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Bringing People and Knowledge Together to Strengthen Care.

Pathways to care for youth with concurrent mental health and substance use disorders

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Executive summary

Concurrent disorders is an umbrella term that describes the simultaneous existence of a mental disorder and substance use disorder. Conduct disorder (severe behaviour problems), attention-deficit/hyperactivity disorder, depression and anxiety disorders are the most prevalent mental disorders that co-occur with substance use disorders among youth (Armstrong & Costello, 2002). If left untreated, youth with concurrent disorders are at high-risk for a variety of unhealthy outcomes including crime, homelessness, risky sexual behaviour, school drop-out, damaged family relationships, multiple hospital visits and suicide. These youth often come into contact with multiple service systems throughout their lives including health care (e.g. emergency room, hospitalizations), justice, and social services (e.g. housing, financial assistance). This higher contact with services means that youth with concurrent disorders incur greater costs across systems (Cohen & Piquero, 2009).

Results from the Ontario Student Drug Use and Health Survey indicated that 13% of Grade 7-12 students had a substance use problem that would benefit from intervention, but only 1% of youth received treatment in the past year (Paglia-Boak, Adlaf, & Mann, 2011). Other studies estimate that 14-25% of children and adolescents are suffering from a mental health disorder at any given time (Boyle & Georgiadas, 2009; Waddell, Offord, Shepherd, Hua, & McEwan, 2002). Youth transitioning to adult mental health and substance abuse services have even higher rates of mental disorders (Pottick, Bilder, Vander Stoep, Warner, & Alvarez, 2008), as the onset of other serious mental disorders, such as psychosis, emerge in late adolescence and young adulthood (McGorry, Purcell, Goldstone, & Amminger, 2011).

Given the high rates of mental disorders and the high rates of substance use during adolescence and young adulthood, it is not surprising that there is significant risk for youth to develop co-occurring disorders. Canadian research estimates that 3% of youth ages 15-24 years old meet diagnostic criteria for a concurrent disorder (Cheung, Bennett, Bullock, Soberman, & Kozloff, 2010). This is a conservative estimate of potential longer-term negative outcomes, as it does not capture the high prevalence of youth in the early stages of substance use and psychiatric symptom development who do not meet diagnostic criteria (Paglia-Boak, Adlaf, & Mann, 2011).

The service needs of youth with concurrent disorders are complex and the necessity of individualized assessment and treatment plans makes a 'one-size-fits-all' approach impossible. Because of the complexity and diversity of needs, the majority of youth with concurrent disorders do not receive services. Attitudinal barriers exist that prevent youth from accessing services on their own accord. For example, youth often do not identify as having a problem requiring formal supports, or they feel they can deal with the problem on their own (Wu & Ringwalt, 2006). Those who do wish to access services often encounter systemic barriers that hinder the effectiveness of their recovery process. For instance, funding for mental health services and addictions services come from different Ministries in Ontario, thus situating them in separate sectors. The result is a lack of coordination and continuity of care between service providers (Bukstein & Horner, 2011), or problems with transitions between services such as from child to adult services. There is a strong rationale for policy-makers to support initiatives that improve services across sectors and settings to meet the needs of youth with concurrent disorders.

This paper focuses on youth aged 12-24 years old, and the recommendations are intended for policy-makers in Ontario. Although much of the supporting literature is focused on youth under 18, given the importance of the transition years

and the difficulty youth experience in transitioning to adult health services, it is important to consider how care pathways are applied for all youth. The table below summarizes the barriers youth experience that can compromise their ability to access care, with the corresponding recommendations to improve how services are structured and provided. Full recommendations can be found in the conclusion of this paper.

	Barrier	***Recommendation***
1.	Youth with concurrent disorders often do not see their substance use as problematic. They might not access treatment because they want to handle their problems independently, are skeptical about treatment, or feel stigmatized accessing services. High rates of trauma and maltreatment among youth with substance use disorders suggests that many of these youth may have negative expectations of relationships with adults.	Service providers can be challenged from the outset in engaging with youth and gaining their trust. The system should make access to screening and assessment accessible and safe, and all service providers should be trained in **youth engagement**. Service providers are encouraged to work collaboratively with youth to develop a treatment plan and to implement motivational enhancement strategies targeted to the youth's readiness for change. A **harm reduction** approach is recommended to engage youth in the treatment process.
2.	Those youth who are most impaired tend to receive the timeliest services, but there is often a significant delay between when concurrent disorders begin and when youth are screened and finally access treatment. Identification, screening and assessment do not consistently happen early or at key service locations.	Service systems require a population health approach by ensuring that *any door is the right door*. This requires the involvement of multiple sectors including primary health care, education, juvenile justice and specialized mental health and addictions services. **Screening** should be conducted for both mental health and substance use disorders in all service settings, with referral to appropriate services where necessary. Brief, cost effective screening instruments have been shown effective in Canada and can be used by a variety of practitioners.
3.	A lack of understanding of referral processes among service providers often requires youth to access multiple service providers before receiving the proper care.	Determining referral processes across sectors is a priority, along with clear definitions of the roles and responsibilities of each in the process. Inter-professional meetings across sectors are recommended as a way to establish collaborative relationships. Communities should develop **protocols** and clear **clinical care pathways** that function across service locations and sectors.
4.	Mental health and substance use disorders are often treated in separate settings, through separate sectors, which can lead to service providers feeling confused as to who is responsible for treating youth with concurrent disorders. In addition, mental health services often require that a client's substance use be	Substance use disorders should not be exclusionary criteria for mental health services. Better outcomes are achieved when there is **coordination** and **integration** of mental health and addictions services to address both issues concurrently. Mental health and substance use disorders should be treated simultaneously in a coordinated and integrated manner.

