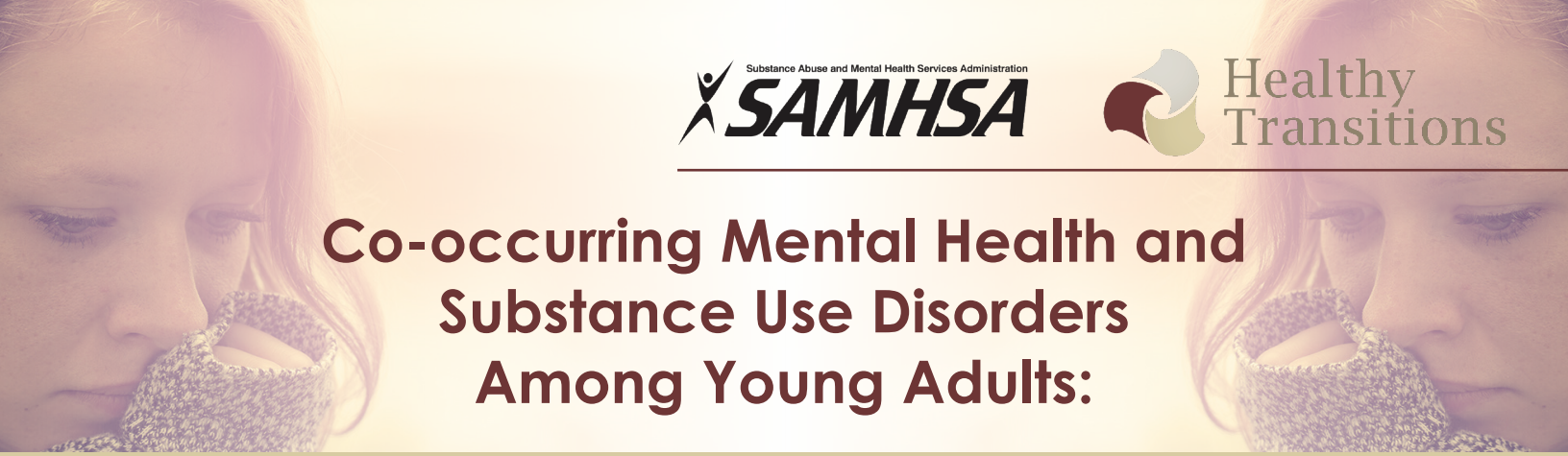


Co-occurring Mental Health and Substance Use Disorders Among Young Adults:

A Fact Sheet for Providers

Introduction

The transition from adolescence to adulthood can pose many challenges to young adults and their families. During transition age, young adults are called upon to make new and sometimes complex decisions about school, work, finances, and relationships with friends and family. This stage of life presents significantly greater challenges for the more than 3 million young adults (ages 18-25) with serious mental health conditions. Youth with mental health diagnoses are over-represented in the juvenile justice system, foster care, school disciplinary referrals, and high school dropout rates.[1,2] National and international studies involving youth have shown that one in every four to five are affected by a mental health condition at some point in their lifetime. Many experience major difficulty and distress in daily living as a result. The range of categories of mental health diagnoses includes mood and anxiety disorders, as well as behavior disorders.[3-5]

Substance use disorder (SUD) has been found to be the most common diagnosis for young people, followed by anxiety disorders, depressive disorders, and attention deficit hyperactivity disorder. When diagnoses of serious mental health conditions are taken into account, the rate for young adults ages 18 to 25 (7.4 percent) is higher than for any other age group over 18. For 50 percent of adults with mental health diagnoses, the first appearance of mental health challenges occurs by age 14, and for 75 percent of adults onset happens by age 24.[6,7]

Many youth and young adults experience both mental health and substance use disorders simultaneously, a condition referred to as co-occurring disorders (COD). What we know about the development of COD in young people is that each can contribute to the development of the other, and the causes are complex and intertwined. Research is also providing us with promising and effective practices for intervening to address COD among young adults. This fact sheet on COD among young adults is provided to assist service providers, administrators, and implementers in better understanding COD among young adults.

