THE INTEGRATED CO-OCCURRING TREATMENT (ICT) MODEL:
A promising practice for youth with mental health and substance abuse disorders

Rick Shepler, PhD
Helen Cleminshaw, PhD
Center for Family Studies
The University of Akron

Eric Baltrinic, MA Ed, PC/CR, LICDC
Child Guidance and Family Solutions, Akron, Ohio

!8th Annual Research Conference: A System of Care for Children's Mental Health: Expanding the Research Base
Tampa, Florida
March 6 – 9, 2005

Acknowledgements

The research and development of the ICT treatment model was funded by grants from the Ohio Department of Mental Health, the Ohio Department of Youth Services, and Ohio's Office of Criminal Justice Services.

Special Thanks:
- Patrick Kanary, Center for Innovative Practices
- John Starr, Ohio Department of Mental Health
- Win Turner, AIR & Dartmouth College

*Adapted from a paper to be presented at the All-Ohio Institute on Community Psychiatry, 2005.

The President's New Freedom Commission on Mental Health

- "Co-occurring substance use and mental disorders can occur at any age. A substantial number of children and adolescents also have co-occurring mental illnesses and substance use disorders."

Identification and Reporting

- Youth with co-occurring conditions are under identified and under reported
- Limited clinical research
- Limited knowledge on the characteristics, etiology, and progression of the condition

(Turner)

Prevalence of co-occurring psychiatric and substance abuse disorders

Community Sample
- Estimates of lifetime prevalence among 12 to 18 year old youths range from 2% to 8.5% (Glaconia, et al., 2000; Kandel, et al., 1999; Turner & Gil, 2002).

Prevalence of co-occurring psychiatric and substance abuse disorders

Clinical Sample
- Among mental health treatment samples, estimates of lifetime co-morbid substance abuse samples range from 24% to 50% (Aarons, et al., 2001; Eisen, et al, 1992; Greenbaum et al., 1991; Grilo, et al., 1995, 1996; King, et al., 2000).
- Among youth who have received substance abuse treatment, estimates of lifetime co-occurring psychiatric disorder range from 59% to 87% (Garland, et al., 2001; Molina, et al., 2002; Robbins, et al., 2002; Westmeyer, et al., 1994).

Tenn Care in Tennessee (Managed Care system)

- 45 to 49% of youth treated for substance use disorders also have co-occurring psychiatric disorders

MH Needs of Youth in JJ System NIMH Study 2002

- 66% of boys and 75% of girls in Cook County Juvenile Detention had at least 1 psychiatric disorder
- 50% abused or addicted to drugs
- When Conduct Disorder removed, 60% of males and 66% of females met Dx criteria one or more MH or SA disorders
- Rates of dysthymia or depression: 17.2% for males; 26.3% for females

Progression

- Which disorder develops first in youth?
- Research indicates the onset of the mental disorder often precedes the addictive disorder (Temporal order)
- Disruptive behavior disorders associated with earlier onset of use and higher rate of substance abuse for both genders
- Family drug problems were the strongest correlates of earlier onset of SUD

(Turner)

Poorer Prognosis

- Less motivation, increased academic, family, and behavior problems, limited coping and social skills.
- Lag in important adolescent development tasks – individuation, moral development and conceptualization of future family, vocational and educational goals.

(Turner)

Reasons for integrating care

- Unrecognized mental health disorders reduce engagement, retention and completion
- Untreated co-morbid disorders persist after recovery: ADHD, Mood Disorders
- After recovery form SUD, depression in youth is much more likely to persist compared to adults.

