A Review of Adolescent Research: A Case for Continuing Care Services and Recovery Management

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2008 Co-Occurring Disorders Conference
Embracing Best Practices that Change Lives

Objectives

- Why do adolescents need a System of Care?
- What can be done to improve treatment beyond episodes of care?
- How will clinical services evolve to serve youth and families in expanding environments?
- What are the continuing care models?
- What do I need to know about linking treatment and communities of recovery?

Major Health Problem

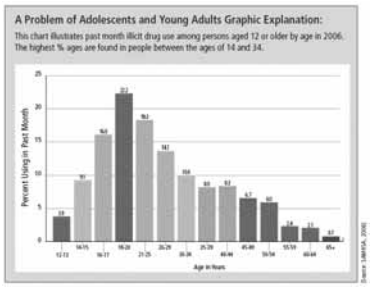
- 90% of adults with SA started before the age of 18
- Half before the age of 15
- 67% of youth in Juvenile Justice have AOD
- 74% of youth in Juvenile Justice have MH
- Mid 90's there was a 50% increase in youth Tx admissions

Source: Adolescent Substance Abuse: A Public Health Priority. Physician Leadership on National Drug Policy

Major Health Problem

- 1.6 M youth between 12-18 need Tx
- 1 in 10 receive Tx
- Of the 175,000 only 25% receive enough (3 months)
- Less than 50% stay six weeks
- 80% use again within a year (Journal of Substance Abuse Treatment)
- Often limited to acute care
- Total economic cost 414 Billion (not limited to youth)
- Healthcare cost 114 Billion

Source: The Addiction Danger Zone, Richard Scheinin. Public Access Journalism. Office of Applied Statistics 2005



Source: SAMHSA 2006

Youth Strategic Plan Priorities

- There is a shortage of Chemical Dependency Professionals, dually certified clinicians and adolescent-specific qualified staff throughout the State.
- Mental health services for kids with co-occurring disorders are very limited and difficult to access.
- Recovery support services such as transitional and recovery housing, drug-free youth activities, vocational training, youth-specific support groups, and peer/adult mentoring are needed in all communities.
- The current funding system provides minimal (if any) reimbursement for the following services: case management, supervision, pre-treatment services, family treatment, and incentives.
- Many youth, families, and referral sources view outpatient treatment as being ineffective, due to the lack of structured programming, inadequate monitoring of drug & alcohol use, failure of youth to actually attend sessions; opportunities in outpatient for associating with youth who may have even more serious A& D problems.

Source: Adolescent Strategic Plan, January 2008

Treatment Need

Adolescent Treatment Gap Rates in Washington State for Publicly Funded Chemical Dependency Services (ages 12-17)

Year	Needing & Eligible for DASA-Funded Treatment	Received Treatment with DASA-Funded Support	Number of Eligible Individuals Unserved	Treatment Gap Rate (Unserved Need)
2004	18,930	5,875	13,055	69%
2005	19,622	5,739	14,227	70.86%
2006	19,545	5,765	13,246	67.80%

- Data excludes adolescents covered by Behavior Health Plan, private-pay, and military insurance
- Source: Division of Alcohol and Substance Abuse; Tobacco, Alcohol and Other Drug Abuse Trends in Washington; 2004, 2005, 2006.

Source: Adolescent Strategic Plan, January 2008

Episodes of Care

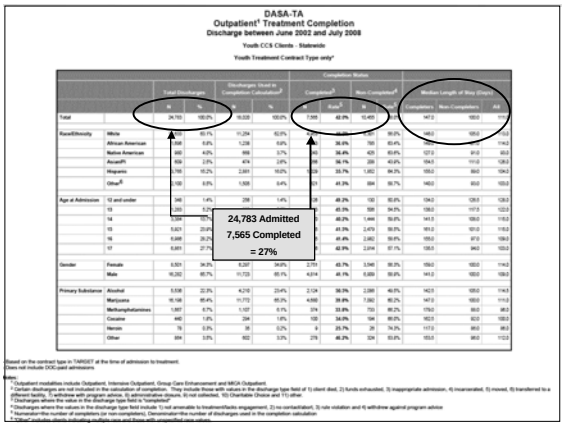
- The state publically funded system served on average 5,793 youth per year from 2004 -2006.
- 4,894 were in Outpatient and 1,298 in Residential (a percent were served in both levels)

