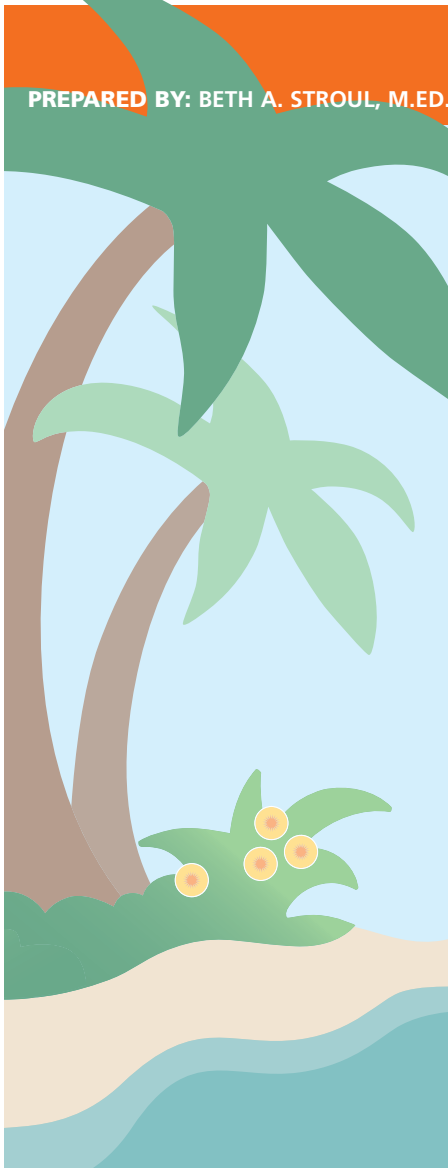


Services for Youth with Co-Occurring Mental Health and Substance Abuse Disorders and their Families

SUMMARY OF THE SPECIAL FORUM HELD AT THE
2006 GEORGETOWN UNIVERSITY TRAINING INSTITUTES
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PREPARED BY: BETH A. STROUL, M.ED.



Introduction

A series of Special Forums were held at the Georgetown University Training Institutes in July 2006 to provide opportunities for dialogue about critical issues in order to contribute to the development of future policy and technical assistance. The Special Forums were designed as interactive discussions about communities and populations with unique service needs, requiring specialized planning and service delivery approaches within systems of care. Specifically, the goals of the Special Forums were to:

- Summarize issues and challenges related to each topic
- Identify effective service delivery strategies for local systems of care
- Develop recommendations for policy and technical assistance that will support communities in implementing these effective service delivery strategies

Each Special Forum began with brief framing presentations summarizing issues and challenges related to the topic and offering examples of effective service delivery strategies. The remainder of the forum consisted of facilitated discussion among forum participants focusing on recommendations for services, financing, policy, advocacy, information development and dissemination, and training and technical assistance. The Special Forums were tape recorded and transcribed, and additional input was collected from participants through worksheets completed at the conclusion of each forum. These materials were used to prepare a paper summarizing the issues and recommendations resulting from each Special Forum.

This paper presents the issues and recommendations from the Special Forum on Services for Children with Co-Occurring Mental Health and Substance Abuse Disorders and their Families. Presenters included:

- Doreen Cavanaugh, Ph.D., *Research Associate Professor, Georgetown University Health Policy Institute, Washington, DC*
- Beth Dague, M.A., *Director, Tapestry System of Care, Cleveland, OH*
- Brent Matthews, M.S., *Program Director, ACES Project, Choices, Inc., Indianapolis, IN*

Issues and Strategies

Integrated Co-Occurring Treatment

Beth Dague described the strategies used in the system of care in Cuyahoga County, Ohio, to address the needs of youth with co-occurring mental health and substance abuse disorders and their families. Cuyahoga County has a federal system of care grant from the Comprehensive Community Mental

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Health Services for Children and their Families Program and a Strengthening Community Youth grant from the Substance Abuse and Mental Health Administration's Center for Substance Abuse Treatment (SAMHSA/CSAT) and has striven to implement a "data-driven" decision making approach. Examination of data gathered through the Strengthening Youth Community grant indicated that there were a significant number of youth who were drug and alcohol involved and had co-occurring depression. This led the community to recognize the need to do something about youth who have substance abuse and mental health problems. The community then began to explore evidence-based or promising practices for working with this population. The Ohio Department of Mental Health funds a center at the University of Akron, the Center for Innovative Practice, which identifies and disseminates evidence-based and promising practices. They identified a promising practice called "Integrated Co-Occurring Treatment" (ICT) for youth with both mental health and substance abuse problems. There was some experience with this integrated approach in Summit County, Ohio (Akron), which was achieving good outcomes.