(Turner)

Treating one disorder in isolation is not sufficient

- *Substance abuse treatment helps to reduce the frequency of use and the number of abuse/dependence symptoms but has only indirect impact on emotional and behavioral problems*

(M. Dennis, 2004)

Multiple Co-occurring Problems

- *Multiple co-occurring problems are the norm among adolescents with substance abuse problems.*

(White, M.K., White , W.L., Dennis, M.L., 2004)

Juvenile Justice Youth with Co-Occurring Disorders

- Integrating services for SA and MH alone, is a necessary but not sufficient step
- Youth with co-occurring disorder who are involved in the juvenile justice system can be considered to have Tri-Occurring conditions
- Because we provide services in silos and by systems it is very possible to have three or more providers utilizing three different case plans, with three different sets of interventions
- **Services, therefore, need to be integrated across diagnoses and system involvement**

Multiply-Occurring Conditions

- Need term that reflects the complexity of presentation of youth served. Diagnosis is just one way of describing these youth.
- The term **Multiply-Occurring Conditions** more comprehensively accounts for the complexity of these youth-in-context

Dimensions of MOC

- **Diagnoses:** youth who meet the criteria for both MH and SA diagnoses
- **Functional Impairment:** Amount and depth of system involvement or life domain impairment. (Probation/Parole; Mental Health; Substance Abuse; IEP/Truancy/ Expulsion; Child Welfare; Education)
- **Risk and Recovery Environments**: Environmental risk and recovery conditions (trauma, safety, negative influences, family conflict, poverty)

Interactive Determination

Youth's behaviors are interactively determined based on his or her mental health, substance abuse, functional environments, developmental abilities, safety, and mandates

Adult Treatment Research (Drake, 2003)

- After twenty years of development and research, services for adult clients with severe mental illness and substance abuse/dependence are emerging as an evidence based practice
- Integrated Dual Diagnosis Treatment (IDDT)
- Comprehensive long-term staged approach to recovery
- Assertive outreach
- Motivational interventions
- Skill Training & Support to meet Functional Goals
- Cultural Sensitivity and Competence (Turner)

Important differences between adults and youth with co-occurring SAMI

Youth
- Mandated supports
- More family involved
- Invincible & Concrete
- Substance Abuse and Behavioral MH
- Groups may be harmful
- Sobriety is for adults
- Consequences: "about getting caught"

Adults
- No mandated supports
- Less family
- Vulnerable & Abstract
- Substance Dependency and Serious MH
- Group supports helpful
- Sobriety: an option
- Consequences: increasing awareness of costs

How is treatment for youth different?

- Treatment is briefer
- Treatment addresses family system
- Need for collaboration with other child-serving systems (e.g., school, court, child welfare)
- Groups are sometimes harmful; should be based on stage of treatment
- Treatment needs to be matched to developmental stage
- Youth have had less treatment experience
- Multiple system mandates

Multiple System Mandates

- *Adolescents are involved in multiple systems competing to control their behavior* (White, White, and Dennis)
- Schools, family, courts, peers, etc
- To best understand and interact with youth and family you should be familiar with what is being required of them (VanDenBerg) and their interpretation and response to these mandates (Baltrimic)

Mandated Treatment

- *Coerced entry into addiction treatment and superficial compliance with institutional rituals of treatment should not be mistaken as a foundation for post-treatment recovery.* William White, 2004
- It is important to understand how mandates affect perspective, treatment cooperation, and long term recovery.

Common Elements of Effective Practice

(Hubble, Duncan, & Miller, 1999)

- **Client Factors (40%):** The largest single contributor to change is the client and family. Strengths; Abilities; Talents; Social Supports; Beliefs; Resources; Motivation for Change.
- **Relationship (30%):** Use of empathic, supportive, motivation-enhancing techniques to improve alliance, engagement, and retention.
- **Expectancy and Hope (15%):** The extent that the family believes that your prevention or treatment programming will be beneficial to them.
- **Techniques (15%)**

Common Elements of Effective Practice

(Riggs, 2003; White & Dennis, 2004)

- **Comprehensive Assessment:** systematic evaluation to identify problems and treatment needs in multiple domains, including psychiatric co-morbidity
- **Drug Monitoring**: Use of behavioral techniques informed by urine toxicology results to promote and shape desired, pro-social behaviors and discontinuation of drug use and other problem behaviors
- **Skill Building:** Self- efficacy, problem solving, decision-making, communication, anger management, mood regulation, coping, and relapse prevention skills.