What is COD?

Co-occurring disorders refers to at least one substance use disorder and at least one other mental health disorder occurring together. Use of the term "disorder" here has its background in the medical model of understanding illness. The medical model is just one approach to describing conditions in which the expected functioning of something has become disrupted, resulting in changes in a person's regular behavior. The term "disorder" when talking about mental health and substance use conditions is common language among clinical professionals, and we also encounter it when reading research studies about these issues as well as government publications (e.g., SAMHSA, NIH) that provide information directly to consumers. Alternately, we use terms such as "conditions" or "challenges" as we seek to reduce stigma and better align with the preferences of people seeking services. Mental health advocacy groups such as Youth M.O.V.E and NAMI prefer the language of "challenges" as a means of destigmatizing mental health conditions.

In the case of COD, the term "co-occurring" may refer to conditions that occur at the same time, or one following the other. In either case, the interactions between them can worsen both, and make treatment planning much more complex. It is often hard to tease out sets of symptoms when young people first seek services. Sometimes, a cluster of symptoms can result from a single disorder, or the symptoms that are present at a given point in time do not meet the criteria for a diagnosis of one or both conditions. It may be easier to plan for services when there is a clear dual- or multiple-diagnosis, but treatment planning can and should occur whether or not diagnoses of both conditions have been established. The best service plans include continuous evaluation of both conditions as treatment proceeds. This is known as the "service-level definition" of COD – one that reflects the tangle of symptoms that result when mental health and substance use diagnoses co-occur. Getting treatment started is a higher priority than establishing the "individual-level definition." Service-level definitions may refer to individuals who are:

- At risk, and in need of prevention-level services;
- Pre-diagnosis, with perhaps a clearly diagnosed disorder in one domain and emerging symptoms within the other domain;
- Post-diagnosis, suggesting that one or both disorders were previously diagnosed but have diminished for period of time;
- In the midst of temporary symptoms that do not meet criteria for one disorder or the other, but are severe to the point of needing immediate attention (e.g., suicidal ideation that co-occurs with a substance-related disorder, or intoxication in a person with an ongoing history of mental illness).[8]

How common are co-occurring mental and substance use disorders in young adults?

Many people with substance use conditions are also diagnosed with other mental health conditions, and vice versa. Compared with the general population, people experiencing addiction are roughly twice as likely to suffer from mood and anxiety disorders, with the reverse also being true.[8] Young adults appear to be particularly vulnerable to COD. Consider the data in Figures 1 and 2 from the 2015 National Survey on Drug Use and Health (NSDUH), which provides estimates of any mental illness and serious mental illness for adults aged 18 or older. Any mental health illness (AMI) refers to having any mental health, behavioral, or emotional disorder in the past year that met DSM-IV criteria. This category includes mild to moderate disorders that do not substantially interfere with a person's ability to function. Serious mental illness (SMI) includes severe mental health, behavioral, or emotional disorder that "substantially interfere[s] with or limit[s] one or more major life activities."[9]

Young adults who experience either AMI or SMI are the group most likely to also have a substance use disorder, which means that mental illness and substance use is more likely to co-occur for young adults than any other age group. Conversely, when young adults have a substance use disorder they are significantly more likely to also have a mental health disorder. Figure 1 and Figure 2 provide additional data.

Why do these disorders often co-occur?

Questions about COD are fueled by two common misconceptions: 1) that the substance use must have caused the mental health disorder, or 2) that the presence of mental health diagnoses caused an SUD. Neither is true. These disorders often co-occur and, typically, the symptoms of one are noticed first, followed by symptoms of the other. However, this does not necessarily mean that one caused the other. While the causes of substance use and mental health disorders are related, there is not always a causal relationship. We also cannot assume that the one that came first is the more severe problem, or the "primary" disorder. Let's consider these misconceptions more fully.

