



Working
Wonders

A profile of substance use amongst
young people presenting for
mental health treatment:
*Service identification of
and response to youth dual diagnosis*

Sophie Morson
CYMHS, RCH & HSD

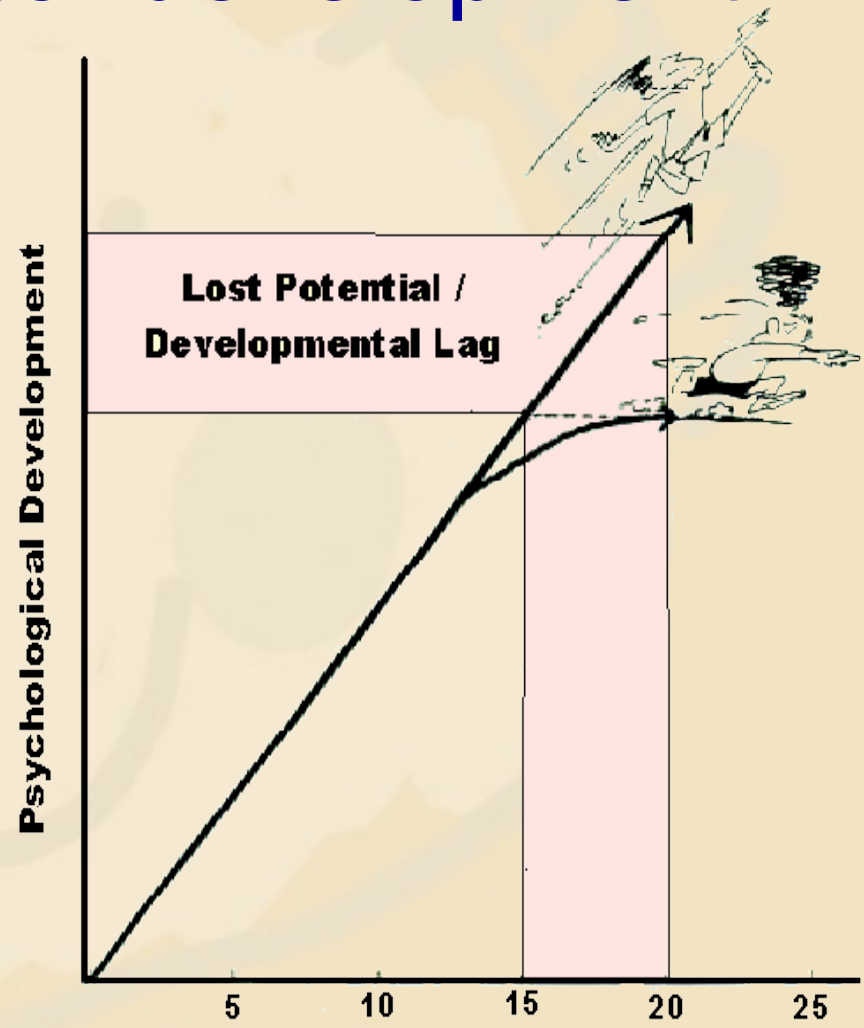
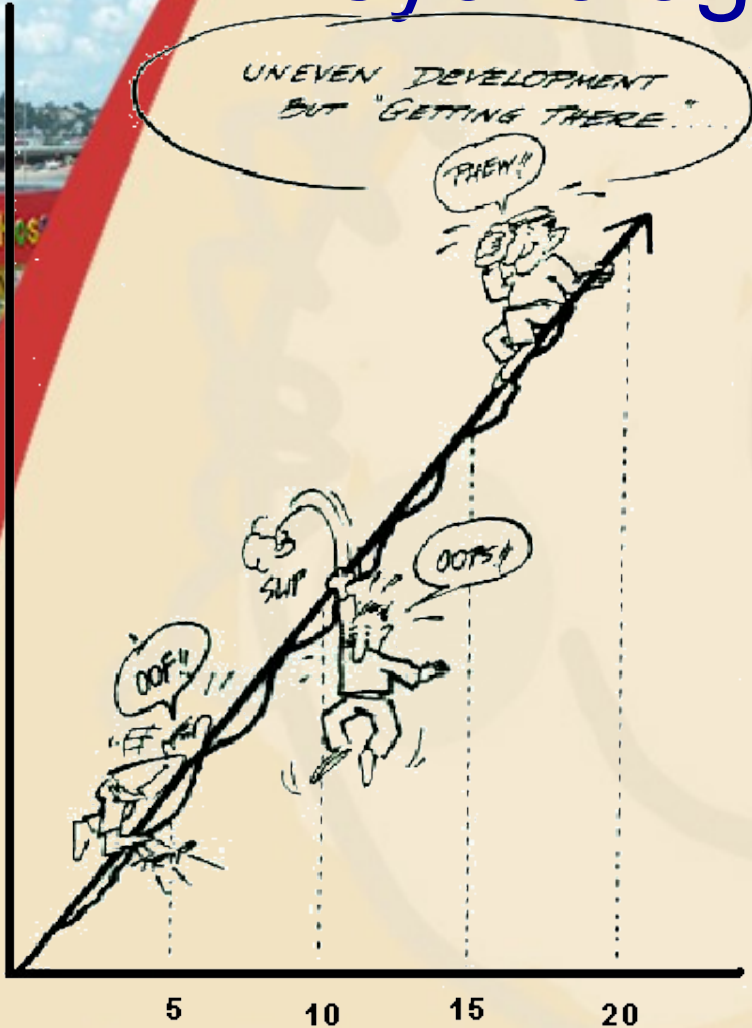
Royal Children's Hospital and Health Service District (Brisbane)

