know that from the perspective of either system, people with co-occurring disorders are more likely to relapse and be rehospitalized, be treatment resistant, be treatment non-compliant and be medically involved. There is a higher risk for sexually transmitted disease among substance using and dually diagnosed populations. They also can be criminally involved. Among mentally ill offenders in the adult population, recent state studies indicate a prevalence of co-occurring substance use disorders in the 90% range. Most states will find a high prevalence of adolescent substance users among the adolescent offender population, usually 80% or more, of which at least half will be identified as having some kind of co-occurring psychiatric disorder.

In addition, there is a high prevalence of co-occurring psychiatric and substance disorders in the homeless population. This may not only include individuals who have co-occurring disorders but, when we are dealing with children and adolescents, it increasingly includes families who are dually diagnosed in which different members of the family have different disorders. All of this contributes to poor outcome including housing instability, vocational instability, educational performance problems, involvement with social service protective service systems around abuse and neglect issues and the like.

In addition, people with co-occurring disorders, adolescents and adults, are more likely to engage in violent and self-destructive behavior. Recurrent studies indicate that among emotionally disturbed individuals the presence of substance use disorders may be the most powerful predictor of either self destructive or violent behavior.

Moreover, individuals with co-occurring disorders tend to have poor outcomes from the perspective of a scarce resource service system. They are often over represented among the highest system utilizers, utilizing acute expensive resources in both mental health and substance settings. They may be experienced as system misfits. They are misfits at every level of the service system. These are individuals or families who are suffering from more than one disorder in systems of care that are designed for one disorder at a time. The programs within those systems tend to be similarly designed so that those of us working with real families and real systems are constantly experiencing a need to either contort our patients to fit our programs or contort our programs to fit our patients. These individuals also tend to be misfits at the level of our own skills as clinicians, since most of us are trained to be either mental health clinicians or substance clinicians but not both.

In addition, these individuals tend to be difficult in other ways as well because of how we encounter them in the service system. Some of the difficulties may come directly from the adolescents, while some of them are experienced more because the adolescents are embedded in families with multiple problems with often multiple locations, all of whom are difficult and in conflict with one another. These are individuals and families who present frequently in crisis and states of disarray. Adolescents are showing up often with impulses to harm themselves or others. They may be demanding instant relief. They are often using multiple categories of substances and multiple categories of psychotropic medication, all of which they are using in interesting and creative ways and about which they are also not terribly forthcoming.

As a result these people or families are difficult because they tend to stir up feelings in us. The feelings include feelings of helplessness, hopelessness, and despair as well as frustration, irritation, and rage. They often acquire the special labels we reserve for people who make us feel that way, “antisocial, manipulative, borderline, med-seeking, and sociopaths.” It becomes very difficult to engage in these very difficult situations in a positive manner.

MODELS OF EVIDENCE-BASED TREATMENT

There are certain principles of care based on the variety of best practice models that have emerged. Most of the research is more adult specific but those models that do work specifically with families also incorporates certain common principles into their design. There are research models that arise from both mental health related research working with individuals with serious mental illness or emotional disturbances with high prevalence of substance disorders who are disengaged from treatment and from addiction research that identifies complex addiction populations of public health interest such as pregnant and parenting women, homeless families with co-occurring disorders, IV drug users, people with HIV infections and the like. These models incorporate certain common themes.

INTEGRATED INTENSIVE CASE MANAGEMENT

One of the most commonly looked at models is the concept of the integrated intensive care management team model. This has been most commonly studied in adults with serious mental illness in New Hampshire through the continuous treatment team approach. It involves creating a team of clinicians with multiple areas of expertise with access to psychopharmacology that offers direct clinical care and work with individuals and their families incrementally over an extended period of time.

