

RESOURCE CENTER AND CLEARINGHOUSE

Center of Alcohol Studies, Rutgers University

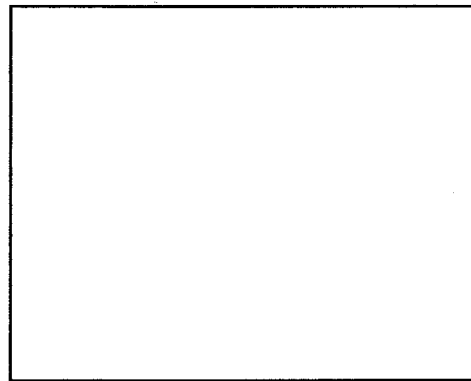
FACTS ON MENTALLY ILL CHEMICAL ABUSERS

NAN FIORENTINO, PH.D. AND PHYLLIS REILLY, PH.D.

The New Jersey Division of Mental Health and Hospitals defines mentally ill chemical abusers (MICAs) as persons with diagnoses of severe mental illness and alcohol and/or drug dependency. More specifically, an individual is considered to be MICA when: the client is psychotic and actively abusing alcohol and/or drugs; the client is actively psychotic and has a history of alcohol/drug abuse; and/or the client is actively abusing alcohol/drugs with a history of severe psychiatric diagnoses. MICA clients are most likely to be young adults (18 to 35 years), male and unemployed. Suffering from concomitant illnesses of psychiatric disability and chemical dependency has been variously referred to throughout the country as SAMI (Substance Abusing Mentally Ill), Dual Diagnoses, SEICA (Seriously Emotionally Impaired Chemical Abusers), and PICA (Psychiatrically Impaired Chemical Abusers). Whatever term is used to describe clients who are suffering from a dual diagnosis, there is a clear constellation of behaviors, symptoms and risk factors.

In the general population, about 13% have experienced alcohol abuse or dependence at some time during their lives, and about half of this group also has had a psychiatric diagnosis. Diagnosis of alcohol dependence is five times more prevalent among men than among women, but the association of alcoholism with other diagnoses is stronger in women. As many as 65% of female alcoholics have a second diagnosis compared with 44% of male alcoholics. Of 1.4 million persons treated for alcoholism in the U.S. in 1987, two-thirds had a current psychiatric disorder in addition to substance abuse. In 1989 MICA clients comprised approximately 30% of New Jersey's state and county hospital ad-

missions and 17% of admissions to community programs. About 20% of all mental health service clients had alcohol problems. About 9% had problems with drugs. In the general population, about 5% of mental health service clients have alcohol problems and 2% have drug



problems. Between 1984 and 1989, the proportion of MICA clients rose by 7% in community programs and 4% in hospitals.

Psychiatric disability is more common among addicted persons than in the general population. Addiction is more common among psychiatrically disabled persons than among the general population. Both illnesses may in an acute stage simultaneously, or one may be in remission while the other is active, or both may be in remission.

It is frequently difficult to distinguish psychiatric disability and chemical dependence in a client, both because clinician's tend to be trained in one specialty or the other and because the symptoms mimic and mask one another. For instance, chemical dependency produces temporary psychoses, hallucinations, paranoia, even suicidal tendencies. These conditions improve with

recovery and abstinence. Psychiatric disability frequently looks like addiction, particularly when the psychotic episode took place during a period of intoxication or when high. Also, chemically dependent people frequently experience depression and anxiety as a normal part of withdrawal and adjustment to a life of recovery. For some persons psychiatric treatment will be necessary, and for others the depression will lift as they adjust to the new abstinence lifestyle.

In the past, because chemical dependence treatment and psychiatric disability treatment took place in different settings with different technologies and specialization of health care personnel, these treatments took place sequentially and frequently were contradictory of one another. Therefore, a person who was dually diagnosed could possibly have received treatment for both chemical dependence and psychiatric problems, but these treatments would not take place concurrently, nor would they be coordinated. This led to frequent relapse and contradictory treatment instructions from the two systems to the client and family.

There was no combined treatment up until the mid-1980s. Researchers, mental health and chemical dependency practitioners have noted a rise in the number of MICA clients during the last 10 years. The state hospital population has declined from over half a million people to slightly over 100,000. This exodus of persons to community care and unsupervised living has led to an increase in the phenomena or persons with chemical dependence and psychiatric disability. The increasing ranks of homeless and impoverished persons is a factor contributing to the increase.

