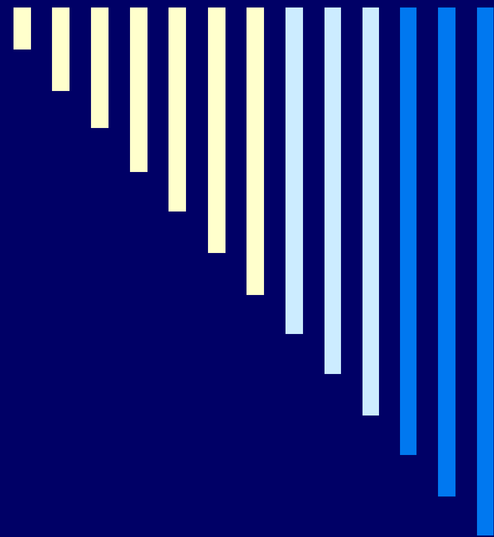


Treating Adolescents with Co-Occurring Disorders

Holly Hills, PhD

Florida Mental Health Institute

University of South Florida

Tampa – February 25, 2008

Adolescents with Dual Disorders

Experience multiple difficulties

- Behavioral Problems
- Skills Deficits
- Academic Difficulties
- Family Problems
- Mental Health and Substance Use Disorders

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Adolescents with Dual Disorders

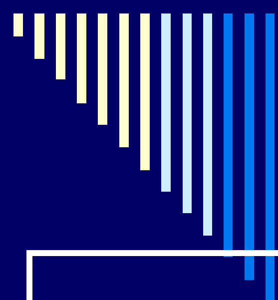
Scope of the Problem:

- Up to 1 in 5 children / adolescents has an emotional or behavioral disorder
- Only 1 in 10 who need SA Tx get it
- Only 23% of those who need it get MH care (*Physician's Leadership on National Drug Policy)*

Epidemiological Data (NHSDA,1999)

- The NHSDA (SAMHSA, 1999) surveyed individuals aged 12 years and older in the civilian, non-institutionalized, United States population

- 52% of those with a lifetime history of alcohol abuse or dependence also had a lifetime mental disorder; 59% of those with DA/DD



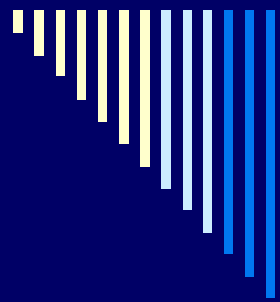
Prevalence Rates of Adolescent Co-Occurring Disorders (Young & Hills, 2004)

Setting	# Studies Reviewed	Total Sample Size	Prevalence Rate Range
Mixed SA	2	244	83% - 86%
Criminal Just.	4	429	36% - 74%
Res. SA	4	1,070	67% - 82%
Outpt. SA	2	342	34% - 52%
Res. MH	4	257	33% - 71%
Outpt. MH	2	389	11% - 33%
High School	1	1,507	10%

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Rates of CODs in Adolescents

- 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)
- Having a ‘dual diagnosis’ is now considered the “norm” (Roberts & Corcoran, 2005)



Possible Paths to Drug Use

- Aggressive behavior
- Rejection by peers
- Punishment by teachers
- Academic failure
- Drop out
- Association with drug using peers

…..involvement with the CJ system

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hills@fmhi.usf.edu

Development of SUD in Adolescents

- Early ‘difficult’ temperament (aggressive, impulsive, low frustration tolerance)
- Hx of abuse, neglect, family problems
- More likely to have had early LD / ADHD / ODD
- More likely to have been in ‘special’ classes

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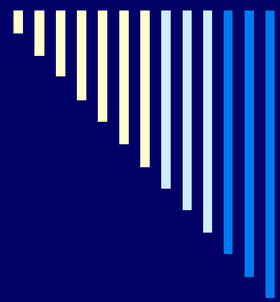
hills@fmhi.usf.edu



Development of SUD in Adolescents

- Limited Academic Success leads to demoralization, escalating behavior problems
- Path leads to increased global social marginalization, and increased association with ‘deviant’ peers

Development of SUD in Adolescents

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

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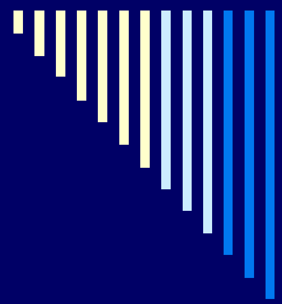
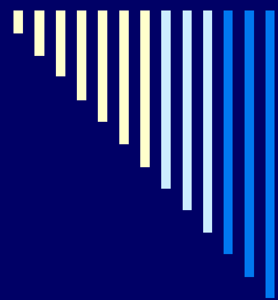
hills@fmhi.usf.edu



Development of SUD, and CODs, in Adolescents

- In addition to the family and psychiatric problems
  - lag in individuation
  - moral development
  - planning for educational, vocational, family goals



Common Co-Occurring Disorders in Adolescents

Mental Health Disorders

- Conduct Disorder
- Mood Disorders
- Anxiety Disorders
- ADHD
- To a lesser degree, early onset schizophrenia

