Co-Ocurring Adolescent SUD and Mental Illness: Case Discussion

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Disclosures

No commercial interests; no financial disclosures

There will be discussion of off label medication use. This will be highlighted as it is discussed.

Objectives

1. Apply structured diagnostic approaches to assess and distinguish co-occurring substance use, ADHD, and mood disorders in adolescents.

1. Develop integrated treatment plans for adolescents with co-occurring SUD and mental illness, using case-based discussion to address medication management, psychosocial interventions, and level-of-care considerations.

John Part 1

You work in a psychiatric partial hospital program.

John is a 16yo male with history of MDD, recurrent, severe and GAD presents for intake as a step-down from the inpatient hospital after admission for an overdose attempt using fluoxetine and melatonin.

Urine drug screen was positive for THC when patient presented to the ED after ingestion.

John Part 1 Discussion

What else do we need or want to know in order to create a formulation, diagnosis list and treatment plan?

John Part 1 Discussion

What is your case formulation?

John Part 1 Discussion

What are your diagnoses?

DSM-5 diagnostic criteria for substance-use disorders

The DSM-5 criteria for substance-use disorder broadly include 11 items

Severity Level:
Mild: 2-3
Mod: 4-5
Sev: 6+

A problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by ≥2 of the following, occurring within a 12-month period

1	Drug is taken in larger amounts or over a longer period than intended
2	There is a persistent desire or unsuccessful effort to reduce drug use
3	A great deal of time is spent in activities necessary to obtain, use, or recover from the drug
4	Craving for the drug
5	Recurrent drug use resulting in a failure to fulfill major obligations at work, home, or school
6	Continued drug use despite persistent or recurrent social or interpersonal problems caused by drug use
7	Important activities are given up or reduced because of drug use
8	Recurrent drug use in situations where it is physically hazardous
9	Continued drug use despite knowledge of having a persistent or recurring physical or psychological problem that is likely to have been caused by or exacerbated by the drug
10	Tolerance to the drug
11	Withdrawal: either experiencing a drug withdrawal syndrome or taking drug to relieve or avoid the withdrawal syndrome

DSM-5=Diagnostic and Statistical Manual of Mental Disorders – 5th edition

Sadock et al. (eds) Kaplan & Sadock's Comprehensive Textbook of Psychiatry. 2017; APA. DSM-5. 2013

John's Part 1 Discussion

What is your treatment plan?

John Part 1: With ADHD

John's mother reports history of ADHD diagnosis and past use of methylphenidate ER 36mg daily when patient was 10yo - 13yo. She states this was helpful, however stopped taking it due to not liking how it made him feel.

Any treatment plan changes?

John Part 1: ADHD?

John's mother reports no history of ADHD diagnosis but wonders if this is something he has struggled with. She feels he has exhibited impulsivity, poor attention and concentration, forgetfulness, fidgeting, day dreaming.

Any treatment plan changes?

Six Months Later….

John Part 2

You see John is presenting for re-admission to PHP after inpatient hospitalization. Reviewing records from your colleagues…

John Part 2

John presented to the ED with parents after a two-day period of unusual behavior.

He was not attending school and reported he was working on his computer. He was described as hyperverbal and not sleeping. He was fixated on something or someone called “Orion”. He at one point seemed to be talking to someone in his room. He stated he was waiting to receive messages about his “next steps”.

John Part 2 Discussion

What else do we need or want to know in order to update our formulation, diagnosis list and treatment plan?

John Part 2 Discussion

What is your diagnosis?

What is your treatment plan?

John Part 2 Discussion

You attend a family meeting before partial hospital discharge. What are your priorities for communication with parents?

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You Decide to Continue to See John in Your Outpatient Clinic..

John Part 3

John continues on his medication, has an outpatient individual therapist and family therapist. All is well. He is attending school and plays baseball.

John is now 6 months from his acute mood episode.

John Part 3 Discussion

John and parents would like to restart medication for his ADHD, reporting he seems to be trying hard at school but struggles with procrastination, poor task completion, forgetfulness, inattention.

What else do we need or want to know in order to create a formulation, diagnosis list, and treatment plan?

John Part 3 Discussion

What is your formulation and treatment plan?

John Part 3 Discussion

John wants to know when he can stop taking his antipsychotic medication…

What would you tell him?

Another 6 months passes...

John Part 4

John and parents return to clinic and report he has had an increase in depression with return of passive suicidal thoughts. He is having a hard time getting to school. He feels his medications are not working anymore and wants to change them.

John Part 4 Discussion

What else do we need or want to know in order to update his case formulation, diagnosis list, and treatment plan?

John Part 4 Discussion

What are his diagnoses?

John Part 4 Discussion

What is the treatment plan?

Patient and family fall away from care.

8 months later....

John Part 5

John and parents return to clinic. He disclosed to parents he had been using pills “for a while” and wants to stop but can’t. He thinks they are opioids but is not sure. He has also started using cannabis and nicotine again. He denies any other use.

John Part 5

He is acutely ill appearing. He is shivering, has gooseflesh, body aches, a runny nose and stomach cramps. Vitals reveal he is tachycardic with HR at 115 and his BP is 145/85.

John Part 5 Discussion

What else do we need or want to know in order to update his case formulation, diagnosis list, and treatment plan?

John Part 5 Discussion

What are your diagnoses?

John Part 5 Discussion

Clinical Opioid Withdrawal Scale (COWS)

METAPHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION: PRIMARY CARE – HOSPITAL INTEGRATION

Resting heart rate	0 (≤ 80)		1 (81–100)		2 (101–120)				4 (121+)
Sweating	0		1		2		3		4
Restlessness	0		1			3			5
Pupil size	0		1			2			5
Bone/joint aches	0		1			2			4
Runny nose/tearing	0		1			2			4
GI upset	0		1		2		3		5
Tremor	0		1			2			4
Yawning	0		1			2			4
Anxiety/irritability	0		1			2			4
Gooseflesh skin	0					3			5
TOTAL	5–12 13–24	Mild Moderate			25–36 37+	Moderately severe Severe			

John Part 5 Discussion

What are your diagnoses?

John Part 5 Discussion

What is your treatment plan?

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It is now another 2 years later….


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Take Home Points

- Discussions about substance use are important for all primary mental health patients. Even if you don't think it is the main reason they are presenting for care.
- Utilize motivational interviewing spirit and skills to discuss use and treatment planning with youth and their families.
- Family involvement and communication are essential for care.
- Use the DSM Criteria to diagnose SUDs, intoxication and withdrawal syndromes.
- Consider if symptoms describe a pre-existing or separate primary mental health concern or are secondary to the substance use disorder.

Take Home Points

- Create treatment plans that address both mental health and substance use needs – one does not wait for the other.
- Remind yourself and families that the standard of care for youth substance use is psychosocial intervention.
- Pharmacology can be used for treatment resistant cases with appropriate family and patient discussion.
- The exception to this is opioid use disorders: **buprenorphine** and psychosocial interventions are indicated. Always provide **naloxone.**
- Youth are amazingly resilient and recovery is possible.

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