Another factor contributing to the rise in MICA population has been the collaboration during the last 10 years between mental health and chemical dependency providers. Enhanced assessment of clients who are recognized as suffering from dual diagnosis has become available. Historically, persons who demonstrated addiction were discriminated against in the psychiatric system, and persons who demonstrated psychiatric symptomatology were discriminated against in the addiction system. Refusal of treatment to individuals and family members gave rise to the Mentally Ill Chemical Abusers movement.

Individuals with a lifetime history of psychiatric disability have become intoxicated or high and then committed violent or antisocial acts - and in some cases mass killings. Communities demand careful scrutiny of both addiction and psychiatric disability. This has led to a quandary for those with medical and legal Responsibilities. At times the treating professional knows that the client's illness is not under control. Yet, since the person has done nothing to require commitment, treatment is not available. Treatment technologies in both systems have changed to accommodate special MICA needs. The addiction system has become flexible about educational requirements, and the mental health community has become more open-minded about self-help participation. Denial of the concomitant illnesses continues in both systems. Problems are compounded by misdiagnosis, mistreatment, and myths surrounding the treatment of each disability. There are more relapses with MICA clients. There are more problems with medication and treatment compliance. Families feel that they suffer from a double stigma and their denial is even stronger.

Appropriate differential diagnosis and cross-training of mental health and ad-

diction professionals are essential. At the present time, there are many gaps in the continuum of care and treatment services are not appropriate. MICA clients continue to face discrimination. Agencies protect turf and territoriality depending upon funding streams and technical skills. Costs are enormous. Mental health emergency services see persons who are not in stable recovery from the chemical dependence, and chemical dependency programs experience more relapse because of unstabilized psychiatric disability. Treating these clients becomes a revolving door. Their treatment depends upon who the therapist is and the approach. At about the time of the 50th anniversary of Alcoholics Anonymous, a new publication was developed by a group of psychiatrists and physicians who are members of AA on the subject of AA and medication. This pamphlet articulated the problem of psychiatrically disabled individuals attending Alcoholics Anonymous and receiving counsel to cease taking psychotropic and other medications. The pamphlet attempted to make clear that there is a subset of the population for whom medication is a necessary and helpful adjunct to treat-

ment and that this group deserves to be supported in their recovery process through 12-step programs. It served as a basis for the establishment of specialized self-help groups which originally were called Double Trouble meetings in New Jersey. These meetings are particularly for persons who have dual diagnoses.

A codified, state-of-the-art treatment protocol for the MICA client is emerging. Most practitioners agree that both illnesses must be treated concomitantly. The illness that will be given priority attention is the one that is most florid at the time of admission. Stabilization of the psychiatric illness is necessary in order to deal with active chemical dependence and the reverse.

Family members have organized associations for mutual support and as advocates on behalf of the family member under treatment. Renewed attention, funding, and demonstration projects for specialized treatment of this population have resulted, thus addressing the service needs of this population. This has brought about an emerging partnership between the mental health and chemical dependency fields.

REFERENCES

- Alcohol and health, seventh special report to Congress from the Secretary of HHS. Jan., 1990). USDHHS PHS ADMHA NIAAA. 5600 Fishers Lane, Rockville, MD, 20057. Contract No. ADM-281-88-0002.
- Bibliography of abstracts on coexisting substance abuse and mental disorders. (Sept., 1990). USDHHS, PHS, ADAMHA, OTI, 5700 Fishers Lane, Rockville, MD, 20857.
- Daley, D., MSW, Moss, H., MD, & Campbell, F., MSN. (1987). Dual disorders: Counseling clients with chemical dependency and Mental Illness. Hazelden Foundation.
- Evans, K., & Sullivan, J.M. (1990). Dual diagnosis: Counseling the mentally ill substance abuser. New York: The Guilford Press.
- O'Connell, D.F. (Ed.). (1990). Managing the dually diagnosed patient: Current issues and clinical approaches. New York: The Haworth Press.
- Vine, P. (1982). Families in pain: Children, siblings, spouses and parents of the mentally ill speak out. New York: Pantheon Books.

The New Jersey Alcohol/Drug Resource Center and Clearinghouse serves institutions of higher education, state agencies, communities and school districts throughout the state of New Jersey by providing technical assistance, training, and resources in alcohol and other drug abuse education and prevention. For more information on the Clearinghouse, call or write to:

Center of Alcohol Studies
Smithers Hall-Busch Campus
Rutgers University
Piscataway, NJ 08855-0969
(908) 981-0964 FAX (908) 981-8076
© 1992

THE STATE UNIVERSITY OF NEW JERSEY
RUTGERS

CLEARINGHOUSE FACT SHEETS MAY BE REPRODUCED IN ANY QUANTITY FOR EDUCATIONAL USE