

Understanding Young Adults with Co-Occurring Disorders

Holly Hills, Ph.D.

Mental Health Law and Policy

Louis de la Parte Florida Mental Health Institute

At the conclusion of this session, participants will be able to:

- Define what it means to have ‘co-occurring disorders’
- Discuss the prevalence of co-occurring mental health and substance use disorders in youth
- Identify commonly seen presentations
- Discuss emerging evidence-based practices for youth with COD

What does it mean to have “Co-Occurring Disorders”?

- Many forms of ‘comorbid’ or ‘co-occurring disorders’ have been identified in epidemiological studies (Kessler et al., 2005)
- Here we mean having both an addictive, or substance use disorder, and another mental health disorder (not substance use related), simultaneously

What does it mean to have

“Co-Occurring Disorders”?

- Many may be familiar with the term – dual diagnosis – which was commonly used over the past twenty years
- Often, however, youth may present with multiple diagnoses

What does it mean to have

“Co-Occurring Disorders”

- Youth come to Job Corps programs during the years in their life when most mental health disorders are likely to emerge
- Some may have a history of diagnosis and treatment, but others may not -- so it is important to be vigilant about their symptoms and experience

Common Co-Occurring Disorders in Adolescents

Mental Health Disorders

- Conduct Disorder
- Oppositional Defiant Disorder
- Mood Disorders
- Anxiety Disorders
- ADHD

Abused Substances

- Marijuana
- Alcohol
- Cocaine/Crack
- Methamphetamines
- *Increasingly -- Prescription Drugs – specifically opioids*

What disorders co-occur?

Externalizing Disorders:

- Conduct Disorder, ADHD, Oppositional Defiant Disorder

Internalizing Disorders:

- Major Depression, Dysthymic Disorder, Generalized Anxiety Disorder, PTSD

.....One or both categories combined with SU Disorders

Models that explain why disorders co-occur

- Common Factors Model
- Secondary Psychiatric Disorder Model
- Secondary Substance Abuse Model
- Bidirectional Model (Bennett et al., 2012)

What causes these disorders to co-occur? Different Models

Common Factors

- As clear genetic links between categories of mental health disorders and substance use disorders have not been demonstrated, common factors driving the presentation of CODs could include comorbid Antisocial Personality Disorder (ASP), low socioeconomic status, poor cognitive functioning, or having a history of trauma.

What causes these disorders to co-occur? Different Models

Common Factors

- Multivariate models also exist.... A family history of psychopathology, combined with inheritance of deviant personality traits could lead to both the development of Borderline PD and Substance Abuse

What causes these disorders to co-occur? Different Models

Secondary Psychiatric Model

- Onset of early substance use impacts brain development and neuroendocrine system
- Precipitates or exacerbates preexisting psychiatric disorders (CD, ADHD, mood or anxiety disorders)

What causes these disorders to co-occur? Different Models

Secondary Psychiatric Model

- Strongest evidence for this may be in the relationship between Major Depression (unipolar) and alcohol dependence

The Development of Co-Occurring Disorders: Another Path

Secondary Substance Use Model

- Behaviors or symptoms associated with mental health disorders lead these youth to be marginalized within their peer groups, increasing the likelihood that they will come to affiliate with peers that use substances

The Development of Co-Occurring Disorders: Another Path

Secondary Substance Use Model

- The concept of 'self medication' – may be an example of this process unfolding

The Development of Co-Occurring Disorders: Another Path

- Clues to this path involve
 - Evaluating the age of onset of symptoms
 - The association between the person's level of symptoms and their level of substance use
 - Their subjective reasons for using alcohol or drugs, and, to a lesser extent,
 - The types of drugs chosen

The Development of Co-Occurring Disorders: Another Path

'Bidirectional' Model

- Ongoing interactional effects between symptoms of these disorders account for increased rates of comorbidity
- Strongest body of evidence for this may be the association between anxiety and alcohol dependence

Chronology of Adolescent Co-Occurring Disorders

- Studies can be found to support each temporal relationship
 - Most research indicates that MH typically precede SA
- Different diagnostic combinations may have different chronologies

Chronology of Adolescent Co-Occurring Disorders

- Majority of NCS (Kessler et al., 2005) respondents with COD indicated that MH problems began in adolescence
 - *Followed 5 to 10 years later by problematic substance abuse*
- Early identification and treatment of either disorder can serve to prevent the other from developing

What do we know about prevalence rates in community samples?