MODIFIED THERAPEUTIC COMMUNITY

Other models incorporate what has been called the modified therapeutic community approach. This model starts with an addiction residential environment and integrates modifications to take into account people's psychiatric impairments. More flexibility is built in to accommodate people who have more symptomatology or functional impairment in terms of level of expectation. Continuity is built in to follow people as they move from residential settings into less intensive settings where they have more exposure to substance use. Continuity of relationship is maintained while allowing flexibility to allow for people to have the possibility of slips or lapses with treatment consequences without being fully excluded or extruded from the treatment relationship. Using evidence-based models as a starting point, the consensus panel attempted to identify generalizable principles of successful treatment interventions in wider populations.

PRINCIPLES OF CARE

Empathic Hopeful Continuous Treatment Relationship Over Multiple Treatment Episodes

All these models are similar to the work that has been done with complex addiction populations and they all have certain common treatment principles. For any kind of intervention the most significant predictor of treatment success initially is an empathic hopeful continuous treatment relationship in which integrated treatment and coordination of care are provided over the course of multiple treatment episodes. As adolescents and families bounce from acute episode to acute episode and from service system to service system they need someone to engage with them over time.

Outreach

Integration or the ability to provide mental health and substance treatment together in the same place at the same time alone is not enough. It is necessary but not sufficient. One of the key elements that research points to is the capacity to perform proactive outreach, both physical outreach and empathic outreach. The capacity to form a relationship with an individual adolescent or the system in which that person is embedded, regardless of the fact that neither the adolescent nor the members of the system may be aspiring to what would be called traditional treatment readiness or goals. It is the capacity to do empathic outreach and make a connection with people who are unmotivated or only intermittently motivated has been a significant predictor of the ability of these programs to work and be successful.

Continuity

The next aspect has to do with continuity, the ability to maintain or sustain a relationship over time unconditionally, even though people are not necessarily doing what is expected of them in the course of this ongoing connection. The relationship itself is the vehicle in which continuous treatment occurs and in which there is a process of continuous learning and growth. This may mean that different individuals or different members of the system may be engaged in interventions that are more mental health or more substance specific at any point in time. The key element is that there is a primary treatment connection in which all the diverse inputs are integrated into a person's centered coherent whole and that this relationship is maintained across

multiple treatment episodes. Both mental illness and substance disorders are chronic relapsing conditions and at any point in time the individual and/or family may or may not be involved and following treatment recommendations. Part of the recognition of how treatment works is that there is a continuous relationship in which from time to time people have an episode of care and the goal is to link these episodes together in a context of continuous learning.

Establishing the Relationship

The challenge is how to establish empathy, hope and continuity for people and families that we experience as system misfits. One of the ways of approaching this, at least from my point of view, is what I call my empathy mantra. My mantra goes like this. However much it may seem to the contrary, these individuals and families are not engaged in a complex conspiracy to drive me personally crazy. They are in fact doing their job. It is my job to understand their job so that I can join them in it and help them to do it better. This is particularly true for adolescents in whom the job of the individual at the time that we are encountering them is struggling with the very difficult task of identity formation. For an adolescent who has serious emotional disturbances and substance abuse and is a victim of trauma choosing an identity is very difficult. Neither the adolescent nor the families have an easy time signing on to the treatment recommendations that we so easily toss out, nor do they want to participate in the systems of care that we represent. The process of coming to terms with the reality of the changes that need to be made individually and collectively is a terribly arduous task that is normally made through a sequence of approach avoidance maneuvers. People do only a small part of what is recommended while trying to hold onto their sense of autonomy and control even in the face of poor outcomes. Our job is to recognize what a painful task that is so that we can join the adolescent and join the family in the terrible dilemma that confronts them of wanting to be normal and act normal but not being able to, of having to face choices of how to engage with a number of external systems, none of which are terribly pleasant. These are very tough choices.

To the extent that we can join people empathetically over time, present an integrated formulation or conceptual framework for them and help them to make these decisions more effectively over time we will be able to promote better outcomes. This task is the cornerstone of a welcoming approach in a system of care.

