

F P C A L P I N T

YOUTH, YOUNG ADULTS, & MENTAL HEALTH

SUMMER 2014

V. 28



CO-OCCURRING DISORDERS



Summer 2014: Vol. 28

Introduction: Co-Occurring Disorders
L. Kris Gowen 3

Story of Triumph
E. M. Lofgren 5

A New Campus Culture: The Rise and Success of Collegiate Recovery Programs
Benjamin John Chin & Sarah Nerad 8

Data Trends: Treating Young People with Co-Occurring Disorders: What Works?
Molly Oberweiser Kennedy & L. Kris Gowen 12

What's in a Meme: Using Social Networking to Promote Strengths-Based Mental Health
Brittany Smith 15

Destruction & Deliverance: My Story
Milo Rymes 16

Helping Young People Get Treatment in Juvenile Justice and Beyond
Susan Richardson, Jim Carlton, Laura Nissen, Michael Dennis, & Kate Moritz 18

Transition-Age Youth: A Parent Perspective
Shannon Crossbear 23

The Patient Protection and Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA): Addressing Co-Occurring Substance Use Disorder Services for Transition-Aged Youth
Brigitte Manteuffel 25

Data Trends: Disparities in Treatment for Substance Use Disorders and Co-Occurring Disorders in Ethnic/ Racial Minority Youth
Casadi "Khaki" Marino 29

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Focal Point is a publication of the Research and Training Center for Pathways to Positive Futures. This publication was developed with funding from the National Institute on Disability and Rehabilitation Research, United States Department of Education, and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (NIDRR grant H133B090019). The content of this publication does not necessarily reflect the views of the funding agencies.



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INTRODUCTION

CO-OCCURRING DISORDERS



Young adults with mental health challenges also often struggle with substance use disorders and vice versa. Young adulthood is the peak time for alcohol and drug use; additionally, many mental health challenges manifest themselves in late adolescence/ early adulthood. A review of the literature reveals that between one-third and almost one-half of young adults (ages 18-25) with a mental health challenge also have substance use issues.¹ However, co-occurring disorders (COD) – that is, having both a mental health challenge and a substance use issue – despite their prevalence among transition-aged youth, are not well understood or addressed. Many treatment options that have been deemed evidence-based practices often exclude participants with COD from their trials; thus little is known about what works best for this population.

This issue of *Focal Point* examines COD in youth. It was a challenge to compile the series of articles before you for a couple of reasons. First, so little research has been done in this field it was difficult to find information on “what works” best for this population. The complexity of COD poses a dilemma to practitioners,

policy makers, and researchers in determining what best leads to recovery. Additionally, the challenges that are normative for transition-aged youth such as dealing with continued education and/ or finding employment, becoming more independent, and aging out of various support systems (e.g., family, health care) complicate treating COD within this age group.

Second, since stigmatization plays a large role in seeking treatment, it was difficult to find people impacted by COD who were willing to come forward to share their experiences. The young people and family members who contributed their personal stories to this issue, whether under real or pen names, are to be commended for their courage to contribute voices to the struggles that accompany COD.

From the resulting publication, two themes emerge: these young people and their families need both formal and informal support as they strive toward recovery, and better policies are needed to support proper access to care and treatments.

The importance of support is evident in both the types of treatment that have shown promise in effectively treating young people as well as in the stories

from those who have recovered from COD and their family members. An article by Oberweiser that summarizes two promising approaches to treating youth with COD shows that those treatments that are most effective take a team approach – both treatments that include MFT and 12-step programs have shown to increase long-term abstinence in young people with COD. An overview of the Reclaiming Futures program shows that a team approach to working with young people in the juvenile justice system increases services and reduces substance use in those involved in their comprehensive, community-based approach to care. Finally, Nerad and Chin explain how multi-faceted College Recovery Programs provide students with the supports they need to not only remain abstinent from alcohol and drugs, but also thrive in school. Personal stories told by Crossbear, Lofgren, and Rymes reveal how young people and the family members that support them rely on several persons to help them through personal struggles related to COD.

Better policies, which can also be construed as a type of support, are also necessary in order to increase access to promising treatments. Manteuffel explains how the newly implemented Affordable Care Act can help young people with COD get the care they need to begin their road to recovery. Meanwhile, Marino out-

lines how racial and ethnic minorities experience great disparities in treatment for COD and how policies that currently play a role in exacerbating these disparities can possibly be changed to improve them. She concludes that, among other things, more policies and culturally-appropriate programs are needed in order to decrease the differential treatments and access to care that currently are experienced in the United States.

I hope this issue of *Focal Point* increases awareness of the complexities associated with treating COD in transition-aged youth, encourages hope in its stories of recovery, and inspires others to continue to better understand how to best support those affected.

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Story *of* TRIUMPH



When my daughter was sixteen years old, the only option she could grasp to pull herself from her pain was death; her story is one of triumph. In 2011, I was not an expert on the children's mental health system, and I am still not. I am simply a mom who struggled through what felt like a labyrinth of mirrors to access the behavioral health services that would save my daughter's life.

