

# Addiction and mental health

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Introduction An addiction and mentally ill population suffers a series of problems in any society whether developed or otherwise, (Canadian Institutes of Health Research, 2007). It is regrettable that while close friends and relatives are the first to detect signs of addiction and mental problems, very few of them take the initiative of involving concerned authorities. Again, the matter of mental disorder is further complicated when it coupled with addiction. In the modern society, the unedited indulgence in drug and substance abuse has been attributed to be the source of destructive addiction. The advancement in technology, especially the internet, has made drugs and substances targeted for abuse more accessible to the general public. While every society struggles to provide care for the dual disorder population, it is noted from numerous researches that many care giving centres lack in terms of facility and efficiency to handle these problems.

In addition, the two dual disorders (mental problems and addiction) are too problematic to be handled as a pack. Many nations have mooted separate approaches where mental disorders and addictions are dealt with as separate entities and in different centres. The singular approach to these disorders has made it very difficult for the dual disorder patients to access any meaningful and sustainable rehabilitation care. Even though dual diagnosis is being noted, little progress has been made towards developing programs to cub both. Many programs are however being developed to make the attempt a success. Research activities are also coming in quite handy in understanding the problems.

The research recognized 50 percent of the mentally ill patients to be suffering from a kind of addiction. Their addiction is owed to drug abuse. The

most commonly abused drugs are marijuana, alcohol and cocaine. Other drugs include sleeping pills and tranquilizers. Researches by Petersen and Zwerling (2005), have pointed out that males form the greatest percentage of the dual disorder population with their ages ranging from 14 to 45 years.

It is shocking; say Petersen and Zwerling (2005) that family members remain ignorant to early signs of mental disorders only to get engulfed later by the challenges posed by this psychological menace. In addition, many families have abandoned mentally ill and addiction victims the mercies of governments. Many governments have declared this population as a great burden. The main government has always been that addiction is advanced lack of choice that stemmed from earlier urges and choices. The point is, many agents have regarded addiction as self inflicted. Mentally ill persons who are also victims of addiction remain a major source of confusion to only to themselves but the rest of members within the societies they live.

According to (Canadian Institutes of Health Research, 2007), a lot of research work has been conducted with a view to coming up with perfect systems that will ultimately ensure that these dual disorder patients are helped out. Some have been implemented and yielded results while others have become reference points of how a failed system can be. Violence to other members of the society and self has been the greatest source of concerns for many interested parties. While many people wonder why many are inclined towards drug abuse, those addicted to drug and substance abuse, have no idea themselves of what motivates them into it. Many people have been forced into drug abuse to life stresses and disappointments that have become a part and parcel of the modern society. Some of the little social <https://assignbuster.com/addiction-and-mental-health/>

problems that the society ignores today turn out to be the causes for major mental disorders.

They push someone to taking drugs. They turn to drugs to “ solve” their social problems. People eventually become addicted to these drugs. The bottom line remains; they will lose their minds. Other people live within environments where drug and substance abuse is the order of the day. In order to survive in such societies and environments, people are forced to fit into the cliché by engaging in drug abuse.

A person living with people who abuse drugs and substances are more prone to engaging in drug abuse. Considering the social problems associated with these dual disorders, designing a workable treatment program has become inevitable, (Wittchen & Jacobi 2005). The treatment program to be developed should take special courses when solving addiction problems. Treatment procedures should be designed for persons with the two disorders. Many programs designed in the recent past are “ confrontative” trait. This makes them of no help to mental patients.

These traits are difficult to adjust to, especially the mental disordered people. Confrontation stirs up intense emotions and reactions. They may even harbour long-term effects of patients experiencing relapses due to stress. The programs to be used should take gradual strategies. They should see denial as one of the problems associated with the dual disorders. Treatment programs designers should have full knowledge about the nature and complexity of the dual disorders.

The patients need to feel comfortable with the program. It should not make them any different from other people. The program should give them the opportunity to socialize and share their problems among themselves and their care givers. Treatment designed should not harbour any moral negative implications. Discussion Addiction is the physical, mental or psychological dependency on a substance or an action. Drug addiction is the complete dependency on a substance to function normally.

An addicted person is chronically intoxicated and has a compulsive use despite dangerous effects posed (Marchand, 2007). Mental health problems are some of the effects brought by drug use; especially common with drug addicts. Acquisition of both mental health problem such as depression and drug abuse, is termed as dual diagnosis. Some of the common causes of drug and substance abuse are peer pressure, anxiety, environmental stress or even depression. Most people who engage in drug and substance abuse eventually encounter mental health problems.

