BRIEF

December 2014

Implementing Treatments for Youth with Co-Occurring Mental Health and Substance Use Disorders: Opportunities and Challenges

Despite challenges to providing effective integrated treatment services for youth with co-occurring disorders, agencies and communities are implementing strategies to overcome them.

Patrick Kanary

Richard Shepler

The Center for Innovative Practices at the Begun Center for Violence Prevention Research and Education

Jack, Joseph and Morton Mandel School of Applied Social Sciences

Case Western Reserve University

Effective Practices and Programs + Effective Implementation = Positive Outcomes

This well supported formula is a challenging, but necessary strategy to achieve, particularly with regard to services for youth with co-occurring disorders, and there is evidence that no other combination of factors reliably produces desired outcomes for children, families, and caregivers.[1] Perhaps more than many other populations of youth, those with COD test this strategy since the 'typical' challenges of implementation (e.g., work force, financing, administrative procedures, collaboration) are further compounded with this population. The following summarizes some of these challenges and opportunities for advancement and improvement.

Funding

Despite the high prevalence rate for youth with COD, funding, research, and treatment development for this high needs population lags significantly. One of the challenges facing integrated substance use and mental health treatment is siloed funding which often requires different reimbursement fee structures and duplicative paperwork and outcome requirements.2 While a valid issue for concern and an area for continued improvement, the creation of integrated funding mechanisms cannot justify provider hesitation or unwillingness to move forward with implementation. For example, all of the original 'pilot sites' for the Integrated Co-Occurring Treatment (ICT) model, have found ways to continue funding post the initial startup grant. Because youth with COD are often engaged with multiple child serving systems (juvenile justice, education, mental health, substance abuse, and child welfare) there is an opportunity for cross-system discussion about the need for shared funding for mutual outcome benefit. Cross-system funding conversations and agreements should occur upfront before starting a program. One successful example of this is in Ohio. The state uses the Behavioral Health-Juvenile Justices (BHJJ), initiative (a shared effort of the Ohio Department of Mental Health and Addiction Services and the Ohio Department of Youth Services), and the Reclaim, Targeted Reclaim and Competitive Reclaim initiatives to provide 'incentive' funding to local communities to keep youth in their homes and communities while providing flexible funding to implement evidence based and promising practices. Other states such as Indiana and Georgia, have similar examples.

This document was prepared for the Technical Assistance Network for Children's Behavioral Health under contract with the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Contract #HHSS280201300002C. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

Integrated Co-Occurring Treatment (ICT)

The Integrated Co-Occurring Treatment (ICT) model, which utilizes an intensive in-home approach, is one example of an integrated program that has been successfully implemented and sustained in a variety of community settings. 3, 4 As noted above, all seven of the ICT programs initially realized through federal and/or state grants (Substance Abuse and Mental Health Services Administration Center's System of Care grants, Center for Substance Abuse Treatment grants and awards from the Office of Juvenile Justice and Delinquency Prevention) have continued and are now sustained through a combination of Medicaid, state, and local funding. Communities that value integrated services have found ways to effectively finance them beyond grant funding. The clinical, administrative and fiscal complexities of ICT (and other intensive in-home approaches), however, require that they be implemented in secure funding environments. The 'hydraulics' of implementing many evidence based practices require not only clinical reorientation and skill building but also organizational and systemic adjustments. Experience suggests that at least two full years of implementation with fidelity are needed to reach consistent outcomes. The significant investment needed to implement ICT calls for implementation in environments that provide the best opportunity for long term sustainability and necessitates access to initial startup funding (or redirection of existing funding) as well as the commitment of multiple public systems beyond an initial one year startup.

Service Delivery Modality: Integrated, Parallel, or Serial Treatment

Historically, treatment for adolescents with co-occurring disorders was delivered either in a serial manner, where one type of treatment would follow the other (e.g., mental health treatment delivered first or substance abuse treatment delivered first), or in a parallel fashion, where both services were delivered during the same time frame but typically by different providers, each with their own, separate treatment plans.2,5,6 There is growing consensus that integrated treatment models (i.e. one provider, one assessment, one treatment plan) are a more efficient and effective treatment approach for youth with COD.2,7 Integrated treatment leads to reduced treatment confusion, streamlined services, and better outcomes. Therefore, communities and providers thinking about implementing treatment services for this population should first consider integrated treatment models. Because youth with COD are harder to engage and retain in treatment services, communities must consider service delivery modalities with strong engagement and outreach components, like home and community-based programs. Two 'blueprint' models - Multisystemic Therapy (MST) and Functional Family Therapy (FFT), have long served youth with substance use disorders, but recent adaptations have strengthened this focus. Both models have recently enhanced or reinforced certain treatment elements specifically for youth with substance use issues (i.e. MST-SA, and FFT-CM).