Source: Adolescent Strategic Plan, January 2008

Public Tx Services

Level of Care	Beds or Slots	Number of Programs	Annual @ Admission	LOS
Detoxification	14	7	433	6
IP Level I	41	4	477	29
IP Level II	97	8	840	42
Recovery House	36	4	220	51
Outpatients	?	139	4894	147 (median)
Drug Courts		4		

Source: Adolescent Strategic Plan, January 2008



The Current Renaissance of Adolescent Treatment

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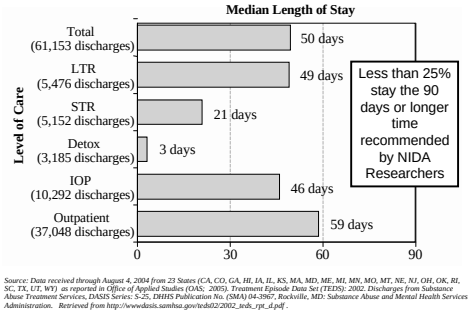
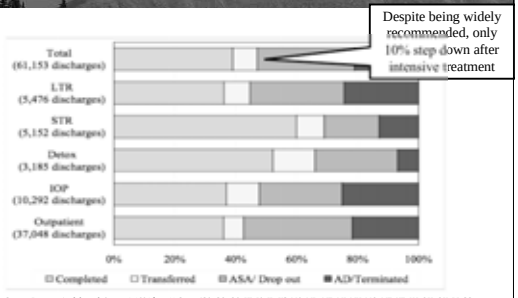
November 16th, 2007 presentation in Portland, OR for the Multnomah County's Department of Community Justice and Department of County Human Services, and the Robert Wood Johnson Foundation's Reclaiming Futures initiative. This presentation reports on treatment & research funded by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA) under contract 270-2003-00006 and several individual grants. The opinions are those of the author and do not reflect official positions of the consortium or government. Available on line at www.chestnut.org/LI/Posters or by contacting Joan Unsicker at 720 West Chestnut, Bloomington, IL 61701, phone: (309) 827-6026, fax: (309) 829-4661, e-Mail: junsicker@Chestnut.Org

Median Length of Stay is only 50 days



Source: Data received through August 4, 2004 from 23 States (CA, CO, GA, HI, IA, IL, KS, MA, MD, ME, MI, MN, MO, MT, NE, NJ, OH, OK, RI, SC, TX, UT, WY) as reported in Office of Applied Studies (OAS; 2005). Treatment Episode Data Set (TEDS): 2002. Discharges from Substance Abuse Treatment Services, DASIS Series: S-25, DHHS Publication No. (SMA) 04-3967, Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://wwwdasis.samhsa.gov/teds02/2002_teds_rpt_d.pdf .

53% Have Unfavorable Discharges



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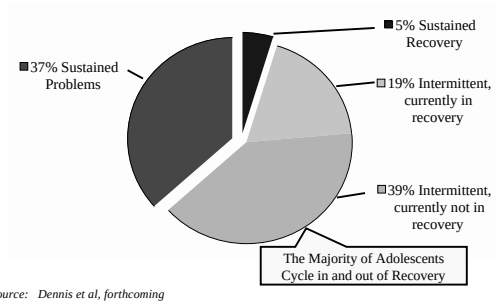
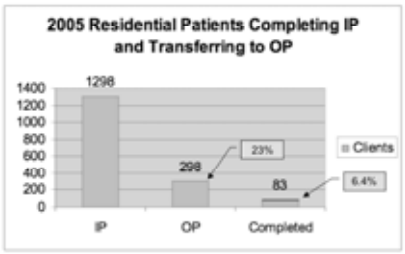
Cumulative Recovery Pattern at 30 Months



Source: Dennis et al, forthcoming

2005 Residential Patients Completing IP and Transferring to OP



Source: DASA TARGET Data, March 2008.