Abused Substances

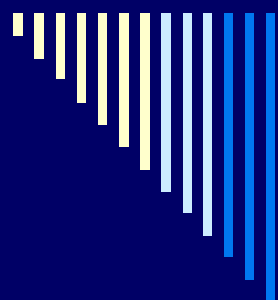
- Alcohol
- Cannabis
- Cocaine/Crack
- Methamphetamine
- *Prescription Drugs*

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Focus for 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)

- Pre-School Students: aggressive behavior, poor social skills, academic difficulties
- Elementary School: Self-control, emotional awareness, social problem solving, academics (particularly reading)
- Middle / High School: Study habits, peer relationships, assertiveness, drug refusal skills, anti-drug attitudes



Symptoms and Behaviors can mask MH disorders

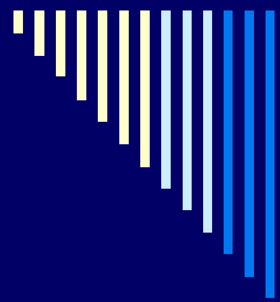
ADHD

Substance Use

Physical Complaints

Delinquency

Conduct disorder



Conduct Disorder

Common features of Conduct Disorder (DSM-IV TR) include

- Characteristic aggression as exemplified by

  - Aggression to people or animals
  - Destruction of property
  - Lying and theft
  - Serious rule violations
  - Bullying or intimidation
  - Initiation of physical fights

Many subtypes have been identified and presentation may vary based on gender differences.

Childhood onset (one of fifteen possible symptoms presenting before age of 10) presentations may be characterized by

- more aggressive symptoms
- a family history of antisocial behavior
- early temperamental difficulties.

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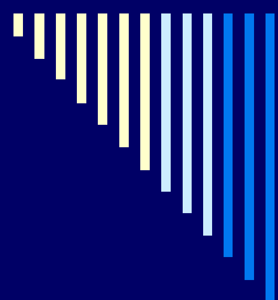
hills@fmhi.usf.edu



Conduct Disorder

This early onset form is thought to have a stronger association with the later development of psychiatric disorders (McMahon, Wells, & Kotler, 2006).

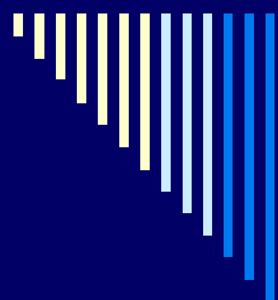
Mood Disorders

- Major Depression: 5% of children aged 9-17 have a major depressive episode; an episode can last 7-9 months (Surgeon General's Report, 1999).
- Dysthymia – or persistent low level depression – may be more difficult to detect but can be found in 3% of adolescents
- Bipolar Disorder – mood swings can cycle rapidly; can evolve into distinct episodes in adolescence

Mood Disorders

Major Depression:

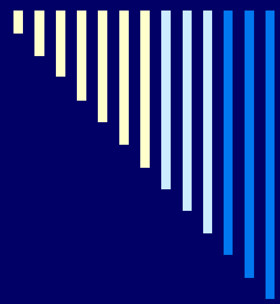
- Sad or irritable mood
- Changes in sleep or appetite
- Changes in body movement
- Not interested in previous activities
- Feels guilt or worthlessness
- Decreased energy
- Frequent thoughts of death/suicide
- Difficulty concentrating



Mood Disorders

Dysthymia:

- General unhappiness
- Pessimism
- Negativity
- Hypersentivity to criticism
- Hard to please
- Always remember feeling this way
- 70% of children / adolescents go on to MD
- Appears to interfere more with normal adjustment than MD (Sur Gen Rpt, 1999)



Mood Disorders

Bipolar Disorder:

Mania + Depression

Manic symptoms include:

Irritability / Agitation

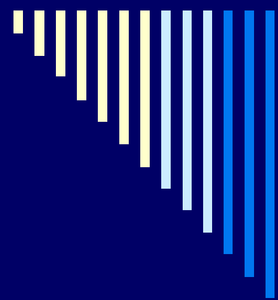
Sleep disturbance

Distractability / Impaired Concentration

Grandiosity

Reckless behavior

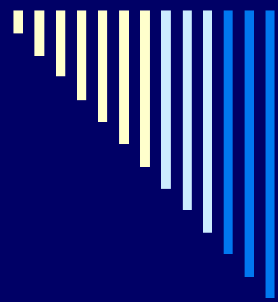
Suicidal thoughts



Behaviors Associated with Mood Disorders

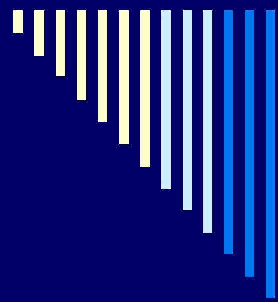
- Frequent physical symptoms without cause
- Boredom, sulking
- Neglect of appearance
- Difficulty in relationships / social isolation
- Anger / hostility
- Alcohol / substance use
- Withdrawal from family members
- Runaway attempts
- Homework changes
- In mania: promiscuous dress / actions, Exaggerated ideas, loud speech, homework done haphazardly