At sixteen years old, she'd already been struggling for several years and suffering more deeply than she revealed. In 5th grade, social anxiety was becoming problematic for her and by middle school, she was cutting herself to relieve the pain that overwhelmed her. On one hand, she was entering her adolescent years with great strengths – she had a joyful sense of humor, held close friendships, and enjoyed great talent in her chosen activities: music, theater, and horses. Academically, she tested above expectations for her grade and was well-liked by her teachers. Although she was successful in showing her strengths, she was steadily declining internally and she struggled to manage the day-to-day expectations of her life. By the time she was a junior in high school, her emotional struggles grew to outweigh her strengths. She found herself in a desperate place, self-medicating with alcohol and drugs, and seeking friends with whom she could hide her growing despair.

This talented teenager's fears about revealing her pain and the response it might evoke from the adults in her life led her to wear a variety of elaborate masks. She knew what people wanted to see and hear, and she became a master at presenting each character in the various stages of her days – at school with her teachers, at home with her family, and in the community with her social group of peers. Teachers and other adults in her life who saw through the "performance" and expressed their concern touched her tender heart, yet became threats to the control she was determined to maintain. She would later tell a school assembly of students and those very same teachers that she strategically surrounded herself with people who would not challenge her, would not express concern, and who would enable her to maintain the act. She revealed that she sought and found people who would not hold her accountable and who would provide a haven for her to avoid addressing her struggles appropriately. Of course, this contributed to her worsening condition and over time she slid into darkness and pain, with no easy way out.

It's a challenge for parents to raise a child through the teenage years and to discern "normal" developmental behaviors and rebellions from the signs and symptoms of mental health concerns. My daughter hated being a teenager. She said it was painful for her and I watched her progressively work harder than other kids her age just to hold it together. In the winter of her junior year, she didn't have the strength to keep

working that hard and she decided to put an end to her unbearable pain. She attempted suicide. She was only 16 years old. It's important to note her age, not only because of the tragedy of seeing a girl with her whole life ahead of her driven to such desperation, but from a clinical standpoint, I was told that there were certain diagnoses that could not be formally made at that age. What I heard was that the doctors didn't really know what was wrong and this led me to wonder, how can I know what to do to help my child if I don't know what is wrong with her?

Digressing for a moment, I'd like to make a point on the topic of diagnosing and labeling. Just because someone cannot be fully "diagnosed" with the name of a medical disorder that fits exactly into a particular definition that can then be billed to insurance to compensate for treatments should not mean that we are unable to identify a child's lagging skills that outweigh

when she turns 18, we can label her and then decide what to do regarding that label.

I was a mom who was unwilling to accept that destiny (and that risk) for my child. I didn't buy the medical business model that seeks a billable code in order to determine adequate clinical responses to a child in need. After all, she was only sixteen years old. I knew that we had two more years where I could "call the shots" as her legal guardian and another half dozen years of brain development remaining. I was determined to do everything possible to counter the raging and debilitating dysfunction that was ravaging my daughter's life before it set in permanently.

I sought open-minded and ethical professionals to give me information and their opinions. I scoured the internet for information about adolescent behavioral health and treatment approaches. I networked with advocates, who helped me to learn what to say to

hospital staff, administrators, and insurance managers to remind them that they were in part responsible for my daughter's safety, even after she was discharged from their care. I researched comprehensive treatment planning and medical case management. Because I was determined to do everything possible to afford my child the opportunity to survive whatever was plaguing her, I

stepped into the role of coordinating all of her care. I learned about treatment options and a variety of providers. I learned how the current system works so that I could get it to work for my child. And these advocacy skills paid off.

Through my refusal to accept a second inadequate discharge plan from a children's hospital setting, I pushed the inpatient therapists to look more closely at the options available to my daughter and which would meet her clinical needs. My daughter was transferred to a residential setting, where her case manager accepted me as part of the team. And we all worked together to help this girl with the rest of her life ahead of her to find a path to healing.

In this particular residential setting, the focus did not seem to aim for a single "diagnosis" or label. The therapists organized around dual diagnosis and co-occurring disorders, and the intensity of the treatment day matched the intensity of my daughter's resistance. Her case manager saw her potential to heal and also knew

I didn't buy the medical business model that seeks a billable code in order to determine adequate clinical responses to a child in need.

their strengths at any given stage of their development. We can identify what is in the way of a child demonstrating the functional abilities to meet expectations placed on them. We can target skill deficits and teach these skills. Because of my experiences, this is how I think we should define "treatment." I would like to see this as a way to help parents organize their ideas about what is "wrong" with their children who are struggling with a learning disorder, mental health condition, developmental delay, or all of the above.

Two weeks following her discharge from an adolescent psychiatric unit (which is essentially mental health intensive care), my daughter had another emotional breakdown and attempted suicide again. When she was admitted to the same psychiatric facility, the psychiatrist assigned to her told me, "your daughter is likely to have recurring hospitalizations before she gets the help she needs and when she turns 18, she'll likely be diagnosed with borderline personality disorder." I heard, there is nothing we can do for her now because of her age and

that it was critical to involve me as an essential participant in the process. At the end of the day, or the week or the month, the young clients receiving services in treatment facilities will likely return to the context of their homes and families, however that family is configured. Until our kids are fully developed adults, approaching mid-twenties in many cases, it is the context of family within which they will likely continue their treatment plans. In the case of my daughter, this was the “secret sauce” that led to our successes. At discharge, we had a comprehensive treatment plan that involved: ongoing individual therapy for each of us, family therapy, individualized education plan (IEP) at school, peer support groups, a newly adopted treatment dog, well-defined structure and family behavior agreements, clearly articulated expectations and accountabilities, and no questions about the priority of addressing mental health needs above all else.

