WASHINGTON STATE INSTITUTE ON ADDICTIONS TREATMENT

PRESENTS

A PLENARY SESSION

FACILITATING PARTNERSHIPS IN THE ADOLESCENT TREATMENT RECOVERY SYSTEMS

JUNE 28, 2007
9:00 – 10:00 A.M.

PRESENTER

FRED DYER, Ph.D., CADC
TRAINER/CONSULTANT

“I thought we were all working for the best interest of the adolescent so that we could effectively address his substance abuse, but I could not get the child welfare worker to collaborate, so my kid got tired of waiting for us to get our act together and lost his motivation for treatment and fell through the cracks. He’s now in the juvenile justice system.”

Susan, M.S., L.P., CADC,
Addictions Therapist

“I have a kid who presently interacts with several other systems, and getting all of us from those systems on the same page with this kid, relative to her substance dependence, is challenging and exhausting.”

William, MAC, Senior Addiction Counseling

“It’s not about egos; it’s not about titles; it’s not about position; it’s about saving lives.”

Fred Dyer, Ph.D., CADC

“In 2001 (the latest data currently available) 1.1 million U.S. youth aged 12-17 were estimated to need substance abuse treatment (Substance Abuse and Mental Health Administration (SAMHSA) 2001a, 2001b)). Of these, 100,000 actually received treatment, leaving a gap of approximately one million untreated adolescent nationwide (SAMHSA 2001a, 2001b).”

POSSIBLE EXPLANATIONS OF THE "WHY"

1. **There are many reasons why adolescents fail to receive treatment. At the individual level, adolescents (perhaps even more than adults) fail to recognize an alcohol or other drug (AOD) problem or minimize the problem (Melnick, DeLeon, Hanke, Jaindill, & Kressel, 1997).**

2. **Additionally adolescent concerns about disclosing sensitive information to parents and competing priorities for multiproblem families render access problematic (Cheng, Savageaue, Sattler & DeWitt, 1993; Cornelius, Pringle, Jernigan, Kirisi, & Clark, 2001; Ford, Milstein, Halpern-Fisher, & Irwin, 1997). These individual problems are significant, and there are already efforts to bring about problem recognition and motivation for change (Rahdert & Czechowicz, 1995; Wagner & Waldron, 2001).**

3. **There is an additional complicating factor that impacts the adolescent recovery treatment challenge, which goes beyond the individual youth and his or her family: the service delivery system (Meyers & McKellan, 2005).**

4. **The systems (e.g., educational institutions, health care, child welfare, juvenile justice, and mental health) are complex systems which offer opportunities to identify, treat, and monitor adolescent substance abusers (Mays & McLellan, 2005).**

5. **The architecture and operating procedures of these systems often serve to inhibit access to needed services and to confuse or confound coordination of complementary service delivery access systems can be formidable challenges to the identification and subsequent intervention and treatment of the adolescent who uses, abuses, or is dependent upon substances (Henggeler et al., 2005).**

THE ADOLESCENT SYSTEMS OF CARE

AS IT IS NOW

1. **The current adolescent treatment system is a collection of public and private agencies, which for the most part grew out of the adult treatment area (Kraft et al., 2006).**

2. **There are approximately 10,800 treatment facilities in the USA (SAMHSA, 1998) over 80% are private organizations that primarily provide outpatient treatment.**

3. **Public funds finance almost two-thirds of all the substance abuse treatment provided, while many of these provide treatment to adolescents, only 75% of the treatment organizations treat fewer than 100 clients and almost half treat fewer than 30 clients (Hargan & Levine, 1998).**

4. **Realistically, most treatment is provided in small, publicly financed, community-based organizations, which may provide treatment to fewer than 30 clients and may not offer ancillary or supportive services, (i.e., general education development test or academic supports, most are unlikely to be part of any continuum of care and they may have fewer connections with other social service agencies (Kraft et al., 2006).**

5. **Only 10% of youth who need treatment for substance use disorders receive any care (CSAT, 2001; NIDA, 2001).**

6. **Of those who do, only 25% receive appropriate services to address the extent of their problems (CSAT, 2001; NIDA, 2001).**

7. **Over 80% of the adolescents entering outpatient treatment have three or more diagnoses or other major problems (e.g., victimization, violence, illegal activities), with even more problems being associated with higher severity of substance use (Dennis et al., 2001).**

8. Treatment providers reported that their adolescent clients are younger, with more problems than they had previously, have much greater treatment needs, and increasingly come from families with multiple problems (O'Neil, 2001).