	managed prior to engaging in mental health treatment, thus making substance use an exclusionary criterion for accessing mental health services.	
5.	Integrated treatment approaches that simultaneously address mental health and substance use disorders are limited because of the lack of clinicians who are trained and experienced to screen, assess and provide integrated interventions. This is in part due to a lack of knowledge among mental health clinicians and addictions counsellors, discomfort talking about alcohol and drug use by mental health clinicians, and differing understandings of abstinence and harm reduction.	A combination of single-site programs with fully integrated mental health and substance abuse treatment (i.e. specialized concurrent disorders programs) and multi-site coordinated programs (where individuals see addictions counsellors and mental health clinicians in separate but closely coordinated settings) are recommended. To support multi-site coordination, mental health and addictions counsellors require **training and support** on concurrent disorders, screening, and evidence-informed treatments. For training to be effective, it must be intensive and include on-going support, coaching and consultation. For multi-site coordinated programs, clarity of roles along the clinical pathway and referral and exit protocols are key. The topic of concurrent disorders should also be incorporated into professional university and college programs responsible for training and certifying direct service providers.
6.	Although collaboration across sectors is recommended, little research exists on how to best implement integrated, multi-site collaboration.	Local task forces should plan cross-sectoral, coordinated clinical pathways and multi-site care integration at the community level. Local implementation activities should be rigorously **evaluated** to demonstrate what works in Ontario and what the key components are of services for youth with concurrent disorders. Common evaluation templates and measures should be used across communities for comparison of sites and to aggregate data provincially.
7.	Those with complex concurrent disorders often have difficulty staying engaged in treatment.	Intensive **case management** and Wraparound [1]services are recommended for high-risk youth and those with established and severe concurrent disorders, and should include a key worker dedicated to coordinating services to ensure ongoing engagement in treatment. The availability of single-site, integrated concurrent disorders services will reduce the problem of requiring youth to attend multiple appointments in multiple settings. Family involvement in services is associated with improved outcomes. Grounding services in **family engagement** and **youth engagement** best practices can improve client retention and engagement.

[1] Wraparound requires a team approach to planning and involves multiple providers so that the complete range of services "wraparound" the client. The services are individualized, family-driven, strengths-based, culturally competent, and community oriented (Burchard, Bruns, & Burchard, 2002).

The Ministry of Children and Youth Services Draft Child and Youth Mental Health Service Framework outlines consistent expectations for the delivery of child and youth mental health services in Ontario, including core services, the importance of pathways to care, and key processes. Our summary recommendations, which are expanded upon in the paper, align with the framework:

1) Service providers in Ontario, across education, health, mental health and other service provision locations, should be part of an integrated continuum of services and supports that ranges from prevention to intensive intervention depending on the profile and needs of youth.
2) All programs should be evidence-informed and evaluated to ensure effectiveness and accountability.
3) A pathway to care for youth with concurrent disorders should include the following principles:
    1) Youth should be able to enter the pathway to care through schools, primary care, hospitals, mental health facilities, addictions treatment settings, child welfare and/or juvenile justice.
    2) Once youth have accessed a service, all service providers should be competent to screen and identify youths' level of need, without having to refer them to another service to do so.
    3) Results of the screening should inform the next step in the process. Individuals should be cared for within the current service or referred to the appropriate treatment that matches their needs. Individuals should be referred to the following:
        a. Primary care physician: when symptom severity of mental disorder and substance use are low.
        b. Addictions specialist: when addictions symptoms are moderate to severe and mental disorder symptom severity is low.
        c. Mental health specialist: when mental health symptoms are moderate to severe and addictions symptoms are low.
        d. Integrated treatment approach: when individuals have a moderate to severe mental disorder and substance use symptoms.

System changes and culture shifts at agencies and among service providers will require dedicated leadership. To train and sustain this level of competency among addictions and mental health workers and to develop integrated and coordinated services, the full support of team leaders and senior management at the community planning and provincial policy tables is essential. As Hides, Elkins and colleagues (2007) wrote regarding developing basic competency among addictions workers, "change will not occur if the service does not articulate this process as a priority and a core service issue" (p. 365-366).