Common Elements of Effective Practice

(Riggs, 2003; White & Dennis, 2004)

- **Family-focused and involved treatment**
- **Relapse Prevention and continuing care**
- **Developmentally, culturally, and gender specific treatment**
- **Integrated Assessment and Treatment**
- **High fidelity; structured supervision**
- **Home-based service delivery for multi-need youth at-risk of placement**

Intensive Home and Community-Based Service Models

- **Multidimensional Family Therapy (MDFT)**
  Targeted at substance abusing youth and their families
- **Multisystemic Therapy (MST)**
  Targeted at juvenile justice involved youth at-risk of incarceration
- **Integrated Co-Occurring Treatment (ICT)**
  For youth with co-occurring conditions of mental illness and substance abuse who are at risk of placement, incarceration or who are being reunified from a more restrictive placement

Service Matching to Level of Care

- Matching the right intensity of service to the level of care needs of the youth
- Evidenced-based practices can be matched to the youth's level of care need

American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC 2-R Criteria)

- Level 0.5: Early Intervention
- Level I: Outpatient
- Level II: Intensive Outpatient and Partial Hospitalization/Day Program
- Level III: Residential/Inpatient
- Level IV: Hospital

Where do best practice treatments fit on ASAM PPC Levels of Care?

- 5 Session MET/CBT (Level I)
- 12 Session MET/CBT (Level I)
- Sub-Levels of Care for Level II
  - Level II.1: Intensive Outpatient (IOP)
  - Level II.5: Partial Hospitalization/ Day Treatment
  - Level II.?: IHCBS (MDMFT; MST; ICT)

3 Types of Treatment for Co-Occurring Disorders

- **Sequential**: Serial treatment
- **Parallel:** both services provided at same time by different professionals in different systems or agencies
- **Integrated:** both services provided by one provider or provider team in same program

(Turner)

Integrated Co-occurring Treatment (ICT)

(H. Cleminshaw and R. Shepler)
© University of Akron

ICT Model Definition

ICT is an integrated treatment approach embedded in an intensive home-based model of service delivery, that serves youth with the co-occurring conditions of substance abuse and serious emotional disability

Key Components of ICT

- System of care service philosophy
- Home-based service delivery model
- Integrated service (MH and SA)
- Stage-wise treatment
- Motivational Interviewing
- Resilience focus

Principles of Care

- Culturally Responsive
- Cross-system Collaboration
- System Navigation and Advocacy
- Child-Centered and Family-Driven
- Partnership with Youth and Family
- Strength-based
- Reasonable Expectations
- Extreme Persistence

Culturally Responsive

- Community-based professionals are culturally competent and responsive to the unique cultural, racial, spiritual and ethnic differences of the families they serve
- "*We don't define families. Families define who they are.*" Karl Dennis

Collaboration

- Community-based professionals establish collaborative relationships with other child and family-serving systems with the goal of enhanced service coordination across providers and systems

Karl Dennis

- " *Inter-agency collaboration is an unnatural act by un-consenting adults*"
- " *If you leave somebody out you already lost but you just don't know it*"

System Navigation and Advocacy

- Providers should help families in navigating the system
- The rights and privacy of youth and families are protected, and effective advocacy efforts are promoted

Child-Centered & Family-Driven

- The need of the child and family dictate the type and mix of services provided
  Stroul and Friedman, 1986
- **Ownership**: parent/child agree with and are committed to any plan concerning them.
- **Voice**: Parent/child are heard, listened to at all junctures of planning

Partnership

- Families are full partners in all aspects of the service delivery process
- The foundation for all service delivery is a supportive and respectful relationship with each youth and family served, as well as, members of their support network

Strength-based

- Services build upon the youths' and family's strengths, resources, and informal supports with the ultimate goals of individual and family empowerment and self-sufficiency
- Services and supports are tailored uniquely to each family's presenting needs, strengths and circumstances

Reasonable Expectations

- Successful outcomes begin with reasonable expectations.
- Reasonable expectations are based (in part) on the youth's behavioral health, current capacities, competencies, and life circumstances.
- Reasonable assistance is often necessary in facilitating recovery.