In my own therapy sessions, I learned what belief systems and life views kept me locked into certain dynamics in my relationships with my children. I learned how to parent my daughter for who she is and what she needs, rather than comparing her to another child in the home or what I needed when I was her age. I learned how to manage my own emotional triggers and to hold the position of adult in the home, accountable

My daughter has the confidence that supports her to create a life that is joyful and fulfilling.

for holding age-appropriate expectations and enforcing balanced rules and safety plans. I learned how to hold tenderly my compassion for her struggles, while simultaneously supporting her to grow stronger and overcome them.

Over time, we have all settled into our new ways of being in the world and my daughter, quickly approaching her twenties, has the confidence that supports her to create a life that is joyful and fulfilling, as well as the skills to push through life’s obstacles and challenges with grace.

In a letter to me, my beautiful daughter shared her perspective reflecting back on that part of our journey together. I share it with you in the hopes that you will find the courage and the path to healing in your own family:


“Everything that’s happened needed to happen... I needed to fight you all these years so that I could prove how strong I was. I needed to prove how strong I was so that I could use my strength to keep me going. I needed to be challenged and put in my place so that I knew I wasn’t the only person I was hurting. I needed to fall in order to get back up. I needed to fall so that you could help me up. I needed you. I needed you to force me to see that I needed me more than anyone else. I needed you to push me. I needed you to make me do what scared me the most; to do what I needed to do. There is no other person in the world that would have done that for me, and you knew that better than I could at the time. Today I know this. And I never would have known it if we hadn’t gone through everything we have.”

AUTHOR

E. M. Lofgren is now a full time family educator and advocate, serving families of children with behavioral and developmental challenges. She is developing a web-based tool kit and educational workshops for parents to learn how they can advocate for their children and effectively navigate children’s mental health systems. If you would like to learn more, you can reach her at CareConnectorSolutions@gmail.com.



A NEW CULTURE



A college campus is not typically thought of as a place for students to get well and recover from substance use disorders (SUD). Fortunately, that is changing with the expansion of Collegiate Recovery Programs (CRP). According to the Association of Recovery in Higher Education,¹ a CRP is a “supportive environment within the campus culture that reinforces the decision to disengage from addictive behavior. It is designed to provide an educational opportunity alongside recovery support to ensure that students do not have to sacrifice one for the other.” Recently, CRPs have been gaining national attention with the number of CRP programs increasing from about 35 in 2010 to near 100 in 2013.

CRPs are filling the gap in the continuum of care for young people by enabling students who are in recovery (SIR) to pursue their academic and personal goals simultaneously and overcome barriers to recovery by providing them with an array of recovery and academic support services. Institutions of higher education have improved greatly in their efforts to implement successful substance prevention, intervention, and treatment programs, but most are lacking in specific programming for SIR.²

BARRIERS TO RECOVERY ON COLLEGE CAMPUSES

Barriers to recovery on college campuses include finding a network of peers, leaving home, experiencing change in routine, returning to academia, and feeling isolated. All of these barriers can compound one another and pose challenges to the recovery of a student who is not vigilant about seeking support and solutions to these barriers.

Maintaining abstinence on campus is incredibly challenging especially with the added stress, insecurity, and social pressure that the college environment often brings. One of the biggest struggles is finding a network of social support to belong to. Other students do not always understand what it means to be in recovery and that partaking in any alcohol or drug use is dangerous for SIR. SIR may feel isolated from the collegiate social scene and not feel a part of the larger community. Even in a setting where there is no substance use occurring, such as a classroom, the topics of informal conversation before and after class are often centered on parties and alcohol.³

Returning to an academic setting is another barrier to recovery. New college students experience a drastic change in their daily schedule and structure, which can be problematic for SIR who do not know how to fill their time with constructive activities in a new environment. The additional change of leav-

CAMPUS

E: The Rise and Success of Collegiate Recovery Programs

ing home is another obstacle in and of itself, but also adds to the scope of change experienced upon going to school. SIR have to uproot and leave the support system that provides comfort, ease, and familiarity.³

Addiction often interferes with a student's motivation and ability to do well in school; this phenomenon often starts in high school. As a result, SIR may be behind other college students and need to take remedial classes or have additional tutoring to catch up on the material not learned earlier. The fear of failing and feeling overwhelmed by the structure and amount of coursework can be challenging barriers to recovery as well.

EXAMPLES OF COLLEGIATE RECOVERY PROGRAMS

The role of a CRP is to create, implement, and maintain peer-to-peer support services that promote a culture of abstinence from alcohol and other drugs.² For many SIR, CRP is the safest pathway to attaining a college degree, and can lead to higher recruitment and retention.⁴ CRPs can vary greatly from school to school due to differences in institutional structure, the organizational department it falls under, the campus culture, and the size and type of institution.