Cost for Re-Admits to Residential Treatment

Client	Re-Admits	Res Cost (31 days)	Total
[redacted]	1	[redacted]	[redacted]
[redacted]	1	[redacted]	[redacted]
[redacted]	1	[redacted]	[redacted]
[redacted]	1	[redacted]	[redacted]
			[redacted]

In the following two years 451 (34%) of the same youth were re-admitted to residential Tx.

Median Length of Stay for the residential admits following was 31 days.

Hypothetical's

1. If the system could reduce re-admits by 10% it would save $300,000, 50% it would save $1.5 million.
2. If all residential youth (1,298) were assigned a Recovery Coach (26 needed) and each Coach had a case load of 50 clients and were paid $40K year, it would cost $1,040,000.
3. If all residential youth received 1 hour a week of group Continuing Care for 6 months it would cost , $817,725 (25.2 rate x 25 weeks x 1,298)

Pause

- Questions
- Comments
- Brief Discussion

Continuing Care-Discrete Level of Service

- The recent research by Dr. Michael Dennis from Chestnut Health System indicate that the there is a strong need for a discreet level of care.
  - Youth who complete a residential phase of treatment and are sent to mixed outpatient group have a 0% predicted positive outcome;
  - Youth who are sent to a continuing care phase have an 81.5% predicted positive outcome.

This data is from Global Appraisal of Individual Needs (GAIN) database and represents a time period from intake to 12 months (N=6,145 adolescents).

Source: Michael L. Dennis, Rodney R. Funk, and Laverne, Hanes-Stevens, Chestnut Health Systems, Bloomington, IL Panel at the Joint Meeting on Adolescent Treatment Effectiveness, March 25-27, 2008, Washington, DC

CC Models

- Assertive Continuing Care (ACC)
- Adolescent Community Reinforcement Approach (ACRA)
- Contracting, Prompting and Reinforcing Substance Use Disorder Continuing Care (CPR).
- Recovery Coaches
- Recovery Management Checkups

UCC Compared to ACC

"The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders" indicating substantial positive outcomes for this model of care. Abstinent rates comparing Usual Continuing Care (UCC) with ACC showed the following:

Source: Research by Mark D. Godley, Susan H. Godley, Michael L. Dennis, Rodney R. Funk & Lora L. Passetti

UCC Compared to ACC

- Were more likely that those given UCC to access at least some continuing care services (94 vs. 54%);
- Received more days of CC sessions (14.1 vs. 6.3);
- Were more likely to engage in 7 or more of 12 activities associated with sustaining abstinence (64 vs. 35);
- Were more likely to remain abstinent 1 to 3 months after discharge from residential (43 vs. 24%);
- Which was, in turn, predictive of abstinence 4 to 9 months after discharge (69 vs. 19%).

Source: Managing Addiction as a Chronic Condition. *Addiction Science and Clinical Practice*-Dec 2007. Michael L. Dennis, Christy Scott Passetti

Mental Health Services in the North Sound MH Administration

- Compass Health-In home outreach for children
- Bridgeway - Transition services post Western State Hospital
- Hope Options-Intervention and case management
- Sun Community Services – Care for people released from jail

All in the Family: Addiction, Recovery, Advocacy

Families and The New Recovery Advocacy Movement

The 1980s and 1990s witnessed significant changes in the cultural perception of people with severe and persistent alcohol and other drug problems.

- Problems were re-stigmatized (positive images of addiction and recovery, e.g., First Lady Betty Ford, were replaced by images that evoked fear and pessimism),
- De-medicalized (redefined as moral problems rather than medical problems), and
- Recriminalized (persons with these problems were transferred from systems of compassion and care to systems of control and punishment).

Source: William White and Bob Savage

Strategic Plan: Recovery Support Services

They represent a relatively new addition to the existing network of treatment services. Recovery support services are delivered over a longer period of time than more acute and intensive forms of care. **They provide a source of community integration, skill building, relapse prevention and a means to improve existing recovery rates.** In order to establish such support services in a recovery oriented system of care it is suggested that DASA:

1. Create **guidelines** for the development of community-based recovery-oriented systems of care for youth and families, including the recruitment and training of recovery mentors.
2. Provide **incentives** for the establishment of recovery support services in community organizations that already provide services to youth (treatment facilities, schools, community colleges, job corps, parks and recreation departments, juvenile justice facilities, health clinics).
3. **Assure coordination** among agencies that provide services to youth.

