

EDITORIAL

ADDRESSING PSYCHOSOCIAL ISSUES AND PROBLEMS OF CO-MORBIDITY FOR NATIVE AMERICAN CLIENTS WITH SUBSTANCE ABUSE PROBLEMS: A CONFERENCE PROCEEDINGS

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This proceedings consists of five papers presented at a conference titled: *Psychosocial Issues and Problems of Co-Morbidity for Native American Clients with Substance Abuse Problems*. The conference was held June 2-4, 1999, in Albuquerque, New Mexico, and was hosted by the Native American Research and Training Center (NARTC) and the National Center for American Indian and Alaska Native Mental Health Research.

This conference was the first of its kind linking substance abuse counselors, mental health care providers, and vocational rehabilitation (VR) counselors concerned about the treatment of American Indian patients with substance abuse problems and a co-existing co-morbid mental health disorder. Conference presentations focused on (a) the epidemiology, diagnosis, and treatment of American Indians with dual diagnosis; and (b) the use of the VR case management model as aftercare treatment for American Indian clients with co-existing substance abuse/dependence and mental health disorders.

The need for this conference emerged from discussions among clinicians and researchers about diagnostic and treatment problems of American Indian clients with dual diagnosis. The problems of diagnosis and treatment of persons with dual diagnosis is complicated by the reality that mental health and poly-substance abuse/dependence programs utilize different diagnostic and treatment approaches, and traditionally these approaches are not well-integrated to deliver a coordinated or an integrated treatment program for substance abuse clients presenting with a co-morbid disorder. Thus, psychiatric problems of clients in treatment for substance abuse are often poorly addressed, resulting in high rates of recidivism. Conversely, mental health clinicians may overlook the patient's history of substance abuse in providing treatment for psychiatric disorders. This fragmentation allows clients with dual diagnosis to "drift" through the system, resulting in high rates of recidivism.

Another problem contributing to poor client outcomes for American Indian clients with dual diagnosis is the lack of aftercare support or programs in their communities. As a result, clients in recovery from substance abuse often find themselves returning to the same environment that initially

facilitated their drinking behavior. These unchanged life situations, e.g., a dysfunctional family context, lack of employment, lack of education and skills, low self-perception, and lack of aftercare programs contribute significantly to the high rates of recidivism (Hassin, 1996).

One approach to aftercare for clients in recovery is the VR case management model. In a number of states and regions, VR has taken the initiative in bringing mental health agencies and poly-substance abuse treatment centers together to address the problems of addiction, psychiatric disabilities, and employment for individuals who have dual diagnosis. The VR case management model represents an excellent aftercare program for dual diagnosed clients in recovery who are eligible for job training and employment. Because the VR case management model is not well known among clinicians and substance abuse counselors, this conference provided a forum to introduce to a wider audience this model and its use as an aftercare program.

Background

Alcohol Abuse and Dual Diagnosis with a Psychiatric Disorder Among American Indians: Prevalence, Morbidity, and Mortality

Epidemiology of Alcohol Abuse

In 1995, the Indian Health Service (IHS) estimated that mortality rates from alcoholism and alcohol abuse among American Indians compared to the general population were 8.0 times as great for ages 25-34 and 6.5 times as great for ages 35-44 (Indian Health Service, 1997). Although these numbers represent American Indians as a group, the actual rates of alcohol and substance abuse vary inter-tribally and by age group, with some tribes and age groups having rates lower than those of the U.S. general population (May 1995). Most reported drinking behavior occurs among American Indians between ages 15-44.

Morbidity and Mortality

Four of the ten leading causes of death among American Indians—chronic liver disease and cirrhosis, suicide, homicide, and accidents—are alcohol related (May 1995; Wallace, Sleet, & James, 1997). According to IHS data, deaths attributed directly to alcoholism, alcoholic psychosis, and cirrhosis with mention of alcohol were 6.45-7.63 times greater for American Indians than for the general population, all races (May 1995).

Citing IHS statistics for the period 1986-1988, May (1995) finds that 17-19% of all American Indian deaths are alcohol related (alcohol abuse and alcoholism) compared with 4.7% for the U.S., all races. These figures include alcohol related deaths from motor vehicle accidents (65%), suicide (75%), homicide (86%), and alcohol dependency. Motor vehicle related injury is the leading cause of death for American Indians, ages 1-44. May (1995) attributes most of these alcohol related deaths to “recreational drinking” as opposed to “chronic alcoholism,” and notes that among American Indians, recreational drinkers outnumber chronic alcoholics by a ratio of 3:1.