Extreme Persistence

- "Communities recognize that needs can be complex, that change is sometimes very difficult to achieve, and commit to a mutual process of extreme persistence in the delivery of services and supports. Providers make a "commitment to never give up on the child or family, changing the plan instead of rejecting the child and family from services and support." (VanDenBerg, 2002)

Quote from Maya Angelou

- "How is it possible to convince a child of his own worth after removing him/her from a family which is said to be unworthy but with whom he/she identifies."

Home-Based Service Delivery Model

- Location of Service
- Intensive
- Flexible
- Available and responsive
- Small caseloads
- Treatment Duration

Location of Service

- Service is delivered where youth and family live and function
- Service are provided in the least restrictive, most normative setting, that provides for safety and the optimal success of the youth, family and community over time

Intensity

- 2 to 5 meetings weekly
- Length of session depends on family needs

Flexibility

- Evening hours/weekends
- Non-traditional schedule
- Meets family's schedule

Availability

- 24/7 on call
- Immediate response to crisis
- Response from primary provider

Case-load Size

- Small caseloads
- 3-6 families per therapist

Treatment Duration

- 12-24 weeks for Intensive Phase
- Length reflects recovery process (i.e., long term)

Assessment

- Comprehensive & Balanced
- Contextual & Ecosystemic
- Risk and Recovery Environment Focus
- Diagnostic Categories
- Assessment Instruments

Multidimensional Assessment

- *Addiction disrupts all aspects of an adolescents life, and that impairment is best addressed within multidimensional assessment processes and multidisciplinary models of intervention*

William White 2004

Comprehensive and Balanced

- Comprehensive assessment of functional life domains: (family, school, community, social, legal, etc)
- Balanced: Strength-based and need focused

Contextual & Ecosystemic Perspective

- Contextual, ecosystemic perspective: Youth-in context of-Family-in context of-Culture and Community; and determination of how each of these contexts interacts and reciprocally affects the other

Risk and Recovery Environment

- Trauma history & safety
- Contributing & influencing conditions and people
- Family Sobriety
- Risk factors
- Resilience factors

Risk Factors

- **Community**: availability of drugs; economic deprivation
- **Family:** family conflict; family management problems; low warmth
- **School:** academic failure; lack of commitment
- **Individual and Peer**: early and persistent anti-social behavior; rebelliousness; negative peers; favorable attitudes toward drugs, impulsivity;
- **Trauma:** History of physical, sexual, and emotional abuse (Dennis, 2004)

Key Elements of Resilience

- **Connections** to individuals, families, and institutions
  - Positive and supportive relationships and environments
- **Competencies** (SAT)
  - Skills
  - Abilities
  - Talents
- **Contribution**: Giving to others
- **Positive view of self and future**: Self efficacy; hope-focused; futures orientation
- **High expectations, standards, and monitoring**: community, family & individual

Diagnostic Categories

Mental Health:

- Mood disorders
- Psychotic disorders
- Anxiety-related disorders
- ADHD

Diagnostic Categories

Substance Abuse:

- Abuse (DSM IV criteria)
- Dependency (active/remission) physical & psychological withdrawal or increase in tolerance levels

Assessment Instruments

- The Child and Adolescent Functional Assessment Scale (CAFAS) K. Hodges
- CALOCUS (AACAP)
- GRAD

Treatment

- Integrated Treatment
- Risk and protective factor framework
- Stage-wise Treatment
- Motivational Interviewing
- Service Array
- Service Matching
- Family Need Hierarchy
- Substance Abuse Treatment Considerations
- Juvenile Justice Considerations

Integrated Treatment

- "If one co-occurring disorder remains untreated, both usually get worse."
- "Integrated services should appear seamless to the individual who seeks and receives care. Mental health and substance abuse treatment can be integrated by one clinician, two or more clinicians working together, one program, or a network of services."
- President's Freedom Commission

Integrated Treatment

- Mental Health and Substance Abuse Services are integrated
- One provider team
- One assessment
- One treatment plan
- One youth

Integrated Treatment

- Addresses the reciprocal interaction of how each disorder affects the other, in context of the youth's family, culture, peers, school, and greater community
- Prioritizes saliency and immediacy of need which may fluctuate from session to session

Risk and protective factor framework

- **Protective Factors:**
  Asset building and resilience orientation
- **Risk Factors:**
  Active safety planning and monitoring
  Goal: Reduce risk behaviors and exposure to risk generating people and environments

Stage-wise Treatment

- Interventions are stage-wise and based on the youth's and family's readiness and capacity to change. (Engagement; Persuasion; Active Treatment; Relapse Prevention)
- Assess youth stage of change
- Assess family stage of change
- Assess other system provider's readiness to receive youth into the community (school, probation etc.)