TREATMENT MATCHING

One of the next challenges is to recognize that as we are developing these kinds of continuing relationships that people with co-occurring disorders are a complex group. We need to recognize how to match systems and services according to the specific needs of these individuals.

Model for Subtyping Co-Occurring Disorders

One of the models that is emerging is a model for subdividing people with co-occurring disorders according to high and low severity of psychiatric and substance disorders. There are 4 general categories: high substance disorder severity and low serious emotional disturbance, high substance disorder severity and high serious emotional disturbance, low substance disorder severity and low serious emotional disturbance and low substance disorder severity and high serious emotional disturbance.

Individuals with High Serious Emotional Disturbances

The categories with high serious emotional disturbance (“SED”) define a mental health priority population. These are people who are the priority targets of scarce mental health resources. In addition, within the larger category of individuals with SED, there is a significant sub category of the individuals who have the most significant impairments, that is individual adolescents who may have persistent psychoses, who are quite disorganized and dysfunctional who even at their best baseline when they were using no substances and taking all their medicine need fairly high degrees of structured care. For these individuals there are distinct clinical needs as well. They are less able to participate in generic substance services. More of their substance services as do all of their services have to be integrated into the mental health support system that manages their severe impairment. Children with SED who are higher functioning, when they are reasonably stable, may have a better ability and more likelihood to participate in generic substance treatment settings both in the community and various kinds of residential episodic treatment. Within the larger group of people with SED it is important to distinguish abuse and dependence, an issue that is also important with adolescents in general.

Individuals with High Severity of Substance Disorder Severity and Low Severity of Emotional Disturbance

Individuals that have substance dependence or severe substance abuse also can present with significant psychopathology in the context of their substance use. This pathology can relate to suicidal or violent behavior, psychotic symptoms which maybe substance induced, a variety of mood instability - anxiety, panic, depression, personality behavior traits, etceteras. Unlike children with SED who ordinarily meet criteria for serious emotional disturbance whether they are using substances or not, these children once they stop using substances for a period of time in a relatively short period of time, weeks or a month maybe at the most, they no longer appear to meet criteria for serious emotional disturbance. In some of these kids, once their substance use is discontinued, all their psychiatric symptoms appear to clear up. Increasingly we are finding, however, that there is a much larger population that still has psychiatric disorders but not necessarily serious emotional disturbances. They have an assortment of attentional problems, emotional problems, mood disorders and anxiety disorders with trauma histories and the like. These may not meet criteria for SED formally speaking but which nonetheless complicate the treatment of their substance use disorders.

In addition, in multi problem families with dual disorders members they may have a variety of combinations of substance symptoms and psychiatric symptoms without meeting the criteria for serious mental illness. What happens often is that these individuals may fall through the cracks of the treatment system the most because the children with SED become the responsibility of the mental health system. For the children without SED the responsibility for their on going care becomes much more murky. They may wind up in a social service, social welfare setting or criminal justice settings without clear accountability for integrating or coordinating their on going services in systems that are even less prepared to provide that integration than the behavioral health system. This group without SED and with co-occurring substance disorders becomes a population that requires distinct planning in the delivery of co-occurring disorder or dual diagnoses services.

Individuals Low Severity of Emotional Disturbance and Low Severity of Substance Disorders

Another group whose needs have not been met adequately are the low low people including the low low adolescent and the low low families. These folks don't realize that in our system it's very rude to present for behavioral health services without first knowing "which one" you are. People get screened into one or the other "box" based on how they present, often by a receptionist, and then both systems shuffle these individuals back and forth between the systems, with neither taking responsibility for their care.

CHALLENGES TO TREATMENT MATCHING

One of the things that this illustrates is some of the difficult challenges in developing an accessible system. In an accessible system we recognize that it is bizarre to think that people should be able to sort themselves into one box or another at the front door. This is an artifact that the system has established that we all sort of fall into. It is equally bizarre to think we should be able to sort them within a very short period of time. In an accessible system we take it that routinely people will show up with multiple problems. It may take time to sort them out and when they are sorted they will wind up in multiple boxes. The whole idea that the goal of our assessment is to figure out which box they belong in is something that we begin to eliminate. We reduce all of the barriers associated with that arbitrary distinction.