The first and oldest recovery support program for SIR on a college campus started at Brown University. In 1977, Professor Bruce Donovan was appointed Associate Dean with Special Responsibilities in the Area of Chemical Dependency. Little did he know, he ignited a movement that would affect thousands of students across the United States. In the 1980s, the three original CRPs were established at Rutgers University, Augsburg College, and Texas Tech University all because Bruce Donovan and Brown paved the way.⁴ Two of these programs are in schools we have attended and therefore

we chose to describe them in more detail to provide a sense of what CRPs are like.

Rutgers University was the first to offer on-campus housing for SIR. The Alcohol and Other Drug Assistance Program for Students (ADAPS) has existed there since 1983. ADAPS provides chemical dependency counseling, recovery support groups, and interventions for high-risk students. It has provided on-campus recovery housing for SIR since 1988; currently, there are two campus residence halls that house 38 students. Rutgers ADAPS also employs a full-time recovery counselor who is responsible for managing all recovery-related programming on campus and serves as the primary counselor for SIR housing residents.

The Collegiate Recovery Community at Texas Tech University began in 1986 due to an abundance of recovering students who were a part of the chemical dependency counselor program. This CRP grew from providing a 12-step meeting on campus, to hiring staff, to building a 17,000-square-foot building dedicated to SIR. Programming includes on-campus support group meetings, a recovery meeting called Celebration of Recovery, a specially trained academic advisor, financial assistance, a seminar in addiction and recovery, a peer mentor system, family weekends, organized community service, and the registered student organization, the Association of Students About Service.²

BENEFITS AND SUCCESS OF COLLEGIATE RECOVERY COMMUNITIES

Although outcomes to measure the success of CRPs are limited, preliminary data show signs of effectiveness. Results from the first national study of CRPs utilized data from 26 schools and 235 CRP students;⁵ 77% of CRP students said that it was very important for their school to offer recovery supports and that they

would not have enrolled in their school if it did not have a CRP. The recovery rate of the SIR students was 92%, meaning only 8% relapsed during the academic year surveyed. Overall retention rates were higher for CRP students than for the average student body (92% vs. 81% respectively); graduation rates were also higher within CRPs (89% vs. 61%).

The benefits of CRPs are not limited to SIR. The campus at large is also positively affected by having a visible CRP and vocal SIR. CRP students that are open about their recovery and are involved in alcohol- and other drug-prevention and awareness efforts on campus can use their lived experience to provide more effective messaging to the other students. SIR also help to reduce the stigma that surrounds seeking help for a SUD.⁶ Another benefit of a CRP is showing other students a counter culture that is alive on their campus and that there are other ways of living besides the stereotypical alcohol/ party scene. The presence of this counter culture may reduce the overall drug and alcohol consumption of students. Typically, recovering students have a tremendous sense of gratitude, grace, and redemption which lends them to being assets in the classroom. SIR take class seriously, are of service to their peers, and take advantage of every opportunity to better themselves.

The success of CRPs is due to creating a supportive community that increases recovery capital and promotes long-term recovery. Recovery capital are those assets that support both beginning and maintaining long-term recovery.⁷ There are four main types of recovery capital: personal, social, community, and cultural. The types and amount of recovery capital depend on a variety of social and environmental factors and differ from individual to individual, as each person needs different types of supports to help her or his recovery. Research found that programs focusing on social and community recovery capital were able to increase long-term recovery outcomes as well as increase quality of life.⁸ More specifically, CRPs that include organized weekly activities that allow for positive socialization and relationship development within the community have higher recovery rates among their members than those without such supports. In addition, this research found that the inclusion of community service activities helps to increase the success of CRPs as measured by student retention and recovery rates.

CONCLUSION

Many approaches have been taken on college campuses to combat the effects of drug and alcohol use on their student bodies. A CRP is the most comprehensive

method to support SIR. We know the power of CRPs from our own experiences and would like to conclude with stories from our lives. Having the opportunity to excel academically at Rutgers because of its CRP, this past year Ben received the Harry S. Truman Scholarship, which is a highly competitive national scholarship. During his finalist interview he openly discussed his recovery, the Rutgers CRP, and being incarcerated when one of the interviewers, a U.S. District Court Judge, said to him, "So, it seems like you're the exception..." Ben interrupted the interviewer and said, "I'm not the exception. I may seem like the exception because I've been given the opportunities that allow me to be here today, but I know countless other people, if given the same opportunities that I was, could be sitting here before you. If I'm the exception and I receive this award, and I move forward, and no one else who has come from where I've come from has an opportunity to win this award, then I haven't done my job and I haven't been a good advocate."

Sarah's CRP experience has come full circle. She was once a student in the CRP at Texas Tech University and is now helping The Ohio State University start its CRP. As a Graduate Administrative Associate in the Student Life Student Wellness Center, she serves in an administrative role helping to increase the recovery capital of the students. Sarah says that there is no greater feeling than to carry the message of recovery to the over 56,000 students on her campus and create a culture that is proud to have a visible recovery community.

