Adolescents with Co-Occurring Disorders:
They Are Already in Your Care

Center for Innovative Practices at the Begun Center for Violence Prevention Research and Education

Ohio’s 2017 Behavioral Health Conference
Co-Occurring Disorders

Introduction
Co-Occurring Disorder

• Simply and globally: when a mental health disorder and a substance use disorder occur at the same time

• More individually and specifically: “when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from [a single] disorder”. (CSAT, 2005)
COD ID Q&A

• What considerations in identifying the current diagnosis of COD?
  – Is there a difference between Mild, Moderate and Severe (think Abuse v Dependence)?
  – What if there was clear dependence, but the youth is now ‘In Remission’?
  – What if a Mental Health condition is being very effectively treated, but SUD is evident?
COCE recommends using a ‘service definition’ (reflecting clinical realities and constraints) identifying COD, which includes:

- ‘Prediagnosis’: an established diagnosis in one domain matched by signs or symptoms evolving from the other
- ‘Postdiagnosis’: either one or both of SUD or MH may have resolved for a substantial time
- ‘Unitary Disorder’ with ‘acute signs’ of the other

This is a fairly broad inclusion for COD identification

CSAT, 2006a
Diagnostic Inclusions ??

Nicotine and Caffeine

- Nicotine contributes to more mortality than alcohol – but is rarely included solely as the SUD diagnosis
- Caffeine Dependence is even less likely to be included (perhaps rightly so...)

Gambling

- Pathological gambling has been moved from Impulse Control Disorder to *Addiction and Related Disorders* in the DSM 5
- COCE recommends Impulse Control Disorders be screened for and included on the SUD side for co-occurring inclusion

CSAT 2006a
No yawning...
Drugs and Alcohol

Adolescents
Too Much Information

There are three major, federally-funded, national surveys about adolescent drug use. Different methodologies are used: only one is conducted in the home (and therefore may under-report actual use percentages)

- **Monitoring the Future** (MTF): sponsored by NIDA
- **Youth Risk Behavior Surveillance** (YRBS): sponsored by CDC
- **National Survey on Drug Use and Health** (NSDUH): sponsored by SAMHSA
Overview of AoD Use

- MTF: Predicts that about 50% of teens have tried an illicit drug at least once in their lifetime
- NSDUH: Estimates that about 10% of all teens have used an illicit drug in the last month
- YRBS: Reported 70.8% of 9 – 12 graders have tried alcohol at least once
Overview of AoD Use

- MTF 2016

Illicit drug use has demonstrated a slight drop in recent trends, mostly due to slowed cannabis use.

In 2016, 21% of 12th graders reported trying at least one illicit drug other than cannabis at least once in their lives.

Source: University of Michigan, 2014 Monitoring the Future Study
Prevalence: Alcohol and Youth

Alcohol use by adolescents has been declining for years – and is currently at historically low levels.

Despite this – alcohol is the most commonly used substance by adolescents

• In their lifetime, between 44 and 66% of youth report having tried alcohol at least once
Alcohol

• During the last 30 days
  – 24-35% of youth reported drinking alcohol
  – 10% of all HS students reported *binge drinking*
    • Drinking 5 or more drinks on a single occasion in the last two weeks
  – 6% of all HS students reported *extreme binge drinking*
    • Drinking 10 or more drinks on a single occasion
Trends: Cannabis & Cigarettes
Any use reported in the last month

- Year 2000: Cigarettes 31.4, Marijuana 21.6
- Year 2001: Cigarettes 29.5, Marijuana 22.4
- Year 2002: Cigarettes 26.7, Marijuana 21.5
- Year 2003: Cigarettes 24.4, Marijuana 21.2
- Year 2004: Cigarettes 25.0, Marijuana 19.9
- Year 2005: Cigarettes 23.2, Marijuana 19.8
- Year 2006: Cigarettes 21.6, Marijuana 18.3
- Year 2007: Cigarettes 21.6, Marijuana 18.8
- Year 2008: Cigarettes 20.4, Marijuana 19.4
- Year 2009: Cigarettes 20.1, Marijuana 20.6
- Year 2010: Cigarettes 19.2, Marijuana 21.4
- Year 2011: Cigarettes 19.0, Marijuana 22.4
- Year 2012: Cigarettes 17.1, Marijuana 22.9
- Year 2013: Cigarettes 16.3, Marijuana 22.7
- Year 2014: Cigarettes 13.6, Marijuana 21.2
- Year 2015: Cigarettes 11.4; Marijuana 21.3
- Year 2016: Cigarettes 10.5; Marijuana 22.5

