ADOLESCENT CO-OCCURRING DISORDERS: TREATMENT TRENDS AND GUIDELINES

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OBJECTIVES

• National and Utah Statistics
• Best Practice Guidelines for Treating Co-Occurring Disorders
• Trauma, Psychosis, and Substance Use
CO-OCCURRING DEFINED

SAMHSA\(^1\) defines Co-Occurring Disorders (COD) as:

“Individuals who have at least one mental disorder as well as an alcohol or drug use disorder. While these disorders may interact differently in any one person (e.g., an episode of depression may trigger a relapse into alcohol abuse, or cocaine use may exacerbate schizophrenic symptoms), at least one disorder of each type can be diagnosed independently of the other”
SUBSTANCE ABUSE STATISTICS

• Approximately 2.2 million adolescents (aged 12-17) are current illicit drug users
• 2.9 million adolescents are currently use alcohol
• Approximately 1.3 million adolescents have an Substance Use Disorder (SUD)²
• 68% of young adults (ages 21-25) are currently using alcohol; 90% have used during lifetime
• 19% of young adults are currently using illicit drugs; 61% lifetime³

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH), 2013.
• More than 1 in 5 children/adolescents have a diagnosable mental health disorder

• Approximately 2.6 million (10%) of adolescents have experienced a Major Depressive Episode in the past year

• About 21% of children 9-17yo have mental health or substance use disorder with at least minimum impairment
CO-OCCURRING DISORDER STATISTICS¹⁻³,⁶

- 1.4% of all adolescents have both SUD and a Major Depressive Episode
- Adolescents with SED (serious emotional disturbance) are five times more likely to have an alcohol dependence problem than those without SED
- 43% of youth receiving mental health (MH) treatment services have a COD
- 90% with COD had one mental disorder prior to the onset of an SUD
- Rates of COD are approximately 50% for adolescents diagnosed with either a mental health disorder or SUD
- Among young adults ages 18-25 with a serious mental illness, 48% report past-year illicit substance use, and 36% meet criteria for a SUD
- 36% of all adults with COD are ages 18-25 years
## UTAH STATISTICS

**Children and Adolescents Served in Utah by Diagnosis**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Diagnosis only</td>
<td>14912</td>
<td>96.8</td>
</tr>
<tr>
<td>MH and SA Diagnosis</td>
<td>487</td>
<td>3.2</td>
</tr>
<tr>
<td>SA Diagnosis only</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15406</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Frequency Percent**

| MH Services only for FY2014      | 14821     | 96.2    |
| Received both MH and SA services within FY2014 | 585       | 3.8     |
| **Total**                        | **15406** | **100** |

**Treatment of Children and Adolescents with both MH and SUD Dx**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>MH Services only for FY2014</td>
<td>240</td>
<td>49.3</td>
</tr>
<tr>
<td>Received both MH and SA services within FY2014</td>
<td>247</td>
<td>50.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>487</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Children and Adolescents Served in Utah by Diagnosis**

![Graph showing the percentage of children and adolescents served in Utah by diagnosis]
CO-OCCURRING TREATMENT

• Integrated care is most effective, but almost half of treatment is sequential or parallel.
• Between 20-50% of adolescents in treatment receive treatment which addresses both the SUD and MH.
"NO WRONG DOOR" 8

“No wrong door” denotes a system of care that is accessible from multiple points:

• Integrates and addresses treatment for both mental illness and addiction
• Collaborates with all entities involved with the adolescent and family:
  • Education
  • Family
  • Medical (Primary Pediatric/Adolescent Care)
  • Mental Health/Substance Abuse Provider
  • Justice System
Based on prevalence rates, clinical practice guidelines for COD should consider the following guiding principles:

• Providers of co-occurring services need to take a “no wrong door approach”

• Assessment and treatment services need to be:
  • Integrated \(^9,^{10}\)
  • Offer a full continuum of services including:
    • Prevention
    • Screening Through Treatment and Recovery
    • Be Family Focused
• Staff should be cross trained and efficient on screening, assessment, and treatment of COD

• Assessment and diagnosis should be ongoing and evolve throughout treatment

• Trauma needs to be screened and addressed clinically due to high prevalence rate among this population

• Developmental/prevention perspective

• There should be an integrated approach including a care plan that includes the biopsychosocial needs of the youth and family\textsuperscript{9,10}

• Medication management, if appropriate

• Assisting adolescents in transitioning to adult treatment options
ASSESSMENT & SCREENING

• “The process of screening, assessment, and treatment planning should be an integrated approach that addresses both substance abuse and mental health disorders, each in the context of the other and neither should be considered primary.” 11

• Co-occurring assessments should include:
  • Comprehensive bio-psychosocial assessment
  • SUD assessment using a brief screening in all youth entering a behavioral or healthcare system
  • Follow-up with a comprehensive SUD assessment for youth who present with COD
  • Assessment for trauma/victimization

• Assessment for suicidality including self-harming behaviors
ASSESSMENT & SCREENING (CONT.)

