Georgetown University, National Technical Assistance Center for Children’s Mental Health, Webinar Series
Designing a Recovery-Oriented Care Model for Adolescents and Transition Age Youth with Co-Occurring Substance Use and Mental Health Disorders

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1:00 – 2:30 PM

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Overview of Webinar

• Context and background on substance use disorders and service system
• Why addressing co-occurring substance use and mental health is important
• Findings of SAMHSA Consultative Session
• Focus on integrated treatment and recovery at clinical and program levels
• Recommendations for system integration, financing, and sustainability
• Polling questions and participant Q and A
Polling Question for Webinar Participants: How do you identify yourself and your role?

- Mental health policymaker or administrator?
- Substance use policymaker or administrator?
- Mental health provider or clinician?
- Substance use provider or clinician?
- Family member or youth concerned with mental health issues?
- Family member or youth concerned with substance use issues?
- Family member/youth concerned with co-occurring mental health and substance use disorders?
Context and Background on Substance Use Disorders and Service System

- Neuroscience of addiction
- Early onset
- Mental health / substance use disorders system differences
Prevalence of Adolescent (ages 12 to 17) Substance Use and Co-Occurring Disorders

- Seven percent of individuals between the ages of 12 and 17 were classified as substance abusive or dependent in 2009.
- In 2009, the rate of alcohol abuse or dependence among adolescents between the ages of 12 and 17 was 4.6 percent and the rate of illicit drug abuse or dependence was 4.3 percent (SAMHSA, NSDUH).
Unmet Adolescent Treatment Need

- Of the 1.8 million youths aged 12 to 17 who needed treatment for an illicit drug or alcohol use problem in 2009, 150,000 received treatment at a specialty facility (about 8.4 percent of the youths who needed treatment for a substance use problem but did not receive it (SAMHSA, NSDUH, 2009)
Increased Awareness of Co-Occurring Disorders (COD)

- Across a range of studies, 54 to 95 percent of youth in alcohol and drug treatment also have conduct or oppositional defiant disorder; mood disorders are evident in approximately half of these teens; and 15 to 42 percent exhibit anxiety disorders (e.g., post-traumatic stress disorder; social phobia) (Brown, n.d.).

- A study of mental health service use among youth revealed that nearly 43 percent of youth receiving mental health services in the United States have been diagnosed with a co-occurring substance use disorder.

- Realization that both medical and social services are needed

- Development of a recovery-oriented system with both treatment and psycho-social services and supports


Co-Occurring Disorders Cont.

• For youth with COD, treatment for substance-related disorders *only* does not improve mental health outcomes, and treatment for mental health disorders *only* does not improve substance abuse outcomes

• Youth with COD in our treatment populations are the expectation not the exception (Minkoff)

• Problems are multiple, complex, and persistent (Dennis)

• Multisystem involvement
2008 SAMHSA Consultative Session:
Designing a Recovery-Oriented Care Model for Adolescents and Transition Age Youth with Substance Use or Co-Occurring Mental Health Disorders

Purpose:

- To conceptualize a recovery system for youth who are or have been involved in substance use or co-occurring mental health disorder treatment;

- To identify key concepts and elements of recovery for youth, families, and communities;

- To determine how these concepts may be operationalized in a recovery-oriented system of care; and

- To build bridges between substance abuse and mental health to achieve improved integration of care.
2008 Consultative Session:
Designing a Recovery-Oriented Care Model for Adolescents and Transition Age Youth with Substance Use or Co-Occurring Mental Health Disorders

- Participants:
  - Family members,
  - Youth in or post-treatment for substance use or co-occurring mental health disorders,
  - Providers,
  - Researchers, and
  - Federal and State level policy-makers.

- Approach included a literature review and briefing materials, a conceptual framework, presentations and consensus development at consultative session, and summary proceedings.
Concepts of Recovery-Oriented Care

- “Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her potential.” (A. Kathryn Power)

- “A recovery-oriented system of care approach shifts the emphasis from how to engage an individual in treatment to how to support the longitudinal process of recovery within the person’s environment. It should support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities……” (H. Westley Clark)
Conceptualizing the Essential Elements of a Recovery-Oriented System of Care
Values and principles to support recovery

• Being family focused;
• Employing a broad definition of family;
• Being age appropriate;
• Reflecting the developmental stages of youth;
• Acknowledging the nonlinear nature of recovery;
• Promoting resilience;
• Being strengths based;
• Supporting youth empowerment; and,
• Identifying recovery capital.
Additional values and principles for a recovery-oriented system of care

- Empowering youth/consumer;
- Being youth guided;
- Being individualized;
- Promoting hope;
- Emphasizing accessibility;
- Providing choice;
- Containing a broad array of services and supports;
- Being culturally competent;
- Promoting individual responsibility; and
- Being integrated.
Services and supports

