Adolescents and Co-Occurring Mental and Substance Use Disorders: Building Bridges in Assessment and Treatment

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10 AM - !2 Noon

A. Polarized Perspectives about Presenting Problems

3 D's
- Deadly Disease – consider addiction in differential diagnosis; ask questions to screen, diagnose
- Denial – conscious lying; amnesia of blackouts; unconscious survival mechanism
- Detachment – healthy distance; don't pin your professional self esteem to client's success or not

3 P's
- Psychiatric Disorders – not all mental health problems are symptoms of addiction and withdrawal
- Psychopharmacology – medications often necessary; can prevent psychiatric & addiction relapse
- Process – often no quick, easy answer to decide addiction versus psychiatric versus dual diagnosis

B. Cultural Clashes in the Behavioral Health Field

1. Different Theoretical Perspectives; Different Treatment Methodologies

1. Addiction System versus Mental Health System
   - 3 D's and 3 P's - implications for medication, staff credentials, attitudes towards physicians, role of staff and team, programs
2. Integrated Treatment versus Parallel or Sequential Treatment
   - hybrid programs - staffing difficulties; numbers of patients and variability, but one-stop treatment
   - parallel programs - use of existing programs and staff, but more difficult to case manage
3. Care versus Confrontation
   - mental health - care, support, understanding, passivity
   - addiction - accountability, behavior change
4. Abstinence-oriented versus Abstinence-mandated
   - treatment as a process, not an event
   - respective roles in both approaches
5. Deinstitutionalization versus Recovery and Rehabilitation

C. **Developmental Issues in Adolescents**

1. Developmental influence is paramount
2. Responses are emotional/behavioral, not mature reflection
3. Adolescents are not independent – rely on adult support
4. Development is a dynamic process
5. Habilitation not rehabilitation
6. Developmental issues are different at different ages – 13, 15, 17

D. **Why Diagnostic Confusion? -** Diagnostic Confusion due to:

- Alcohol/drugs can cause psychiatric symptoms in anyone (acute toxicity)
- Prolonged alcohol/drug use can cause short or long-term psychiatric illness
- Alcohol/drug use can escalate in episodes of psychiatric illness
- Psychiatric symptoms and alcohol/drug use can occur in other psychiatric disorders
- Independent addiction and psychiatric illnesses ("Dual Diagnosis")

(Marc A. Schuckit: Am. J. Psychiatry, 143:2 p. 141 - modified)

1. Cognitive impairments

- Mental retardation
- Dementia – injury
- Learning disability – dyslexia
- Educational deprivation
- Drug related impairment – delerium or other substance-induced disorder such as persistent amnestic disorder, intoxication states

2. Drug-Specific States

- Marijuana withdrawal – insomnia and irritability
- Marijuana intoxication – persistent amnestic symptoms; memory loss; apathy
- Inhalant intoxication – subacute delerium and disorganization
- Stimulant withdrawal – depression
- Stimulant intoxication – psychosis
- Ecstasy, ketamine – affective disorders +/- psychosis
- Hallucinogen induced persisting perceptual distortion syndrome – flashbacks can linger for months and years even

3. Addiction is Not just a Symptom of Underlying Psychiatric Disorder, But can be…

- Self medication of psychiatric illness
- Anesthesia for childhood trauma
- Symbolic expression of intrapsychic conflict – stimulant use for someone shy and introverted

4. Diagnostic Dilemmas in Cluster of Symptoms

(a) Differential diagnosis of inattention and hyperactivity

- Attention Deficit Hyperactivity Disorder
- Mania – looks like lability
- Depression
- Marijuana
- Antidepressants especially specific serotonin reuptake inhibitors (SSRIs) side effects

(b) Irritable Mood

- Depression
- Demoralization
- Mania/Hypomania/Bipolar Disorder
- Intoxication especially with stimulants

(c) Persistent affective instability, mood lability, explosive temper, tantrums, stormy emotions
- Bipolar Disorder
- Depression
- ADHD "plus" – overlap of childhood ADHD plus developmental issues
- Intoxication and withdrawal

E. Adolescent Specific Assessment and Treatment Issues

(i) **Attitudes and Values** - 3D's Deadly Disease; Denial; Detachment
- adolescent drug use as a developmental stage –spectrum from experimentation to dependence

(ii) **Diagnostic Indicators - high likelihood of diagnosis if**:
- someone raises a question about drug usage
- the social or psychological problems the adolescent is presenting came later than the beginning of any drug usage problems
- the social or psychological problems are closely associated, time-wise, with drug usage
- the adolescent cannot stay drug-free without difficulty

(iii) **Diagnosis and Treatment as a Process not an Event**
- Involve family, significant others; "soft sell" techniques