Source: Adolescent Strategic Plan, January 2008

Recovery Management and Support

Adolescent Strategic Plan Goals

Short-term:

1. **Pilot the development**, delivery and evaluation **of evidence-based recovery management services** in a small number of counties or treatment agencies for specific populations of youth enrolled in substance use disorder treatment.
2. **Determine the feasibility** and cost of expanding recovery management services, based on the results and lessons learned during the pilot program.
3. Identify the need to **provide training in recovery management** to adolescent treatment agencies statewide.

Long-term:

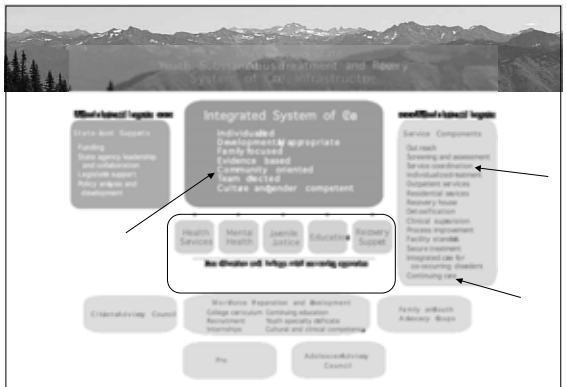
1. Pending success of the pilot project, adopt recovery management as a standard and expected practice in the adolescent treatment community.
2. Provide for the funding or reimbursement of recovery management services at all levels of care within the adolescent treatment system.
3. Assure that pre-service and continuing education programs integrate recovery management theories and methods into educational curricula and training events.
4. Provide technical assistance to community treatment programs in the adoption and implementation of recovery management principles and methods.

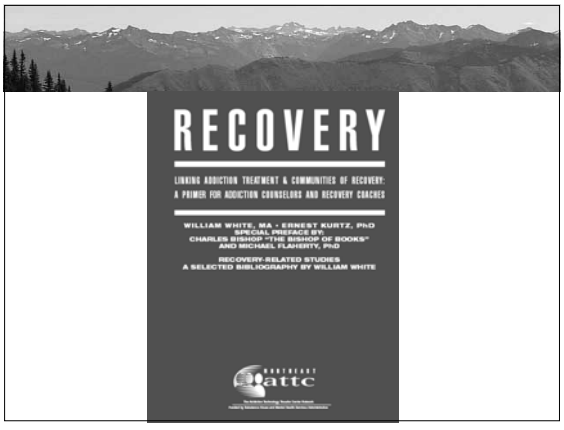
Source: Adolescent Strategic Plan, January 2008

Nine Characteristic of Effective Treatment

- **Assessment and Treatment Matching**; Programs should conduct comprehensive assessments that cover psychiatric, psychological, and medical problems, learning disabilities, family functioning, and other aspects of the adolescents life.
- **Comprehensive, Integrated Treatment Approach**. The adolescent's problems should be addressed comprehensively (medical, psychiatric, family, and environmental) rather than concentrating solely on curtailing substance abuse.
- **Family Involvement in Treatment**; Engaging both adolescent and parents or caregiver and maintaining close links with the adolescent's family, home, school, and where necessary, the juvenile justice system will ensure greater success in treatment.
- **Developmentally Appropriate Program**; Due to the unique and rapid development that occurs during adolescence, it is important that substance abuse programs be specifically designed for adolescents rather than merely modified adult programs.
- **Engage and Retain Teens in Treatment**. Treatment programs should build a climate of trust between the adolescent and the therapist.
- **Qualified Staff**. Staff should be trained in adolescent development, co-occurring mental disorders, substance abuse, and addiction.
- **Gender and Cultural Competence**. Programs should address the distinct needs of adolescent boys and girls as well as cultural differences among minorities.
- **Continuing Care**. Programs should include relapse prevention training, aftercare plans, referrals to community resources, and follow-up.
- **Treatment Outcomes**. Rigorous evaluation is required to measure success, target resources, and improve treatment service

