Co-occurring Disorders among Clients of Emergency Crisis Services

Heather Moore

The prevention, early detection, assessment, and treatment of substance use disorders (SUD) has become a public health priority, notably, due to the nationwide opioid epidemic and the prevalence of opioid-related deaths across the United States. Drug overdose deaths are now a leading cause of death by injury in the United States. In 2014, more people died from a drug overdose than any other year in recorded history (Centers for Disease Control and Prevention [CDC], 2016). Individuals diagnosed with a mental health disorder are more likely to experience SUD, which pose significant challenges to the mental health system, as it is charged with the complex task to effectively address the simultaneous existence of SUD in conjunction with mental illness (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016).

Co-occurring disorders, also known as dual diagnoses, are defined as "the coexistence of both a mental health and substance use disorder" (SAMHSA, 2016). It is common for individuals diagnosed with co-occurring disorders to enter the mental health system through the medium of emergency crisis services, often after myriad admissions to detox and treatment programs, focusing solely on issues and symptoms related to substance use, have failed (Loneck, Banks, Way, & Bonaparte, 2002). By the time individuals self-present, or are referred to emergency crisis services for a risk assessment, they are often hopeless, suicidal, and in desperate need of help to quell emotional pain, unsure of what resources, if any, are available, and how to address both dimensions of their illness.

PREVALENCE AND RISK FACTORS

The reciprocal and cyclical relationship between mental illness and substance use has been well documented in the literature, with mental illness

increasing the risk of substance use and substance use increasing the risk of mental illness (Hilarski & Wodarski, 2001). Approximately 7.9 million adults in the United States were diagnosed with a co-occurring mental illness and SUD in 2014, corresponding to 3.3 percent of all American adults (Center for Behavioral Health Statistics and Quality, 2015). Co-occurring disorders have been found to adversely affect psychosocial functioning (SAMHSA, 2016). Individuals with undiagnosed, untreated, or under-treated co-occurring disorders are at increased risk of homelessness, incarceration, medical illness, suicide, and early death (SAMHSA, 2016). Substance use by individuals with mental illness may increase problems with depression, anxiety, disinhibition, aggression, and may compound pre-existing mental illness (Loneck, et al., 2002). It may also contribute to noncompliance with treatment and medication regimen as well as diminish treatment outcomes, thus perpetuating a cycle of relapse and re-admission to treatment (Loneck, et al., 2002).

Co-occurring disorders affect individuals across all geographic and demographic domains, however, prevalence rates for various mental health and SUD diagnoses differ based on age, gender, race, and ethnicity (SAMHSA, 2016). Among adults diagnosed with SUD in the past year, co-occurring mental illness was highest among people between the ages of 26 to 49 years (42.7 percent); among adults diagnosed with a past year mental health disorder, co-occurring SUD was highest among people between the ages of 18 to 25 years (29.3%) (Center for Behavioral Health Statistics and Quality, 2015).

SOURCES OF STRENGTH AND RESILIENCE

Although the plight of individuals living with co-occurring disorders may appear dismal, due to an abundance of associated risk, applying a systems approach to the problem illuminates the possibility of protective factors that individuals may already have in place. Protective factors have the ability to reduce the impact of risk, provide individuals with strength to overcome adversity, and decrease the likelihood of negative outcomes (SAMHSA, 2015). Individuals do not live in a vacuum; rather, they live within a variety of social contexts and systems, including the family, community, and larger society (SAMHSA, 2015). The presence of protective factors, such as an individual's talents and interests, interpersonal relationships, family involvement in treatment and recovery, community networks, spiritual or faith-based memberships, and/or participation in Alcoholics Anonymous or Narcotics

Anonymous support groups all make a difference. Additionally, one's level of social competence, self-control, self-efficacy, positive self-image, and ability and willingness to seek out professional support serve as protective factors, which may initiate the process of recovery, physical and emotional well-being, and the ability of individuals to achieve a healthy, vibrant quality of life. It should be noted that individuals in the active phase of mental illness and/or substance use/dependence might need assistance to uncover and cultivate sources of strength and resilience in their lives. This is a primary task of the social work professional working with this population.

A Strengths-based Approach to Engagement, Assessment, and Intervention

According to Loneck, et al. (2002), it can be difficult to engage this population in treatment, as many individuals with co-occurring disorders resist treatment and/or deny one or both of their diagnoses. An efficacious approach with this population is one emphasizing a high degree of therapeutic alliance, worker support, client involvement, and client/worker agreement in the formulation of therapeutic tasks and goals. Approaching engagement, assessment, and intervention through a solution-focused framework supports client autonomy and self-determination, which promotes improved referral and treatment outcomes (Loneck, et al., 2002).