As a first step, the federal funding agencies were approached to discuss blending the funds from these grants, along with local dollars from two boards (mental health and drug and alcohol) to implement this integrated approach. The community also began to define the policy implications of implementing an integrated treatment approach, dealing with the "fighting" that needed to occur in order to resolve cross-system issues. In addition, the partner agencies had to define what

integration really means. They ultimately agreed that it means: one clinical record, one audit trail, one clinician, one progress note, and one integrated plan that is family and youth guided. Determining how this would be operationalized also was a difficult process. Ms. Dague noted that agencies should not be afraid to come to the table and argue out those differences. An RFP was issued, requiring providers to have clinical staff who are wraparound specialists and who are dually certified in both substance abuse and mental health. The approach currently is being implemented with the first 10 families.

Individualized, Strengths-Based Services

Brent Matthews directs the "Action Coalition to Ensure Stability" (ACES), a program that serves persons who are chronically homeless and who have co-occurring disorders of mental illness and substance addiction. The program started by taking system of care core values and strategies and applying them to this population. Mr. Matthews talked about "living and breathing system of care values to develop individualized service plans that build on the strengths of the youth, family, and community."

When a substance disorder and psychiatric disorder co-exist, each disorder should be considered primary and integrated dual primary treatment is recommended, whereby each disorder receives appropriately intensive diagnosis-specific treatment. Services are directed at helping people to recover their lives.

Matthews stated: "Children and adults want the same things—they want to have love, they want to have experiences and relationships, they want to have fun, they want to be

successful in school and work, and want to know that they have a future. How do we go about making that happen for people? It gets back to the number one system of care core value: The system of care should be child-centered and family focused, with the needs of the child and family dictating the types and mix of services provided. Twenty years later, we still believe this yet are challenged to make it real for those we serve. This is how we need to develop services and service codes and make decisions. We should not say, 'Well, the policy only funds this service, so we're going to throw that at you.' However, in providing services, we must acknowledge that 'needs aren't services.' If we ask a child or family what they need, they will rarely, if ever, state a service. The language of the family is often heard as, 'I just want to be safe, or I need a break, or I want my child to have friends or get good grades.' Professionals typically treat what they label, and systems only fund the 'fixing of broken parts' or those labels, not the families hopes and dreams. In order to work with the whole person and to help them live their hopes and dreams, to address their needs—that aren't services, then we have think about how to help make a difference in people's lives."

Matthews explained that the approach to achieving this is individualized service planning. The approach involves:

- Assigning a resource coordinator
- Organizing and convening a resource coordination team
- Implementing a strengths discovery planning process
- Designing a plan of care

The ACES program does a strengths-based assessment, not only a functional assessment or other

