Adolescents with Co-occurring Disorders: Who are they and what do we do about them?

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Research

- The majority of youth referred for substance abuse treatment have at least one co-occurring mental health disorder.
  - Adolescents with substance use disorders are at a six times higher risk of having a co-occurring psychiatric disorder (Dennis 2004).
- Trauma/victimization in youth with substance use disorders range from 25% for males to 75% for females (Kanner 2004, Dennis 2004).
- In juvenile justice settings 75% of males and 50% of all females have a co-occurring disorder.

More Research

- Drug abuse changes the brain chemistry of developing brains (Degenhar & Hall 2006, Smit 2004).
- Psychiatric symptoms often proceed the SUD.
- Disruptive & mood disorders are associated with earlier onset of use of substances & increased SUD.
- CSAT sites – 74% of youth with SUD also had a co-occurring mental health disorder (Turner, Muck, Muck et al 2004)

RESEARCH, CONT.

- High levels of confrontation seldom result in better treatment outcomes.
- Social support crucial in recovery and maintenance.
- Therapists with personal history of abuse no more successful than those without.
- No one substance abuse treatment is more successful than others.

Co-occurring Disorders Categories

- Co-occurring disorders in adolescents usually categorized into internalizing & externalizing disorders. These are typically the focus of treatment for mental health interventions.
  - Internalizing disorders – symptoms of anxiety, fear, shyness, low self-esteem, sadness, depression (6%)
  - Externalizing disorders – symptoms of non-compliance, aggression attention problems, destructiveness, impulsivity, hyperactivity, antisocial behavior (18%)
  - Both types of disorders (38-65%)

Most Frequent Co-occurring Mental Health Disorders

- Substance Use/Abuse/Dependence
- Mood Disorders
- PTSD
- Behavioral Disorders (ADHD, Oppositional Defiant, Conduct Disorder)
- Anxiety Disorders
- Personality Disorders (Borderline, Antisocial)
- Severe & Persistent Mental Disorder (Schizophrenia/Severe Bipolar Disorder)
- Eating Disorder

Treating early life trauma

- Early trauma correlates with higher incidence of
  - Violent behavior
  - Criminal behavior
  - Teenage pregnancy
  - Becoming victim of more trauma
  - Psychiatric disorders
  - Substance use disorders
  - Self-destructive behavior
- SUD may have started as attempt to self-medicate

KIDS WHO ABUSE…

- Difficulties with DSM-IV – kids generally abandoned (e.g. ordinary onset of dependence is 20's-40's)
- Must be culturally sensitive – kids from different cultures use different drugs
- Polysubstance use may be indication of increased tolerance (adults stick with one or two preferred substances)
- Engagement is key – problematic for high risk populations – must demonstrate payoff for externalizing kids

FACTORS TO CONSIDER FOR KIDS…

- By nature inclined to take risks
- Live in the here and now more than adults
- Limited perspective on time – difficult to delay gratification
- Rebelliousness
- Sensitivity to peer group
- Adolescent alienation – most insecure are most vulnerable to peer pressure
- Stress
- Insecurity & low self-esteem

THE PROBLEM WITH DIAGNOSIS…

- Complex & problematic – difficult to separate
- Misdiagnosis results from observer bias, preconceptions & moral judgments
- Lack of clinical knowledge about both disorders
- Clinicians don't obtain in-depth histories

Components of diagnosis

- Urine/drug screens
- Stabilize acute intoxication & psychiatric symptoms – clear system of toxic substances
- Medical evaluation & lab tests
- Thorough, detailed history (use asst. tools)
- Obtain family history
- Clinical evaluation during drug-free period

DIAGNOSIS, CONT.

- The best way to circumvent the difficulty in separating out the dually diagnosed from the general psychiatric or SA population is to eliminate the need.
  - Treat what is presented
  - All staff cross-trained
  - Maintaining ability to reassess & adjust services throughout treatment covers inaccuracy in diagnosis

Assessment & Treatment

The process of screening, assessment & treatment planning should be an integrated approach that addresses the SA and MH disorders, each in the context of the other & neither should be considered primary. Expect co-occurring disorders as incidence is higher than realized in adolescents.