SUBSTANCE ABUSE AND DEPENDENCE

Substance abuse and dependence are in fact different disorders. They are of a greater significance when we are talking about adolescents compared to adults and they are even more significant when we are talking about adolescents who may have psychiatric impairments.

SUBSTANCE ABUSE

Substance abuse, according to DSM III R criteria, which allows for a more continuous diagnostic matrix for adolescents regarding abuse and dependence than DSM IV criteria, is a behavioral disorder characterized by people using substances unwisely and harmfully. Harm may occur in any area of an individual's life including exacerbation of a psychiatric difficulty and other problems. People who have substance abuse disorders have never met criteria for substance

dependence. They are presumed to be doing it more or less on purpose and in control although they are making risky choices. Sometimes when they use substances their behavior gets out of control but their use of substances is more or less in the line of what it is they are choosing to do. The outcome of substance abuse treatment involves one to one and group interventions to help people make better choices, and provide skills to implement those choices. The outcome may be abstinence, but does not need to be. The outcome of abuse treatment may be controlled non-harmful use.

SUBSTANCE DEPENDENCE

Substance dependence is a different thing. Substance dependence is a brain disorder in which, apparently, there are significant brain changes that may be irreversible. These changes certainly appear irreversible in most adults, so that the individual loses the ability to reliably control their substance use even when they want to; even when they try to and even when the harmful consequences of that use are so out of proportion to their own sense of what it is they are willing to tolerate. They are still unable to use in a controlled fashion.

The treatment of substance dependence is more intensive than for abuse. In fact substance dependency treatment tends to focus on the treatment of the disease of addiction, using more of an abstinence-oriented model. The treatment, compared to substance abuse per se, needs to be much more intensive to counteract what the brain is doing through a variety of chemical pathways to sort of talk people into using substances, even when they do not choose to or even when they know that it is harmful. The outcome of substance dependence treatment generally needs to be abstinence because even small amounts of use will trigger further lack of control.

One of the challenges of working with people who have demonstrated patterns of substance dependence is the recognition that, even though consciously they may want to not use substances, their brains are essentially on the other team. Their brains are triggered by an incredible array of internal and external conditioned cues to create chemical events internally in the brain that lead the brain to sort of direct the organism into addictive behavior. The target of that behavior is not the actual use of the substance but that the brain essentially has become addicted to itself in the sense of wanting to create internally its own internal states of euphoria or

euphoric relief that are chemically mediated. This becomes the primary focus of the organism progressively over time.

For people with healthy adult brains, by time they get into trouble enough with substances to wind up in the substance treatment systems they are often over the line into dependence or pretty close to it. The more that people have other than healthy adult brains, whether they are adolescents or they have neurological impairments, developmental disabilities, or psychiatric impairments, the lower the threshold of substance use that will be problematic and potentially harmful and the pattern of substance use that is abuse drops dramatically. With adolescents who have co-occurring psychiatric difficulties, their vulnerability to the harmful effects of the use of substances is lower than that of their peers.

PREVALENCE OF CO-MORBIDITY

There have been a variety of epidemiological studies over the past couple of decades looking at the prevalence of co-morbidity, primarily in adults. The indication is that whatever we know about adults, the prevalence of co-morbidity in adolescents is higher. In adults with serious mental illnesses the prevalence of co-morbid substance use disorders in household surveys, lifetime for adults in treatment for schizophrenia is 55% and for bipolar disorder 62%. For adults with alcohol dependence 39% have any kind of co-occurring psychiatric disorder; 56% of those with drug dependence have any co-occurring psychiatric disorder. These are higher with adolescents and they are higher the more that people are acute phases, in crisis, in trouble or entering into the service system. If we look at people who are actually admitted into psychiatric facilities for example, 60 to 80% may have a co-occurring psychiatric substance disorder that is active. For adolescents in treatment in addiction residential facilities the prevalence of co-occurring psychiatric disorder is similarly around 60%.