Motivational Interviewing

- Technique utilized in the engagement and persuasions stages of treatment

Treatment Receptivity

- Response to treatment is dependent not only on the consumer's motivation and readiness for change, but also on perceived provider clinical and cultural credibility and trustworthiness

Establishing Credibility and Trust

- Develop Positive Relationship & Family Partnership
- Accuracy of assessment and intervention
- Start with the family's most basic and immediate problem
- Competency: Effectiveness in first session
- Reliability; Responsiveness
- Cultural understanding and respectfulness

Array of Services

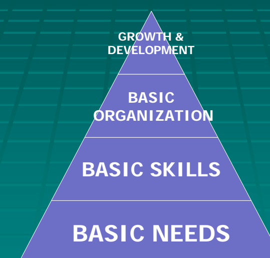
- A flexible array of Individual, family, crisis intervention, and case management interventions are utilized to comprehensively impact youth's mental health and substance abuse needs

Service Matching & Need Hierarchy

- Services and supports are matched to each family's presenting needs, strengths and circumstances
- A family need hierarchy is utilized to assist in assessing and prioritizing the youth's and family needs
- Strategies and interventions are matched to the most salient need, progressing to more complex needs once the primary needs are met
- What key factors if not addressed will lead to relapse or increased behavioral health symptoms or decreased functioning in a key life domain?

FAMILY NEED HIERARCHY

R. Shepler (1991;1999)



Basic Needs and Safety

- **Are there basic safety and material needs that are unmet?** (Food; Shelter; Safety)
- ➢ **Assist with basic needs**: Active Case Management and Advocacy
- ➢ **Establish basic safety**: Crisis Stabilization and Response
- ➢ **Safety plan**: Active safety planning and monitoring
- ➢ **Risk Reduction**: Identify and reduce individual risk factors and behaviors, as well as exposure to risk generating persons and environments

Basic Skills

- **Does the youth and family know how to do what you are asking them to do?**
- ➢ Skill Building
- ➢ Psycho-education
- ➢ Parenting Skills
- ➢ Communication Skills
- ➢ Self-Regulation and Resistance Skills

Individual Context

Main Foci

- Decrease symptoms, use, and risk factors; increase assets
- Cost/Benefit Analysis of use and non-use
- Contingency Management
- Positive replacement behaviors and activities

- **Skill Set Development**
- Recovery process: a learned skill set
- Problem-solving; conflict resolution skills
- Self regulation skills
- Self-sufficiency/independent living skills
- Educational/vocational functioning skills
- Communication & negotiation skills

Basic Organization

- **What is keeping the family from utilizing the skills they do have?**
- ➢ Hierarchy
- ➢ Boundaries
- ➢ Relationships
- ➢ Bonding
- ➢ Monitoring
- ➢ Family substance abuse or mental illness

Family Context: Set Stage for Change

- Structural and solution-focused therapies
- Create family recovery environment
- Reestablish family hierarchy
- Increase supervision and monitoring
- Rebuild bonds and relationships
- Increase positive family communication
- Developmentally appropriate parenting

Growth & Development

- **What resources and supports are necessary for ongoing growth and development?**
- ➢ Asset Building
- ➢ Informal Supports
- ➢ Resilience
- ➢ Positive peers and activities

Community Context: Building Connections

- Advocacy that builds positive system relationships (schools, courts, social service providers, neighborhood)
- Facilitate connections to pro-social activities and peers
- Facilitate realistic expectations
- Encourage community ownership and monitoring