IN SUMMATION OF THE ADOLESCENT SYSTEMS OF CARE -- AS IT IS NOW

Youth who access substance abuse systems are often in other systems (child welfare, juvenile justice, mental health and educational) and have multiple issues. Consequently, the needs of each young person may be managed by multiple agencies, and providing quality treatment for adolescent substance use often requires navigation across multiple service systems. The evidence is clear that effective treatment for adolescent drug abusers requires comprehensive services that span multiple systems and include their families.

Source: Kraft, M.K., S.K., P.A., & M.M.A. (2006) Adolescent Treatment Services: The Context of Care in Adolescent Substance Abuse. *Research and Clinical Advances*, Howard A. Liddle & Cynthia L. Rowe (Eds.).

IDENTIFICATION OF ADOLESCENTS WHO USE SUBTANCES

1. **Adolescents with varying degrees of substance use can be found throughout U.S. communities, coming into contact with a variety of setting and service systems (Megans et al., 2006).**

2. **Identification of these teens, regardless of their level use, is important so that targeted developmentally-focused interventions can be delivered (e.g., brief interventions, outpatient treatment, long-term residential treatment), all followed by the appropriate form of reintervention, step-down or continuing care services, such identification has the potential to reduce the morbidity and mortality related to this condition (Winters et al., 2003).**

3. **The settings within a community can be categorized into two tiers: 1) first-rate generalist settings, and 2) more specialized, problem-focused systems of care (e.g., mental health child welfare, generalist settings, health-care settings, schools) are settings where many adolescents can be found and they have the opportunity to provide the "first gate" into needed behavioral health and social services. (Muck, et al., 2000).**

4. **Specialized problem-focused systems of care, by contrast, center on adolescents with more services and specific problems (e.g., the mental health system, the juvenile justice system, the child welfare system, the adolescent treatment system, the education system, and the adolescent drug treatment system). Therefore in a well-structured system, the general settings and the problem-focused systems would have the training and ability to screen and refer adolescents with presumptive evidence of substance use, or any other specific problems: a) for a more in-depth assessment; b) for a problem-focused agency for intervention (e.g., mental health clinics, substance abuse programs) (Megan et al, 2006).**

5. **Furthermore, an optimized system would have interagency working arrangements in place to ensure multidimensional and continuity of care without unnecessary overlap of services (Myers, et al., 2006).**

6. **Regarding family ideation, it is important for early screening efforts to differentiate substance use from substance abuse or dependence, in that this is important for both the efficiency of system operation (i.e., conservation of more intensive services for those with more severe problems and because these different stages of substance use require qualitatively different types of interventions (Wagner & Waldron, 2001; Winters, 1999).**

7. **Research supports that the appropriate direct response to identified substance use is likely to be one of a variety of recently developed brief interventions designed to prevent escalation of use into abuse or dependence and the associated penetration into the juvenile justice and social service systems which is typically associated with more severe use (Bilchik, 1995; Greenwood, Model, Rydell, & Chiesa, 1998; Rand, 1996; Wagner, & Waldron, 2001).**

8. **The effects of brief interventions may weaken after twelve months, the delivery of a brief reintervention is critical if prevention of escalation is to be maintained (Connors, Tarbox, and Faillare, 1992).**

9. **Important to the contrasting of the appropriate clinical response to substance use, the appropriate direct response to an identified case of abause or dependence is likely to be much more intense, structured, and long-lasting (Wagner & Waldron, 2001; Winters, 1999), designed to change or slow the trajectory of a long-term drug-using career.**

REASONS FOR LACK OF IDENTIFICATION

1. **Unfortunately, those delivering health or social services as part of larger agencies or systems (e.g., hospitals, mental health) rarely screen for alcohol and drug problems (Center for Substance Abuse Treatment (CSAT) 2000).**

2. **There are several reasons for this—first, there has been little effort to train key personnel from these various systems (e.g., school nurses, probation officers, case workers) in the use of some of the proven substance abuse screening instruments (CSAT, 2000; NASADAD, 1998; SAMHSA, 1993).**