The reality is, each step along the way we have had support, mentors, and opportunities; but unfortunately that is not the case for everyone. It is our hope and the vision of the CRP movement that all SIR will have access to similar opportunities and supports. Because of CRPs, students are returning to school and maintaining their recovery. They are contributing to their campus through service, involvement, and leadership. Parents are able to sleep soundly at night while their children are away at college. The necessity for these programs and the benefits of them is clear. By investing in SIR via CRPs, colleges and universities will be sending a message that these students are just as important as any other student and deserve a second chance at higher education.

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DATA TRENDS

TREATING YOUNG PEOPLE WITH CO-OCCURRING DISORDERS: WHAT WORKS?

SOURCES

Cornelius, J. R., Douaihy, A., Bukstein, O. G., Daley, D. C., Wood, S. D., Kelly, T. M., & Salloum, I. M. (2011). Evaluation of cognitive behavioral therapy/ motivational enhancement therapy (CBT/ MET) in a treatment trial of comorbid MDD/ AUD adolescents. *Addictive Behaviors, 36*(8), 843–848.

Chi, F. W., Sterling, S., Campbell, C. I., & Weisner, C. (2013). 12-Step participation and outcomes over 7 years among adolescent substance use patients with and without psychiatric comorbidity. *Substance Abuse, 34*(1), 33–42.

Youth with substance use disorders often also face mental health challenges. Two recent studies analyzed two different treatment approaches for co-occurring substance use and mental health disorders: (1) a standardized therapy approach and (2) 12-step support groups, as modalities for effectively treating and continuing positive outcomes for young people with co-occurring mental health and substance use issues. The findings from these studies are summarized below.

APPROACH 1: COGNITIVE BEHAVIORAL THERAPY AND MOTIVATIONAL ENHANCEMENT THERAPY

Cornelius and colleagues (2011) conducted a two-year follow up study on participants in two studies they had conducted previously to determine the long-term effects of using Cognitive Behavioral Therapy (CBT) and Motivational Enhancement Therapy (MET) together to address co-morbidity in adolescents. In one study, participants had received CBT/ MET to treat their co-morbid conditions. In the other study, participants received treatment as usual (TAU); this second study provided a naturalistic control group for the long-term follow up.

The authors described CBT as a therapy approach based on social learning models that focuses on developing an understanding of the triggers and consequences of drug use. They also stated that their implementation of CBT teaches coping skills to manage craving and other high-risk situations for use. The authors defined MET as an intervention used to increase an individual's engagement in therapy using motivation to make beneficial changes around substance use and high-risk behaviors. This intervention specifically was chosen as a way to encourage treatment adherence in young people because, according to the study authors, young people with substance use disorders have historically possessed low rates of treatment engagement.

At baseline, participants were between 15-20 years old and were diagnosed with both major depressive disorder (MDD) and an alcohol

CBT/ MET can reduce both mental health symptoms and substance use in young people with co-occurring disorders two years after treatment. Young people who had high rates of participation in a 12-step program had higher levels of abstinence from alcohol and drugs years later.

use disorder (AUD). Participants in the first study then received the intervention treatment of CBT/ MET, and those in study two received TAU. Those who received CBT/ MET received the treatment nine times over twelve weeks. Additionally, half of the intervention group also received Fluoxetine, an SSRI antidepressant medication. However, immediately after treatment there were no differences in mental health or substance use outcomes between the group that received the SSRI and the group that did not, so the two groups were combined in the long-term follow up. Other differences between those who received medication and those who did not were compared in a separate analysis.

Out of the 118 participants from the two initial studies, 75 completed the two-year follow up assessment: 48 who had received CBT/ MET and 27 from the TAU study. Differences in substance use and depressive symptoms between the two groups at baseline and two years after treatment were assessed using repeated measures analysis of variance (ANOVA).

Before the treatment phase, those in the CBT/ MET group demonstrated higher depressive symptomatology than those in TAU. There were no differences between the two groups in terms of AUD. After two years, there were no differences in outcomes between those in the CBT/ MET group who received medication and those who did not. Long term follow up did indicate that both the intervention group and TAU group demonstrated decreased diagnostic criteria in both depressive symptoms and alcohol use between the two time points. However, those in the CBT/ MET group demonstrated significantly more improvements than those participants in the TAU group. More specifically, analyses found significantly decreased depressive symptoms on three assessments including the number of DSM criteria for MDD ($f = 14.6, p = 0.000$), the Beck Depression Inventory ($f = 12.4, p = 0.001$) and the Hamilton Depression Rating scale ($f = 16.6, p = 0.000$). A significantly greater improvement in the DSM criteria for alcohol use disorder was also found in the CBT/ MET group ($f = 14.2, p = 0.000$).

These results demonstrate that, in combination, CBT and MET may be an effective treatment for adolescents diagnosed with both MDD and AUD. The effects of this approach lasted two years past treatment. The SSRI Fluoxetine did not appear effective when combined with CBT/ MET in either the short or long term for this particular group. However, the small sample size used to assess long term effectiveness is a limitation to this study and replication of its findings are warranted.

APPROACH 2: 12-STEP PROGRAMS

A study by Chi and colleagues (2013) examined the

long-term effects of participating in a 12-step program on post-treatment substance use abstinence for youth with and without mental health challenges.