Opiates such as heroin, cocaine and codeine, also referred to as Central nervous system (CNS) stimulants are responsible for the mental dysfunction, (Wittchen & Jacobi 2005). Several methods are employed to rehabilitate people suffering from dual diagnosis. Methods used include quarantine of the affected people and keeping them away from drugs that they have been addicted to. There are however modern procedures in treatment of dually diagnosed people. These are more integrated approaches as shall be explained, (Wittchen & Jacobi 2005).

Synthesis of major findings Drug addiction and mental problems go hand in hand. Such combined problems are referred to as co-occurring disorders or dual diagnosis. Mental problems hinder our ability to have a normal function, a normal social relationship and difficulty in life progress. For treatment of these problems, an integrated approach is recommended today. This approach is meant to rehabilitate a drug addict and hook them out of their addiction and at the same time doing away with their mental health problem.

Petersen and Zwerling, (2005) described that recovery from this depended on the simultaneous treatment of both the addiction and mental problem. According to research by Petersen and Zwerling (2005), it is not guaranteed that recovery would happen but there are high chances that persons on dual diagnosis would recover under good treatment and support. The speed of recovery is not as fast. Persons will often get discouraged due to frequent encounters with relapses and slow recovery but with support and motivation, progress is achieved. Since the mental health problem and drug addiction are related, Petersen and Zwerling (2005) described that a combined treatment is best to increase the chances of recovery.

Integrated treatment is acquisition of double treatment for mental and addiction problem from a common health provider and described that during treatment of the problem therapists have to identify what is exactly at hand (Petersen and Zwerling (2005). It is hard to convince drug addicts to admit what they are really addicted to. Therefore, there exists difficulty in diagnosing the drug abuse problem and its consequent mental disorder.

Reasons attributed to this denial behavior from affected persons are

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ignorance and hope by addicts that the problems will eventually disappear. Addicts are further faced with the fear of being considered as a minority in society.

Addicts have a common instinct to go back to their addictive lives and evade the “ problematic” rehabilitation. An array of procedures involving the community integration must be employed so as to aid in improvement of mentally ill patients. Integrated methods are supported by researches done. According to these researches, the major symptoms common to co-occurring disorders are weight changes and loss of appetite, concentration problems, anger and rage, impaired judgment. Right programs for the treatment of co-occurring disorders must be backed up by research.

It is recommended by recent reliable studies that procedures of conducting treatment must be certified. Lastly, procedures employed in treatment must be particular with the mental health problem addressed. During treatment, therapists must use selected approaches to provide best results. Approaches to be employed according to Burdort, (2008) are: simultaneous treatment of both drug abuse problem and mental disorder, mutual decision making and locating goals, lessons on skills to use as a strategy to cope with drug abuse. Recovery rates of co-occurring disorders after treatment using the integrated approach are high as dual methods employed suppress the above stated problems simultaneously.

According to the APHA meeting held in 2007, the integrated approach method entailed staff being trained to expand their knowledge on mental disorders and skills in dealing with addiction. The Integrated Dual Recovery

Program in New York State today is the only existing inpatient treatment program that integrates both addiction and mental disorder experts to work in alliance on dually diagnosed patients. Approaches recommended for use included: orientation of addicts and individual treatment. These were meant to be enforced by a team specialized in interdisciplinary treatment. The caste team was obligated with a responsibility to help patients discover how to deal with psychiatric symptoms; while at the same time coming up with emotional coping skills based on effective sobriety. In recent past, governments have had a responsibility to avail physically safe working and living environments.

Today, courts have come out to address this issue intensely. Indeed, it is a legal responsibility for governments to provide psychologically safe working and living areas (Shain, 2010). In the labor markets, employers are vested with the responsibility of avoiding litigation and reckless treatment to employees. Employees working in mental and addiction rehabilitation centers also count a lot in the recovery of these dually diagnosed persons. Good employee treatment brings about high staff productivity and increase in rate of recuperation for patients in the rehab (Shain, 2010). Clinicians and employees having psychiatric or addiction experiences must be taught how to make diagnoses for every disorder using the Clear Diagnostic Criteria shown in DSM-III-R (American Psychiatric Associations, 1987) What Integrated treatment methods entail.