Why the Interest?

- Adolescence and early adulthood is the peak period of onset for many mental health and substance problems
- Increased access to many substances amongst parents as well as young people
- Adolescence is a critical period with increased vulnerability to the long-term impact of adverse experiences including substance use (e.g., Patton, 2004)
- “Downward developmental trend” noted, with age of initiation of substance use a significant risk factor for future trajectories
- Developmental milestones many be disrupted by the onset of mental health and/or substance problems

Psychological development

Psychological development
Cognitive / Social / Emotional



Why the Interest?

- Approximately 50% of adolescent mental health inpatients have a co-existing substance problem, of which further 50% are poly-substance users (Caton et al, in Milin 1996)
- Young people with a substance use disorder 3x more likely to have psychiatric diagnosis (Kandel et al, 1999), which is a higher rate than for adults (Beitchman et al., 2001).
- Dual diagnosis is particularly problematic amongst at-risk young people, including those who are homeless (Rossiter, Mallett, Myers & Rosenthal, 2003) and in foster care (Pilowski & Wu, 2006).
- Those dually diagnosed have worse prognosis:
 - “*it basically tore my family apart*” (from Blamed and Ashamed report, US, 2000
 - Roswell (1997) has suggested dual diagnosis needs to assume the same importance as other government policies (e.g., on gun control), such is the burden on families and communities
- Multiple barriers identified to youth-appropriate service provision (NYARS, 2004)

Service Responses

- Parallel and sequential responses to service delivery have failed to meet the holistic needs of clients and their families
- Integrated treatment increasingly accepted as best practice via a “no wrong door” policy, and consistent with the recovery model of mental health (Anthony, 2002)
- Review of integrated treatment revealed high rates of engagement, less substance use and some reduced hospitalisation (Drake, Yovetich, Bebout, Harris & McHugo, 1997)
- Integrated treatment recommended locally (Morson, 2005)

The CYMHS Response

- Early 2002: observations on the need to better support clients independently made by two CYMHS project workers
 - Mid 2002: internal working party formed
 - October 2002: survey of current needs and practice of CYMHS staff (n = 33)
 - April 2003: Strategic plan launched
 - July 2004: Plan reviewed for consistency with new Queensland Health Dual Diagnosis Strategic Plan)
 - Annual plans developed since then
 - Statewide priority via enhanced service capacity for DD
- Royal Children's Hospital and Health Service District (Brisbane)

CYMHS Dual Diagnosis Initiative

Infrastructure

- Resourced by one full-time coordinator, with DD being one of a number of early intervention priorities
- Supported by a wider steering committee of representatives from 15 agencies that meets every two months for 2.5 hours
- DD now embedded as a CYMHS strategic priority
- Current focus is expanding priority to those young people with DD issues not accessing CYMHS

CYMHS Dual Diagnosis Initiative

Goals

- Responsive early identification of young people with or at risk of developing dual diagnosis issues
- Consolidate/deliver training on identified needs, with input from dual diagnosis experts as required*
- Responsive service delivery including comprehensive assessment, treatment, support and aftercare to young people with dual diagnosis issues
- Enhanced intersectorial collaboration to provide increased service commitment to young people with dual diagnosis issues
- Increase consumer and carer access to resources and services relevant to dual diagnosis*
- Increase consumer/carer involvement in the development/delivery of a range of dual diagnosis initiatives to ensure provision of holistic and integrated service responsiveness for young people with dual diagnosis issues.