Evaluations of adolescents in substance abuse treatment have revealed rates of psychiatric comorbidity between 50-90%

(Reebye, Moretti, & Lessard, 1995; Rounds-Bryant, Kristiansen, & Hubbard, 1999).

What do we know about prevalence rates in community samples?

Having a 'dual diagnosis' is now considered the "norm"

(Roberts & Corcoran, 2005).

Substance Use Disorders: Presentation and Onset

- Many youth will come to you with a history of substance use / abuse – these patterns change over time -- as does drug use slang (www.noslang.com)
- In the 2012 Monitoring the Future Study: (<http://www.monitoringthefuture.org//pubs/monographs/mtf-overview2012.pdf>)
 - Marijuana use continued to increase slightly in use (over the past five years) whereas alcohol use has had a slight downward trend.

Substance Use Disorders: Presentation and Onset

- Use of Oxycontin and Vicodin also have been trending downward, across grades, over the past three years.
- Across almost all drug types, we see continued rates of increase in prevalence from 8th through 12th grades – typically doubling or tripling during those years.

Substance Use Disorders: Presentation and Onset

- Marijuana (cannabis) abuse or dependence continues to be the most common drug bringing youth in contact with juvenile drug courts (80% vs. 38% for alcohol, while 16% met criteria for abuse or dependence on some other illegal substance (Henggeler et al., 2012).

Substance Use Disorders: Presentation and Onset

- Pattern of use in adolescents with co-occurring disorders is thought to have earlier onset, with greater frequency and chronicity of use
- Within the group of those with CODs, those with ‘mixed’ type (internalizing and externalizing + substance abuse) appear to have the poorest clinical **outcomes** (Bender, Springer, & Kim, 2006).

Impact of Co-Occurring Disorders: Clinical Outcomes

- Youth with ADHD had *2.5x greater* risk to substance use relapse within the first six months following treatment, even when Conduct disorder and other pretreatment factors were controlled for (Latimer et al., 2004).

Impact of Co-Occurring Disorders: Clinical Outcomes

- Youth with CODs returned to substance use at increased rates during the first six months following substance abuse treatment, as compared to their SUD-only peers (Tomlinson, Brown, & Abrantes, 2004; 87% vs. 74%).

Identification of CODs in Adolescence

When evaluating adding measures to better capture those with CODs, ensure that screening and assessment measures are:

- Standardized
- Research-Based
- Designed for use with adolescents

Screening & Assessment for Co-occurring Disorders

- All youth should be screened for *both* mental health and substance use disorders
- Do the measures you receive information on adequately capture an adequate range of symptoms and behaviors?

Process of Screening for CODs

- Initial screenings should be brief and are intended to look for indications of a possible substance abuse and/or mental health disorder.
- They can be administered by appropriately trained clinical and nonclinical staff who understand relevant policies -- including 'next steps' based on what is found

Screening Outcomes

- Should generate a 'yes' or 'no' response about the need for assessment (based on endorsing certain items or achieving a certain 'score')
- Process for how to obtain assessment and appropriate referral sources should be clear

Screening Measures

- State of Connecticut website (MHSF-III; Modified M.I.N.I.; SSI-AOD; CAGE-AID)
<http://www.ct.gov/dmhas/cwp/view.asp?a=2901&q=392802>
- State of Minnesota website (K-6, CAGE-AID, GAIN-SS)

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_145318

Assessment Goals

- To determine the presence of any co-occurring diagnoses
- To evaluate patterns of mental health symptoms and substance use
- To make appropriate referrals to and confirm that service is being delivered for both categories of disorder

Assessment Measures

- Structured interview measures are considered the 'gold' standard of assessment processes.
- In clinical practice, these are administered by trained professionals, who can make a diagnosis and treatment recommendations, if warranted.