Rates of Recidivism

According to Marlatt and Gordon (1985), rates of recidivism in the general population after treatment for substance abuse dependency are as high as 86% 2 years post treatment, with the majority of the relapses occurring within 6 months of treatment. Hassin (1996) notes that for American Indians the high rates of recidivism are the result of a number of factors, including socio-economic issues, limited aftercare support, and an inability to see alternative options to a lifestyle that supports addictive behavior.

Psychiatric Disorders Associated with Substance Abuse

Data listing the number of ambulatory medical clinical impressions indicates that 317,745 American Indians, aged 5-54, were seen for mental disorders in FY1995 by IHS clinicians (Indian Health Service, 1998). Alcohol dependence with a co-morbid disorder is a problem particularly impacting American Indian and Alaska Native clients. Estimates of psychiatric disorders among American Indians with substance abuse problems range from 35-60% (Regier et al., 1990; Smail, Stockwell, Canter, & Hodgson, 1984; Westermeyer & Neider, 1994). Available data suggest that a co-morbid psychopathology is as least as prevalent in American Indian and Alaska Native populations with substance abuse problems as in the general population.

The types of mental disorders reported in association with substance abuse as a co-morbid condition among American Indians are major depressive disorder (Shore, Manson, Bloom, Keepers, & Neligh, 1987; Westermeyer & Neider, 1984); bipolar I and bipolar II disorder; dysthymia; anxiety disorders, including post traumatic stress disorder (PTSD) (Matsunaga, 1997; Neligh, Baron, Braun, & Czarnecki, 1990; Robin 1997a; 1997b; Scurfield, 1995; Westermeyer, 1993); and schizophrenia (Westermeyer, 1992).

Dual Diagnosis: Substance Abuse Presenting with a Psychiatric Disorder

Epidemiology and Dual Diagnosis

According to the Epidemiological Catchment Area (ECA) Study (Regier et al., 1990), clients with either a psychiatric or a substance abuse/dependence disorder are at increased risk for the other problem. Regier et al., (1990) found that among clients presenting with a mental disorder, 29% also had an alcohol or drug abuse disorder, and of the clients diagnosed with an alcohol or drug abuse disorder, 37% also had a co-occurring mental disorder. Eighty-three percent of individuals diagnosed with antisocial personality disorder also suffered from substance abuse/dependence disorder, and 60% of the individuals diagnosed with bipolar disorder also presented with substance abuse/dependence disorders. Regier et al. (1990) also found a high occurrence of co-morbidity among those clients presenting with a drug abuse disorder other than alcohol, with more than half of these clients (53%) also presenting with a co-occurring mental disorder.

Galanter et al. (1990) estimate that alcohol and/or drug consumption are the direct cause for one-third to one-half of psychiatric clients seen for admission, crisis intervention, or in emergency rooms following suicide attempts. Drake and Wallach (1989) found that 45% of schizophrenics hospitalized were also abusers of alcohol; however, alcohol abuse/dependence disorder was not listed in the diagnosis of these patients. Drake and Wallach (1989), suggest that estimates of co-morbidity are low because of denial by both client and clinician.

Problems in Treatment of Dual Diagnosis/Co-Morbidity

Society's pressures for accountability in mental health and substance abuse treatment outcomes in the past few years have led to increased interest in dual diagnosis. Dually diagnosed individuals present co-existing problems in treatment as a result of both mental health disorders and substance abuse/dependence disorders (Sciaccia & Thompson, 1996). As noted above, when these clients seek treatment, they often find themselves between competing and conflicting treatment systems, or they are lost in the system and fail to receive adequate or appropriate treatment.

Dual diagnosis is difficult for both the client and the clinician. The clinician must be skilled and knowledgeable in treating both substance abuse and psychiatric illnesses, but often only one problem is addressed. Traditionally, mental health professionals have been reluctant to treat clients with substance abuse. In some instances, addiction professionals have complained that mental health providers ignore and/or under-diagnose

substance abuse disorders, inappropriately prescribe minor tranquilizers, or hospitalize alcoholics in mental institutions rather than in alcohol treatment facilities (James Hagel, personal communication, 1998). Furthermore, mental health facilities may refuse to treat clients with substance abuse histories, and conversely, substance abuse programs may reject those with psychiatric histories.