Which drug did the spider take?

In a NASA study (reported in New Scientist), spiders were given a variety of substances, and their web structure was studied.

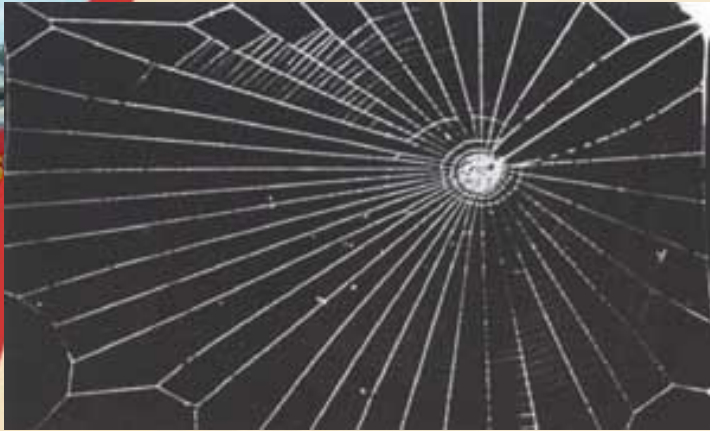
ACTIVITY

- Try to match which web structure was generated for each of the following web conditions..... and why!
 - *Cannabis (depressant)*
 - *Caffeine (stimulant)*
 - *LSD (hallucinogen)*
 - *Control: Normal web*

Which drug did the spider take?

LSD, cannabis, caffeine, normal web

A



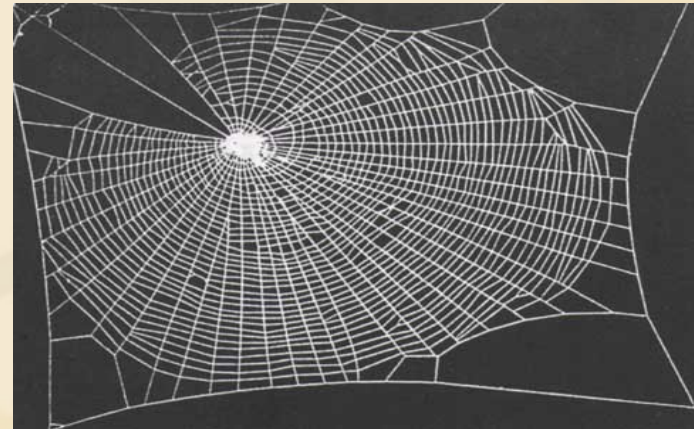
B



C

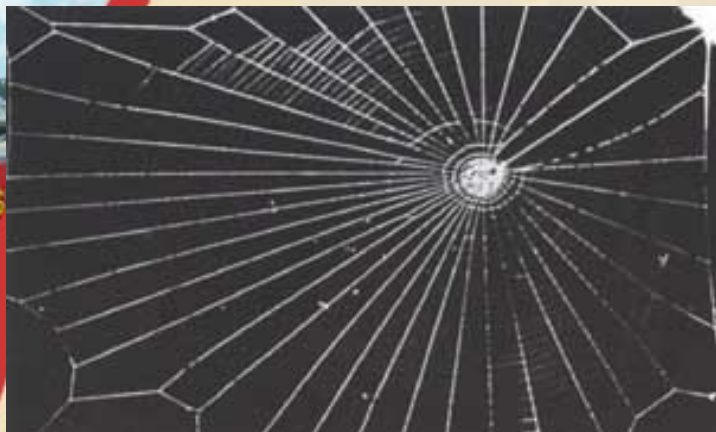


D



Which drug did the spider take?