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu



Schizophrenia: Symptoms and Behaviors

- Little range to emotions / few facial expressions
- Few friends / shy / withdrawn
- Confusion / suspicion / paranoia
- Hearing voices / seeing things
- Problems with abstraction
- Odd speech / content as well as monotone
- Unusual fears
- History of suicide attempts
- Difficulty in school functioning



Schizophrenia: Onset in Childhood

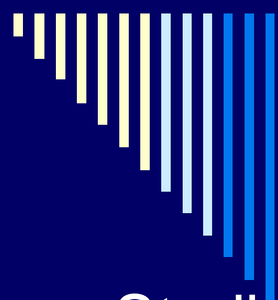
- Onset is slow but development of the full disorder before age 12 is rare
- Developmental problems – may appear as early as age 6-7; teachers may be first to recognize
- Can be observed as withdrawn from peers
- Poor eye contact
- Delays in language
- Unusual motor behaviors
- Odd speech
- Fail to meet full criteria for PDD or autism (Rapoport, 1997).

Posttraumatic Stress Disorder

- Diagnosis and Development
- More likely to be misdiagnosed as depressed, or Borderline PDO -- if they don't meet the full criteria
- Earlier onset, more chronic exposure predicts the greatest symptoms later on

Eating Disorders

- Diagnosis and Development



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
- Majority of NCS respondents with COD indicated that MH problems began in adolescence
  - Followed 5 to 10 years later by problematic SA
- Early identification and treatment of either disorder can serve to prevent the other from developing

hills@fmhi.usf.edu

Identification of Adolescents with Co-Occurring Disorders

Ensure that screening and assessment measures are:

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

Don't focus on which disorder is primary

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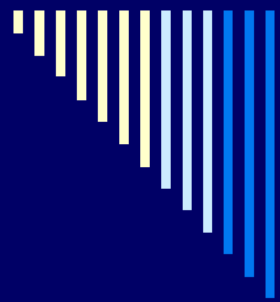
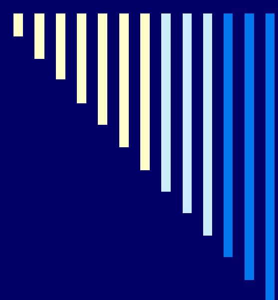
hills@fmhi.usf.edu



Screening & Assessment for Co-occurring Disorders

- All clients should be screened for both mental health and substance use disorders
- Screening for mental health and substance abuse problems should be completed at the earliest possible point after involvement in the treatment system



Key Points Regarding Screening for Co-occurring Disorders

- Provide screening at different stages of treatment
- Use similar or standardized screening instruments across different treatment settings
- Information from prior screenings / assessments should be communicated across different points in the system

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

- Basic Demographics – including historical probable diagnoses
- General strengths or problem areas
- Stage of Change for both MH and SA disorders
- Initial impression of severity of any CODs
- Encompasses any medical / legal / gender / cultural issues

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hills@fmhi.usf.edu

Will be impacted by:

- Reason / referral source driving assessment
- Instructions to the person being evaluated
- Setting / privacy
- Issues of trust and rapport
- Cultural context

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hills@fmhi.usf.edu

Screening

- Should generate a ‘yes’ or ‘no’ response about the need for assessment
- Should be connected to a protocol or cutting score recommendation for when an assessment should occur
- Can be done by anyone without legal / professional constraints

Do’s and Don’ts of Assessment for COD (TIP 42)

- Do keep in mind that each person is a unique and complex individual; Don’t rely solely on the findings from a tool
- Do contact collaterals – family members, teachers, previous treaters, probation officers
- Do become familiar with diagnostic criteria for common MH disorders, names and uses of common psychiatric medications
- Don’t feel that you must have complete certainty or understanding of the client you are assessing – Do consult with supervisors or others who are knowledgeable

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Do's and Don'ts of Assessment for COD (TIP 42)

- Don't assume that there is one correct treatment approach that will come from the assessment findings – assess stage of change of each category of disorder
- Do familiarize yourself with the range of persons your organization can serve within your local service system context
- Do remember to be empathic and hopeful – even if the person's presentation is complicated and will need continued evaluation to develop the best treatment plan over time

Relationship between MH and SU Disorders

- Have they previously been diagnosed simultaneously with a mental health and substance use disorder? How do they explain the initial onset of their symptoms? Have their previous treatment attempts focused both categories of disorder?

- Evidence from history
- Has substance use worsened, exacerbated, in any way impacted their mental health disorder? How do they explain the relationship between the two?

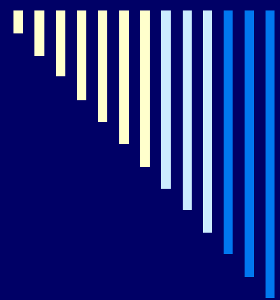
- During any periods of abstinence (30 days or more) did symptoms of their mental health disorder change? Did symptoms resolve? Did the effects of their mental health treatment improve?

Relationship between MH and SU Disorders

- Do episodes of increased symptoms of their mental health disorder prompt increased substance use?
- Do they report that psychiatric symptoms have been triggered by increased periods of substance use?
- What do they see as their triggers for relapse to substance use? Interpersonal conflict, boredom, increases in psychiatric symptoms?