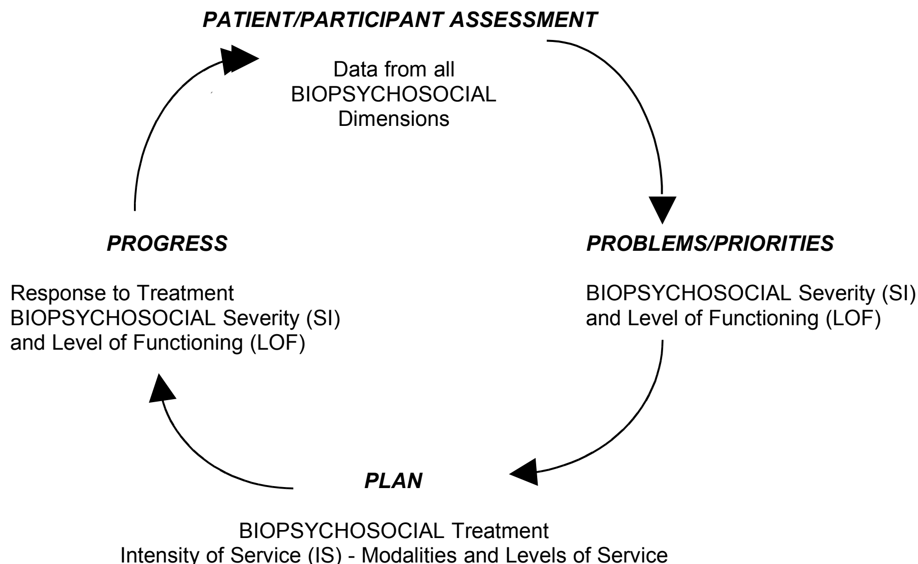
F. Assessment Dilemmas

- Pharmacological and psychosocial aspects of addiction can mimic psychiatric disorders
- Decision tree for "Addiction versus Psychiatric Diagnoses: Either or Both?"
- Take a good history - A definitive psychiatric diagnosis by history requires the psychiatric symptoms to have occurred during drug-free periods of time
- Observe the client for a sufficient time drug-free - shorter time for objective, psychotic symptoms; longer for subjective, affective symptoms

G. Person-Centered Assessment and Treatment Services

1. Biopsychosocial Perspective of Addiction and Mental Disorders

A common view allows a common language of assessment and treatment for all involved.



2. <u>Multidimensional Assessment</u> - ASAM Assessment Dimensions

The common language of the six assessment dimensions can be used to determine multidimensional assessment of obstacles and needs to help the client get what they want.

Assessment Dimensions	Assessment and Treatment Planning Focus
1. Acute Intoxication and/or Withdrawal Potential	Assessment for intoxication and/or withdrawal management. Detoxification in a variety of levels of care and preparation for continued addiction services
2. Biomedical Conditions and Complications	Assess and treat co-occurring physical health conditions or complications. Treatment provided within the level of care or through coordination of physical health services
3. Emotional, Behavioral or Cognitive Conditions and Complications	Assess and treat co-occurring diagnostic or sub-diagnostic mental health conditions or complications. Treatment provided within the level of care or through coordination of mental health services
4. Readiness to Change	Assess stage of readiness to change. If not ready to commit to full recovery, engage into treatment using motivational enhancement strategies. If ready for recovery, consolidate and expand action for change
5. Relapse, Continued Use or Continued Problem Potential	Assess readiness for relapse prevention services and teach where appropriate. If still at early stages of change, focus on raising consciousness of consequences of continued use or continued problems as part of motivational enhancement strategies.
6. Recovery Environment	Assess need for specific individualized family or significant other, housing, financial, vocational, educational, legal, transportation, childcare services

3. <u>Biopsychosocial Treatment - Overview: 5 M's</u>

* Motivate - Dimension 4 issues; engagement and alliance building
* Manage - the family, significant others, work/school, legal
* Medication - detox; HIV/AIDS; anti-craving anti-addiction meds; disulfiram, methadone; buprenorphine, naltrexone, acamprosate, psychotropic medication
* Meetings - AA, NA, Al-Anon; Smart Recovery, Dual Recovery Anonymous, etc.
* Monitor - continuity of care; relapse prevention; family and significant others

4. <u>Treatment Levels of Service</u> - **ASAM Levels of Care/service to match severity of problems**

I Outpatient Services
II Intensive Outpatient/Partial Hospitalization Services
III Residential/Inpatient Services
IV Medically-Managed Intensive Inpatient Services

H. <u>**Improving Treatment Systems**</u>

There are many <u>systems boundaries</u> that work against effective continuity of care:

- Excessive boundaries, exclusion, and territoriality - policy, funding and practice ignore and sacrifice the complexity of individual needs to achieve and maintain bureaucratic simplicity; continuity of care is nearly impossible under these circumstances.

- Inadequate assessment and diagnosis - on an individual basis, addiction and mental illness are often not diagnosed; inadequate assessment of community needs affects system planning and development of services.

- Lack of trained staff - the polarization of the mental health and addictions fields, historically, has resulted in knowledge gaps only now beginning to improve; lack of experience in both addiction and mental health fields results in fear and resistance to learn and broaden counseling knowledge

- Inadequate array of services - dual diagnosis services either do not exist, or represent a few model programs; even in states where it is more of a priority, there are too many gaps.

- Rigid funding streams - there still are inadequate resources, turf battles and a reluctance to pool resources for training, research or service delivery.

- Lack of a strong shared constituency - because there is little common ground between the addictions and mental health constituencies, the ability to influence policy and service delivery is greatly limited.

- Limited dissemination of effective program models - too little is done to publicize what works in model programs; programs are too infrequently evaluated, or if evaluated, the findings are often not applied in future funding or program planning

- Fragility - when barriers have been overcome, it is usually due to individual efforts that are too fragile and dependent on that person's leadership; positive changes are therefore not sustained by basic structural changes in the mental health and addiction service systems.

(Wayne Thacker, MSW., Leslie Tremaine, Ed.D: "Systems Issues in Serving the Mentally Ill Substance Abuser: Virginia's Experience" Hospital and Community Psychiatry, Vol. 40, No. 10 pp. 1046-1049, Oct. 1989.)

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American Society of Addiction Medicine - 4601 Nth. Park Ave., Arcade Suite 101, Chevy Chase, MD 20815. (301) 656-3920; Fax: (301) 656-3815; www.asam.org; (800) 844-8948.

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