• Ensuring ongoing family involvement;
• Providing linkage to services;
• Assuring that the range of services and supports address multiple domains in a young person’s life;
• Including services that foster social connectedness;
• Providing specialized recovery supports; and,
• Providing therapeutic/clinical interventions.
Infrastructure elements

- Family involvement at the design/policy level;
- Policy change at the Federal, State, and provider levels;
- Collaborative financing;
- Collaboration and integration across all youth-serving systems;
- Workforce development;
- Leadership; and,
- Accountability.
Challenges Identified to Achieving a Recovery-Oriented System of Care for Youth with COD

- Lack of shared language and common vision
- Complexity of achieving change
- Stigma
- Disparities
- Lack of culturally and linguistically competent services and supports
- Limited family and youth involvement
- Lack of infrastructure
- Lack of system and care coordination
- Lack of services and supports including those focused on recovery
- Financing
- Inadequate workforce capacity
- Lack of appropriate outcome measures and accountability
- Confidentiality issues
- A need for more research and evaluation
Focus on Integrated Treatment and Recovery
At the Clinical Level
Integrated Treatment for Co-Occurring Disorders

What do we know?

• The presence of a co-occurring disorder adversely affects treatment engagement, retention and completion rates with youth;
  – Relapsing conditions
  – Long-term treatment needs

• Treatment for youth with COD involves engaging the youths’ families and supports in the process

• Often, consumers do not receive treatment at all, or receive sequential or parallel single-service treatments vs. integrated treatments
Integrated Treatment
What is it?

• **At the clinical level:**
  – Developmentally appropriate matched interventions for mental health, substance use, and other concerns are combined in the context in a clinical relationship
  – Youth and family relationship with an individual clinician or team (within program)
  – Individual and family experiences the intervention(s) as strength-based, family & youth focused, and culturally sensitive

Select Sources: Minkoff, 2007; Riggs; CIP
Focus on Integrated Treatment and Recovery
At the Program Level
Integrated Treatment

Terms

• **COD (Dual Diagnosis) Capable:**
  • Primary focus on services for one disorder (MH or SA)
  • But, are capable of treating individuals with relatively stable or sub-diagnostic co-occurring disorders
  • Provide appropriate matched services within context of current program mission to existing COD cohort accessing services in that program

Select Sources: Minkoff; Minkoff & Cline, 2007; ASAM PPC 2R
Integrated Treatment

Terms

• **COD (Dual Diagnosis) Enhanced:**
  - “Specialized” programs that are designed to provide more integrated mental health and substance abuse services; targeted populations with in COD Capable framework is ideal
  - Individuals are more severe in both mental health and substance abuse categories and/or have more specialized treatment needs
  - Ex: IDDT-Integrated Dual Disorder Treatment (Adult); ICT- Integrated Co-occurring Treatment (Youth)

Select Sources: Minkoff; Minkoff & Cline, 2007; ASAM PPC 2R; SAMHSA COCE; CIP
Integrated Co-Occurring Treatment (ICT)

• ICT utilizes an integrated treatment approach, embedded in an intensive home-based method of service delivery, to provide a set of core services to youth with co-occurring disorders of substance use and serious emotional disability and their families.

• There are currently five ICT programs being piloted nationally, three of which were implemented as part of SAMHSA System of Care grant sites.

• Cleveland, Akron, Columbus, Kalamazoo, and McHenry County, Ill.
Contextual Assessment and Treatment

Baltrinic and Shepler (2008)

$+$ = Protective Factors
$-$ = Risk Factors

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Ongoing Recovery & Continuing Care Planning

- Expectation that youth will need ongoing services, supports, and monitoring beyond ICT program

- Focus on community linkages, family monitoring, and informal supports

- ICT providers take an active role in:
  - Identifying and connecting youth and family to continuing care services and supports
  - Linkages and follow-up

- Availability for booster sessions and re-involvement
Typical Weekly Service Activities

• Crisis Availability and Response

• Case Management for Youth & Family

• Integrated Treatment (MH & SA) for Youth

• Consultation/Coaching for Family

• Consultation for System (School, Community)

E. Baltrinic, 2010
Target Outcomes

**Increase functioning in major life contexts** so that the youth is:

- Living at home or in a permanent home setting
- Attending and achieving at school/work
- Reduced involvement in the JJ system
- Reduced use/no use of substances
- Participating in positive family, peer, and community life
- Improved family recovery environment
- Accessing resources and natural supports as needed to maintain gains and prevent recidivism