Human Resources

Recruiting and retaining qualified staff to work with youth with COD are two of the most difficult challenges in COD program implementation. Most states have a shortage of dually trained and licensed substance abuse and mental health professionals. Many locales also face difficulty in recruiting Master's level therapists, which is typically the skill level preferred for intensive models like MST and FFT. Many graduates of social work, counseling and psychology programs have had limited exposure to this topic area; therefore the responsibility for training staff falls primarily to the provider agency implementing the co-occurring program. In order to help reinforce new practice skills and to maintain fidelity, it is important for agencies to choose a model with a strong ongoing training and consultation component. It is equally important for agencies to staff their COD programs with dually-trained and licensed supervisors who can provide the day-to-day clinical guidance to assist staff in learning and applying the necessary integrated skill sets and thereby help maintain fidelity to the selected model. Dually trained and licensed supervisors therefore, become the foundation for ongoing clinical and training needs of direct care staff doing this work.

Psychiatric services such as assessment, psychopharmacology management, and consultation are other critical components for effective treatment of this population of youth. Unfortunately, as is generally the case in children's mental health, there is a significant child psychiatry shortage and an even smaller number of child psychiatrists with addiction training and those comfortable with prescribing medication to youth with co-occurring substance use disorders.8

Promoting Collaboration While Protecting Confidentiality

As system of care communities know well, youth with COD are typically involved with multiple systems (i.e. mental health, juvenile justice, education, and child welfare), which necessitates strong relationships with cross-system partners. Under the best of circumstances, multi-system collaboration to meet the needs of youth with COD can be challenging. Stringent federal confidentiality standards for substance use treatment add to this challenge especially for system of care communities with strong histories of cross system collaboration. These Federal confidentiality regulations (Confidentiality of Alcohol and Drug Abuse Client Records 42CFR Part 2) require additional restrictions for the disclosure and use of alcohol and drug abuse client records for federally funded programs. The rule is intended to provide a safe environment for substance use treatment that protects client information from being used for prosecution, investigation, or substantiation of criminal charges against the person in treatment. One of the unique aspects of 42 CFR Part 2, is that a consent form signed by the youth is required in order to release information to anyone, including parents or guardians. For more information on the regulation, see SAMHSA TIP 42, Appendix K.9 High Fidelity Wraparound (HFWA) www.nwi.pdx.edu10 is an effective teaming process for cross-system planning, monitoring, and oversight of the complex needs of youth with COD.

Implementation Considerations: Clinical and Practice Issues

There are a number of clinical issues that need to be considered when implementing treatment programs for youth with co-occurring disorders. Youth with COD present with multiple problems that impact functioning in multiple life domains (most commonly family, school, peers, and community). A more accurate term might be 'youth with multiple-occurring conditions' given the prevalence of multiple and simultaneous disorders.

- **Safety.** Youth with co-occurring disorders present with multiple risk factors, risk behaviors, and safety issues which require active management and monitoring. Consider choosing programs that have on-call capacity to participating youth and their families 24 hours a day/7 days a week, and ones that have active and ongoing risk and safety planning and monitoring components.

- **Victimization and Trauma.** Youth with co-occurring disorders have high rates of victimization and trauma ranging from 40% to 90% depending on the study, with girls having higher rates than boys.[11,12] Youth with high rates of victimization and trauma typically have higher rates of substance use.[13] This data mirrors the Adverse Childhood Experiences (ACE) study which found that trauma can lead to an increase substance use, mental health, and physical health issues later in life.[14] Traumatic stress experiences contribute to impaired emotional and behavioral functioning and to the adoption of risk and substance use behaviors, which in turn may lead to further exposure to victimization, violence, and trauma experiences. Therefore, COD treatment should incorporate trauma-informed approaches and focus on strategies that assist youth and families in creating safe recovery environments, reducing high risk behaviors and risk generating environments, and reducing impulsive decision-making that could potentially lead to re-traumatization. *Seeking Safety* is one EBP that has shown positive results in treating youth with co-occurring trauma and substance use presentations.[15]

- **Heterogeneous Clinical Presentation.** The clinical presentation of youth with co-occurring conditions is quite heterogeneous in terms of age of onset, severity, and complexity. Adolescent females typically have greater psychiatric severity. Females have similar amounts of externalizing disorders (e.g. oppositional defiant or conduct disorder) as males, but more internalizing behaviors (e.g. social withdrawal, sadness, difficulty concentrating, changes in sleeping/eating) and family problems than males.[16] Programs must have components that address both internalizing and externalizing disorders, and are able to address gender-specific issues. Multidimensional Family Therapy (MDFT) i for example, has created

treatment modules specific to the needs of female adolescents.[17] ICT is an example of an integrated program that is designed to treat youth with high psychiatric acuity (i.e. internalizing and externalizing mental health disorders) in context of their co-occurring substance use disorder.