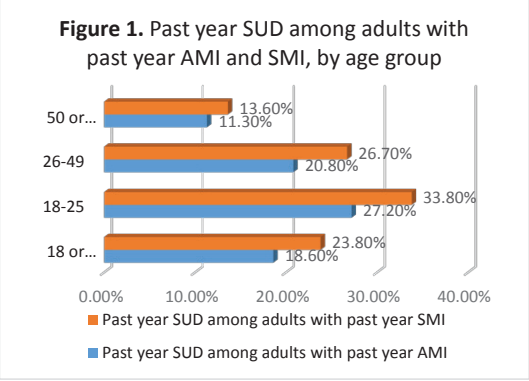


Figure 1. Among all adults with past year SUD who also present with AMI, young adults age 18-25 represent the age group with the highest percentage, at 27.2%. The same is true for young adults with past year SUD and SMI, at 33.8%.

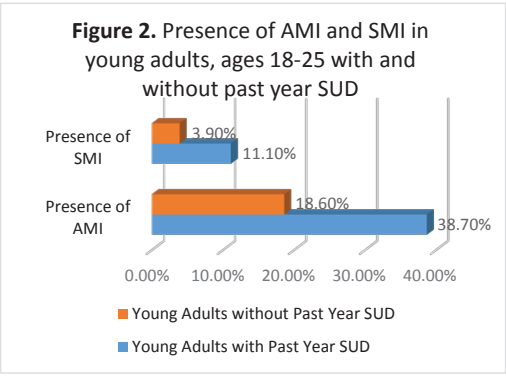


Figure 2. When compared with young adults, ages 18-25 without a past year SUD, those with SUD were more than 3 times likely (38.7% compared to 11.1%) to have AMI and nearly five times as likely (18.6 % compared with 3.9%) to have a SMI.

Myth #1 – Substance abuse causes mental health challenges.

This idea comes from the notion that events or circumstances that happen around the same time as the appearance of a mental health condition must have caused it. If a person is heavily abusing drugs and alcohol around the time of the onset of a mental health condition, then the substance abuse gets "blamed" as the cause. Instead of a simple causal relationship, there is a complex interplay of factors that can foster the co-occurrence of mental health disorders in the context of substance abuse. There is some data that suggest that chronic substance abuse, especially during periods of brain development, can increase a genetic predisposition toward mental illness.[10] Other data support the conclusion that particular substances—when chronically abused—can lead to changes in brain chemistry that increase the likelihood of mental illness, though other research contradicts this.[11] These findings, however, are about heightening existing risk factors. They do not support a direct causal relationship between substance abuse and mental health disorders.

We know that mental health disorders are often noticed first at times of stress, major life changes, or traumatic events. These events and circumstances are factors in how and when a mental health challenge appears and then develops. We also know that chronic substance abuse can result in a great deal of stress, which is also a factor in the initial appearance of mental health symptoms. For treatment purposes, however, a mental health diagnosis can only be made if the symptoms exist independently of substance use. A mental health diagnosis reflects the presence of a set of symptoms that occur over time and lead to challenges in the way a person lives life on a day-to-day basis. These symptoms continue even when a person stops substance use/abuse. With the cessation of substance abuse it becomes clear that the mental health diagnosis is an independent disorder, and not the result of chronic substance abuse.

Myth #2 – Mental health challenges cause substance use disorders.

