TREATING SUBSTANCE USE IN THE CHILD AND ADOLESCENT MENTAL HEALTH DIVISION

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CAMHD OVERVIEW

Serve youth ages 3-18 (sometimes up to 21)

- Approx. 41% female
- $M$ age 13.6 years ($SD = 3.7$ years)
- Primarily multiethnic (58.4%)

Most frequent primary dx

- Disruptive, impulse control, and conduct disorders (24.1%)
- Depressive disorders (19.8%)
- Attention-deficit/hyperactivity disorder (16.3%)
- Adjustment disorders (14.6%)
CAMHD OVERVIEW (CONT.)

Eligibility Criteria (basically, the federal definition of a serious emotional disturbance [SED])

1) Qualifies for a mental health diagnosis by qualified mental health professional (not only a substance use dx or developmental disability)
2) Significant functional impairment at home, school, or in the community

+ Eligible funding source
CAMHD OVERVIEW (CONT.)

What services does CAMHD provide?

- Care Coordinators provide intensive case management services as part of a clinical team with a psychologist and/or psychiatrist
- CAMHD contracts with private agencies and cases are co-managed between CAMHD and the treatment provider
- Offer a wide array of home and community-based mental health treatment services, based on youth’s specific needs
  - E.g., Intensive in-home therapy, Independent living skills, Transitional family home programs, Residential programs, Crisis services, Hospital-based services
- CAMHD promotes use of evidence-based services across levels of care
Substance Use Disorders and Treatment in CAMHD:
- Substance use disorders on their own do not qualify for CAMHD services but can co-occur with another psychiatric disorder
- All contracted providers should have substance use treatment integrated into their care
  - Evidence-based services for substance use: Multisystemic Therapy (MST), Functional Family Therapy (FFT)
  - One specialized residential program is often utilized the most for SU youth
Number of Youth Served by CAMHD Within Each Fiscal Year: Past 10 Years

The graph shows the number of youth served by CAMHD within each fiscal year over the past 10 years, from 2012 to 2021. The number of youth served has fluctuated, peaking around 2016. The start of the pandemic is indicated by a red vertical line, showing a significant decrease in the number of youth served starting in 2020.
Trends in Total CAMHD Youth With Any Open Case Within Each Month: Comparing Pre-Pandemic to Pandemic Periods

- Pre-pandemic
- Pandemic
SUBSTANCE USE PROBLEMS IN CAMHD’S YOUTH
Percent of CAMHD Youth with Substance Use Problems:
FY 2020

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Youth w/ Any Dx of Substance-Related and Addictive Disorder</td>
<td>18.5%</td>
</tr>
<tr>
<td>% of Youth w/ Primary Dx of Substance-Related and Addictive Disorder</td>
<td>0.4%</td>
</tr>
<tr>
<td>% of Youth w/ a Treatment Target of Substance Use</td>
<td>13.1%</td>
</tr>
</tbody>
</table>

**Treatment Target** – the strengths and needs being addressed as part of the mental health services for youth and family clients.
% of CAMHD Youth with Substance Use Problems: Since FY 2009

- % of Youth w/ Any Dx of Substance-Related and Addictive Disorder
- % of Youth w/ Primary Dx of Substance-Related and Addictive Disorder
- % of Youth w/ a Treatment Target of Substance Use

MORE ABOUT SUBSTANCE USE AS A MENTAL HEALTH TREATMENT TARGET...
Treatment Targets

Hyperactivity
Impulsivity
Independent Living Skills
Learning Disorder/Underachievement
Mania
Occupational Functioning/Stress
Oppositional/Non-Compliant Behavior
Peer Involvement
Peer/Sibling Conflict
Personal Hygiene
Phobia/Fears
Positive Family Functioning
Positive Peer Interaction
Positive Thinking/Attitude
Psychois
Runaway/Elopement
School Involvement
School Refusal/Truancy
Self-Esteem
Self-Injurious Behavior
Self-Management/Self-Control
Sexual Misconduct
Sleep Disturbance/Sleep Hygiene
Social Skills
Substance Use
Suicidality
Traumatic Stress
Treatment Engagement
Willful Misconduct/Delinquency

Practice Elements – the discrete clinical intervention strategies applies by the therapist and/or treating provider within a treatment session.

Activity Scheduling
Assertiveness Training
Attending
Behavioral Contracting
Biofeedback/Neurofeedback
Care Coordination
Catharsis
Cognitive
Commands
Communication Skills
Crisis Management
Cultural Training
Discrete Trial Training
Educational Support
Emotional Processing
Exposure
Eye Movement/Tapping
Family Engagement
Family Therapy
Free Association
Functional Analysis
Goal Setting
Guided Imagery
Hypnosis
Ignoring or Differential Reinforcement

What treatment practices should we use for a specific treatment target???
1. What does the research literature say is effective in treating substance use problems?