School: Key functional life domain

- Reconnect youth to school in a positive way
- Increase school readiness to accept and welcome youth
- Complete educational and vocational strengths discovery
- Assessment of barriers to successful school functioning (e.g., learning disabilities often missed with behaviorally disordered or absent youth)

Substance Abuse Treatment Considerations

- Harm reduction vs. abstinence
- Dealing with Relapse
- Relapse Prevention
- Use of psychotropic medication
- Responsibility for change

Abstinence vs. Harm Reduction

Short Term Goal	**Long Term Goal**
Harm Reduction	**Abstinence**
Asset Building	**Thriving**

Recovery and Relapse

- *Relapse and continued problems are the norm among adolescents who have received substance abuse treatment.*
- *Recovery for many adolescents takes multiple attempts and episodes of care spanning many years.*

***White,* White, and Dennis**

Substance Use is a Chronic Condition

- Relapse is common, particularly in the first 90 days
- From first use to a year of sobriety averages 27 years
- From first treatment to a year of sobriety averages 8 years with 3 to 4 admissions to care
- The majority of adults and adolescents in higher levels of care have been in treatment before
- Even in adolescent outpatient, over 1 in 4 have been in treatment before
- Yet the treatment and finance system has traditionally be set up with an “acute care” model.
- Need for more assertive models of public health and chronic care

Source: Dennis et al in press

Relapse

- Relapse is seen as part of recovery and an opportunity for learning
- Relapse is not viewed as treatment failure

Relapse Prevention Planning

- **Goal:** Manage Risk and Build Resilience
- Typical components of relapse prevention:
  - Knowledge of triggers
  - Resistance skills
  - Avoidance of substance abusing environments and people
  - Develop pro-social peers and activities
  - Mentoring/sponsorship
  - Community connections
  - High structure and monitoring
  - Building competencies

Ongoing Recovery & Relapse Plan

- Expectation that youth will need ongoing services, supports, and monitoring beyond ICT program
- Focus on community linkages, family monitoring, and informal supports
- Availability for booster sessions and re-involvement

Role of Medications

- Medication to stabilize mental health condition when deemed necessary by the psychiatrist
- *Abstinence is not a prerequisite, but there is an expectation of decreased or decreasing use* (M. Fishman)
- Medication compliance is monitored by the parents and tracked by the therapist

Shared Responsibilities for Outcomes

- **Provider is responsible for treatment persistence and fidelity to model**
- **Youth is responsible for his or her sobriety**
- **Family is responsible for setting stage/environment for youth's safety and recovery**

Juvenile Justice Considerations

- Risk Management
- Mutually supportive efforts and sanctions
- Regular, structured communication
- Cross-training
- Commitment

Risk Management: Active and Community Involved

- Risk is best managed as a community
- Parents are first line defense for managing risk
- ICT assists with safety planning and crisis intervention
- Juvenile justice and child-serving systems provide secure alternative if risk concerns cannot be stabilized

Mutually supportive efforts & sanctions

- Graduated consequences by family
- Graduated intensity and treatment response
- Graduated sanctions by courts
- Efforts are collaborative and complementary

Regular & Structured Meetings

- Regular communication between professionals
- Cross-system collaboration with parole through weekly staging reviews

Cross-training

- Educate MH/SA professionals on mandates of juvenile justice system
- Educate juvenile justice professionals on co-occurring disorders and the recovery process

Commitment

- Gain local juvenile justice support to diversion and treatment
- Establish program credibility and effectiveness
- Responsiveness

Putting It All Together

- **Seamless:** Services should appear seamless to the youth and family
- **Salience:** Right service, in right amount, matched to diagnosis, need, and context
- **Collaborative:** Shared responsibilities for success
- **Interactively determined:** Youth's behaviors are interactively determined based on his or her mental health, substance abuse, functional environments, developmental abilities, safety, and mandates

Program Operation

Staff Credentials
- MSW/MA in counseling or related field
- License or license eligible
- Dual certification desirable

Supervisory Credentials
- MSW/MA in counseling or related field
- Dual certification/licensure