Assessment of Co-occurring Disorders

- Comprehensive biopsychosocial assessment
- Assess for substance use disorder using a brief screening tool in ALL adolescents entering any system
- Follow-up with a comprehensive substance use disorder assessment for adolescents who present with a co-occurring SUD
- Assess for trauma/victimization

Substance Abuse Assessment

- Should include
  - Drugs used
  - Onset, progression, patterns of use
  - Assessment for patterns of use of multiple druggs
  - Consequences of drug usage
  - Motivation for treatment
  - Family history regarding substance use including extended family
  - Use of instruments
    - Adolescent Alcohol Involvement Scale
    - Adolescent Drug Involvement Scale
    - Problem Oriented Screening Instrument for Teenagers
    - Practical Adolescent Dual Diagnostic Interview (PADDI)
    - Cage-AID

Treatment of Co-occurring Disorders

- Incorporate empirically based treatments for co-occurring disorders into routine practice
  - Stage-wise treatment
  - Motivational enhancement strategies
- Target most common co-occurring disorders, e.g., depression, ADHD, PTSD, trauma
- Medication has a place in treating co-occurring disorders, particularly the internalizing disorders

Integrated Co-occurring Treatment

- All staff cross-trained for both disorders – single provider can address both issues/problems
- Stage-wise treatment – readiness for change
- Motivational enhancement – motivational interviewing – facilitates youth's, family's, & community's readiness for change
- Working with family critical
- Services can be provided where the youth & family live – not bed driven
- Focus on collaborative relationships

Evidence Based Treatments

- "…the integration of the best research evidence with clinical expertise and patient (consumer) values". Based on definition used in "Crossing the Quality Chasm: A new Health System for the 21st Century" (2001) Institute of Medicine
- Hold promise for improving outcomes
- Have different levels of support
- Target specific populations/specific outcomes
- Implemented with fidelity to ensure outcomes
- Implementation/fidelity/model adherence: a robust process
- Practitioner is responsible for engagement
- A word of caution – just because there is no evidence doesn't mean it doesn't work – research may not have been done

Model Characteristics

- A framework for understanding behavior change as a *process*; change is not all-or-none
- Individuals follow a powerful, predictable course when changing behavior
- An alternative approach to viewing youth as in denial, resistant, or uncooperative if not ready (or willing) to change

STRATEGIES FOR SUPPORTING CHANGE

- Finding the strengths & building on them
- Managing emotions – anger, depression, anxiety, boredom, loneliness
- Support through skill development – both are equally important
- Flexibility in delivery of services

What is the key to success?

- Engagement & motivation!!!
- How?
  - Express empathy
  - Unconditional acceptance
  - Non-confrontational approach to recovery
  - Match interventions with motivation

Principles in Operation

- Express empathy
  - Acceptance facilitates change
  - Skillful reflection is fundamental
  - Ambivalence is normal
- Develop discrepancy
  - Client (not therapist) presents argument for change
  - Change motivated by perceived discrepancy between behavior, goals, & values

PRINCIPLES, CONT.

- Roll with resistance
  - Avoid arguing
  - Resistance is not directly opposed
  - New perspectives are invited, not imposed
  - Client is primary resource in finding answers & solutions
  - Is a signal to respond differently
- Support self-sufficiency
  - Client's belief in possibility to change important motivator
  - Client responsible for the change (choice & change)
  - Therapist's belief in the client's ability to change becomes a self-fulfilling prophecy

Resistance

- Observable client behavior that occurs within the context of treatment
- Represents signal of dissonance within the counseling relationship
- Associated with dropout early in treatment

Resistance Process Categories

- Arguing – challenging, discounting, hostility
- Interrupting – talking over, cutting off
- Negating – blaming, disagreeing, excusing, minimizing, reluctance, unwillingness
- Ignoring – inattention, non-answer, no answer, sidetracking

Factors contributing to relapse

- Poor compliance
- Ignoring early warning signs
- Emotional distress
- Interpersonal problems/deficits
- Relationships with active substance abusers
- Thinking errors

More factors

- Personality factors
- Deficits in coping skills
- Illness related factors
- Medication induced symptoms
- Family factors – minimizing, enabling, family use, unwillingness to participate in treatment (fix the child, not our problem)

Evidence Based Practices for Co-occurring Disorders

- Psychosocial interventions
  - Cognitive Behavioral Therapy
  - Group therapy model
  - Skill development
  - Individual therapy
  - Contingency Management
  - Relapse Prevention
  - Integrated Co-occurring Treatment (ICT)
- Psychopharmacological interventions
- Family interventions
  - Functional Family Therapy
  - Family Behavior Therapy
- Self-help Groups – AA/NA
- Motivational Enhancement Strategies – Motivational Interviewing
- Use of assessment instruments
- Cross trained staff with demonstrated competencies & clinical supervision
- Multisystemic Therapy (MST)

THINGS TO REMEMBER…

- Rarely in treatment voluntarily
- Self-motivation does not readily occur
- Staff faced with power & control issues
- Psychological upheaval in kids due to:
  - Identify confusion
  - Self-esteem issues
  - Process of maturation
  - Lack of social skills
  - Feelings of invincibility
  - Inordinate reliance on peer group
  - Impact of abuse/family issues

Motivation for Change

Critical components

- Ready – a matter of priorities
- Willing – the importance of change
- Able – confidence for change

Ready, willing, & able indicate high motivation for change.