The highest rate reported in the last 36 years:
- Year 1978: Cigarettes 36.7, Marijuana 37.1

Source: NIDA – MTF 2016
Cannabis: Youth Numbers

NIDA: MTF 2016

Reported Use in Last Year
(change from 2015)

- 8<sup>th</sup> Grade: 9.4% (-2.2)*
- 10<sup>th</sup> Grade: 23.9% (-1.5)
- 12<sup>th</sup> Grade: 35.6% (+0.7)

*Significant @ .05

Reported Daily Use

- 8<sup>th</sup> Grade: .7% (-0.3)
- 10<sup>th</sup> Grade: 2.5% (-0.5)
- 12<sup>th</sup> Grade: 6.0% (0)

Daily use was defined as using on at least 20 of the last 30 days
Synthetic Cannabinoids: K2

• For the first time, in 2011, the MTF Survey asked 12th graders about use of synthetic cannabinoids (K2, Spice)
  – 2011: 11.4
  – 2012: 11.3
  – 2013: 7.9
  – 2014: 5.8
  – 2015: 5.2
  – 2016: 3.5

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Prescription and OTC Abuse

For Adolescents
(same for adults)
Alcohol is the number one abused substance
Cannabis is easily number two
Nonmedical use of Rx and OTC drugs is third for all adolescents

*Not including nicotine

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Prevalence: Rx Drugs
2016 MTF

Prescription drugs – and OTC drugs – can be misused in several ways and there can be the misperception that these types of drugs are ‘safer’

In the last year
12% of HS Seniors reported misuse of a Rx drug
(this is a continuing declining number)

In the last 30 days
2% of all students reported Rx misuse
5% of HS Seniors reported Rx misuse
Top Drugs among 8th and 12th Graders, Past Year Use

8th Graders
- Marijuana/Hashish: 11.7%
- Inhalants: 5.3%
- Synthetic Marijuana: 3.3%
- Cough Medicine: 2.0%
- Tranquilizers: 1.7%
- Adderall: 1.3%
- Hallucinogens: 1.3%
- OxyContin: 1.0%
- Vicodin: 1.0%
- Cocaine (any form): 1.0%
- MDMA (Ecstasy): 0.9%
- Ritalin: 0.9%

12th Graders
- Marijuana/Hashish: 35.1%
- Adderall: 6.8%
- Synthetic Marijuana: 5.8%
- Vicodin: 4.8%
- Tranquilizers: 4.7%
- Cough Medicine: 4.1%
- Sedatives: 4.3%
- Hallucinogens: 4.0%
- MDMA (Ecstasy): 3.6%
- OxyContin: 3.3%
- Cocaine (any form): 2.6%
- Inhalants: 1.9%
- Salvia: 1.8%
- Ritalin: 1.8%

* Only 12th graders surveyed about sedatives use
Source: University of Michigan, 2014 Monitoring the Future Study
Others of Note

- Salvia
- Dextromethorphan (DXM)
- Inhalants
- MDMA
- Kratom
- Marijuana Pops
- Flop
- Flakka

Weedsmokersguide.com
Adolescent Mental Health

And Development
• A large study supported by NIMH (2005) regarding prevalence and severity of mental illnesses noted:

Unlike most disabling physical diseases, mental illness begins very early in life. **Half of all lifetime cases begin by age 14;** three quarters have begun by age 24. Thus, mental disorders are really the chronic diseases of the young. For example, anxiety disorders often begin in late childhood, mood disorders in late adolescence, and substance abuse in the early 20's. Unlike heart disease or most cancers, young people with mental disorders suffer disability when they are in the prime of life, when they would normally be the most productive.
Adolescent Mental Health

• In October of 2010, the Journal of the American Academy of Child & Adolescent Psychiatry published the analyzed data from the National Comorbidity Study – Adolescent Supplement (NCS-A): a survey of more than 10,000 youths ranging in age from 13 to 18 years.