Participants for this seven-year study (N=419) were recruited from four Kaiser Permanente Chemical Dependency Recovery Programs in California, and were aged 13-18 at baseline. This sample was 34% female, and race/ ethnic distribution was as follows: 50% of participants reported as Caucasian, 21% Hispanic, 14% African American, 8% Native American, and 6% Asian/ Pacific Islander.

Psychiatric diagnoses were taken from Kaiser Permanente's inpatient and outpatient databases. Adolescents with co-occurring disorders were those who received at least one psychiatric diagnosis on the International Classification of Diseases (ICD)-9 in the two years prior to the study through six months after entering substance abuse treatment. Severity of symptoms was measured at intake by internalizing and externalizing scales on the Youth Self-Report questionnaire (YSR). Follow up evaluations were conducted by phone at one, three, five, and seven years after intake.

To measure 12-step group participation, the Alcoholics Anonymous (AA) Affiliation scale was modified to include Narcotics Anonymous (NA), Cocaine Anonymous (CA) and other 12-step groups. Meeting attendance was measured by the number of meetings attended in the six months prior to the assessment; activity involvement within the program (e.g., considering oneself a member, having a sponsor, having sponsored anyone, calling other members for help, etc.) was measured by adding up the total number of activities selected (scores ranging from 0 to a maximum



of 3+). Substance use was measured by assessing thirty-day abstinence from alcohol and drug use measured at each time interval.

Differences between adolescents with co-occurring disorders and those with only substance use issues were compared. At baseline, when compared to those who presented with only a substance use disorder, adolescents with co-occurring issues had higher levels of substance use, reported more abuse/dependence symptoms and had higher YSR internalizing and externalizing scores. There were no differences in substance use treatment retention or length of stay between the two groups at any time intervals. However, 12-step meetings were more highly attended in years one and three by young people with co-occurring diagnoses than those who were just managing a substance use disorder (33% vs. 19%, $p = .0032$; and 16% vs. 7%, $p = 0.0106$). Those with co-morbid conditions also reported being abstinent more often than those with SUD only.

Analyses were conducted to examine the relationship between post-treatment participation in 12-step groups and substance use outcomes for young people with both co-occurring and substance abuse-only diagnoses. Adolescents with and without co-occurring disorders who attended at least ten 12-step meetings in the prior six months of each measurement interval were more than three and five times as likely to be abstinent from alcohol at follow-ups as those who attended fewer or no meetings (OR = 3.02, $P = .0049$; and OR = 5.29, $P = .0063$, respectively). Adolescents in both groups who had high meeting attendance were also 5 times more likely to be abstinent from drugs. Similarly, those with and without co-occurring disorders who were more actively involved in their 12-step programs were more

than twice and eight times as likely to be abstinent from alcohol over time as those with less involvement (OR = 2.55, $P = .0322$; and OR = 8.17, $P < .0001$, respectively). Results from this study show that 12-step programs may help some young people with psychiatric and substance use issues maintain abstinence from substance use over the long-term.

CONCLUSION

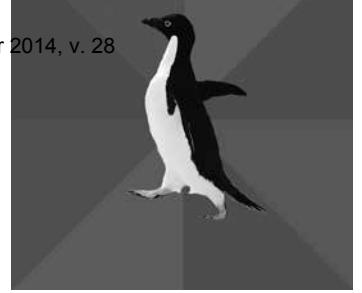
These two recent studies demonstrate promising initial results regarding the long-term effectiveness of various non-medicine based treatment approaches for supporting adolescents and young adults with co-occurring disorders. The first study showed that CBT/MET can reduce both mental health symptoms and substance use in young people with co-occurring disorders two years after treatment. The second study found that those young people with co-occurring disorders who had high rates of participation in a 12-step program had higher levels of abstinence from alcohol and drugs years later. However, more research needs to be done to replicate these findings and to better understand the best ways to treat young people who face both mental health and substance use challenges.

AUTHORS

Molly Oberweiser Kennedy is a PhD student in the Portland State University School of Social Work and a Graduate Research Assistant with the Regional Research Institute.

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What's in a Meme:

Using Social Networking to Promote Strengths-Based Mental Health

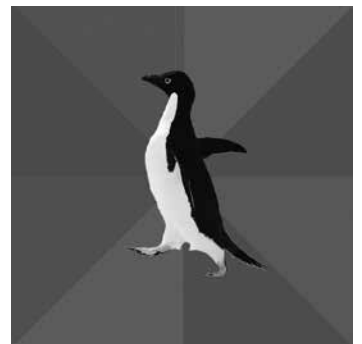
In December 2013, Pathways hosted its first-ever social media meme contest! If you're not sure what a meme is, don't worry: you're not the only one. Formally, a meme is a bit of cultural knowledge – an idea, behavior or style – that passes quickly from person to person. An Internet meme is a meme in the form of an image with a quirky caption that can go "viral" on various social media platforms.

Memes range from a cute dog speaking poor English, to manatees giving calming wisdom, to Keanu Reeves looking really sad. For young adults, memes are a way to connect with each other in a fun way. On a deeper level, memes can also serve to process, challenge, laugh at, and sometimes confront issues such as poverty, drug abuse, and celebrity culture.