Staff Characteristics

- Flexible
- Dedicated
- Family friendly and Strength-based
- Ability to work as a team
- Able to build positive working relationships with difficult to engage families
- Clear boundaries
- Strong advocacy skills
- Positive relationships in the community
- Ability to think eco-systemically

Results of ICT Two-Year Study

- **ICT Youth**
- 56 youth
- 25% recidivism rate

- **Usual Services Comparison Group**
- 29 Youth 72% commitment rate

Recidivism

- Total rate of recidivism for 76 youth served through 2003:

  19 youth (25%) out of 76

Key Challenges

- "A key challenge to developing integrated treatment programs is overcoming the traditional separation between mental health and substance abuse treatment."

  Presidents Freedom Commission

Policy Issues

P. Kanary and K. Stork

- **Funding:** Separate funding streams at local, state, and federal levels
- **Knowledge base:** Lack of knowledge on prevalence and characteristics of population. Need increased research and funding for research
- **Training:** Lack of training on integrated treatment for youth
- Lack of **cross-system integration** at federal and state levels
- **Credentialing:** Separate and competing credentials for professional

Practice Issues

- Dually diagnosed individuals are likely to be treated in the system in which they first present
- Diagnosis and treatment focus on the system in which they were referred
- Traditional treatment approaches for complex issues (outpatient; group)
- Differences in MH and SA treatment philosophies and approaches
- **Aftercare and continuing services:** Fee for service is designed for episodic care and not continuing care.

Clinical Practice Recommendations

- No wrong door
- Treatment should be matched to the intensity and depth of need
- Continuum of service options should be available
- Use of evidenced-based and promising practices
- Family involved
- Developmentally appropriate
- Designated staff: do not use partial FTE staff for program
- Importance of solid clinical and strength-based supervision

Policy Recommendations

P. Kanary and K. Stork

- Cross-system collaboration at the state and federal levels
- Cross-system developed and disseminated training
- **Juvenile justice youth:** Develop diversion, and treatment strategies to specifically target youth involved with JJ who have co-occurring disorders, given the prevalence rates for this population

Policy Recommendations

P. Kanary and K. Stork

- Technical assistance, support, and financial incentives to community systems that approach integrated treatment for adolescents as the preferred modality
- Dedicate state and federal research and development funds to support integrated treatment
- Create billing codes to record the delivery of integrated assessments and therapeutic interventions that can be reimbursed under either SA or MH funding streams

Organizational recommendations

- Supports innovative practice
- Comfortable with higher levels of risk
- Administratively and clinically supportive of evidenced-based practices
- Administratively flexible: Allows use of comp time and flexible schedules
- Values the use of outcomes in continuous quality improvement
- Understands and embraces the role of accountability in system improvement

Summary

- **Awareness:** Expectation and not exception
- **Knowledge:** Cross-training
- **Identification:** Comprehensive
- **Treatment:** Seamless and coordinated
- **Diversity:** Develop understanding of co-occurring disorders across cultures
- **Tracking:** Develop knowledge base

References

- Dennis, M ((Spring, 2004). *Traumatic Victimization Among Adolescents in Substance Abuse Treatment* Counselor, 5 (2) pp. 36-40.
- Hubble, Duncan, & Miller (Eds.; 1999). The Heart and Soul of Change
- White, W. (Spring, 2004). *The Birth of Adolescent Treatment.* Counselor, 5 (2) pp. 18-21.
- Shepler R. (1991). Integrating home-based practice: A transdisciplinary model for treating multi-need families. In P. Cibik, S. Gwatkin, C. Pastore, & R. Shepler (Eds.), *A Practitioner's Guide to Home-based Services: A Resource Manual* (pp. 311-331). Akron, OH: The Center for Family Studies, The University of Akron
- White, M.K., White, W. L., Dennis, M.L. (Spring, 2004). *Emerging Models of Effective Adolescent Substance Abuse Treatment.* Counselor 5 (2) pp. 24-29

Contact Information

- Rick Shepler, Ph.D., PCC
  Center for Innovative Practices &
  Center for Family Studies
  330-455-3811
  ricks@cipohio.org