- **Systemic and Contextual Factors.** The impact of co-occurring disorders on relationships and functioning is pervasive and can have multiple adverse consequences (e.g. court involvement, school failure, family stress, etc.). Contextual risk and protective factors (peers, family, school, neighborhood, and community) play a mediating role in youth behaviors, use patterns, and recovery trajectory. Programs for adolescents with COD should focus on contextual and systemic issues (family, peers, school, community, etc.) that impact the youth. Programs that have access to the environments they are targeting for change, such as home and community-based programs like MST, ICT, MDFT, FFT, and others best impact contextual functioning.

- **Developmental Factors.** Developmental factors and brain development impact substance use. Adolescents have increased likelihood of risk taking behaviors and are more prone to impulsive decision-making. Effective programs should recognize the developmental differences of treating youth versus adults and models developed specifically for adolescents are preferable.[18] Programs should focus on building developmental adaptive skills sets and positive resiliency and recovery environments for the youth's ongoing success.

- **Engagement and Treatment Retention.** Youth with co-occurring disorders have poor treatment retention[7]. Treatment engagement, motivation, and progress are more difficult to attain and sustain. Therefore, programs with strong engagement, outreach components, and treatment persistence, and that have a history of strong treatment retention and completion rates should be considered. Most home and community-based program models focus on strong youth and family engagement and have strong retention and treatment completion rates.

- **Ongoing Management and Treatment Perspective.** While single-episode treatment programs are effective in the short term, ongoing treatment, support, and monitoring is necessary for long term recovery.[19] Recovery support strategies that are low cost, ongoing, and supportive should be considered (see Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide for recovery support programs).[18] As noted above, High Fidelity Wraparound (HFWA) can also be used to facilitate continuing planning and monitoring of the unique ongoing mental health and recovery support needs of youth with COD.

- **Drug Testing.** Drug testing for youth with substance use disorders is considered best practice, however many mental health professionals are unfamiliar and/or uncomfortable with drug testing. Therefore, while acknowledging the potential reluctance of staff to administer drug tests, special attention must be paid to training. In addition, working in home and community settings presents special challenges to staff who do drug testing in the field. Some home and community-based programs (MST, ICT) take a family empowerment approach and coach parents to test their children. Regardless of who does it however, drug testing should be used to enhance treatment efficacy and not for punishment. Best practice protocols for drug testing are beyond the scope of this brief but SAMHSA offers guidance on drug testing in one of the SAMHSA/CSAT Treatment Improvement Protocols appendices: Urine Collection and Testing Procedures and Alternative Methods for Monitoring Drug Use.[20]

- **Community Education.** Because of the lack of community awareness about the prevalence and special treatment needs of youth with COD it is important for communities to educate practitioners, child-serving systems, and the public. The overview could include education on screening and identification of youth with co-occurring disorders, as well as what programs currently exist in that community that address the needs of youth with COD. Such an overview could also provide the basis for dialogue and an opportunity for communities to

strategically plan for new approaches and programs for addressing any unmet service and support needs for youth with COD.

Summary

This brief is a part of a series on Youth with Co-occurring Disorders which, taken together, we hope will provide a foundation for further exploration of the opportunities to serve this population. Youth with co-occurring disorders are not new to our systems. We are already involved with them and their families, often in ways that are parallel and disconnected. The opportunity to use promising and evidenced-based integrated approaches for treatment is an exciting option to comprehensively address the behavioral health needs of adolescents. Because of the complexity of the presenting concerns of youth with COD, communities need to consider implementing programs that target the multiple individual and contextual risk factors and concerns that significantly impact the youth's functioning across life domains and over time. Integrated care recognizes that success is defined for this population not only by clinical and functional outcomes but by shared system outcomes that help these young people stay with their families, succeed in their schools, thrive in their communities, and begin to see hope in their futures.

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The Technical Assistance Network for Children's Behavioral Health (TA Network), funded by the Substance Abuse and Mental Health Services Administration, Child, Adolescent and Family Branch, partners with states and communities to develop the most effective and sustainable systems of care possible for the benefit of children and youth with behavioral health needs and their families. We provide technical assistance and support across the nation to state and local agencies, including youth and family leadership and organizations.

This resource was produced by Case Western Reserve University in its role as a contributor to the Clinical Distance Learning Track of the National Technical Assistance Network for Children's Behavioral Health.