Latching onto this concept, we asked our 18-30 year old fans on Facebook to create a strengths-based meme that demonstrates how they manage their mental health. The memes with the most votes won \$100, \$50, and \$25 respectively. The entries to the contest were funny, inspiring, and interesting.

AUTHOR

Brittany Smith is Owner of Portland-based social media consulting firm Build Social, LLC.



See the graphics that go with our 1st, 2nd and 3rd place winners at pathwaysrtc.pdx.edu/memes:





DESTRUCTION & DELIVERANCE: MY STORY

I began making regular visits to therapists, psychologists and psychiatrists when I was twelve years old. My emotional, mental and behavioral difficulties, however, began much sooner than this. All of my own personal struggles related to psychological health began to develop by the time I was four years old. It wasn't until these issues began to manifest themselves in my academic and conduct performance in middle school that a problem was recognized. Although I began receiving help at such a young age, these tribulations only got worse until I reached my breaking point with a suicide attempt when I was 25 years old.

To fully convey my struggles and my story I must begin with the trauma at the heart of the snowball. At four years old I was molested at the daycare/ preschool at which I stayed while my parents were at work. Every day I would return to this place and bide my time until I could return home. Once my parents were off from work I could leave but there was little solace to be found at the house. I never told my parents about the abuse (something they still know nothing about). I was too ashamed and too afraid to say anything. Life at home

wasn't much better. I wasn't sexually abused there but lived with a father dealing with his own struggles. I never turned to him; I avoided him because of the physical and emotional abuse he inflicted upon me.

As I got older I no longer had to attend the daycare that surrounded me with painful memories yet those experiences never left me. In elementary school I was withdrawn, suffering from social phobia (for which I was later diagnosed) and became the victim of relentless bullying from my peers. Due to my traumatic experiences I was a "weird" kid; the type of kid who is a prime target for bullying. I was able to push through these difficulties for my first few years of schooling, making good grades and representing a model student. This all changed when I reached the third grade. For the first time in my life, and unfortunately not the last, bullying was no longer only a problem with my peers but with my teacher as well. One day at recess, my classmates were all (literally) singing and dancing on one end of the playground. My prime bullies were leading the group which led me to stay away and play by myself on the other side of the playground. There I sat, playing with a stick, when my teacher called us all in from recess 20

minutes early. Ms. Teacher proceeded to inform the class that recess was cancelled because of my behavior (playing with a stick) and instructed my classmates to “thank” me for “ruining” recess for them. A choir of bitter voices attacked me. That was the moment I learned to hate school and began to give up.

For the rest of my time in school, despite having an extremely high IQ and being placed in all of the “academically gifted” classes, I never tried again (at least not until late into college). I remained distanced and withdrawn from my peers, finding solace in playing musical instruments and writing poetry. Engaging in my own artistic pursuits at home was my only escape from the torment of daily life. My father hated this because I was “supposed” to be out playing with other kids and began to beat and batter my instruments just as he would me. At the age of twelve I was old enough to fight back. After I hit my father back in defense I attempted suicide for the first time. I would like to add that after this incident my father took a long look in the mirror and after attempting his own suicide he learned to be the father he never was; he became a happier man and went through his own recovery along with beginning to assist me in my own.

From this time in middle school until I went to college I was on more medications than I could name and was in intensive psychiatric counseling. I continued to find peace in the arts and felt a wave of relief when I moved away to attend a university. Upon moving away from home and into a new environment I was filled with hope and great expectations. I got to meet new people who knew nothing about my psychiatric problems and began to make new friends. It wasn’t long, however, until my mental health issues began to become apparent to my new group of “friends” in college. My newly formed personal relationships as well as my academic success began to rapidly deteriorate. I realized that my college peers were no more informed on mental health issues than my primary school classmates when everyone I knew seemed to mistake my name for “crazy.” My new friends, my only friends in the world, would soon invite me for a spring break vacation to promptly uninvite me after a public panic attack.

Once the panic attacks began I was prescribed new medications; namely, 3mgs of Xanax a day. Taking them helped me to manage my anxiety but I could still feel the pain of memories. I began taking four to five times my prescribed amount so as to deaden all worries and concerns of both the past and present. I saved them up at first, and then I binged. I bought more from others; I stole them from dorm-room drug dealers. I was strung out every day for three years. Benzodiazepines eliminate all sense of stress, worry and responsibilities. I was

living in a day dream and wanted nothing to do with the world outside; I wanted to stay there forever. Needless to say, my grades began slipping until I was kicked out of school and my friends didn’t know me anymore. I was losing everything I had but was too high to notice.

After spending so much of my time in a fog, too dense to see the world in front of me, I was running out of places to procure more Xanax. I began to add more drugs into the mix to try and cope with my mental health issues through self-medication. I couldn’t list everything I did for you here because the list would be far too long. I began doing anything I could get my hands on to try and escape life again. One evening, for better or worse, I experienced a horrific “bad trip” on LSD, the first in a dozen to have such an effect. This experience encouraged me to quit using drugs. On the down side, it convinced me that death was a good option. I attempted to take my own life shortly after at the age of 25 by drinking a bottle of gin and skateboarding downhill on a five lane road into oncoming traffic.

I’ve always heard that facing one’s own death can permanently change a person.