A



LSD (hallucinogen)

B



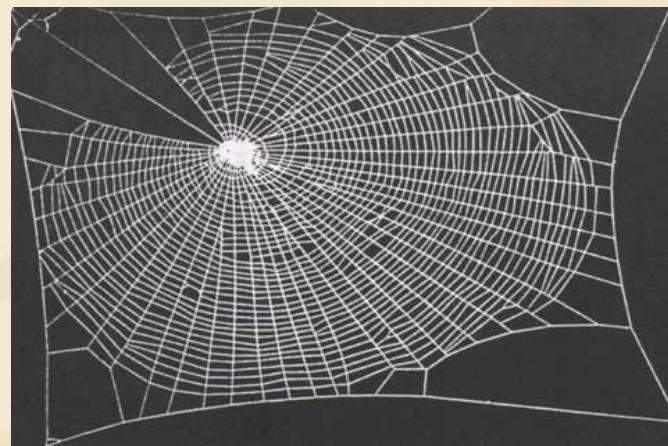
CANNABIS (depressant)

C



CAFFEINE (stimulant)

D



NORMAL WEB

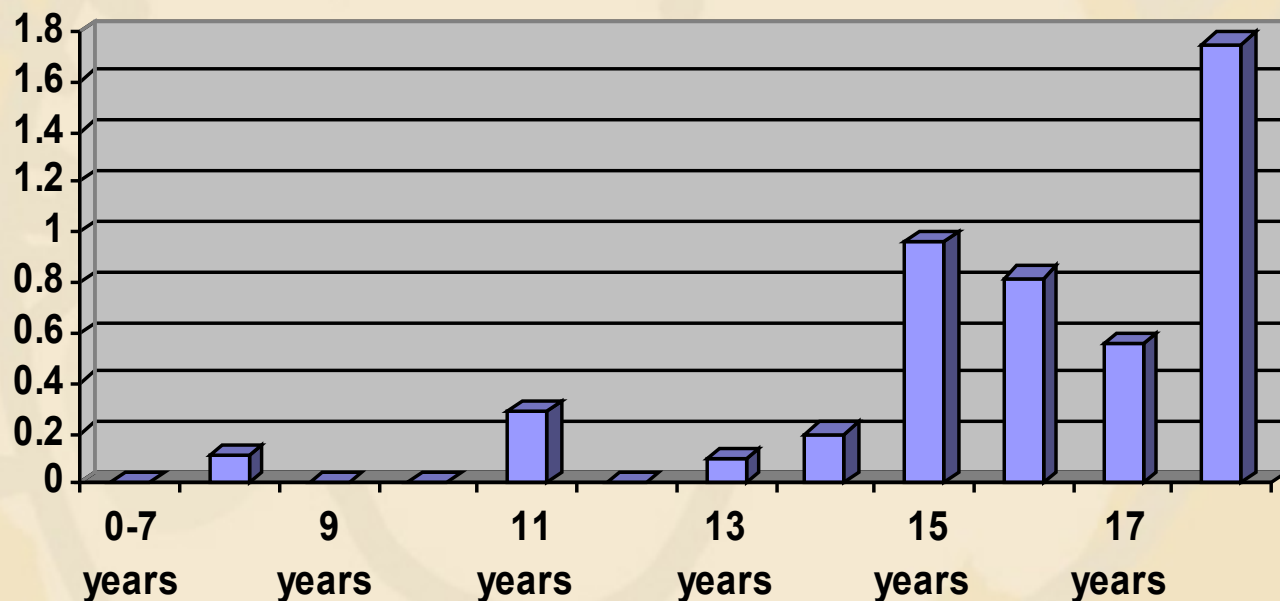
Quantifying Substance Use

- Decision undertaken to examine prevalence of substance use in clients presenting for MH treatment September – December (inclusive) 2003
- Chart audit encompassed age, gender, HoNOSCA, initial assessment* and treatment plan
- * Prompts: Type, amount, frequency, route of administration, impact on functioning, relationship to MH problems
- Chart audit repeated for same period repeated for CYMHS initial presentations in 2004 and 2005