EXPECTATION NOT AN EXCEPTION

Dual diagnosis therefore is an expectation not an exception. The thing that is amazing about this principle is not so much that we don't know that it is true from our own clinical experience but that our entire system of care has been designed as if it is not true. In a system of care with scarce resources we have continued to organize all of our services in single disorder

service systems, guaranteeing that people with co-occurring disorders have the poorest outcomes at the highest cost. All the while, we keep wishing for new pots of money to develop specialized services for these “weirdoes” when, in fact, they are not “weird”, but “expectable.”

INTEGRATED SERVICE SYSTEMS

The problem is that there is never going to be enough money and that there needs to be another approach. If dual diagnosis is an expectation, then we need to plan the entire system according to that principle. We have to look at every aspect of the resources that we have across the systems and build the use of those resources based on the idea that dual diagnosis is an expectation. It takes an integrated system planning effort. It does not mean that we combine all the substance and mental health services funding together into one blended pot. In fact in many ways it is important that we maintain distinct substance specific treatment and mental health specific treatment. But it does mean we plan all of the ways in which that money is spent to deal with this issue wherever it goes in an integrated system planning effort with structures to oversee that planning.

In addition we recognize that integration of services has to occur at every level of the system organization. In other words, and research is increasingly starting to support this, if we look at best practice models of treatment they generally are individual demonstration projects funded to provide integrated services to individuals and families who otherwise would be disengaged from treatment. What the research is starting to discover is not only that integration has to be supported by proactive outreach and continuity but that isolated demonstration projects do not do the job as effectively unless they are supported within a total system context. Integration has to occur at the client level, program level, network level and system level.

PROGRAM LEVEL INTEGRATION

At the program level, what this implies is that all programs have to be dual diagnosis programs. It does not mean that they all have to be dramatically other than what they are so much that each program has to meet standards for competency in treating the people with co-occurring disorders that are already there. For example, there are in most states no regulations around standards for the treatment of co-occurring disorders for psychiatric inpatient units

despite the fact that in such units 50-80% of the people may have co-occurring substance use disorders in which the cost of services are the most expensive and most highly regulated. There are no standards for assessment, diagnosis, staff competency, treatment programming, treatment planning and discharge planning for the people who represent a substantial majority of the individual clients in that program. This is just one of many examples of where these basic standards and competencies need to be built into the expectation of all programs.

CLINICAN LEVEL INTEGRATION

The same thing applies at the clinician level. If dual diagnosis is an expectation then dual competency among clinicians needs to be an expectation as well. Even though substance use disorders are the single most common category of psychiatric illness, mental health professional programs routinely may not provide basic substance abuse training nor do substance abuse programs routinely provide basic mental health competency. There are specialized postgraduate programs but the question is why isn't it built into the pre-graduate programs. Basic competency needs to be built into routine expectations associated with licensure and certification and associated with people's basic job competencies in all behavioral settings.

OVERCOMING MYTHS

Genetic Predetermination

In order to achieve integrated care at the system, program and clinician competency level, we have to overcome some myths. One of the myths is what I call the myth of genetic predetermination. This states that people are genetically predetermined to be either mental health clinicians or substance clinicians and once they become one they can never ever become the other. This has been conclusively disproved; people who have acquired one set of skills to talk to people with one disorder can actually use similar skills to talk with people with different disorders.

