Integrated Co-Occurring Treatment for Youth with Mental Health and Substance Abuse Disorders: From Development to Implementation

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Defining Co-Occurring Disorders
CSAT, 2005

- A diagnosis of co-occurring disorders occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder

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Take Home Points

- More common than we think
- Complex presentations
- For integration to be effective- needs to occur at the policy, funding, and treatment levels
- Collaboration with key system partners is essential (Courts; Schools; Child Welfare)

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Problems are multiple, complex, and persistent

- Multiple problems (5+) are the norm (Dennis)
- Trauma and victimization in 67 to 80% of youth (Dennis; Hussey)
- Most youth have multiple system involvement (juvenile justice; schools)
- Chronic relapsing disorder, requiring multiple treatment attempts over time (White and Dennis)
- 60 to 80% of youth relapse within the first year

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Cross-System Involvement JJ and Substance Use
(Hussey et al., 2005)

Table 1. SCY youth cross-system involvement using multiple self report and official data sources.

Indicator	SCY (N= 188 enrolled)
Juvenile Justice	95% report ever being on probation or in jail/on parole
Substance Abuse	99% of youth qualified for at least one DSM-IV Axis 1 substance diagnosis.
Mental Health	**62%** of youth have at least one DSM-IV mental disorder, primarily disruptive disorders (54%), mood disorders (30%), and generalized anxiety disorder (14%). 14% reported current use of psychotropic medication.
Education	29% of SCY youth reported receiving special education classes
Child and Family Services	58% of SCY youth have at least one allegation of maltreatment, including physical abuse (59%), sexual abuse (15%), neglect (63%) or emotional abuse (12%). 18% of SCY youth had a history of one or more out of home placements.

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Court Involvement & Substance Use
(Hussey et al., 2007)

- 75% of youth had a DSM-IV Cannabis Dependence Diagnosis
- Youth reported they were, on average, 13.1 years old the first time they got drunk or used any drugs
- 18% of youth reported ever receiving substance abuse treatment
- Nearly ¾ of youth (74%) had low or no confidence that they could resist relapse in different situations

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Victimization: JJ and SU Youth
(Hussey et al.)

- 64% of youth report any victimization on the GAIN
- 47% of youth had a substantiated/ indicated incident of maltreatment
- If considered together, **80% of all SCY youth** have a history of some type of victimization

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Multiple-Occurring Conditions

Need term that more comprehensively accounts for the complexity of these youth-in-context

I. **Diagnoses:** youth who meet the criteria for both MH and SU diagnoses

II. **Contextual Functioning:** Degree of functional impairment per life domain

III. **Developmental Functioning:** (cognitive functioning, emotional, & behavioral maturity)

IV. **Risk and Recovery Environments**: Environmental risk and recovery conditions (e.g. trauma, safety, negative influences, family conflict, poverty)

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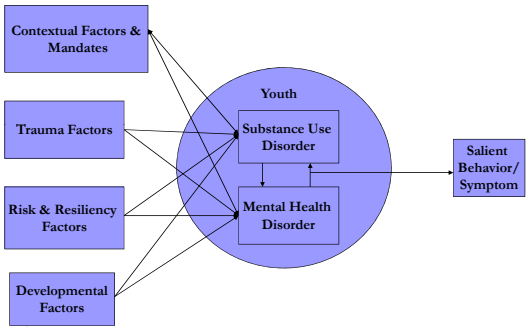
Influence, Interaction, and Manifestation of Co-Occurring Disorders



Service to Science Development

- Naturalistic progression
- Responsive to family and community need
  - Youth with multiple safety, risk, and functional impairments
- Multiple consumer and community feedback
- High family and community saliency

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Integrated Co-Occurring Treatment (ICT)
Phase I Development

- Collaborative development process beginning in 1999 (U. Akron; ODMH)
- Goal: design a developmentally appropriate, integrated treatment model for youth with co-occurring disorders
- Utilized information from multiple sources:
  - Consumer feedback
  - Practice-based knowledge
  - Review of the literature
- Conducted focus groups informed by youth, parents, juvenile justice, mental health, substance abuse, and school professionals to assist with model development

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Integrated Co-Occurring Treatment (ICT)
Guidelines for model development

- System of Care service philosophy; partnerships with youth and family; cultural mindfulness
- Integrated treatment approach
- Home-based Intervention service delivery mechanism
- Developmentally appropriate
- Grounded in prior empirical research
- Theoretically and conceptually driven

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Integrated Co-Occurring Treatment Definition

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

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ICT: Components

1. Intensive home-based service delivery grounded in system of care service philosophy
2. Integrated contextual approach to assessment, case conceptualization & intervention
3. Comprehensive service array matched to need
4. Systemic engagement across systems & cultural discovery orientation to providing integrated treatment
5. Risk, resiliency, and developmental focus

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Home-Based Service Delivery Model

- Location of Service: Home & Community
- Intensive: 2-5 sessions/wk
- Crisis Response: 24/7
- Small caseloads: 3-6 families
- Flexible: Access and availability
- Treatment Duration: 12-24 weeks
- Cross-system collaboration: Child & Family Team Mtgs.