  – This survey was supported by NIMH
49.5% met criteria for some level of disorder

Of this...

Nearly half (22.2%) met criteria for a mental disorder to an extent that they had difficulty functioning (Severe Impairment)
Adolescent Mental Health
NCS-A

- **Major Depressive Disorder and Dysthymia**
  - 11.7% overall
  - 8.7% severe impairment

- **Anxiety Disorders**
  - 31.9% overall
  - 8.3% severe impairment

- **ADHD**
  - 8.7% overall
  - 4.2% severe impairment
  - (3X as many males)

- **Other Behavior Disorder**
  - ODD – 12.6%/6.5%
  - CD – 6.8%/2.2%

- **Substance Use Disorders**
  - Alcohol – 6.4% overall
  - Drug – 8.9%
  - Total – 11.4%

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Developmental Considerations

- Erikson: Identity v. Role Confusion
- Prefrontal Cortex Development
- Family and Genetics
- Sexual Maturation and Pressures
- Piaget Cognitive

Teenager

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Developmental Considerations

Triadic Model
Ersnt, Romeo and Andersen (2009)

Prefrontal Cortex
(Modulation)

Striatum
(Approach)

Amygdala
(Avoidance)

Interactions

Implications for risk-taking

• Prefrontal Cortex: self-monitoring and inhibitory
• Amygdala: conditioned fear and avoidance
• Striatum (includes nucleus accumbens): motivation and incentive

Adolescents appear to weigh risk more heavily toward reward and discount loss – riskier choices
Developmental Considerations

National Institute of Mental Health (www.nimh.nih.gov)

Impulsive decision-making

“... in teens, the parts of the brain involved in emotional responses are fully online, or even more active than in adults, while the parts of the brain involved in keeping emotional, impulsive responses in check are still reaching maturity. Such a changing balance might provide clues to a youthful appetite for novelty, and a tendency to act on impulse—without regard for risk”
Integration

The Process

Screening, Assessment and Engagement
Screening

Identification

Typically from sources in authority (parents, teachers, police…)

Mental Health

Substance Use

COD

Objective Measures and Clinical Impressions

Assessment

Treatment Planning

Dx

Integrated Assessment

Integrated Treatment Planning

One sided

Both

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Co-Occurring Disorders in Youth

• 70% of youth entering substance use treatment were identified as having a co-occurring mental health disorder

• 43% of youth receiving mental health treatment were identified as having a co-occurring substance use disorder
Expect Co-Occurring entering Substance Abuse Treatment

**WHAT THE NUMBERS SAY**

**Most People Entering Drug Treatment Have Additional Mental Health Problems**

<table>
<thead>
<tr>
<th>Mental Health Problem</th>
<th>Percent of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any</td>
<td>70%</td>
</tr>
<tr>
<td>Depression</td>
<td>60%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>50%</td>
</tr>
<tr>
<td>Traumatic Distress</td>
<td>40%</td>
</tr>
<tr>
<td>Attention Deficit</td>
<td>30%</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>20%</td>
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</tbody>
</table>

In 77 studies that included 4,930 adolescents and 1,956 adults, two-thirds of patients entering substance abuse treatment programs reported at least one co-occurring mental health problem during the previous year. Attention deficit and conduct disorders were most common in young patients, anxiety and depression in older patients.

Adolescent Mental Health

• 67% of youth in Center for Substance Abuse Treatment funded programs reported experiencing victimization in their lifetime.
• 13% of youth reported creating a plan for suicide in the last year.
• 8% of youth reported attempting suicide in the last year.
Youth Juvenile Justice

Juvenile Justice involvement increases risks in many areas, including: school failure, current and later unemployment, adult arrests, family problems and the likelihood of both mental health and substance use disorders.

• Of juveniles in any detention
  – 70% have at least one MH diagnosis
  – 40% have substance use disorder
  – 60% have co-occurring disorder
Expect and Screen

“In mental health services, substance use screening not only should be required during diagnostic evaluation but also should be done periodically thereafter, especially if a youth’s treatment progress is slow or inconsistent.”
Uh, expect what?