A clash also occurs over the selection of a client's primary treatment goal; in mental health, treatment often begins with stabilization, followed by therapy that encourages increasing insight and subsequent behavior changes. Some mental health clinicians may decide that sporadic use of alcohol does not jeopardize the client's capacity for treatment. However, many substance abuse counselors believe that any use of a non-prescribed mind-altering substance interferes with recovery. For example, in substance abuse treatment, the goal is accepting dependency, maintaining sobriety, and abstaining from alcohol and drugs. The treatment goal is to eliminate all drugs that affect the central nervous system.

The use of empowerment strategies also differs in treating mental health and substance abuse disorders. From the mental health view, empowerment is used to enhance self-esteem and to assist clients to better deal with their problems. However, from the substance abuse perspective, recognizing one's powerlessness is an important step in accepting one's disease (James Hagel, personal communication, 1998). This is the paradox inherent in the Alcoholics Anonymous (AA) philosophy: when one accepts that one is powerless over the disease, it comes under control.

Clinicians from these disciplines often suffer from negative attitudes, some of which may be rooted in the clinician's own background or through personal use or experience with substances (James Hagel, personal communication, 1998). Clinicians may also have difficulty trying to determine which illness—the substance abuse dependency or the mental health disorder—comes first (Kessler et al., 1994; Robins & Regier, 1991; Ross, Glaser, Germanson, 1988; Schuckit et al., 1997; Swendsen et al., 1998). Some are fearful of trying to address both problems, and as a result, the client's treatment may be fragmented. Clients are referred to other facilities, which then also refer them out, resulting in a "dumping syndrome," which delays necessary, coordinated, comprehensive treatment (James Hagel, personal communication, 1998).

The most problematic issue in treating co-existing diagnoses is how lapses and relapses are viewed and handled. For example, in the classic mental health model, a "slip" or lapse is seen as a form of self-medication, an acting-out of unresolved conflicts, or simply misbehavior. However, in the classic substance abuse model, the substance abuse counselor might perceive the "slip" as a relapse that results from not adhering to their program (usually 12-step). In substance abuse treatment, only a few number of "slips," or lapses, are tolerated, as opposed to the mental health model in which any number might be accepted.

Summary

Major barriers to effective treatment of dual diagnosis are complicated by a number of factors: (a) determining a primary diagnosis, (b) determining who should best treat the client, (c) deciding which is the most appropriate facility, and (d) determining what treatment approach should be used. Even when these steps are followed, however, the client might not receive appropriate treatment until a crisis arises and hospitalization and/or emergency room visits are required. For the American Indian client with dual diagnosis, the lack of aftercare programs further compounds the problem of recovery. The need for effective aftercare programs for this patient population is critical.

Significance of the Conference

The purpose of this conference was to respond to some of these problems by bringing together mental health clinicians, substance abuse/dependence counselors, VR counselors, researchers, and policy makers to exchange information about successful cross-cultural primary and aftercare treatment of American Indian clients with substance abuse problems and a co-morbid psychiatric disorder. This conference was the first of its kind to discuss (a) dual diagnosis, poly-substance abuse/dependence, and psychiatric disorders in primary treatment in American Indian communities; and (b) the linking of aftercare treatment to vocational rehabilitation programs. The conference objectives were as follows:

1. To provide a forum for researchers, clinicians, and service providers to present and discuss critical psychosocial issues and problems of co-morbidity as they relate to substance abuse and American Indians.
2. To present information on the epidemiology of co-morbidity in American Indians and Alaska Natives as seen in both the research and clinical arenas.
3. To present research and clinical information on specific diagnostic characteristics of co-morbidity among American Indians.
4. To identify key issues related to culture in the treatment of co-morbidity.
5. To identify specific age and gender issues related to diagnosis and treatment of co-morbidity among American Indian people.
6. To present information on the case management model used in vocational rehabilitation as an effective aftercare model program for patients with a co-morbid disorder.

Conference Proceedings

The five papers that comprise the proceedings encompass the six objectives of the conference. They reflect the major topics -

epidemiology, diagnosis and treatment of co-morbid psychiatric disorders associated with substance abuse, the impact of cultural issues on the diagnosis and treatment of clients with dual diagnosis, the problem of gender differences in diagnosis and treatment, and the VR case management model as an aftercare program.