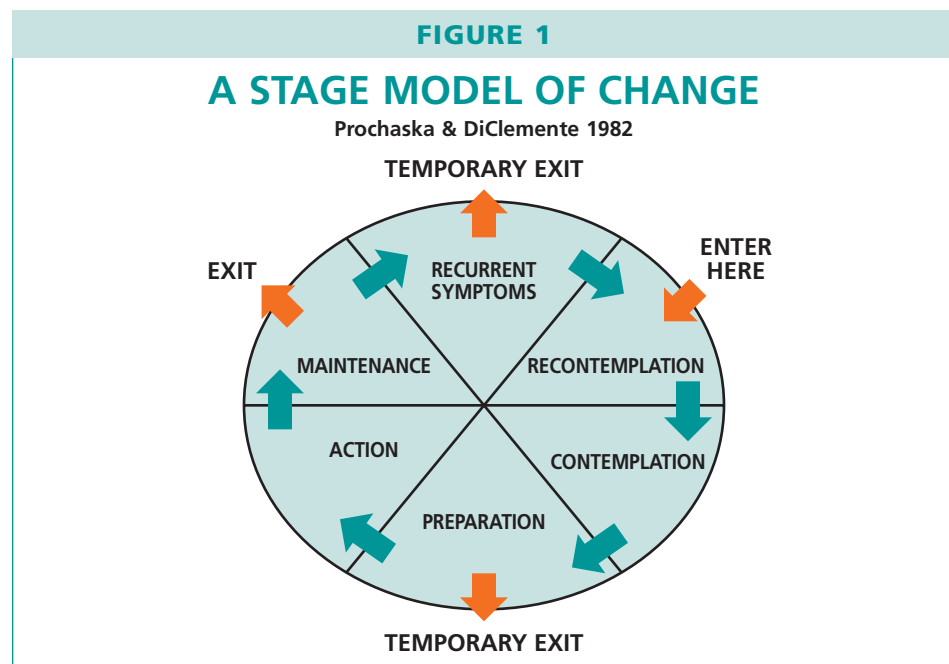
diagnostic assessment, but a strengths-based assessment followed by a strengths discovery planning process. This approach reflects an “advanced practice” through which all aspects of care are explored—the political, legal, fiscal, bio, psycho, social, familial, cultural, academic, geographical, spiritual, and eco-systemic. This is also called “holistic” or comprehensive care. The team that is brought together involves all of the relevant “systems”—the resource coordinator, family system (child and family), provider system, school system, child welfare system, juvenile court system, and community system—determining together how to help people change. Team members work together to develop a coordinated plan of care. Further, the team holds the belief that families don’t fail, plans do. “If the plans don’t work, everybody in all those systems comes together again to revise the plan with the child and family. The strengths-based discovery planning process looks at people through a positive lens, because ‘how we see the world changes how we respond to it.’ If we look at people through the language of confused, chaotic, enmeshed, dysfunctional, we see them in this sort of way, and become intent on ‘fixing’ them. But if we learn how to see people differently, through strengths, then we will see people through their culture, their ancestry, who they are, their hopes and dreams, who they want to become, their community, and then we become creative in how to support the family.... Do you want to go to your job and see people through their strengths so you can feel enlivened by it and make your own work better, or do you want to go there looking at all the problems and say we can only fix those problems, because the money only allows us to look at people through their broken parts?”

In this advanced care model, Matthews explained that the job of care providers is to help people figure out their own solutions in their lives and to provide help and support. Help and support can include functions such as assessing, planning, monitoring, advocating, coaching, locating resources, referring, contacting, consulting, linking, and coordinating. Often, people say, “I don’t need any more therapy, I need help.” Consumer-driven care means determining what “help” is according to the child and family. As noted in *Free To Choose: Transforming Behavioral Health Care to Self-Direction*, “Imagine the changes needed in states and localities to shift from a situation in which physicians sign off is required on all care plans, to one in which only consumers sign off is required.” This shift tells us that recovery is not only possible, but it is the expectation and it is accomplished by supporting care that is youth and family driven. The consumer driven plan of care is the core of the recovery-oriented mental health and addiction system.

Matthews pointed out that symptoms can be continuous and recurrent, leading to multiple treatment episodes. He stressed that people should not lose services when they are not symptomatic. This is shown in the “Stage Model of Change” shown on Figure 1.

Implementing the changes needed to provide effective, integrated treatment for youth with co-occurring mental health and substance abuse disorders requires change at multiple levels, as outlined by Matthews:

- **Systems**—At the system level, money must follow the person in a holistic, needs-based approach, not an approach guided by a “broken part” that needs to be fixed.
- **Program**—At the program level, services must be individualized to provide family and youth-driven services. There should be continuous access to care.
- **Clinical Practice**—At the practice level, system of care values should



guide services. Clinicians should rely on the strengths, hopes, and desires of the youth and family and should use evidence-based practices and processes.

- *Clinician*—At the clinician level, changes are needed to promote self-awareness, working as a team and collaborator with the youth and family, and the competencies needed to integrate mental health and substance abuse treatment.