3. **Second, and intimately connected to the first reason, is the lack of reimbursement for screening and early intervention activities. Few states currently reimburse adolescent screening efforts outside the specialty sector substance abuse treatment system and there are a number of payment restrictions for AOD screening and diagnostic assessments within primary care settings (Buck & Umland, 1997; Rivera, Tollefson, Tesh, & Gentilello, 2000; CSAT; 2001). Even if the services are reimbursed through insurance programs, roughly 4 million adolescents in this country are without any form of health insurance.**

4. **Third, the complex interrelationships between the parents' right to know about assessment and the legal protection of the adolescent's privacy and confidentiality can further complicate identification. Adolescents want their health issues to be kept private and want to receive certain services without their parents' or guardians' consent (Ford & English, 2002; Ford et al, 1997). Without these guarantees, adolescents will forego services (Ford, Bearman, & Moody, 1999; Klein, Wilson, McNulty, Kapphahn, & Collins, 1999).**

RECOMMENDATIONS FOR FACILITAING PARTNESHIPS

1. **Numerous barriers and challenges experienced during the day-to-day operations of adolescent treatment providers, which include categorical funding streams, restrictive client confidentiality laws, narrow professional paradigms and exclusive professional cultures, and limited leadership, are in part responsible for the existing situation.**

2. **Researchers and practitioners need to collaborate on intervention design and testing. Research needs to document clearly the skills and personal characteristics necessary to work effectively with youth and to create training programs and recruitment strategies that will deliver those skills.**

3. **Policy makers and funders should find ways to reward clinicians for competently delivered interventions and make sure that incentives are in place for providing more comprehensive, coordinated care.**

4. **Innovative support options should be encouraged and non-traditional supports (i.e., horse riding programs or physical activity programming) should be linked to rigorous testing opportunities.**

5. **Policy makers should understand the administrative and eligibility requirements of existing funding mechanisms, and streamlined procedures should be developed.**

6. **Policy makers can rethink funding requirements and focus more on comprehensive youth outcomes rather than targeted problems. Funding and budgets could be linked to youth performance on a range of developmental outcomes, not just reducing problem behaviors.**

7. **Researchers need to provide a better understanding of what it takes to implement comprehensive systems of care, and they should develop implementation manuals for administrators and practitioners similar to treatment manuals. Practitioners, direct line staff, supervisors, and management levels can learn to transcend professional boundaries and begin creating care teams that deliver high-quality, evidence-based treatment and necessary supportive services.**

8. **For evidence-based interventions to be delivered, viable treatment systems, competent providers, and available funding streams must be in place. The recent economic downturn has left states financially strapped as new public health issues and security concerns demand resources. These pressures are being played out in every social service system but are particularly difficult for adolescent treatment services, where only one in ten adolescent needing treatment can access services (Muck et al., 2001).**

9. **The increased financial constraints that substance abuse providers are facing is coupled with the maturing of requirements for measuring performance monitoring outcomes, and establishing credentials, each of which requires additional capital investments on the part of treatment organizations. The combination of increased demands and fewer resources will further diminish existing treatment capacity.**

10. **Critical stakeholders must begin to work together now to prevent such diminution from happening.**

Source: Adolescent Substance Abuse: Research and Clinical Advances (2006), Howard Liddle & Cynthia Rowe (Eds).

ADDITIONAL RECOMMENDATIONS FOR FACILITATING PARTNERSHIPS IN THE ADOLESCENT TREATMENT RECOVERY SYSTEM

1. **A continual, ongoing commitment to the development and practice of cultural competency in servicing children, adolescents, and families, regardless of what systems they interact with.**

2. **Seeing the necessity and daily inclusion and practice of gender-responsive practices and principles.**

3. **The encouragement of the utilization and practice of EBPs.**

4. **An expansion of outpatient treatment programs, which provide for the entire spectrum of therapies needed to treat the substance abusing adolescent, including but not limited to 12-step treatment. Treatment should also include individual psychotherapy family therapy, group therapy, drug education, educational remediation, socialization, peer selection, and judicious use of medications. In all of these settings, 12step treatment plays a crucial role.**

5. **Working with the substance abusing adolescent's family is crucial and utilizing promising family-based treatments is necessary.**

6. **Substance abuse issues and substance abuse counselors/professionals must be included and participate in the initial assessment during treatment or incarceration and be part of and included in the transition plan/aftercare plan.**

7. **Addressing substance abuse must also be a part of the student's IEP.**

8. **Professionals, whether substance abuse, juvenile justice, mental health, child welfare, or education, must be willing to listen, develop patients, work on developing relationships with other administrators from other systems for the purpose of developing an integrated approach.**