Training

Another myth has to do with the myth of training. The training myth that is perpetrated by clinicians on their managers is as follows, "If you want me to work with those duals, I will do it but you have to train me first. Here is the thing about training, first of all, if I am not trained

first, I might make mistakes and that would be nasty. Secondly, I don't train easily. It takes lots of training before I feel trained." The truth is that none of us has ever been trained to do any of the things we do before we did them. The way to move people toward competencies is to create the expectation that this needs to be there. Give people some basics to get started and then provide supervision on the job so that people learn. Create a context in which it is okay to make mistakes and help people to become gradually better over time. This is part of a comprehensive approach to system change.

Irreconcilable Treatment Philosophies

Another thing that we have to do is move past the idea that there are inconsistent treatment philosophies between the two service systems that cannot be reconciled. These barriers have to do with the way in which treatment and treaters are validated within each field. The mental health system builds its relationships based on case management and care taking, with individualized nurturing wrap around support and flexibility. "We own our clients and we own them indefinitely, and we try to fix their problems proactively, whether they want them fixed or not."

The addiction system creates relationships based on empathic detachment. A connection is made with empathy but there is no assumption of responsibility for trying to fix everything that ails them. The philosophy is that people need to be confronted with the negative consequences of their own poor choices as a rationale for making different decisions bearing some pain and in doing so work toward getting better. Also, the addiction treatment tends to occur in episodes. People receive an episodic intervention, return to their naturally occurring support system and are expected to use those skills to go forward. Of course, one of the dilemmas with adolescent treatment in particular, is that residential treatment puts them in an artificial environment and when they leave they may return to support systems that are not terribly supportive or sober.

Each system tends to look askance at what the other system does. The addiction people look at the mental health people and think they are just controlling and enabling because they are trying to do all this stuff for people and people are not doing anything at all. The mental health

people think the addiction people are cold and cruel because they are talking about people hitting bottom when the people may be on the streets engaging in self-destructive behavior, and they do not realize how “wonderful” it is that they have hit bottom. We have to figure out how to bring this together.

In addition, each system wants its own disease to be primary either for billing purposes or for clinical approach. The philosophy is that if the primary disease is taken care of first that will take care of everything else. This is a challenge because all of our schemes for figuring out which is primary, in adolescents in particular, never seem to work. In addition the adolescent does not want either disease, let alone both, so adolescents may try to throw us off the mark, whether through using “shifting denial”, or by using our own denial of the comorbidity against us.

Shifting denial means whatever disease you want to talk about; I have the other one using the clinician’s own denial to avoid addressing the issue. Shifting denial involves the assumption that the mental illness is causing the substance use or the substance use is causing the mental illness, and just forgetting the clinician’s “more familiar” disorder will solve both problems.

PRINCIPLES OF SUCCESSFUL TREATMENT

How do we bring this together? We have to adopt the principle of mutual validation. Each system has something valid to contribute. If we are not familiar with how it works and why it works this is something that we need to learn. Mental health clinicians have to learn why addiction interventions are valid. Conversely, addiction clinicians need to learn that there really are such things as mental illnesses and people with substance disorders get them, too, and require similar treatments to stabilize their mental illness including medication as people without substance disorders do. We can bring this mutual validation together through adoption of the following principles.

Principles

- Co-morbidity is an expectation not an exception. At the clinical level this needs to be incorporated into a welcoming manner into all clinical contact.