Identifying Mental Health and Substance Use Problems of Children and Adolescents: A Guide for Child-Serving Organizations (SAMHSA) notes:

“Few mental health and substance abuse professionals are cross-trained”: a deficit traced back to academic programming.

Recommends the use of screening tools by both sides of the profession

Other problems in looking for co-occurring disorders:

- Co-occurring youth tend to be more difficult to engage and retain
- Parallel or Sequential treatment has been the accepted norm for a long time

Sources: Hawkins, 2009; Hendrickson, 2009
Advantages to Integration

- Both AoD and MH problems are considered ‘primary’ and addressed equally
- Single course of action: goals and treatment plans are not at odds
- Medication – and potential interactions – can be more easily monitored

Integration has also been shown to:
- Increase retention
- Yield more positive outcomes: higher abstinence and fewer MH symptoms
- Fewer hospitalization days
- Fewer arrests

Compiled by CASA Columbia June 2012
Screening

- Screening is a brief and formal process that is intended to identify signs and symptoms that indicate a need for a more in-depth assessment.

- This is often the first face-to-face contact with the client and represents the prime opportunity to increase the likelihood of long(er) term retention.
Screening Tools

• Tools should be short and brief
• Wording should be easy for the client population to understand
• Should be easy to administer by a wide range of staff – not just clinicians
• Cheap or free is nice too

Adapted from Minnesota DHS Chemical and Mental Health Services Administration report from July 2009
Integrated Screening

In addition to screening for the signs of possible co-occurring conditions for a more in-depth assessment, CSAT’s COCE Overview Paper 2 recommends:

A comprehensive, integrated screening will also include an exploration of a variety of related service needs, such as:

Medical    Housing
Trauma(!)    Safety
School    etc.
Other Screening Tools

- **ASSIST: Alcohol, Smoking and Substance Involvement Screening Test.**
  - Developed by the WHO
  - Free
  - 8 questions
  - Requires some training and practice
  - Developed for adults: some suggestions may be appropriate for adolescents

- **CAGE-AID: (Adapted to Include Drugs)**
  - Cut down?
  - Annoyed?
  - Guilty?
  - Eye-opener?
  - Obviously very brief
  - Applicable to adults and adolescents
Other Screening Tools

- **GAIN-SS**: Global Appraisal of Individual Needs – Short Screener
  - 20 items: screens for internalizing, externalizing, SU and crime/violence disorders
  - Little training: BUT requires licensing (this one isn’t free)

- **CRAFFT**: name refers to questions involved in the screening (Car, Relax, Alone, Forget, Family, Trouble)
  - Screens adolescents for lifetime risky AoD use
  - Quick, easy, little training
  - Free: in public domain
Other Screening Tools

• **POSIT**: Problem-Oriented Screening Instrument for Teenagers
  - Developed by NIDA
  - AoD specific, but includes physical health and social relations
  - 20 to 30 minutes; little training; Free

• **SASSI-A**: Substance Abuse Subtle Screening Inventory – Adolescent Version
  - Screens for and differentiates Abuse and Dependence
  - Requires little training
  - $120 starter kit (25 paper tests)
Screening vs Assessment

The line between Screening and Assessment is often blurred: it can be difficult to understand the differences from the descriptions (even from sources like TIP 42!) if an instrument is for screening or for assessing.
Screening vs Assessment

Screening instruments are brief and easy: often do not require any training. They are intended to identify a need for more comprehensive investigation.

Assessment instruments are comprehensive and provide more specific diagnostic information. They require interpretation by trained or licensed professionals.
Integrated Assessment

• An Integrated Assessment addresses both Mental Health and Substance Abuse Disorders in the context of the other disorder

1. Establish a formal diagnosis
2. Evaluate current level of functioning
3. Determine readiness to change
4. Make initial decisions about appropriate level of care

The Integrated Assessment seeks to

COCE Overview Paper 2
TIP 42: Recommended 12-step Assessment Process

1. Engage the client
2. Obtain releases – then gather collateral information (see next)
3. Screen for/detect COD
4. Determine severity of MH and SU disorders
5. Determine appropriate care setting
6. Determine diagnosis
7. Determine disability and functional impairment
8. ID strengths/supports
9. ID cultural and linguistic needs
10. ID additional problem areas (ecosystemic...)
11. Determine Readiness for Change
12. Plan Treatment
Assessment – on the heels of the 12-steps...