According to Kenneth Minkoff, M.D., “Dual diagnosis is an expectation, not an exception. This expectation must be incorporated in a welcoming manner into program design and all clinical contact.... There is no one type of dual diagnosis program or intervention. For each person, the correct intervention must be individualized according to subtype of dual disorder and diagnosis, phase of recovery/treatment, and level of functioning and/or disability associated with each disorder.” He also goes on to say that the most significant predictor of treatment success is “the ability of a program or intervention to provide through an individual clinician, team of clinicians, or a community of recovering peers and clinicians an empathic, hopeful, continuous treatment **relationship**, which provides integrated treatment and coordination of care through the course of multiple treatment episodes.”

Financing Streams

Doreen Cavanaugh discussed the possible funding sources that can be used to support treatment for adolescents with co-occurring disorders. The first major source of funding is health insurance, including both private employer sponsored health insurance or privately purchased health insurance and public health insurance that includes Medicaid

and SCHIP (the State Child Health Insurance Program). Additionally, there are many federal funding sources that are not insurance based and can come from the federal government in many different ways, sometimes to states, sometimes to counties, and sometimes to local communities. The challenge is to coordinate and integrate all of these federal, state, county, and local funds. It is also challenging to develop joint purchasing strategies across agencies that would make service delivery more efficient; that would get more services to more children and families; that would make it easier for children, families and providers; and that would help to realize the vision of the system of care.

Cavanaugh explained that Medicaid is the primary health insurance program for low-income children and families in the country and is the most significant funding source for mental health and substance abuse treatment. There are many optional benefits under the Medicaid program, including mental health benefits which are optional. States have a great deal of influence in determining what will be funded for children and families; state influence was increased further by the passage of the Deficit Reduction Act (DRA) in 2006. Thus, it is essential to understand the new provisions and how your state responds.

Among its many provisions, the DRA specifies that states can extend Medicaid eligibility up to 300% of the federal poverty level. It also requires individuals seeking Medicaid coverage have to furnish written proof of citizenship, including new people applying and families already receiving Medicaid. Additionally, it allows the states to require Medicaid recipients pay a portion of the Medicaid premium and/or to pay co-payments so that

Medicaid recipients will carry some of the burden for paying or defraying the cost of services, if the state so chooses. The most important thing is that states have a choice. Another thing that the state can do is change its benefit package so that services that are covered can be significantly altered. States can choose a benchmark equivalent package, which would offer a lower level of benefit. The requirements for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) coverage were decreased from age 21 to age 19, and benefits under EPSDT also can be a benchmark equivalent plan. In addition, an optional waiver under Medicaid allows alternatives to hospitalization such that if a state can prove that a child can be served at home for the same or less cost than in a psychiatric hospital, it is allowable under Medicaid. The DRA creates a program whereby if a child can be served at home at the same or less cost than putting them in a psychiatric residential treatment facility, Medicaid will allow that as well; there will be a demonstration of this funded in ten states. Further, the DRA created changes to targeted case management. Medicaid currently is auditing the use of the targeted case management funds and is particularly concerned that case management money that might be used for what is considered to be the responsibility of other state agencies, particularly child welfare.

Cavanaugh noted that funds for co-occurring disorders also are provided by block grants, categorical funding, or discretionary grants, such as system of care grants. Funding that can be used to support the treatment of children and adolescents with mental health and substance abuse disorders falls into six different policy areas: health care, juvenile justice system, child welfare system, education, housing, and labor.