- Treatment success derives from the implementation of an empathic, hopeful, continuous treatment relationships, in which integrated treatment and coordination of care takes place over multiple treatment episodes. Treatment needs to start with maintaining continuity. Data from integrated care management models for individuals who have high utilization patterns on out patient basis has shown that after a period of 6, 12, 18 months expensive utilization is reduced and harm reduction outcomes have improved. The reduction in expensive utilization precedes the attainment of absolute abstinence.
- In the context of the treatment relationship case management and care and empathic detachment are not mutually exclusive but absolutely complementary. That is for each individual, for each individual adolescent, for each individual family there is a right amount of what we need to do to support the things that they cannot do for themselves and at the same time each individual or system needs to be able to bear appropriately the degree of consequences that allows it to make better decisions and choices about the work that needs to be done to enter into treatment. The philosophical battles can be resolved into individual or family centered strategic discussions about the right place to draw the line for each system or individual at any point in time. The bad news is that there is no rulebook that absolutely tells you how to do this. The balance at each point in time is in accordance with the individual's motivation, capacity for treatment adherence, level of functioning, and extent of disability.
- When mental illness and substance disorders co-exist both disorders are considered primary. Two primary disorders, each of which requires specific and appropriately intensive primary treatment, integrated dual or multiple primary treatment. All disorders need treatment with as much treatment as it would need if it existed separately while also taking into account that the treatment may be more complicated because there is a co-morbid condition. In fact with co-occurring disorders people often need more addiction treatment not less to obtain a similar outcome. They will need more practice, more support, more rehearsal, and more repetition to achieve the same level of skill acquisition because their psychiatric illness will interfere with their skill acquirement.
- Finally to create an integrated model we need to move to a common treatment philosophy across both the mental health and substance system. Mental illnesses and substance dependence or addictions both are chronic biologic mental illnesses, which can be understood using a disease and recovery model. The parallels between addiction and major

mental illness are many. Both persistent disorders have both positive symptoms and deficit symptoms, stabilizing treatment regimes and are associated with denial, depression, despair, shame, guilt, failure, and stigma both on the part of the individual and their families. The process of working through these feelings is the process of recovery.

PHASES OF RECOVERY

Recovery is a hopeful term that comes through the mental health system from the substance system. It implies that even in the face chronic, incurable, unchangeable conditions that are associated with mental illness, dual disorders, trauma, homelessness, impoverishment and the like, there is a process of recovery by which people can emerge as well. People are able to recover or gain a sense of pride, self worth, hope, purpose and meaning.

The recovery process itself occurs in distinct phases. They include phases of acute stabilization, phases of engagement or motivational enhancement, prolonged stabilization, and recovery. What the research has taught us is not only the value of identifying these stages but that the treatment not only has to be divided into phases but it has to be phase specific. If we try to put pre-contemplators, adolescents or otherwise, in action oriented treatment it tends to backfire. The challenge of the work is providing phase specific interventions so that pre-contemplators become contemplators, contemplators become preparers, preparers move to action, and those in action move into maintenance. This model, in fact, not only defines specific interventions, it also defines measurable outcomes.

CONCLUSION

Within this integrated model we not only have a common language for talking about mental illness and substance disorders using the disease and recovery philosophy that can make sense for both mental health treatment and substance treatment, we actually recognize that there is no single set of interventions that is correct. For each individual adolescent and/or family the particular interventions have to be individualized according to subtype, diagnosis, phase of treatment, stage of change, and level of functioning or disability, which will determine the nature of the phase specific intervention that is required. It will determine the amount that we need to do for them versus where they have to take responsibility for themselves and how that relationship

will proceed over time. Within a managed care system, we have the further challenge of assessing level of care within which these interventions may take place. Models for vertical continuity need to be developed so that people can move through different levels of care, from residential to less intensive environments, with a continuous treatment relationship matching phase specific interventions as people's service intensity needs change.

This overall model allows us to do two things. One, it allows us to develop practice guidelines for individualized clinical service matching. The other thing it allows us to do is to design a comprehensive system of care in which each element of total systems supports these phase specific interventions in various ways. Within the context of this we have a design model for a comprehensive continuous system of care that matches the needs of adolescents and their families at each point of contact within the service system using a common language and treatment philosophy.

About the Presenter

Director of Integrated Psychiatric and Addiction Services for Arbour Health System, Kenneth Minkoff, MD, is a board certified psychiatrist with a certificate of additional qualifications in Addiction Psychiatry. He is nationally known for his expertise on co-occurring disorders and integration of mental health and substance disorder services. Dr. Minkoff has authored and edited numerous works on co-occurring disorders and is an experienced psychiatric administrator with considerable expertise in developing public and private managed care systems.

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