Who should screen?  
- Schools
- Health Care Delivery System
- Juvenile Court
- Mental Health Providers
- Youth Outreach Workers

Who should be screened?  
- Youth in the juvenile justice system
- Youth receiving mental health assessments
- Youth entering child welfare system
- Runaway and homeless youth
- Youth with substantial behavior changes
- Youth with trauma
Purpose of screening for substance use:
- Accurately identify youth who need treatment
- Further evaluate if a SUD exists and determine severity of substance use and if youth meets diagnostic criteria
- Family involvement in treatment

Screening procedures should include, but are not limited to:
- Process should not take longer than 30 minutes
- Consider age, ethnicity, culture, gender, sexual orientation, socioeconomic status, literacy level
- Broad applicability across diverse populations
- Should focus on youths substance use severity and associated factors including legal, mental health status, educational functioning, and living situation, and support system
- Youth’s awareness of problem and motivation to change
SCREENING AND ASSESSMENT INSTRUMENTS

• Screening Instruments
  • Adolescent Alcohol Involvement Scale
  • Adolescent Drug Involvement Scale (ADIS)
  • Problem Oriented Screening Instrument for Teenagers (POSIT)
  • Global Appraisal of Individual Needs Short Version (GSS)
  • CAGE-AID
  • Modified Mini-Screen (MMS)

• Comprehensive Assessment Instruments
  • Comprehensive Adolescent Severity Inventory (CASI)
  • The American Drug and Alcohol Survey (ADAS)
  • Personal Experience Inventory (PEI)
  • Substance Abuse Subtle Screening Inventory (SASSI)
  • American Society of Addiction Medicine (ASAM)
• 1 in 4 children and adolescents in the United States experience at least 1 potentially traumatic event before the age of 16

• More than 13% of 17yo (1 in 8) have experienced PTSD at some point in their lives

• Every year, approximately 1 in 5 American adolescents engage in abusive/dependent or problematic use of illicit drugs or alcohol

• Teens who had experienced physical or sexual abuse/assault were 3 times more likely to report past or current substance abuse than those without a history of trauma

• More than 70% of patients receiving treatment for SUD had a history of trauma exposure

• This correlation is particularly strong for adolescents with PTSD. Studies indicate that up to 59% of young people with PTSD subsequently develop SUD
FIVE CORE VALUES OF TRAUMA-INFORMED CARE

"Creating Cultures of Trauma-Informed Care (CCTIC):
A Self-Assessment and Planning Protocol"

Safety
Trustworthiness
Choice
Collaboration
Empowerment

Roger D. Fallot, Ph.D and Maxine Harris, Ph.D

Community Connections: http://www.communityconnectionsdc.org/
According to the Robert Wood Johnson Foundation & The National Academies:

- An estimated 4 million young people will develop a severe mental disorder such as schizophrenia or bipolar affective disorder
- 70% of youth in the juvenile justice system suffer from mental health disorders and in 27% functional ability is seriously impaired
- Among adults, 50% of all mental, emotional, and behavioral disorders were diagnosed before the age of 14
- First symptoms typically precede a disorder by 2 to 4 years
- Early detection and intervention shows promise in helping young people with warning symptoms of serious mental disorders
- In a five year study, Early Detection and Intervention for the Prevention of Psychosis Program (EDIPPP) show declining rates of hospitalization among teens and young adults, as well as reduces rates of psychotic episodes among young people with early symptoms

- There are increased levels of substance use and misuse, among adolescents with psychosis as compared to adolescents from the general population.
FIRST EPISODE PSYCHOSIS

• Clinical Characteristics of First Episode Psychosis:
  • Typically adolescent or young adult
  • Families are often actively engaged
  • Have lived with severe untreated psychotic symptoms on average for at least a year

• Compared to Peers:
  • Cognitively impaired
  • Poorer psychosocial functioning
  • more likely to smoke
  • more likely to use substances
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REFERENCES


REFERENCES (CONT.)