Recommendations

Service Delivery

- *Provide single points of access* for mental health and substance abuse services and integrated treatment approaches.
- *Provide individual and group therapy incorporating both mental health and substance abuse*—A combination of individual therapy to deal with mental health issues, group approaches involving motivational interviewing, and the stages of change approach is recommended for working with this population.
- *Provide continuous, ongoing access to services and do not impose arbitrary time limits on services*—There are periods of time when a child does better, but many disorders, particularly co-occurring disorders are long-term and require repeated access to services over a long period of time—even over a lifetime. Systems currently are organized so that once progress is made, or a child is considered “fixed,” they are discharged and not necessarily expected to return. Policies and funding must be established to provide continuous support and follow up. There is a need to help legislatures and state and federal governments understand that these are chronic and relapsing problems. We cannot continue to look at services as having firm beginning and discharge times, all or nothing, but rather as holistic and continuous allowing youth to move among different levels of service intensity as their needs shift.
- *Incorporate prevention and promotion into mental health and substance abuse services*—We typically deal with the top 3-5% of the population at the top of the public health triangle who are the youth with serious disorders. Mental health promotion activities and targeted prevention efforts for youth at risk must be incorporated, in addition to services for treatment and recovery.
- *Expand programs for early identification and intervention of youth at risk for co-occurring disorders*—Programs with improved screening to identify early signs of mental health and substance abuse disorders should be implemented. Early intervention for high-risk populations should address both mental health and substance abuse issues.
- *Provide and integrate natural supports to youth in addition to treatment interventions*—Often, recovery for youth with mental health/chemical dependency problems is directly related to things such as finding a job, getting into an appropriate school program that builds on strengths, getting involved in a sport, or going to a drop-in center for after school and evening recreation. These supports are important in addition to clinical treatment services to help people move towards recovery. Non-traditional supports often are found outside of the treatment system and outside of agencies, in places like faith-based organization, boys and girls clubs, YMCAs, and others.
- *Provide parent partners*—Parent partners are family members who work with other families, providing support, identifying family strengths, connecting with schools and other systems, and providing parent to parent assistance.
- *Provide “family access and connection” teams*—Family access and connection teams can become involved when children have multiple problems or co-occurring disorders and cannot access appropriate services. These teams can initiate a child and family team service planning process and can avert the needs for youth and families to go to court.
- *Provide supports to families of youth with co-occurring disorders*—Both treatment and supports should be provided to families who often are “drowning” from the stress of coping with children with mental health and substance abuse disorders. Support groups should be organized and facilitated for parents of youth with co-occurring disorders.

Financing

- *Change funding streams at federal and state levels* to allow and create incentives for integrated mental health and substance abuse treatment.

Policy and Advocacy

- *Do not “criminalize” behavior resulting from mental health disorders and additions*—Often, youth with co-occurring disorders are suspended from school, removed from the home, or incarcerated without having addressed the disorders with appropriate services first. Even when in facilities, appropriate services rarely are available. Strategies are needed to

Recommendations

stop these children from being criminalized, frequently resulting in much worse situations.

- *Implement policies that allow parents to obtain treatment for youth over the age of consent*—Age 13 is the age of consent in some states, making it difficult for parents to obtain treatment for youth with co-occurring disorders who do not consent. In 2005, the State of Washington passed a parent-initiated treatment law that facilitates the process of obtaining treatment.
- *Build advocacy skills for youth with co-occurring disorders*—Help families develop the skills to advocate for youth with co-occurring disorders and for integrated, cross-system interventions. Families can be highly effective telling legislators and policy makers about their personal stories, their efforts to battle two systems, and the need for solutions.
- *Expand parity laws for insurance coverage of mental health and substance abuse services*—Insurers should be mandated to provide adequate coverage for mental health and substance abuse disorders.
- *Build partnerships* between state mental health and substance abuse agencies.
- *Undertake advocacy efforts* to encourage states to use applicable Medicaid options to finance mental health and substance abuse services.
- *Require provider agencies to obtain dual certification* as both a mental health and substance abuse provider agency.

Information/Resource Development and Dissemination

- *Identify, document, and disseminate examples of effective services for youth with co-occurring disorders*—In order to advocate, effective service approaches must be identified. Descriptions, along with data on effectiveness and cost, should be widely disseminated to promote their adoption more broadly. A participant related that her daughter recently was hospitalized for both her substance abuse and her mental health disorders, and she was told from a private insurance company that she had to choose which door—mental health or substance abuse. Ultimately, she was treated for several weeks for the mental health problem and

then went to a substance abuse facility afterwards. Integrated treatment approaches and approaches based on research evidence are not generally known or available. Families and others want to know what works for youth of different ages with co-occurring disorders.

- *Develop and disseminate resources for assessment* of both mental health and substance abuse disorders in youth.
- *Compile and disseminate information for states and communities about how to finance* mental health and substance abuse services.
- *Conduct research* on the long-term, societal costs of not intervening for youth with co-occurring disorders.

Training and Technical Assistance

- *Train providers to have skills in treating both mental health and substance abuse problems*—Both pre-service and in-service training should be directed at developing clinicians with skills and competencies in providing integrated treatment for both mental health and substance abuse disorders.
- *Provide technical assistance to systems of care and provider agencies* to develop the capacity for integrated service approaches for youth with co-occurring disorders.

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