• The recommended Assessment Process seeks to:
  – Get a detailed chronological history of both MH and SU
  – ID supports and limitations
  – Determine Stage of Change for each problem (next)
  – What does the client want? How will change occur?

• Assessment Instruments – by themselves – do not constitute a complete Assessment.

• They are included along with:
  – In-depth clinical interview
  – Social history
  – Treatment history
  – Collateral interviews
  – Medical history
  – Lab tests
  – Etc...
Assessment Tools

CASI
Comprehensive Adolescent Assessment Tool

Covers 10 independent modules, including:
Health, family, stressful events, legal status, sexual behavior, AoD use, mental health, peer relationships, education, free time

*Requires 2-day training for $2,000
Assessment Tools

T-ASI
Teen Addiction Severity Index

Covers 7 domains:
Substance use, school status, employment status, family relationships, peer relationships, legal status and psychiatric status

*One-day training: cost dependent upon number
Assessment Tools

GAIN
Global Appraisal of Individual Needs
Whole host of assessment and screening instruments: GAIN-I is comprehensive initial assessment – well tested and accepted

*Requires 3 ½ day training for about $3,000
Other Assessment Tools

• CAFAS: Child and Adolescent Functional Assessment Scale
• CANS: Child and Adolescent Needs and Strengths
• MMPI: Minnesota Multiphasic Personality Inventory
• DISC-IV: Diagnostic Interview Schedule for Children – Fourth Edition
Beyond Prepared Instruments

Clinical instruments are very helpful and are designed to aid in decision-making: but other information is useful:

• Achievement and abilities
• Learning disabilities
• Level of emotional maturity
• Ability to think abstractly
• Genogram mapping
Beyond Instruments

SAFETY
SAFETY
SAFETY
SAFETY
SAFETY
SAFETY
SAFETY
SAFETY
SAFETY
SAFETY

DANGER
THIN ICE

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Contextual Assessment

- The youth’s behaviors are interactively and multiply determined based on his or her mental health, substance use, functional environments and abilities

- Importance is placed on the contextual functioning of the youth in each of his or her major life domains
Screening and Assessment
Do’s and Don’ts

• *Do*: approach Screening and (especially) Assessment as opportunities to ‘get to know’ the client/family – use as rapport-building and motivation-enhancing

• *Don’t*: rely too much on prepared instruments: clinical judgment is most important – and is enhanced by instruments

Do’s and Don’ts are adapted from: TIP42 and Mental Health Screening and Assessment in Juvenile Justice
# Do’s and Don’ts

<table>
<thead>
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<th><strong>DO</strong></th>
<th><strong>Don’t</strong></th>
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<tbody>
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<td>Consider adolescent symptoms in the context of development:</td>
<td>Rely too strictly on adult diagnostic categories and criteria.</td>
</tr>
<tr>
<td>adolescence can be naturally turbulent</td>
<td>Adolescence is not ‘junior adulthood’ or ‘advanced childhood’.</td>
</tr>
<tr>
<td>Disorders can be emerging during this key developmental period</td>
<td></td>
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</tbody>
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Do’s and Don’ts

Do
Increase the contextual perspective
• Gain as much collateral information as possible
• Consider demographic, gender and cultural factors

Don’t
Assume that one treatment approach fits all assessed Co-Occurring Disorders

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Do’s and Don’ts

Do
Increase familiarity with diagnostic criteria (remembering to keep this in context of adolescence…)
• For Substance Use
• For Mental Health

Don’t
Get too focused on ‘what causes what’:
Ex: ‘these mental health symptoms are just a result of the drug use…’
or
‘she is obviously using to self-medicate her mental health symptoms…’
Don’t

• Be afraid to admit you don’t know: co-occurring disorders are hard enough without adding adolescence to the mix
• Do: consult