For effective integrated methods, differently specialized health experts are required to share work stations. These professionals must be able to test and treat both addiction and resultant mental problems. They need to work in a <https://assignbuster.com/addiction-and-mental-health/>



coordinated manner for quick and full recovery of their patients. Therefore, patients receive continuous treatment without having to move from one mental health institution to another. Time wastage during consultations and bureaucracy is minimized if both services are provided from one centre. From a research by Macpherson (2004), clients with dual diagnosis have to follow their own pace in their improvement.

Patients know well their depth of syndrome and can describe better how they feel as they improve. Macpherson, (2004) also considered that social networks that could also serve reinforces be given extra attention. Abstinence methods may be employed but they should not be made to be conditions for embarking on treatment. They should be allowed and granted opportunities to get social with others and to participate in recreational activities and grow peer groups. Macpherson's research further recommended that patient's families be offered education on how to cope by not reacting with guilt or blame but to accept and cope with the two illnesses.

An improvement or total recovery by patients can come about after well conducted integrated services. There is guarantee to improve a patient's health and restore the good effects that addiction stole from his or her friends, family and the society as a whole. Degree of Encroachment of the Dual Illness According to reports published in the Journal of the American Association (JAMA): research has shown that mental illness going hand to hand with drug addiction is rampant. Nevertheless, there is no exact information on the actual number of people suffering from the co-occurring

disorders. It is stated that roughly 50% of people with mental disorders are affected or had already been affected by drug abuse.

Rothenbacher et al, (1998) concluded from his research that 37% of alcohol abusers and 53% drug abusers have at least one mental illness. Among all people diagnosed with mental illness, 29% abused alcohol or drugs (Rothenbacher et al, 1998). Other results from the National Comorbidity Survey (NCS) and Epidemiologic Catchment Area (ECA) indicated that there were increased rates for co-occurring drug abuse syndromes. From these results, 47% of individuals with a 12- month addictive disorder had at least a year experiencing mental disorder. The relevance of the data provided here above is to show the extent of prevalence of this mental illness in conjunction with drug addiction.

These simultaneous disorders lead to great chances of relapses and poor physical and mental functioning. Integrated approach methods are best in dealing with these problems. Integrated methods help in closing the gap created by fragmented and uncoordinated services. Practical Suggestions The choice of programmes for use in treatment of the subject patients is dependent on the degree of prevalence of the patients' disorders. Before a programme is suggested, diagnoses must be made.

This is referred to as diagnostic clarity. The New York State Commission of Quality of Care for the Mentally Disabled (1986) developed a term MICAA for the “mentally ill chemical abusers and addicted.” These individuals were described to have severe and persistent mental illness accompanied by chemical abuse and/ or addiction (Sciacca 1987). Others were described to

be having severe alcohol or drug addiction with slight associations of mental illnesses. They were given the term CAMI for “ Chemically Abusing Mentally Ill.

” Patients in need of these services have to be aware of what addiction they are suffering from. They must be ready to accept the treatment offered. The patients must also be willing to accept the probable consequences in case of faulty participation in the process of therapy. The MICCA Treatment Programme was first developed by Sciacca in 1987 Sciacca, (1987). In this approach, patients are absorbed by their peers and engaged in normal life activities and discussions.

Its base is the non-judgmental embrace of the symptoms and experiences associated to both mental disorder and substance abuse. Treatment begins by taking the patients on a tour around the area they shall be recovering from through non-confrontational approaches (Sciacca, (1987). Rules must be established and made known to the patients. Common occurrences such as aggression and violent behaviour to self or colleagues, whether or not from intoxication, would not be put up with by the management. The approach’s nine critical steps Step 1: The client is informed of a special programme regarding his/her condition. He/she is notified that he/she has been referred to a MICCA group programme and that he/she can interact with his/her group members.

In case of questions, the client is allowed to contact the MICAA group leader and most probably, a meeting be arranged. If the patient is not cooperative then the clinician is advised to intensify his/her engagements with the client.

Step 2: During this step, groups are made and interviews held. The clients are informed of their purpose in such an institution. They are made to understand that the institution and their group have no problem with substance abuse. The mode of communication must not be in a threatening way.