The epidemiology of substance abuse among American Indians is the focus of a paper by Drs. Philip May and J. Phillip Gossage, who conducted a study of alcohol consumption among four northern U.S. tribes. The authors sought to determine frequency of consumption, quantity consumed, and abuse of other substances among a random sample of 1,421 enrolled tribal members. Results indicate that the pattern of alcohol consumption for most informants was binge drinking on social occasions punctuated with very long periods of abstinence. Men consumed larger quantities than women. Highest prevalence of drinking occurred under the age of 30, and an older age group (40+) had very low rates of consumption. This study also confirmed earlier observations by May (1995) that most of the serious consequences of alcohol related behavior—accidents, suicides, homicides—occur as a result of binge drinking as opposed to solitary drinking behavior.

One of the major issues for clients with substance abuse problems and a co-morbid disorder is screening and assessment of the psychiatric disorder. By matching specific patient subtypes to specific treatments, McCLEllan (1986) found that treatment outcomes improved by 37%. Therefore assessment of psychiatric severity is essential in order to match patients to treatment. However, it should be noted that traditionally substance abuse programs and mental health programs within IHS have not assessed patients for a co-morbid condition. Consequently, the severity of any psychiatric disorder is unknown to both the patient and the substance abuse counselor.

An excellent overview of the screening, diagnosis, and treatment of patients with dual diagnosis is presented in the paper by Dr. Joseph Westermeyer. After discussing methods of screening and treatment for patients with dual diagnosis, Westermeyer discusses mood disorders, anxiety disorders, schizophrenia and other psychiatric disorders, alcohol related mental disorders, and behavioral disorders associated with substance abuse. The author includes case studies to illustrate some of the disorders and briefly discusses disorders of children and adolescents associated with substance abuse. Westermeyer stresses the importance of diagnosing psychiatric disorders in patients with substance abuse problems and adds that traditional healing practices may have a role in treatment of some co-morbid disorders.

Those substance abuse programs that do assess for co-morbidity often fail to address traditional American Indian cultural issues, which are a significant factor in the diagnosis and treatment of American Indians with dual diagnosis. The impact of culture on the diagnosis and treatment of a

psychiatric disorder was a focal point of several presentations at the conference. An overview of some of these issues is presented in a paper by Dr. Michelle Christensen, who provides background on the inclusion of culture in the latest edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). After a brief discussion of the history and evolution of the different editions of the DSM, Christensen briefly discusses the cultural variations presented in 76 DSM listed disorders as well as an appendix that includes a list of culture bound syndromes. The author also presents a case study that illustrates how traditional American Indian culture impacts psychiatric assessment and treatment.

There are a number of gender differences related to substance abuse, including different physiological responses (Lieber, 1997). Women have less alcohol dehydrogenase than men, making them more susceptible than men to cirrhosis, gastric disorders, cardiomyopathy, and brain impairment. Women who abuse alcohol are also more apt than men to be poly-substance abusers. Finally, women with substance abuse problems tend to experience different trauma than men, i.e., women who abuse alcohol report higher rates of sexual and physical abuse. These gender differences as they relate to clients with a co-morbid and psychiatric disorder are addressed in a paper by Drs. Norma Gray and Pat Nye, who observe that PTSD in woman contributes to the “co-morbid problems of addiction, depression, and violence.” The authors indicate that women with PTSD are more likely than men to be diagnosed with a mood disorder and anti-social disorder. The authors also briefly discuss the use of the medicine wheel as an effective treatment approach for American Indian women with dual diagnosis.

If treatment outcomes are to be improved, professionals must actively work toward coordinating and integrating alcohol and drug treatment programs with psychiatric and social services. McClellan (1986) observed that treatment efficacy improves when patients and therapists are presented with a variety of treatment options, and treatment efficacy significantly improves with the inclusion of employment.

An innovative aftercare program that leads to employment for American Indian clients in recovery is discussed in a paper by Sheila Hitchen, a VR counselor in Portland, Oregon. Based on the VR case management model, this particular aftercare program was developed as a collaboration between the Oregon VR Division, the University of Arizona, and a number of community and urban alcohol treatment and recovery programs. This model program has had significant success in rehabilitating American Indian clients with substance abuse problems (and dual diagnosis) who are interested in gainful employment or furthering their academic skills toward obtaining a job. Over 50% of those participating obtained and sustained employment through the VR system. This program,

which is the result of collaborative activity between a number of agencies, is the kind of effective aftercare program for clients in recovery that is necessary to help clients with dual diagnosis to maintain sobriety.

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