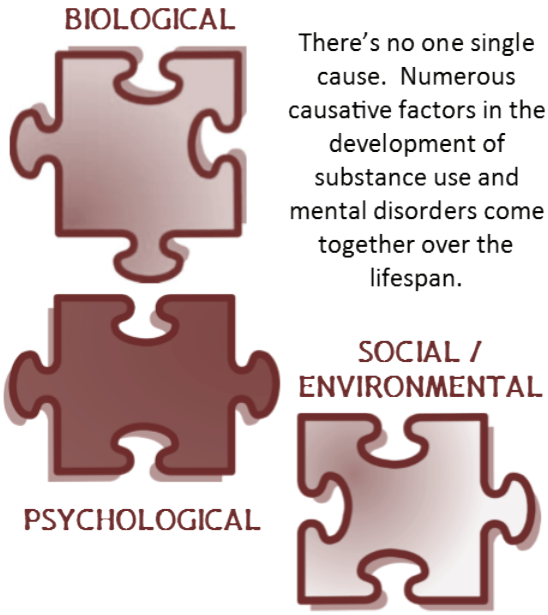
This myth is often expressed as the idea that people "self-medicate" the symptoms of mental health challenges. People who are experiencing symptoms of anxiety or depression, for example, may use various drugs to change how they feel and help them cope with the distress they are experiencing. People with mental health challenges who are not receiving appropriate treatment may attempt to self-medicate with mood-altering substances, which can lead to dependency.[12] In other cases, medication prescribed to treat a mental health disorder may have unpleasant side effects which people attempt to mediate with substance use.[13] However, substances such as alcohol or amphetamines do not medicate mental health symptoms. Because the cycle of repeated intoxication and withdrawal from substances is temporarily more overwhelming to the brain than the symptoms of depression or anxiety, people may feel that mental health symptoms have been "medicated." However, the substance abuse is only masking the symptoms for a brief period of time, much like a Band-Aid covers a scrape. Once the "Band-Aid" of intoxication is removed, the disorder is often more clearly identifiable. Also, dependence on a drug is the result of continued use of that substance in large enough quantities over a long enough period of time that a habit or pattern of use develops. This can happen in the presence or absence of a mental health diagnosis.

Let's also remember that both mental health and substance-related conditions are developmental in nature. They often begin in the childhood, adolescence, or teen years, during times of dramatic developmental changes in the brain. Rather than a situation where one disorder emerges first and "causes" the other disorder, co-occurring disorders develop in cyclic patterns over the lifespan with each tending to make the other worse.

So then, what DOES cause substance-related and mental health disorders?

Mental health and substance-related disorders are caused by the same or similar causative factors and influences. There is a shared set of risk factors for these conditions and it is important to note that there is *no one single cause* of a mental health or substance use disorder. These conditions are the result of multiple causative factors and influences that come together over the lifespan. They can be categorized this way:

Biological: There are genetic factors that may make a person more likely to develop both mental health and substance use disorders. These "predisposing factors" can make a person more vulnerable to these conditions or cause a greater risk of a second disorder developing once the first one has emerged. Chemical imbalances or errors of metabolism in the way that the brain makes or uses certain brain chemicals have also been linked to the onset and course of both mental health symptoms and SUD. The brain is not fully formed until about age 25. This is one reason why both mental health and substance abuse disorders are more likely to emerge during adolescence and young adulthood.[14]



Psychological: An individual's personality, psychological strengths and vulnerabilities, responses to stress and trauma, and personal intellectual or emotional defenses can also impact mental health and substance use. Over time, challenges coping with life changes combined with repeated presentation of mental health *symptoms* can result in diagnosable disorders. The same is true for psychological factors that increase the likelihood that a person will become dependent on substances once unhealthy patterns of use are established. Adolescence is a particularly stressful moment in the lifespan and a predisposition towards substance abuse or mental health disorders can be triggered by stress.[15] Trauma can also play a role in hastening the emergence of these disorders, including sexual abuse, physical abuse, domestic violence, community and school violence, medical trauma, motor vehicle accidents, acts of terrorism, war experiences, natural and human-made disasters, suicides, and other traumatic losses.[16] Data on trauma exposure among children in the United States suggests that as many as 25% of young people experience trauma before the age of 16.[17]

Social / Environmental: Numerous social and environmental factors are involved in the development and progress of mental health diagnoses and SUD. These include: the environment into which one is born; personal exposure to abuse and trauma; drug use in the home or among family members; and other challenges to the family environment, including events and circumstances that cause instability or that limit social support. Protective factors (things that support healthy growth and development) include a supportive family, stable relationships, adequate housing, and financial security, to name a few. The absence of some or all of these protective factors, coupled with the lack of resilience (the capacity to "bounce back" or effectively cope in the face of adversity), can leave a young adult at greater risk of developing mental health and substance use diagnoses. Research on adverse childhood experiences (ACES) demonstrates a significant link between childhood risk factors and the emergence of mental health and substance use disorders.[18]

So, in sum, biological, psychological, and social/environmental influences occur together and increase how vulnerable one may be to the occurrence of mental health and substance use conditions. It is also difficult to tease out these influences from each other. For example, if a person is raised in a household in which one or both parents struggle with mental health symptoms and/or SUD, and that person later develops symptoms in one or more of these conditions, we may question whether that is due to a genetic predisposition, the stressors of the home environment, or the influence of parent behavior. The answer is often a combination of all of these, along with personality features that make someone more vulnerable and the absence of protective factors and resilience.