Goals of the Assessment

- To gather a detailed chronological history of mental health symptoms, treatment, both before substance use began and during periods of extended abstinence
- To understand current strengths, challenges, skill deficits, and cultural barriers and issues related to treatment response
- To determine stage of change for each identified problem, and external contingencies that might promote treatment adherence



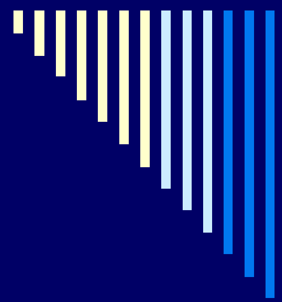
Identification of Adolescents with Co-Occurring Disorders

Comprehensive Review of Measures at www.ncmhjj.com

Review of screening and assessment measures by Grisso and Underwood provides the age ranges for administration, whether they have been applied with juvenile justice involved youth, administration time and how to obtain.

Grisso and Underwood emphasize that

- instruments should not be used if there is no research on their reliability and validity
- The greater the consequences of any decision that is based on the screen or assessment, the more important it is that valid and reliable measures be applied.



Assessing with Structured Interviews

Review of measures at www.scattc.org

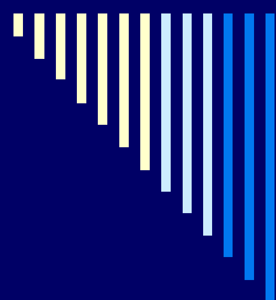
- MINI kid
- GAIN
- ADI
- CIDI-SAM
- Teen - ASI

Screening and "Detection"

Mental Health Screening Form III

- 18 yes / no questions that inquire about previous history of mental health treatment / contacts; should be used as an interview method that can be inquired about re when did the problem begin, what was happening in your life at that time, did the problem begin before, during or after you were using substances?
- Offers one screening question that addresses depression, PTSD, delusional disorder, gender identity disorder, manic episodes, panic disorder, obsessive /compulsive disorder, phobias, intermittent explosive disorder, eating disorders, pathological gambling, learning disorders / mental retardation.

Available in TIP 42



Methods for Assessment

M.I.N.I. / M.I.N.I. Plus / MINI kid

Format: Structured interview intended to be administered by trained interviewers who do not have training in psychology or psychiatry

- Takes 15-20 minutes to administer
- Spanish version is available, computerized version is also available
- Available on the internet at www.medical-outcomes.com at no charge for single use by clinicians / researchers

Global Appraisal of Clinical Need (GAIN)

- Format: Structured interview method that covers treatment arrangements, substance abuse, mental health , physical health, legal, environmental, and vocational issues.
- Takes 15- 30 min to administer; 20 minutes to score
- Cost: Proprietary tools of Chestnut Health Systems. Currently considered in development, it can be used for evaluation and research at the cost of $1 under limited license.
- Available from: Chestnut Health Systems, Inc.

www.chestnut.org/li/gain

Special Considerations in Working with Adolescent Females

- **Interpersonal Violence and Victimization**
- **Discrimination and Oppression**
- **Devaluation**
- **Limited Economic Resources**
- **Role Overload**
- **Relationship Disruption**
- **Work Inequities**
- **Unrealistic Media Images (APA, 2007)**

hills@fmhi.usf.edu

Special Considerations in Working with Adolescent Females

Mental Health Issues

- **Girls 7x more likely to be depressed (than boys)**
- **Girls and Women are 9x more likely to have Eating Disorders**
- **Women 2-3x more likely to suffer from a range of Anxiety Disorders**
- **69% of women experience a traumatizing event over their lifetime; 2x more likely than men to develop chronic PTSD symptoms as a result (APA, 2007)**

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Child Sexual Abuse

- **Occurs 2.5x more often to girls than boys**
- **Can result in immediate symptoms but also puts the individual at lifetime risk for**
  - **Self-destructive / suicidal behaviors**
  - **Anxiety and panic attacks**
  - **Eating Disorders**
  - **Substance Abuse**
  - **Issues of Sexual Adjustment (APA, 2007)**

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Special Considerations in Working with Adolescent Females

Development of Values, Beliefs, and Attitudes are Created by

- **Age**
- **Race / Ethnicity**
- **Class**
- **Sexual Orientation**
- **Marital / Partnership / Parental Role**
- **Abilities**
- **Culture (APA, 2007)**

Special Considerations in Working with Adolescent Females

Problems in Adolescent Females ….