2. What does our local research say is effective with our youth in Hawai‘i?

3. What does my clinical expertise and experience say?

4. What has been working and not working for this particular youth?
<table>
<thead>
<tr>
<th>Practice Element</th>
<th>% in Research Protocols</th>
<th>Local Evidence (β)</th>
<th>% of Youth Receiving PE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Higher Research and Local Evidence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td>47%</td>
<td>0.023</td>
<td>78%</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>42%</td>
<td>0.215</td>
<td>79%</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>39%</td>
<td>0.198</td>
<td>67%</td>
</tr>
<tr>
<td>Assertiveness Training</td>
<td>32%</td>
<td>0.146</td>
<td>28%</td>
</tr>
<tr>
<td>Cognitive</td>
<td>26%</td>
<td>0.289</td>
<td>67%</td>
</tr>
<tr>
<td>Modeling</td>
<td>21%</td>
<td>0.065</td>
<td>57%</td>
</tr>
<tr>
<td>Self Monitoring</td>
<td>18%</td>
<td>0.163</td>
<td>43%</td>
</tr>
<tr>
<td>Functional Analysis</td>
<td>16%</td>
<td>0.048</td>
<td>19%</td>
</tr>
<tr>
<td><strong>Higher Research Evidence; Limited Local Evidence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Therapy</td>
<td>37%</td>
<td>-0.208</td>
<td>69%</td>
</tr>
<tr>
<td>Family Engagement</td>
<td>32%</td>
<td>-0.588</td>
<td>76%</td>
</tr>
<tr>
<td>Goal Setting</td>
<td>24%</td>
<td>-0.393</td>
<td>82%</td>
</tr>
<tr>
<td>Behavioral Contracting</td>
<td>18%</td>
<td>-0.224</td>
<td>55%</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>18%</td>
<td>-0.076</td>
<td>64%</td>
</tr>
<tr>
<td><strong>Limited Research Evidence; Higher Local Evidence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insight Building</td>
<td>8%</td>
<td>0.105</td>
<td>67%</td>
</tr>
<tr>
<td>Attending</td>
<td>3%</td>
<td>-0.037</td>
<td>34%</td>
</tr>
<tr>
<td>Commands</td>
<td>3%</td>
<td>0.148</td>
<td>14%</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>3%</td>
<td>-0.063</td>
<td>54%</td>
</tr>
<tr>
<td>Response Cost</td>
<td>3%</td>
<td>-0.016</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Limited Research Evidence; Limited Local Evidence</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tangible Rewards</td>
<td>13%</td>
<td>-0.275</td>
<td>39%</td>
</tr>
<tr>
<td>Activity Scheduling</td>
<td>11%</td>
<td>-0.177</td>
<td>63%</td>
</tr>
<tr>
<td>Relaxation</td>
<td>11%</td>
<td>-0.219</td>
<td>48%</td>
</tr>
<tr>
<td>Social Skills Training</td>
<td>11%</td>
<td>-0.213</td>
<td>42%</td>
</tr>
<tr>
<td>Educational Support</td>
<td>5%</td>
<td>-0.404</td>
<td>60%</td>
</tr>
<tr>
<td>Cultural Training</td>
<td>3%</td>
<td>-0.288</td>
<td>22%</td>
</tr>
<tr>
<td>Parent Coping</td>
<td>3%</td>
<td>-0.517</td>
<td>47%</td>
</tr>
<tr>
<td>Personal Safety Skills</td>
<td>3%</td>
<td>-0.386</td>
<td>42%</td>
</tr>
</tbody>
</table>
MAIN FINDINGS OF A FEW STUDIES

- In months when substance use was targeted, disruptive behavior targets were the most commonly endorsed (Turner et al., 2016)

- Substance use commonly endorsed in the first 6 months of intensive in-home treatment (23.8% of youth)
- Substance use treatment target reached an average highest progress rating of 3.58 (SD=1.88; between “some improvement” and “moderate improvement”) on a scale of 0-6
- Took an average of 100.2 (SD=58.3) days to reach highest progress rating (Love et al., 2014)
In examining documentation of elopements from residential treatment facilities, the 3 major motivational categories for the elopement were:

1) peer influence,

2) escape from negative stimuli within the facility, and

3) approach toward reinforcing stimuli outside the facility – with a common subcategory being a desire to use substances (Milette-Winfree et al., 2017)
Use of family interventions and involvement in predicting substance use treatment progress for geographically isolated and non-isolated youth in intensive in-home was examined:

- No evidence that average substance use progress ratings were lower in geographically isolated areas (i.e., non-Oahu counties)
- No difference in the use of family interventions for geographically isolated and non-isolated youth
MAIN FINDINGS OF A FEW STUDIES (CONT.)

- Families of geographically isolated youth were involved in treatment more frequently than non-isolated families.
- Only individual interventions and involvement in treatment were significant predictors of average substance use progress ratings when considered alongside family interventions and involvement.
- Family interventions (but not involvement) was a significant predictor of average substance use progress ratings when considered independently of individual interventions and involvement (Hee et al., 2021).
QUESTIONS OR COMMENTS?
MAHALO!

Resources

For information on CAMHD and how to refer: https://health.hawaii.gov/camhd/

For more CAMHD research: https://health.hawaii.gov/camhd/publications/

For the Practice Element Matrix: https://health.hawaii.gov/camhd/clinical-tools/

For other questions:

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