



ADOLESCENT SUBSTANCE ABUSE FACT SHEETS

What is the relationship between mental illness and substance abuse for adolescents?

What is mental illness?

The National Alliance on Mental Illness (NAMI) describe mental illnesses as "medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others, and daily functioning," on their website.¹ WebMD, an online resource for health information, lists a similar definition for mental illness.² Someone who has a mental illness may face challenges in coping with the ordinary demands of life. It is important to understand that mental illnesses are biological disorders that occur in the brain and do not have anything to do with the intelligence or the character of the person who has the illness. There are differing severities of disorders; both across different disorders and within the same disorder. Typically, mental illnesses first show up in adolescence and young adulthood.¹

What do the terms co-occurring, comorbidity, dual diagnosis, and dual-disordered mean?

Generally, when someone is suffering from more than one mental illness they can be referred to as having co-occurring disorders. The terms "comorbidity," "dual diagnosis," and "dual-disordered" are also used; however, the use of the word "dual" is misleading because most clients have more than two disorders. These terms are non-specific and may be used to describe people who have co-occurring mental illnesses, a mental illness and a physical illness, and/or a mental illness and a substance abuse problem. There is a more complete list of other terms and abbreviations that are used listed in the sources cited for this section.^{3,4}

In the early 1970s treatment for those with mental health issues was transferred from state hospitals to community clinics.⁴ As a result, younger patients received care in outpatient settings and so they were not isolated from their peers. Receiving care in the community had many benefits, including being more convenient and less stigmatizing. One of the unintended consequences was that youth with mental illnesses had more access to peer groups engaging in unsafe behaviors like substance use. This led to an increase in the population of people who had both mental health and substance abuse problems.⁴

There were separate treatment facilities within the substance abuse field for those who were using alcohol and those who were using other drugs until the early 1990s.⁴ Separate ideas about the causes of substance use accompanied the separate facilities with those who treated alcoholism considering it to have a primarily biological or genetic basis and those treating drug abuse believing that drug problems were caused by those patients trying to cope with underlying psychological issues.⁴ Mental health issues were treated in their own separate facilities as well and most of them did not screen for substance abuse because they thought that substance abuse problems would stop after mental health treatment.

In 1980, the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* was published by the American Psychological Association.⁴ This paved the way for the recognition of co-occurring disorders because the manual *allowed* for people to be diagnosed with multiple disorders which older editions did not.⁴ An early model of co-occurring disorders was the primary illness model. This model stipulated that one disorder is the cause of all the symptoms that are presenting in the client. Therefore, you only had to treat one disorder and all the symptoms would clear up once treatment was completed.

By the late 1980s, the concurrent conditions model had become popular and it suggested that co-occurring disorders should be treated together.⁴ The early version of this model led to the development of three treatment plans: the sequential model, the parallel model, and the integrated model. The sequential model involved treating one disorder completely in one facility and then transferring the client to a second facility for more treatment. The parallel model and the integrated model advocated treating both disorders at the same time, the former involved the client going to separate treatment facilities for each problem and the latter had the client going to the same facility for treatment of both disorders. The first two were found to be ineffective because both disorders needed to be treated together and it was

This publication was produced by UNCG's Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).



SAMHSA



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES



NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services



Says who?

1. National Alliance on Mental Illness (2007). *What is mental illness: Mental illness facts*. Retrieved August 16, 2007 from http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Mental_Illness.htm

2. Chakraborty, Amal. (2007). *Mental Health: Mental Illness Basics*. Retrieved September 6, 2007 from <http://www.webmd.com/anxiety-panic/mental-illness-basics>

3. Sacks, S. & Ries, R. K. (2005). *Treatment improvement protocol (TIP) series: Substance abuse treatment for persons with co-occurring disorder Series 42*. (DHHS Publication No. (SMA) 05-3922s). Rockville, MD: U.S. DHHS.

4. Hendrickson, E. L., Schmal, M. S., & Ekleberry S. C. *Treating co-occurring disorders: A handbook for mental health and substance abuse professionals*. Binghamton, NY: The Haworth Press, Inc.

hard to coordinate treatment across different facilities especially when they had differing ideas about how to actually treat the conditions.

By the mid 1990s, integrated treatment had emerged as the accepted treatment model for dealing with co-occurring disorders; however, many facilities found their staff was unqualified to actually provide that type of treatment.⁴ Tremendous progress has been made in this area, but many communities still do not have access to integrated treatment and issues surrounding unqualified staff still persist.⁴

How many adolescents have both? How many are receiving treatment for both?