- **May be overlooked or underdiagnosed due to their tendency to internalize problems or express them with less overt symptoms**
- **Example: Girls with ADDs demonstrate fewer disruptive behavior problems but often have more severe cognitive disabilities .. And having attentional problems is associated with lower self-esteem and more frequent peer rejection**

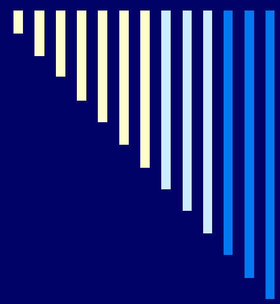
- Long term mistrust between juvenile justice system and service delivery system

- Longstanding adversarial relationship between parent’s of the youth and justice-system representatives

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Challenges in Serving Justice-Involved Youth

- Concern about their ‘dangerousness’
- Perception that these youth are not as ‘in-need’ of services as more seriously disturbed youth



Areas of Resource and Resilience in Adolescents

- Healthy attitudes toward parents / important adults
- Participation in Athletics
- Positive attitude toward Sciences
- Assertiveness
- Good problem solving skills
- Positive ideas about self-efficacy

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

" ...treatment for adolescents is most effective when it attends to the patient's many psychosocial problems and mental health needs in addition to their drug abuse" (Riggs, 2003)

Treatment of CODs

Philosophy and Orientation

- Expectation rather than Exception
- No wrong door

Integration of Services

- Integrated vs. Parallel vs. Serial
- One multidisciplinary treatment team
- Cross-Trained in SA and MH
- Treats both disorders concurrently in one setting

Essential Integrated Treatment Components

- No one ‘correct’ model of care
- Core components include:
  - Standardized screening and assessment
  - Drug testing
  - Multidisciplinary treatment team, planning
  - Multidisciplinary case management
  - Long-term and stage-specific
  - Family/social network involvement
  - Appropriate psychopharmacology for MH

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Motivational Components are Critical

Client involvement with treatment planning:

- Individualized
- Comprehensive
- Focus on each client’s range of needs
- Offer practical assistance

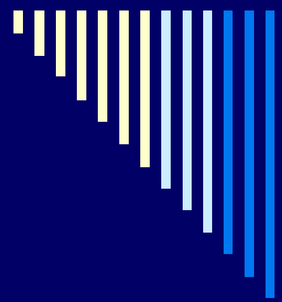
Essential to establish a trusting relationship

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Barriers to Integrated Treatment

- Shortage of child psychiatrists with addictions training
- Poor coverage for integrated services
- Longstanding separation of provider networks
- Until recently, no research base

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu



Psychopharmacology for SUDs in Adolescents

- Not evaluated in controlled trials with youth
- If used, must do so with caution, careful monitoring, eye toward developmental issues (impulsivity, polydrug use)

- Latimer et al. (2004): Youth in the ADHD group were found to have 2.5 times greater risk to relapse within the first six months following treatment even when conduct disorder and pretreatment factors are controlled for

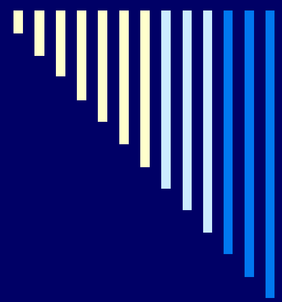
- Tomlinson, Brown, & Abrantes (2004): 87% of COD group returned to substance use within the first six months, as compared to 74% of the SUD only group; most in the COD group met criteria for both internalizing and externalizing disorder (77%-B; 13% - E; 10% - I)

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Interaction and Impact of Co-Occurring Disorders

- Shane, Jasiukaitis, & Green (2003) found 65% of their sample had ‘mixed’ (I / E) presentations; they came into treatment with the most problems and remained at higher rates at 12 month follow up

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu



Evidence-based Treatments: Family Intervention

- Family-based Interventions
  - Community Reinforcement and Family Training (CRAFT)
  - SFT (Structural Family)
  - Behavioral Family Counseling
  - MST (Multisystemic)
  - MDST (Multidimensional Family)

All operate on the assumption that problems in family dynamics contribute symptom experience and recovery in SU and MH disorders – See B.C. Moore (2005) for a review

- Multisystemic Therapy (Henggeler et al., 1999)
- Family Behavior Therapy (Donohue & Azrin, 2001)
- Individual Cognitive Problem Solving (Azrin et al., 2001)
- Cognitive Behavior Therapy (Kaminer et al., 2002; Reinecke, Datillo, & Freeman, 2003).

Evidence-based Treatment for SUDs in Adolescents

- Behavioral Therapy
  - Operant principles
    - Reward behaviors or activities that are desired / incompatible with DU
    - Withhold reinforcement / sanction when other targeted behaviors occur
    - Urine monitoring links consequences to targeted behaviors

Evidence-based Treatment for SUDs in Adolescents

- Cognitive-Behavioral Therapy
  - Delivered in individual / group, uses
    - motivation enhancing techniques
    - functional analysis (evaluates use patterns, skills deficits, dysfunctional attitudes / thinking)
    - focuses on coping with craving, moods, anger

Evidence-based Treatment for SUDs in Adolescents

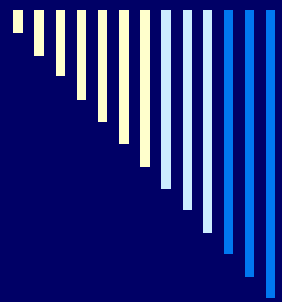
- Cognitive-Behavioral Therapy
  - Improves problem solving and communication
  - Uncovers interests / activities incompatible with drug use
  - Tasks delivered as homework, then reviewed

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

- Motivational Enhancement Therapy (MET)
  - Can be used alone or with CBT
  - Focuses on reducing ambivalence
  - Motivates for change