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ICT Core Services

- Crisis Intervention and Stabilization
- Case management-oriented activities to meet basic needs
- Individually-Focused Interventions
- Family-Focused Interventions
- Cross-System Interventions
- Facilitation of resiliency-focused supports and activities

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Service Matching & Need Hierarchy (Shepler)

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Integrated Co-Occurring Treatment Logistics

- Dually certified agency; dually licensed supervisor
- 2 to 4 FTE clinical staff either dually licensed or dually trained, with mix of SU and MH expertise on the team
- Consultation, training, and technical support to:
  - Provide initial and booster trainings
  - Provide regular monitoring and coaching of ICT
- Years 3+:
  - ICT Supervisor Monitors Fidelity
  - Consultation negotiated based on need
  - Yearly fidelity review

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Phase II Initial Implementation

- Pilot site: Mental Health Agency with dually certified supervisor
- Initial implementation funding partner was juvenile justice (JAIBG and Byrne Grants from 2001 to 2004)
- Utilized feedback from implementation team to refine and enhance model

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Results of ICT Study (2001-2002)

ICT Youth	Usual Services Comparison Group	Size of Difference in commitment and/or recidivism rates
○ 56 youth ○ 25% recidivism rate	○ 19 Youth ○ 47% commitment rate	Chi Square (1, 19): 3.338 Level of significance: (p one-tailed = .034)

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Phase III Multiple Site Piloting

- Multiple site piloting, 2005 to present: (Akron, Ohio; Cleveland, Ohio; Kalamazoo, Michigan; Salinas, California; & McHenry County, Illinois)
- Further model refinement
- Quasi-experimental comparison study (Akron site)

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Ohio Scales Gain Scores (2005 – October 2006)

	General Clinical Population (Statewide)			ICT Participants		
	30 days	180 days	Gain	30 days	180 days	Gain
Problem Severity Adult	28.60	22.74	5.86	31.28	19.38	11.90
Problem Severity Child	23.93	18.85	5.08	30.33	19.48	10.85
Hopefulness Adult	12.29	10.60	1.69	13.52	10.88	2.64
Hopefulness Child	10.60	9.44	1.16	13.09	10.18	2.91
Satisfaction Adult	8.87	6.42	2.45	10.25	7.25	3.00
Satisfaction Child	10.60	8.53	2.07	10.13	8.05	2.08
Functioning Adult	44.98	48.65	3.67	36.20	44.71	8.51
Functioning Child	55.75	59.34	3.59	49.42	58.76	9.34

Total = 27 youth; 3 ODYS Commitments

- For "Functioning", the higher the score the better - for all others, the lower the score the better
- Clinical cutoffs= 20 for problem severity and 51 for parent rating functioning and 60 for youth rated functioning

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Phase IV: Increasing research rigor

- Apply for R34 with focus model components and fidelity to control diffusion of ICT allowing cross-site comparison with other treatments
- Randomized controlled study (R01)
- Sustainability and durability of results

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Balancing Risk, Reward, and Responsiveness

- There is risk to innovation
- Pros and cons
  - Not as tightly controlled
  - Allows for ongoing innovation and adaptation as you go
- Risk – Learn - Respond pathway
- Community Responsiveness: Letting the community set the bar for who needs served

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Comparisons of Groups at Admission: ICT vs TSS

Variable	ICT	p
Degree of Offense (e.g. Felony 1 vs 5)	Higher	.033
Age of First Offense	Younger	.001
Non- Lethal Suicide Intent (SPPI)	Greater	.026
Substance Misuse	Greater	.003
Variety of AOD	Greater	.003
Chemically Dependent	Greater	.01
Substance Use/Abuse (GRAD)	Greater	.001
Learning Disabilities	Greater	.04

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ICT 2005- 2008 Study

- Quasi-experimental- not randomized
- Real world
- All youth were involved in local co-occurring court
- All youth received intensive probation as a part of enrollment in Co-Occurring Court
- Compared ICT to Typical Services

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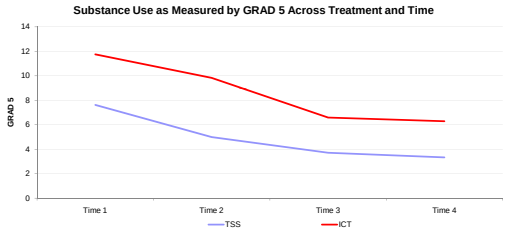
Both groups had significantly reduced substance use over time ($p < .001$); with significantly greater improvement of ICT compared to TSS ($p < .001$)



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Implementation success from a community perspective

- **Credibility**: Is service meaningful and helpful to community and family?
- **Predictability:** Can family and community rely on service?
- **Liability and risk management**: Does the program help community manage safety?

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What we have learned

- Think trajectory of wellness not cure
- Continuing care needs: "For chronic medical conditions, relapse would be an expected outcome if the treatment were discontinued …further supporting the efficacy of the treatment (Dennis)"
- Risk reduction versus abstinence as an outcome result
- Picking the right outcome tools
- Resolve infrastructure issues prior to implementation (integrated funding and paperwork requirements)
- Juvenile justice collaboration is critical (referral source; weekly teaming)

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