Solution-focused brief crisis intervention provides a client-centered guide to engagement, assessment, and intervention. This approach assumes that clients are the experts on their problems, and therefore, solutions to problems are elicited from the client, rather than imposed on the client by the worker (Walsh, 2013). This approach is well suited for assessment and intervention in emergency crisis services, based on its brief assessment protocol and focus on strengths and solutions. This practice approach is future-oriented and highlights the resilient nature and ability of people to know what is in their own best interest (Walsh, 2013). Using solution-focused crisis intervention, the worker and client identify solutions and exceptions to problems, rather than focusing exclusively on problems (Walsh, 2013). "Its focus is on helping clients identify and amplify their strengths, so that available resources can be better utilized as solutions to the crisis" (Walsh, 2013, p. 323). This approach is in line with the findings of Loneck, et al. (2002), as it engages and empowers clients to be active participants in their treatment, encourages collaboration with workers to achieve concrete solutions, and values client choice and autonomy towards activating change. Additionally, this approach requires a high level

of worker empathy, compassion, and non-judgment, and assumes "people want to change, are suggestible, and have the capability to develop new and existing resources to solve their problems" (Walsh, 2013, p. 237).

DISCUSSION

The field of social work is appealing to those who believe wholeheartedly in the value of service to others, and who are committed to improving the welfare of vulnerable and oppressed individuals. Emergency crisis services plays an important role in the provision of mental health services, as this setting is often a client's point of entry into the mental health system (Loneck, et al., 2002). Individuals with co-occurring disorders have complex needs that often go undiagnosed, untreated, or under-treated, increasing their risk of homelessness, incarceration, suicidality, and diminished quality of life (SAMHSA, 2016).

Regrettably, it is common for crisis clinicians to focus on individual pathology when assessing for risk; however, much is missed when assessment is conducted from a deficit-laden perspective, as it undermines the potential of individuals to overcome adversity. Individuals are best served when strengths, talents, and natural supports are explored. Clients in crisis often underestimate their true potential and need to be reminded of their innate capabilities. Shifting the focus from problems to solutions provides clients with a sense of hope and possibility for the future, which may improve post-assessment and intervention outcomes. The development of a strong therapeutic alliance provides the safe holding environment conducive to client autonomy, self-efficacy, and the cultivation of solutions and exceptions to problems.

Individuals with co-occurring disorders experience profound stigma in the community and may be reluctant to seek help from professionals. It is imperative for crisis clinicians to provide clients with empathy, compassion, unconditional positive regard, and to respect clients' inherent worth and dignity. Reaching out for professional help can be extremely difficult and demoralizing for clients during a crisis; however, it is a critical step towards physical and emotional well-being and should be praised by clinicians whenever possible during the assessment process. Social workers possess a high level of competence regarding the specific needs of the populations with whom they work; therefore, crisis clinicians should be well versed on evidence-based practices addressing both the mental health and substance use aspects of co-occurring disorders.

There are myriad systemic barriers preventing individuals from accessing the therapeutic supports needed to achieve and maintain sobriety and to cope with mental illness. The values of larger society greatly influence social policy and the ability of social workers to effectively intervene on behalf of individuals who are at-risk of adversity. Social workers have an ethical responsibility to engage in advocacy efforts, preserve and guarantee client access to vital community resources, and lead efforts to eliminate the societal stigma attached to mental illness and SUD.

References

Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50).

Centers for Disease Control and Prevention. (2016). Injury prevention & control: Opioid overdoses. Retrieved from http://www.cdc.gov/drugoverdose/epidemic/index.html

Hilarski, C., & Wodarski, J. (2001). Comorbid substance abuse and mental illness. *Journal of Social Work Practice in the Addictions, 1*(1), 105-119.

Loneck, B., Banks, S., Way, B., & Bonaparte, E. (2002). An empirical model of therapeutic process for psychiatric emergency room clients with dual disorders. *Social Work Research, 26*(3), 132-44.

Substance Abuse and Mental Health Services Administration. (2016). Co-occurring disorders. Retrieved from http://www.samhsa.gov/disorders/co-occurring

Substance Abuse and Mental Health Services Administration. (2015). Risk and protective factors. Retrieved from http://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors

Walsh, J. (2013). *Theories for direct social work practice (3rd ed.).* Stamford, CT: Cengage Learning.