Evidence-based Treatment for SUDs in Adolescents

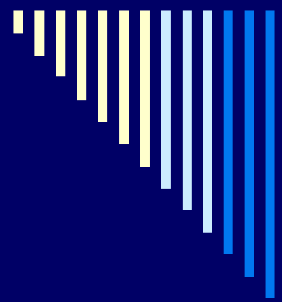
- Community Reinforcement Therapy
  - Combines cognitive, behavioral, motivational, family therapies
  - Uses incentives to further encourage outcomes



Common Features of Effective Programs

- Comprehensive Evaluation
- Empathic, motivation enhancing
- Use behavioral techniques
- Emphasize skill building
- Involve the family

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu



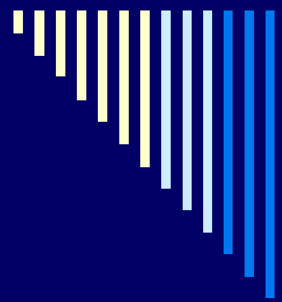
Common Features of Effective Programs

- Focus on Relapse Prevention
- Do staff training, development
- Offer developmentally appropriate interventions
- Measure treatment outcomes
- Integrate treatment of substance abuse and psychiatric illness

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Treating CODs in Substance Abuse Treatment

- Historically, youth with comorbid psychiatric illness had poorer SA treatment outcomes
  - Due to untreated disorders
  - Reduce likelihood of engagement, retention, completion of treatment



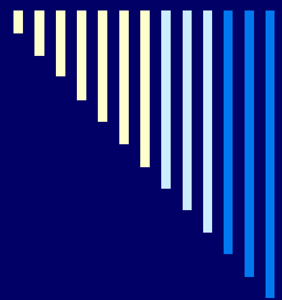
Treating CODs in Substance Abuse Treatment

- ADHD and Mood Disorders will persist even after abstinence is achieved (Grella, 2001)
- Depression thought to be less likely to remit following abstinence in adolescents as compared to adults (Burkestein, 1992)
- Correspondingly, treating psychiatric illness will not cause the substance abuse to stop (Geller, 1998)

- Until recently, a lack of information regarding the efficacy of psychopharm in adolescents lead to the a “sequential” orientation to treatment
- Always have to weigh the risks of not treating a psychiatric disorder – consider the consequences
- If SA treatment is tried ‘first’, clients may fail, decide treatment doesn’t work, get reincarcerated

Treating CODs in Substance Abuse Treatment

- Recent controlled investigations have demonstrated the efficacy of psychopharmacology for
  - Bipolar Disorder
  - Depression
  - ADHD



Treating CODs in Substance Abuse Treatment

- Most common comorbidity with SA in adolescents is Conduct Disorder
- ‘First-line’ treatment for this is behavioral and family-based interventions, not psychopharm
- These techniques address both CD and SUDs, with incentives, contingency management plans added

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Treating CODs: ADHD

- No controlled studies with adolescents with SUD
- IMPORTANTLY, use of these meds will not reduce substance use in the absence of specific intervention – interventions must be multimodal

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Treating CODs: Bipolar Disorder

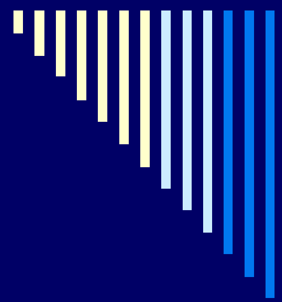
- Without SUD, mood stabilizers (lithium, etc. are first-line treatments)
- A controlled study in adolescents (lithium vs. placebo) showed good control of symptoms and some reduction in substance use in the lithium treated group -- but no substitute for SUD treatment

Treating CODs: Depression

- Severe Depression: Psychotherapy and Medication
- Mild to Moderate: Psychotherapy (CBT or Interpersonal both have shown efficacy in non-SA adolescents)

Treating CODs: Anxiety

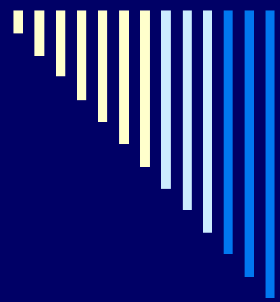
- In non-SUD adolescents, Cog-Behavioral Treatment with SSRIs
- Preliminary results suggest this combination is good for PTSD (Najavits, 2003)
- Can help with sleep problems, hyperarousal, intrusive thoughts
- Benzodiazepines are contraindicated due to their abuse potential



Treating CODs: Development of a Treatment Plan (Riggs, 2003)

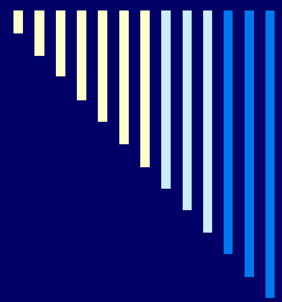
Step 1. Integrate all assessment info, including patient’s goals, into a problem list

Step 2. Engage the adolescent in treatment, initially through collaborating on goals



Treating CODs: Development of a Treatment Plan (Riggs, 2003)