What are some of the key strategies and interventions for working with young adults with COD?

The best strategies for working with young adults with COD may seem as complex as the disorders themselves. So, let's simplify: If the causative factors of these conditions are biological, psychological, and social/environmental in nature, then the treatment activities must also be biological, psychological, and social in nature. When we think of biological treatment interventions, we may first think of medication. It is true that there are many psychotropic medications (those that affect the mind, emotions, and behavior) that help to relieve symptoms of mental health and SUD. However, biological interventions also include healthy diet and nutrition, physical activity, and a regular sleep-wake cycle. Think about physical health interventions that are meant to boost your immune

system. These things make for a healthy body as well as a stronger, healthier mind. **Psychological** treatments include a host of therapies that have been shown to support the improvement of coping skills and a better understanding of stressful events or past trauma. They help individuals develop skills to manage thoughts and emotions in response to day-to-day stress or life changes, and to effectively manage medication when it is recommended. These interventions include group and individual therapies, as well as family counseling in a variety of settings. Interventions that involve ways to change or cope with social and **environmental** factors are also important. These include basic changes that improve social networks. Examples include support groups and activities, but also guidance to young adults as they make decisions to avoid negative people and places that have led to risky behavior in the past.

There are several treatment and service delivery models that combine interventions to effectively address the complex biological, psychological, and social needs for young adults with co-occurring disorders. Early models integrated **Assertive Community Treatment and Intensive Case Management (ACT/ICM)** programs and later cognitive behavioral and motivational enhancement therapies (CBT/MET) to address COD. Other models have emerged specifically for youth and young adults. These include:

- **Adolescent Community Reinforcement Approach/ Assertive Continuing Care (A-CRA/ACC)** is an outpatient program for youth and young adults ages 12-24 that uses behavioral and cognitive-behavioral techniques to address and replace environmental factors that supported alcohol or drug use. Prosocial activities and new social skills that support recovery replace the former activities, settings, and environmental cues.
- **Assertive Continuing Care (ACC)**. A-CRA is the main component within ACC and ACC was developed to follow a period of residential, intensive outpatient, or other outpatient treatment. It provides for visits with youth in community settings, such as home, school, or other places to help ensure that the gains made in treatment continue, and that youth acquire new recovery skills.[19]
- **Transition to Independence Process (TIP)** approach is an evidence-informed model that underscores access to appropriate services and efforts to engage young adults in their own future planning process. It is a strengths-based and person-centered model that interacts with young people through the development of relationships and accessible, tailored supports; the enhancement of individual competencies; and a focus on the future.
- **Systems of Care (SOC)** framework relies on multi-agency sharing of resources and responsibilities with the full participation of professionals, families, and young adults as active partners in planning, funding, implementing, and evaluating services and system outcomes. Cross-agency coordination of services is viewed as imperative regardless of where or how young people and families enter the system.

These and other models work to improve treatment and address COD in an integrated manner, connecting young adults to positive activities and helpful community providers. SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) provides a searchable database of effective and promising programs and treatment models.[20] Additionally, NREPP's Resources Site provides a wealth of information on the selection and implementation of new programs and practices.

Key Strategies for Supporting Young Adults with Co-occurring Needs

- Develop an understanding of the interplay between mental health and substance use disorders
- Gain insight into clinical and non-clinical approached to outreach, engagement, treatment, and service coordination
- Deepen the understanding of clinical and administrative competencies related to providing a quality co-occurring practices model
- Consider facilitators, barriers, and strategies associated with implementation and sustainability of co-occurring practice models

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