This step is generally for the education of the patients. They are made to understand the need to improve and why they should detach from denial and accept the integrated approach methods for their recovery. Step 3: This is a continuation of step 2 above. The rehabilitation procedure employed here takes a mutual interactive form. Group leaders organise and facilitate healthy discussions relevant to drug abuse. Patients are let to contribute and their perspectives are keenly noted.

Later on, particular patient's perspectives and views are used to gauge their progress regarding rehabilitation. Step 4: At this stage the patient is now conversant with aspects of drug abuse. Therefore, this step involves general talk about drug addiction. Unlike the third step, discussions are here not held. Here, the group leaders make presentations through lecture(s), demonstration or informative forums.

Group leaders are here faced with a challenge and objective to built trust with their patients. The patient-leader relationship is indeed a determinant of the success of this process. Therefore, building rapport and most importantly trust is inevitable. The aim of the group leader in this step is to create trust through talk of realistic and understandable negative effects resulting from abuse. Step 5: This step is ushered in by the beginning of unfolding of denial.

The clients start talking of their past use of drugs. As implied, a group leader's role or duty is here reduced to listening and recording of what patients have to say. However, once in a while, the group leaders may speak to break the ice, motivate the scared and to make the patients contribution lively. It has been noted in past studies that most patients will here tend to be more focused on the negative effects faced from drug abuse. Thus, group leaders are also expected to encourage the clients to speak of their “positive experiences” during their use of drugs.

This is done to help in the determination of why different people use different drugs. Thus, both negative and positive effects are equally needed in this study. Step 6: This is a more persona stage. At this stage, it is expected that the group leader who is also a trained therapist has critically analysed particular cases of each patient. The group leader is then obligated to hold a one on one talk with each client. Most likely, the client realizes that substance abuse is a problem.

Through the talk held, a client's willingness to change is gauged. The group leader may choose to assign relevant activities to specific patients with regards to their case. For instance, a client could be asked by his or her group leader to hold a one on one talk with another patient, outlining the effects of drugs and drug abuse as well as the importance of shunning from drug use. Through these activities, the group leader is able to tell of how committed a patient is to the process of rehabilitation. The client receives increasing feedback from group leaders and with the help of the leader he is able to acknowledge that substance use has adverse effects. Step 7: Here, the client personally makes the decision to abstain.

Effects of drug abuse have already been defined and the patients are willing to take measures to avoid usage of drugs. This happens when the client reduces or eliminates use of his most harmful substances that they are using. Step 8: In this stage, interventions from the group on reduction or termination of use of drugs are employed. They are even encouraged to try and go out for one day without taking the drugs and come and report to the group leader. The aim here is to give them some stability. When the stability is achieved then rehabilitation recovery is initialised.

Step 9: The goal for the treatment and therapy is achievement of total abstinence. This may take months or years depending on the extent of prior addiction. On achievement, the clients are encouraged to participate in social clubs and community activities. Clients are encouraged to develop other substance free social networks and activities further, they are encouraged to get additional therapy. Desired Characteristics and Skills for Working with Dual Disorder Problem 1: Symptom Recognition The counsellor must have the skills to give the differences between symptoms of these coexisting disabilities (Rissmiller & Rissmiller, 2006). He or she needs to be aware of all the characteristics exhibited by the dual diagnosed patients.

Academically, he must be knowledgeable of the characteristics and have ability to find out the suitable therapeutic methods and effective planning services. 2: Communication skills Communication among staff members is considered an essential mechanism for effective operation in the health centre. Personnel working in these institutions must have good communication skills. They ought to be able to understand that the group of people they will be interacting with poses danger to them. They must learn <https://assignbuster.com/addiction-and-mental-health/>

how to gain trust of their clients and must have good public relations skills. The people in the mental institutions and addiction rehab centres need a calm environment.

Relating with patients must never be threatening. 3: Experience and Competence The ultimate goal for dual disorder therapy is to attain total abstinence and rehabilitation of the client. Employees must be competent in their works delivered and must have gained enough experience in the field. The progress to attain total rehabilitation is slow therefore, patience and endurance is a great requirement for the employees. Other skills essential in working with the dually diagnosed people are care management skills.

Appropriate training such as community support and address to an individual's medical care must be done. The employees must also be good decision makers and uphold high moral standards. 4: Management and Leadership at Care Centres Management and leadership are essential in the centres designed for attending to patients with addiction and mental disorders. The two concepts are very closely related concepts in health care. It is through these two concepts that disorder rehabilitations centres excel.