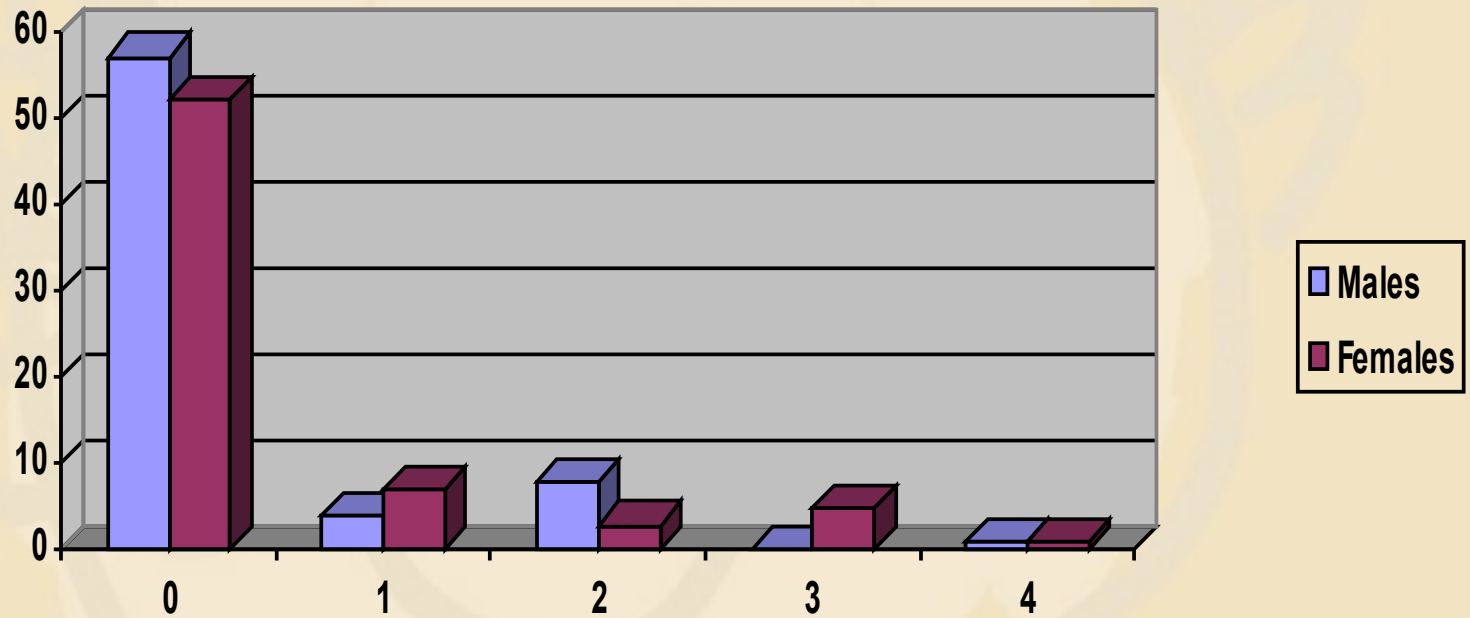
Profile of Substance Use

	2003	2004	2005
<i>Number charts audited</i>	138	271	259
<i>Average age</i>	12.6 years	12.43 years	11.74 years
<i>Average HoNOSCA</i>	0.35	0.29	0.21
<i>% current usage</i>	26.81%	20.30%	13.60%
<i>Inclusion in treatment plan for current users</i>	9.38%	23.64%	21.74%

Average HoNOSCA by Age



HoNOSCA Distribution by Gender



Type of Substance Use

	2003	2004	2005
Alcohol	30.6	61.8	61.1
Marijuana	28.2	32.7	13.8
Cigarettes	20.2	38.1	31.8
Amphetamines	8.2	3.6	4.8
Inhalants	4.7	5.4	-
Ecstasy	2.3	1.8	2.8
Coffee	1.1	1.8	-
Mean substances	1.9	1.4	1.6

TP Inclusion Status	Percentage	HoNOSCA range	Average HoNOSCA
Client refused to sign	6.25	0-3	1.50
Not completed	25.0	0-4	1.86
No reference to SU	62.5	0-4	1.05
Reference to SU	9.38	2 - 3	2.3

Implications for Service Delivery

- Greater engagement and flexibility required
- Likely underreporting, especially for prescribed drugs
- Take D&A history from middle primary school
- Assess for parental substance misuse
- Assume polysubstance use
- Strategies to address prevalence of smoking
- Strategies to address marked increase in alcohol
- Enhance and harness motivation
- Support carers e.g. via PKD program