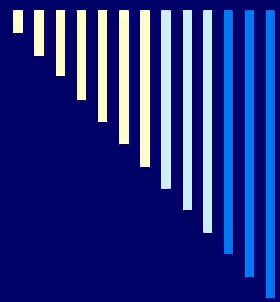
Step 3. Determine medication need, requiring at least weekly therapy appointments, emphasizing motivational techniques, cognitive-behavioral interventions in early treatment



Treating CODs: Development of a Treatment Plan (Riggs, 2003)

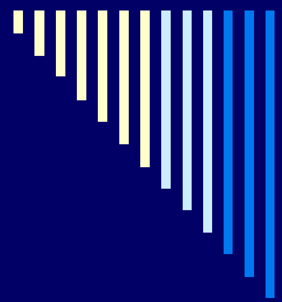
Step 4. If substance use or symptoms of psychiatric illness do not 'significantly improve' in a 2 month period

- Reassess Diagnosis
- Consider changing medication
- Increased the intensity or frequency of treatment



Treating CODs: Development of a Treatment Plan (Riggs, 2003)

Step 5. Convey from the beginning, an understanding of the need for long term monitoring of psychiatric disorder, and continued attention to factors related to substance use relapse



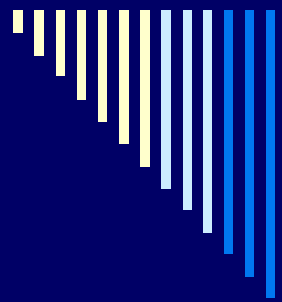
Treating Adolescents with CODs: Increasing Communication

Communicate on the:

- The comprehensiveness of the evaluation being done
  - What measures were used?
  - What were the diagnostic conclusions?
  - What is still unclear?
  - What MH disorders are still being considered or are 'rule-outs'?

Treating Adolescents with CODs: Increasing Communication

- Confirm that findings re any co-occurring disorders have been 'integrated' into the treatment plan – and been given equal, and specific weight
- Understand the goals and objectives for each diagnosis
- Discuss the type of psychotherapeutic intervention and 'dosage'



Treating Adolescents with CODs: Increasing Communication

Communicate with parents / any service providers / teachers

- Target symptoms that have been observed
- Any changes in psychosocial functioning
- Medication compliance / side effects

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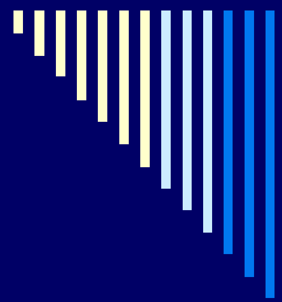

Treating Adolescents with CODs: Increasing Communication

Communicate about

- What constitutes ‘progress’ in treatment?
- How urine tests are used
- What realistically can be expected to be achieved during any period?

Treating CODs: Engagement

Everyone involved should work to maintain the individual in treatment.

Suggested strategies….

- Clear expectations of each 'system' and associated consequences
- Communicate with a single voice
- Make sure response to critical events is supported by all 'systems'

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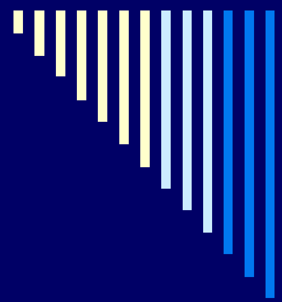


Considerations to better serve Youth with CODs

- Improve early identification of MH / SA disorders
- Build alternative coping methods

hills@fmhi.usf.edu

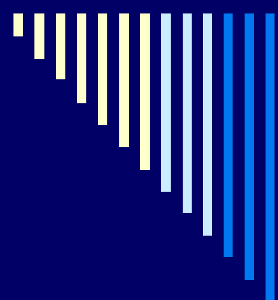
Considerations to better serve Youth with CODs

- Determine if standardized screening measures for both MH and SA are being used
- Evaluate whether the treatment provider is offering "integrated" treatment (i.e., equal emphasis on both MH and SA disorders)

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Considerations to better serve Youth with CODs

- Help parents to understand how treatment plan addresses both categories of disorder
- Inquire how treatment content specifically addresses MH and SA
- Discuss importance of continuity of care – what is the long term plan for this?



Additional Resources

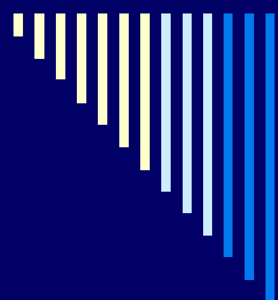
TIP 42
Web Resources

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu

Twelve Steps in the Assessment Process (TIP42)

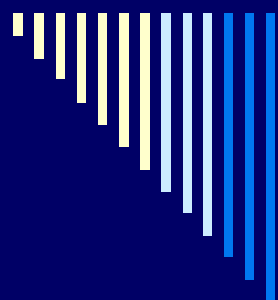
- Engage: Create a safe, private, nonjudgmental environment to build rapport; determine cultural issues that may impact, importantly language

- Five essential elements of engagement:
  - Universal access (‘no wrong door’)
  - Empathic Detachment
  - Person Centered Assessment
  - Cultural sensitivity
  - Trauma sensitivity