Assessing with Structured Interviews

- **Mini-International Neuropsychiatric Interview**
(M.I.N.I.- Kid; www.medical-outcomes.com)
- **Diagnostic Interview Schedule for Children- IV**
(DISC- IV; Shaffer et al., 2000)
- **Global Appraisal of Individual Needs** (GAIN;
www.chestnut.org/li/gain).
- **Adolescent Diagnostic Interview** (www.wpspublish.com)

Assessing with Structured Interviews

- A review of measures for youth can be found at www.scattc.org
- Grissom and Underwood also review a range of interview and self-report measures for screening and assessment in youth, with special emphasis on those that have been used with juvenile justice populations (www.ncmhjj.com).

Treatment Models: Early Intervention

Early intervention focused on risk factors such as aggressive behavior and poor self-control can have a greater impact than trying to change a child's path once problems occur

“.....delaying intervention until adolescence will likely make it more difficult to overcome risks” (NIDA, 2003)

Examples of interventions that you can reinforce

- ❑ Self-control, emotional awareness, social problem solving, academics (particularly reading)
- ❑ Study habits, peer relationships, assertiveness, drug refusal skills, anti-drug attitudes

Treatment Models: Moving toward Integrated care

- Over the past 15 years, the concept of 'integrated care' has become the goal of treatment programs in an effort to best address youth with complex clinical presentations.
- This form of care 'integrates' the focus of treatment on both categories of disorders and improves their understanding of the interrelationship between their CODs.

Treatment Models: Moving toward Integrated care

- If you believe that a youth has CODs – seek out treatment that offers on-site integrated care
- Encourage youth to continue to attend throughout their contact with the JC program

Treatment Models: Moving toward Integrated care

- Seek out service providers that can identify the specific evidence based practice model that they are using to address youth with CODs
- Verify that this model has been researched with this population (www.nrepp.samhsa.gov)

Treating CODs with Evidence-based Practices (EBPs)

- **Individual Cognitive Problem Solving** (ICPS; Azrin et al., 2001)
- **Cognitive Behavior Therapy** (CBT; Kaminer et al., 2002; Reinecke, Datillo, & Freeman, 2003)
- **Multisystemic Therapy** (MST; Henggeler et al., 1999)
- **Family Behavior Therapy** (FBT; Donohue & Azrin, 2001)
- **Contingency Management with Family Engagement** (CM-FAM; Henggeler et al., 2012)
- **Family Integrated Transitions** (FIT; Trupin et al., 2011)

Challenges in Accessing Integrated Care

- Many community-based programs are still early in their development and/or implementation of integrated services.
- While significant adoption of evidence-based practices as occurred, limited access to these, or other validated models, may be available in your area.
- Prescribers of psychotropic medications who have a thorough understanding of addictive disorders remain in short supply.

Psychopharmacological Interventions

- Some youth may be prescribed medication for the first time while in your program
- Building Skills and Understanding
 - How to ask about the benefits of a medication
 - Understanding how to ask about side effects
 - Using medication safely – ‘how-to’
 - What are alternatives to using medications?

Psychopharmacological Interventions

Resource for youth regarding decision making and medication effects

- www.nrcyd.ou.edu/psych-med-youth-guide

Summary: What to look for, what to do – Suggested Next Steps

- Determine whether your screening measures are designed for and are identifying rates of co-occurring disorders at the rates you would expect
- If not, work on outlining a process to implement new measures, and actions associated to their findings.

Summary: What to look for, what to do – Suggested Next Steps

- Determine whether currently delivered services have an ‘integrated’ care orientation.
- Discuss with service providers what evidence-based practices are being used and how the burden of receiving care can be reduced so that the youth can continue in the Job Corps program.

Summary: What to look for, what to do – Suggested Next Steps

- Actively encourage all youth with CODs to engage in long term care – to avoid relapse or symptom exacerbation.
 - Screening and assessment doesn't ensure follow through in receiving treatment.
 - Motivate youth to understand their need for care and ongoing risk for relapse and recidivism.

Web Resources

- www.scattc.org
- www.surgeongeneral.gov/library/mentalhealth
- www.samhsa.gov
 - www.nrepp.samhsa.gov -- Program Registry
- www.nrcyd.ou.edu/psych-med-youth-guide