Future Directions

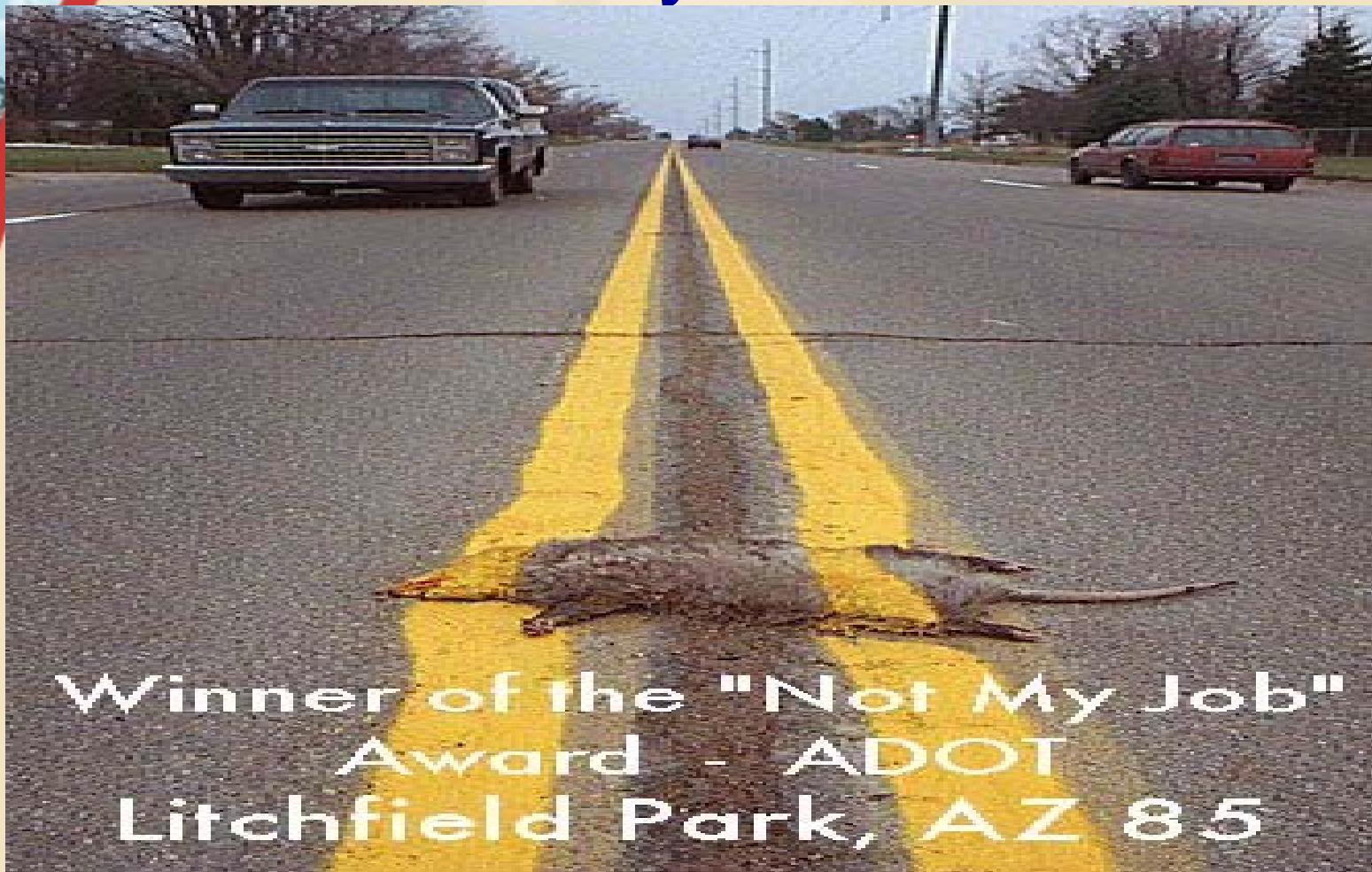
- Launch D & A assessment policy
- Review for data beyond treatment plan
- Analyse data by MH diagnosis
- Source credible youth DD treatment package
- Deliver ongoing training with focus on practical skills, including in engagement
- Offer consultation-liaison on substance use assessment and management
- Define parameters of referring to local service
- Implement co-location with local service

The Final Word

- “The tragedy of the current approach: Shifting young people with co-occurring disorders into the criminal justice system.
- The best approach to solving the problem of locking up young people ... would be **prevention, early intervention and integrated treatment**”

“we need programs that deal with our child as a whole”

Why You?



Royal Children's Hospital and Health Service District (Brisbane)

Working
Wonders

Children's Hos

*Sophie Morson
Coordinator
'Minding Young Minds' Early Intervention Program
Child and Youth Mental Health Services
Royal Children's Hospital and Health Service District*

*Ph: (07) 3835 1444
Fax: (07) 3839 8191*

sophie_morson@health.qld.gov.au

Royal Children's Hospital and Health Service District (Brisbane)