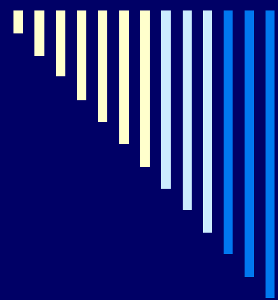


- Identify collaterals
  - May be unwilling or unable to report their history accurately, obviously must be done with permission

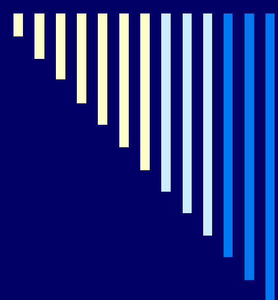
- Screen for COD
  - Safety issues related to acute intoxication and withdrawal
  - Present and past SU, related problems and disorders
  - Screen for MH safety issues (suicidality, violence, self-care, risk behaviors for HIV, Hep C or victimization)
  - Past and present MH disorders
  - Cognitive / Learning Deficits
  - Past and present victimization and trauma



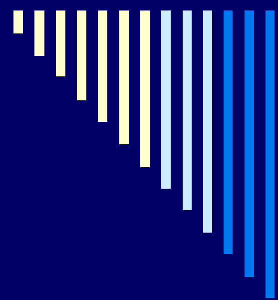
- Determine Quadrant
  - Quad I: Less severe MH and SA; Quad IV: More severe MH and SU disorders
  - Severity of mental disorders are typically determined by diagnosis, severity of disability and duration of disability (6 mos+)
  - Substance Abuse clinicians should be familiar with what criteria eligibility is established to be a MH 'priority' client, may be eligible for services
  - Severity may be determined by using ASAM PPC-2R Dimension 3 or LOCUS
- Level of care
  - ASAM ranges from 1. Acute intoxication to 6. Recovery
  - MH on Dimension 3. -- five areas – suicide potential, interference with addiction recovery efforts, social functioning, ability for self care, and course of illness



- Diagnosis
  - Determine history of past or current treatment of MH disorder; existing stabilizing treatments should be maintained; should accept this diagnosis presumptively, confirming with collaterals; most important is to tie symptoms to specific life periods
  - Can use M.I.N.I. Plus, Timeline Follow Back, or SCID
  - Can use outlines of common DSM-IV disorders and inquire whether the symptoms were ever met, how treated, and success
- Disabilities and Impairments
  - Cognitive capacities, social skills, need for special education

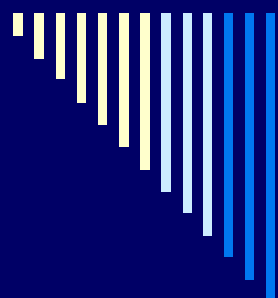


- Disabilities and Impairments
  - Capable of living independently?
  - Capable of supporting self financially?
  - Can engage in social relationships? Has social supports?
  - Level of intelligence? Memory impairments, learning disabilities, limited ability to read, write, understand? Problems with concentration, completing tasks?
  - Ability to use transportation, budgeting, self-care, ability to participate in treatment
- Strengths and supports
  - Current strengths, skills, support in relation to managing their disorders
  - May focus on talents or interests, vocational skills, creative self expression
  - Areas connected to motivation for change
  - Important relationships, family or treatment staff



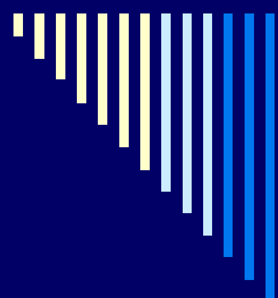
- Strengths and supports
  - Previous treatment successes, what has worked?
  - Current successful attempts to manage symptoms
- Cultural and linguistic needs
  - Not substantially different for the COD population but should consider
    - Fit in the treatment culture, conflicts in treatment
    - Cultural / linguistic service barriers
    - Literacy
- Problem Domains
  - Medical, legal, social, vocational, family, social that impact treatment engagement and outcomes; ASI does this
  - Identify contingencies that promote treatment adherence

- Stage of Change
  - Interventions must be matched to stage of change
    - No problem / interest in change (precontemplation)
    - Might have a problem, may consider some change (contemplation)
    - Definitely believes they have a problem; getting ready to change (preparation)
    - Working on changing actively, though perhaps slowly (action)
    - Achieved stability in this area – trying to maintain status (maintenance)
    - Measures include SOCRATES, URICA
    - SATS is a case manager rated scale covered in TIP 35



Plan Treatment

- Treatment placement should be matched to the needs of the individual client
- Concept of dual primary treatment
- Focus is on integrated treatment planning,where intervention choices for each disorder are matched
- Must take into account impact of other disorder on ability to comply with recommendations



Web Resources

- www.ncmhjj.com
- www.scattc.org
- www.aacap.org/publications/factsfam/schizo.htm
- www.surgeongeneral.gov/library/mentalhealth/chapter3
- www.fmhi.usf.edu
- www.samhsa.gov
  - Co-occurring Center of Excellence

Holly Hills, Ph.D., 2008
hills@fmhi.usf.edu