Characterizing substance abuse programs that treat adolescents. *Journal of Substance Abuse Treatment 31 (2006) 59–65.* Tami L. Mark, PhD, MBA1Associate Director, Xue Song, PhD1 Economist, Rita Vandivort, M.S.W. Public Health Analyst, Sarah Duffy, PhD2 Senior Economist, Jutta Butler, B.S.2 Public Health Advisor, Rosanna Coffey, PhD1 Vice President, Vernon F. Schabert, PhD3 President





Presentation Resources

White, W. & Kurtz, E. (2006). *Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches*. Pittsburgh, PA: IRETA/NeATTC.

White, W. & Kurtz, E. (2005). *The Varieties of Recovery Experience*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

Citations for all statements and studies can be found in these two monographs.

Goals

- Explore the professional and scientific rationale for assertive linkage of clients from addiction treatment to indigenous communities of recovery
- Place such linkage processes within the redesign of addiction treatment from a model of acute interventions to a model of sustained recovery management

Context: Toward a Recovery Paradigm

- Pathology Paradigm: Focus on study of psychoactive drugs and the etiology and patterns of alcohol & other drug (AOD) problems
- Intervention Paradigm: Study of interventions into AOD problems
- Recovery Paradigm: Study of lived solution to AOD problems that exist in lives of millions of individuals/families

Signs of the Emerging Recovery Paradigm

- The New Recovery Advocacy Movement
- Emerging recovery research agenda at NIDA & NIAAA
- CSAT's Recovery Community Support Program (RCSP)
- White House initiated Access to Recovery (ATR) program
- New recovery support institutions and roles, e.g., recovery support centers, recovery coaches

Implications for Addiction Counselors

- Greater focus on what happens BEFORE and AFTER primary treatment
- Transition from professional-directed treatment plans to client-developed recovery plans
- Greater emphasis on the physical, social and cultural environment in which recovery succeeds or fails

Implications for Addiction Counselors

- Integration of professional treatment and indigenous recovery support groups
- Increased use of peer-based recovery coaches (guides, mentors, assistants, support specialists), and
- Integration of paid recovery coaches and recovery support volunteers within interdisciplinary treatment teams.

Treatment Plan (TP) Vs. Recovery Plan (RP)

1. The RP is developed, implemented, evaluated and refined by the client, not the treatment professional.
2. The RP is based on a partnership/ consultation relationship between professional and client rather than an expert-patient relationship.
3. The RP is broader in scope, e.g., physical health, education, employment, finances, legal, family, social life, intimate relationships & spirituality.

Treatment Plan (TP) Vs. Recovery Plan (RP)

4. The RP consists of a master plan of long-term recovery goals and a weekly action plan of steps that will mark progress toward those goals.
5. The RP emphasizes drawing strength and strategies from the collective experience of others in recovery.

Source: Borkman, T. (1997). *"Is Recovery Planning Any Different From Treatment Planning?"*, Journal of Substance Abuse Treatment 15(1), 37-42.

Resistance to Recovery Paradigm

- Conceptual
- Personal/Professional
- Financial
- Technical
- Ethical
- Institutional

Scientific Background

"If addiction is best considered a chronic condition, then we are not providing appropriate treatment for many addicted patients."

Dr. Tom McLellan, 2002

Scientific Support for Shift from Acute Care to Sustained Recovery Management

1. The need for post-treatment check-ups and sustained recovery support services intensifies as problem severity increases and recovery capital decreases.