There are several estimates concerning how many adolescents have both a substance abuse problem and a mental illness. The range is anywhere from 21%⁵ to 76%⁶. Overall, only 9.9% of people (both adults and adolescents) who needed treatment for substance abuse actually received treatment.⁷ In 2004, a study was done examining facilities that treat adolescents for substance abuse. SAMHSA found that 35% of the facilities had special groups or programs for clients who had a co-occurring mental health disorder. They also found that the programs that accepted payment from the government (Medicaid/Medicare) were more likely to have these special programs.⁸

Does this trend continue into adulthood?

The same study that found that 21% of adolescents had co-occurring disorders also looked at adults and found that 19% of adults had co-occurring disorders.⁵ Kandel et al. (1999) reported that 76% of adolescents had co-occurring disorders and found very few significant differences between adults and adolescents. They found that adults had higher rates of disruptive disorders and antisocial personality disorder combined with substance abuse than adolescents.⁶ Rohde et al.⁹ conducted a study where they interviewed adolescents between the ages of 14-19 and then followed up on them throughout their lifetimes until they were 30 years old. They found that adolescent substance abuse in general was related to fewer years of completed education, recent unemployment, lower annual income, engagement in risky sexual behavior, suicide attempts, poor coping skills, stressful life events, and poorer global adjustment. As part of their analysis they controlled for the effects of adolescent co-occurring disorders and found that all of the results were still significant except for risky sexual behavior and stressful life events.⁹

Does either mental illness or substance abuse cause the other?

Clark & Parker (1999) examined the relationship between mental illness and substance abuse in adolescent boys. Specifically they studied the chronological relationship between the onsets of each. They found that antisocial disorders had an average onset of age 9, ADHD of age 5, and negative affect disorders of age 8. Alcohol and cannabis started after with onset ages of 13.8 and 14 respectively. They also looked at the effects of having a father with a substance abuse problem and this did not affect the age of onset. Those boys having a father with substance abuse were categorized as being a high average risk (HAR) and those without substance abuse in their immediate family were categorized as having a low average risk (LAR). Due to the correlational nature of the study, causation cannot be assumed. However, the study suggested that there is a pathway from paternal substance abuse to childhood disorders to use of substances in adolescence and later problems.¹⁰ There is a lack of research looking at the specific mechanism of how substance abuse and mental illness interact with regards to causation in adolescent girls.

What do adolescents with co-occurring SA and MH need?

Adolescents with both SA and MH problems need integrated treatment. We need to increase the number of providers that can provide treatment for both substance abuse and mental health issues. In the mean time, we need to create stronger partnerships between Substance Abuse and Mental Health agencies to address the current need.

5. SAMHSA (December 23, 2005). *The DASIS report: Adolescents with co-occurring psychiatric disorders: 2003*. Retrieved August 16, 2007 from <http://oas.samhsa.gov/2k5/youthMH/youthMH.htm>.

6. Kandel, D. B., Johnson, J. G., Bird, H. R., Weissman, M. M., Goodman, S. H., Lahey, B. B., Regier, D. A., & Schwab-Stone, M. E. (1999). Psychiatric comorbidity among adolescents with substance use disorders: findings from the MECA study. (Methods for the Epidemiology of Child and Adolescent Mental Disorders). *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(6), 693-700.

7. SAMHSA (2005). *Overview of findings from the 2004 national survey on drug use and health* (DHHS Publication No. SMA 05-4061). Rockville, MD: U.S. Department of Health and Human Services. Retrieved August 17, 2007 from <http://oas.samhsa.gov/nsduh/2k4nsduh/2k4overview/2k4overview.htm>.

8. SAMHSA (2006). *The DASIS report: Facilities offering special programs or groups for clients with co-occurring disorders: 2004*. Retrieved August 16, 2007 from <http://oas.samhsa.gov/2k6/DualTX/DualTX.htm>.

9. Rohde, P., Lewinsohn, P. M., Seeley, J. R., Klein, D. N., Andrews, J. A., & Small, J. W. (2007). Psychosocial functioning of adults who experienced substance use disorders as adolescents. *Psychology of Addictive Behaviors*, 21(2), 155-164.

10. Clark, D. B. & Parker, A. M. (1999). Psychopathology and substance-related problems during early adolescence: A survival analysis. *Journal of Clinical Child Psychology*, 28 (3), 333-341.

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

Written by Megan Smell;
last updated September, 2007

Adolescent Substance Abuse Fact Sheets are designed to provide answers at a glance to common questions about adolescent substance abuse. They are by no means a complete summary of available literature on the subject. For further information on each topic, we recommend you start with the "says who" section of each fact sheet. Reproduction of the text is encouraged; however, copies may not be sold.