E. Baltrinic, 2010
Recent ICT Study

- Real world study: Utilized naturally occurring comparison groups from a specialized co-occurring court

- All youth received the co-occurring court’s intensive probation program

- Compared ICT to traditional non-integrated services
  - (Treatment As Usual - TAU)

- Due to ethical concerns, randomization into groups was not allowed

- Randomized controlled study with follow-up needed to confirm results
Results: Promising and Mixed
Positive Results: Improvement Over Time

All Youth Considered Together

- Substance use variables (GRAD; Drug Screens)
- Mental health variables: (Ohio Scales; GRAD)
- Family/Parenting (GRAD)
- Pro-Social Activities (GRAD)
- Educational Functioning (GRAD)

- Possibly due to the positive effect of the special court docket and the intensive probation program

ICT Did Better than TAU

- Substance Use Variables (GRAD; Drug Screens)
- Mental Health Problem Severity: (GRAD only)
- Pro-Social Activities (GRAD)
- Pro-Social Peers (GRAD-Parent Rating)
- Family/Parenting (GRAD-Youth Rating)
Youth Collectively had Increased Criminal Behaviors and Recidivism

Across all youth studied
- New charges (felony and misdemeanor)
- More days in detention
  - Possibly due to increased surveillance and drug screening by intensive probation program

ICT
- ICT had significantly more recidivism than TAU (Days in Detention; GRAD Prior Offense domain)
  - Possibly due to higher severity of ICT group at time of admission
    - Earlier age of first adjudication
    - Higher substance use severity
    - Higher level of felony charges
Implementation Challenges

• **Funding:** no state process for efficiently billing Medicaid for integrated services

• **Staff and Training:** Right staff; dual licensure/experience; consistent coaching; targeted supervision

• **Fidelity:** Tracking progress; circling back to core components and processes of the model

• **Administrative:** Clarity of target population; realistic outcomes; monitoring referral patterns and collaborating with referral sources and stakeholders; finding ICT’s role in local system of care

• **Outcomes:** Tracking outcomes; continuing to add to the ‘N’ to help collect data and evidence of effectiveness
Implementation Challenges

• Community planning that assesses the placement of COD treatment within the context of the system of care

• Capacity of the community and providers, e.g., resources, staff, community support

• Sufficient stakeholder investment
Recommendations from Consultative Session for Integrated Care, Financing, and Sustainability
Consultative Session Recommendations

INTEGRATION

Federal Level

• Improve integration across substance abuse, mental health, and other Federal youth-serving agencies.
• Support State and community substance abuse and mental health integration initiatives; and,
• Hold States accountable for integration.

State Level

• Streamline State bureaucracies;
• Increase collaboration among youth-serving State agencies and establish an interagency council at the State level for planning and coordination; and,
• Build State level staffing capacity across relevant agencies and youth services providers.

Source: Substance Abuse and Mental Health Services Administration. (2009). Designing a Recovery-Oriented Care Model for Adolescents and Transition Age Youth with Substance Use or Co-occurring Mental Health Disorders. Rockville, MD: U.S. Department of Health and Human Services.
Consultative Session Recommendations

FINANCING STRATEGIES

Federal Level

• Align Federal policy and funding for substance abuse and co-occurring mental health treatment and recovery support;
• Foster collaborative funding (braided/blended funding);
• Utilize Federal block grant funding and develop process to support recovery-oriented systems of care for youth; and,
• Incentivize States to build recovery-oriented systems of care through grants.

State Level

• Develop a comprehensive financing strategy examining various funding streams;
• Enhance the use of Medicaid; and,
• Examine alternative revenue strategies.

Source: Substance Abuse and Mental Health Services Administration. (2009). Designing a Recovery-Oriented Care Model for Adolescents and Transition Age Youth with Substance Use or Co-occurring Mental Health Disorders. Rockville, MD: U.S. Department of Health and Human Services.
Consultative Session Recommendations

SUSTAINIBILITY AND IMPLEMENTATION

Federal Level

• Use permanent statutory vehicles to ensure sustainability.

State Level

• Develop a comprehensive implementation approach for developing recovery-oriented systems of care, which will include public awareness, outreach, access, availability, capacity, and quality;
• Conduct outreach and encourage the development and implementation of recovery-oriented systems of care; and,
• Align licensure and administrative regulations to support recovery-oriented systems of care.

Source: Substance Abuse and Mental Health Services Administration. (2009). Designing a Recovery-Oriented Care Model for Adolescents and Transition Age Youth with Substance Use or Co-occurring Mental Health Disorders. Rockville, MD: U.S. Department of Health and Human Services.
Second Polling Question

To what extent are you involved in either policy or program related to integrated care for co-occurring? (Scale of 1 to 5 with 1 being very little)
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