   "*Recovery capital* is the quantity and quality of internal and external resources that one can bring to bear on the initiation and maintenance of recovery." (Garfield & Cloud, 1999)

Scientific Conclusions

2. Addiction treatment outcomes are compromised by the lack of sustained recovery support services.
   - ❑ Less than 50% admitted to Tx complete
   - ❑ Over 50% discharged use AOD in year following discharge (80% of those within first 90 days)

Scientific Conclusions

3. Professionally-directed, post-discharge continuing care can enhance recovery outcomes, but only 1 in 5 clients actually receives such care.
4. Participating in peer-based recovery support groups following Tx enhances recovery outcomes, but there is high attrition in such participation following discharge from Tx

Scientific Conclusions

5. The resolution of severe substance use disorders can span years (sometimes decades) and multiple treatment episodes before stable recovery maintenance is achieved.
6. For many individuals, recovery sustainability is not achieved in the short span of time treatment agencies are currently involved in their lives. Point of recovery sustainability--risk of future lifetime relapse drops below 15%--is 4-5 years of stable remission.

Scientific Conclusions

7. Addiction treatment has become the revolving door it was intended to replace.
   - 64% of persons entering publicly funded treatment in the United States have already had one or more prior treatments.

There may be cumulative and synergistic effects resulting from multiple treatment episodes.

Scientific Conclusions

9. There is a growing body of evidence that enmeshing clients with high problem severity and low recovery capital within sober living communities can dramatically enhance long-term recovery outcomes.

The Big Picture

Most people discharged from addiction treatment are precariously balanced between recovery and re-addiction in the weeks, months and even years following treatment.

Post-treatment check-ups and support and assertive linkage to communities of recovery and other recovery support services can significantly enhance long-term recovery outcomes.

The Big Picture

Addiction professionals do not do assertive post-treatment monitoring and early re-intervention, but there is substantial anecdotal evidence that drug dealers and addicted peers do.

The Big Picture

Most recovery support systems are designed for adults and adapted for youth.

Context: American Communities of Recovery

- Growth in size of communities of recovery.
- Growing diversification of American communities of recovery.
  - Varieties of Twelve Step experience.
  - Growing spectrum of religious, spiritual and secular frameworks of recovery.

History/Science of Recovery Mutual Aid

1. Over 250 years of support
2. Alcoholics Anonymous has dominated the mutual aid
3. Participation enhances long-term recovery outcomes.
4. Recovery rates for people of color, COD, etc are comparable to those reported for general A.A. membership.
5. Alternatives to A.A. and Twelve Step programs
6. Evidence of a dose effect (number of meetings attended) and an intensity effect (broader pattern of participation).
7. Completion of addiction treatment AND participation with recovery mutual aid groups is more predictive of long-term recovery than either alone.
8. All recovery mutual aid groups experience individuals who fully respond, individuals who partially respond, and individuals who do not respond at all to their program
9. Individuals may initiate recovery through one framework and then shift to another

What Providers Need to Know About Communities of Recovery

- Choice Philosophy
- Actualizing a Choice Philosophy
- Choice and Stages of Recovery
- Linkage Principles
- Goals of the Linkage Process
- The Science of Linkage
- Assertive Approaches to Continuing Care versus Traditional Aftercare
- Linkage Steps

Youth in Recovery

- Supplement clinical services to help youth and family with:
  - School Based Recovery
  - Support Services
  - Youth Oriented Recovery Groups
  - Recovery Activities

Resource Guide

- Faces and Voices of Recovery
- Peer based recovery support services
- Recovery Community Services Program (CSAT)

Summary

- Adolescents are system dependent and rely on us to actively support their recovery
- Need to improve and strengthen the transition from Tx to recovery.
- Need to build communities of recovery for youth, “Adolescent Recovery Paradigm”

Summary

- Assertive linkage to communities of recovery can elevate long-term recovery outcomes.
- Assertive linkage is best achieved within a philosophy of choice.
- Assertive linkage requires specialized procedures that are markedly different than traditional aftercare approaches.
- Assertive linkage to communities of recovery is best accomplished within the larger frame-work of sustained recovery management.

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What Recovery Support Groups Share in Common

- Contain members who have transformed their lives using the group's key ideas and methods
- Provide an esteem-salvaging answer to the question, "Why me?"
- Provide a rationale for dramatically altering one's pattern of AOD consumption
- Provide daily prescriptions for recovery maintenance and
- Enmesh each individual in a sanctuary of shared "experience, strength and hope"