In general terms, leadership is about determining and setting direction to be followed while management is about controlling and directing resources in a team guided by set rules and regulations. The interrelationship between these two concepts is therefore important to understand in order to make the implementation of the proposed approach to treating these patients meaningful.. It is important to note that these two cannot operate in isolation given that it is challenging to have a strategies direction even when there is

no one to manage (Armstrong, 2006). This direction has to be new since leadership is more of a skill as compared to management which is a position.

This difference can be reinforced by the fact that the leader in disorder care centres must maintain effective communication skills in order to remain relevant to the rest of disorder care givers. In the ancient times, rehabilitation centres for mentally challenged and addiction disorders called to task manual ways of perform various essential tasks. On the other hand, current rehabilitation settings are encouraging care givers and rehabilitated patients a chance to give feedback since leadership has evolved from a tool to a source of effective advantage (Gankar, et al., 2004). The current psychiatric dynamics imply that the disorder care givers have continually increased their disorder therapy knowledge base.

However, management in disorder centres without leadership is risky and therefore new supervisors need to understand that leadership and management are compliments. In doing all this, centres will have reduced the distance between junior care givers and managers which is a key in determination of efficiency. One of the avenues where management has motivated the informed care giving to dual disorders is by initiating feedback sessions. In coaching, management and management skills is a product of human character. In explaining the relationship further, it can be said that leadership skills is one of the key attributes of a successful dual disorder therapist.

Indeed, the aim of a disorder centre manager is to always maximize output in efforts of giving meaningful and sustainable therapy through planning,



directing, planning, organization, staffing and controlling. The concept of leadership is derived from the directing function based on the understanding that a manager requires some formal authority to reinforce regulation. However, some positions do not require leadership especially in a situation where self motivated individuals have come together for common good. A good example is in community based dual disorder care centres inherent in developed countries. In terms of the thinking orientation, managers are known for thinking incrementally while managers are radical thinkers. This is a simple illustration that managers are likely to make use of available policies and procedures to not only manage their workforce but the entire dual disorder population.

Many theories have been advanced in seeking ways of improving leadership skills for dual disorder centre managers. A supervisor can enrol for management development classes, attend workshops or work on a real case of dual disorder therapeutic project. In many occasions, dual disorder care givers can change their skills through taking secondment to key institutions where they enrich themselves with knowledge. For the proposed approach, it recommended that care givers shadow. Shadowing is extremely valuable in getting a comprehensive picture of the level of disorder rehabilitation since every care giver assumes the duties of a manager for a specified amount of time, an exercise which is also a motivator (Armstrong, 2006). A dual disorder care giver can also seek the services of a mentor who is usually a person who has excelled in the area of tending to dual disorder patients.

One of the roles of a dual disorder centre manager is to motivate his fellow care givers and the sick patients. For new supervisors this role has changed

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from the traditional ways to modern techniques applied by rehabilitation centres in motivating a sustainable manner of handling dual disorder people. In the first days of a new dual disorder patient, the manager should be able to set targets in terms of the expected state of mind of the patient over a period of time which will form the basis for future care giving performance appraisal. This is a simple way to motivate dual disorder therapy since care givers will remain focused and dedicated to achieving set goals. Conclusion As highlighted earlier in this paper, addiction is the physical, mental or psychological dependency on a substance or an action. Drug addiction is the complete dependency on a substance to function normally.

An addicted person is chronically intoxicated and has a compulsive use despite dangerous effects posed (Canadian Institutes of Health Research 2007). Mental health problems are some of the effects brought by drug use; especially common with drug addicts. Acquisition of both mental health problem such as depression and drug abuse, is termed as dual diagnosis. According to researches of the 21st century, some of the common causes of drug and substance abuse are peer pressure, anxiety, environmental stress or even depression. Most people who engage in drug and substance abuse eventually encounter mental health problems.

Opiates such as heroin, cocaine and codeine, also referred to as Central nervous system (CNS) stimulants are responsible for the mental dysfunction. Programmes suggested, like the MICAA have had clients attend them and attained a long term abstinence from substances that had addicted them, (Sciacca, 1997). For these reasons, this paper is justified to draw a conclusion that integrated treatment of patients with a dual diagnosis of <https://assignbuster.com/addiction-and-mental-health/>

addiction and mental illness has demonstrated to be the most effective and efficient way to rehabilitate dually diagnosed patients.