I consider this to be the most positive direction-changing moment of my life. I’ve always heard that facing one’s own death can permanently change a person and after a few weeks in the hospital recovering from my attempt, I now understand this saying. Not succeeding in my suicide gave me a new lease on life. For the first time in over two decades I was ready to appreciate both the world around me and within myself. I could enjoy sunsets and flowers and finally realize the beauty of life. Feeling renewed, I learned how to grow personally and use my own experiences to help both myself and others. I became heavily involved in my own recovery, eventually joining advocacy groups and becoming a Certified Peer Support Specialist, all within a year of my attempt. I now help others, professionally, using my story. Working with others who are struggling serves as a reminder of how precious my life is. Education, compassion and understanding from other people are the reasons that I’m able to type this right now.

AUTHOR

Milo Rymes is a Certified Peer Support Specialist, Youth Advocate and artist.

HELPING YOUNG PEOPLE GET TREATMENT IN JUVENILE JUSTICE AND BEYOND

Why focus on the juvenile justice system? Despite the fact that most juvenile justice-involved young people are not being treated for substance abuse and mental health needs, the juvenile justice system is still the single largest referral source for adolescent treatment and this system is where young people in trouble often first come to our attention.¹

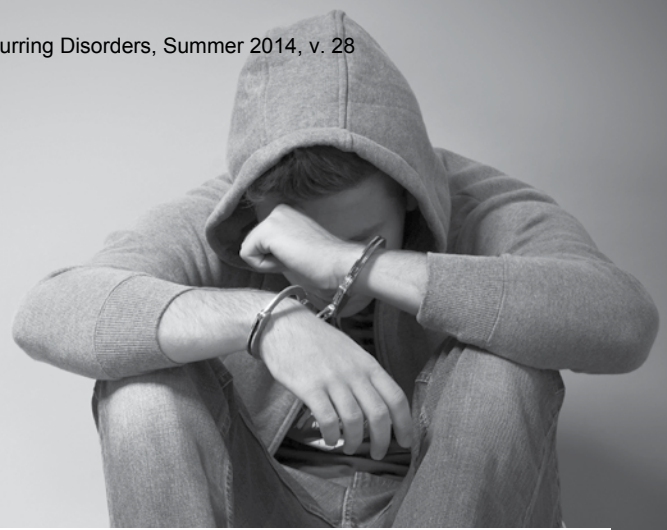
Young people involved in the juvenile justice system often are challenged with substance use issues. Nationally, about half of young people in the juvenile justice system have drug related problems.² In fact, four of five young people in the juvenile justice system are under the influence of alcohol or drugs while breaking the law; test positive for drugs; are arrested for committing an alcohol or drug offense; admit having substance abuse and addiction problems; or share some combination of these characteristics.³ Additionally, many young people in the juvenile justice system have a co-occurring disorder (both substance abuse and mental health). Yet in spite of research that shows treatment helps reduce recidivism⁴ and saves money, juvenile courts usually are not set up to detect and treat substance abuse or to provide mental health and other important services. Instead, most of the young people in the juvenile justice system who need treatment for drugs, alcohol, and mental health problems are not getting it. Fewer than one in twelve young people who need such supports actually receive treatment of any kind.⁵ For those who receive treatment, less than half are retained for 90 days as recommended by research.⁶ Many communi-

ties are not using evidence-based treatments that have been tested in the field for many years. Young people need different care than adults: care that addresses adolescent development and brain science, and that utilizes support from families and community. Too many juvenile courts mirror a more punitive approach appropriate to adult criminal court rather than the rehabilitative civil court envisioned when the juvenile court was first established in the late nineteenth century.

THE RECLAIMING FUTURES APPROACH

The Robert Wood Johnson Foundation (RWJF) recognized that there was no uniform system of care for young people in the juvenile justice system and as a result launched Reclaiming Futures in 2000 to address the lack of treatment young people received for their substance use and mental health challenges. Reclaiming Futures founder, Dr. Laura Nissen, and ten pilot sites drew upon emerging research to establish new national benchmarks, and develop and validate the Reclaiming Futures model during a five-year pilot phase beginning in 2002.⁷

RWJF, by launching this initiative, reinvented how juvenile courts work. Reclaiming Futures brings together judges, probation officers, treatment providers, families and community members to improve drug, alcohol, and mental health treatment for young people in trouble with the law. This is in part accomplished through a system change framework of “more treatment, better treatment, and beyond treatment” that screens young people for drug and alcohol problems, assesses the severity of substance use, provides prompt access to



a treatment plan coordinated by a service team, and connects young people with employers, mentors, and a wide range of community pro-social activities.

Specifically, “more treatment” is about addressing the lack of treatment available in many communities and the screening and assessment of young peoples’ treatment needs. “Better treatment” refers to the best evidence-based continuum of treatment options that can be implemented with fidelity by a community. “Beyond treatment” is the process of fully engaging the community in supporting young people and families early in formal services, and in providing supportive opportunities for them outside of the court setting. The goal is to get young people out of the system and not return. “Community,” which is broadly defined, is very important to the Reclaiming Futures model and requires many partners such as young people, parents, families, mentors, child welfare, faith leaders, education, defense attorneys, public defenders, volunteers, youth advocacy organizations, employers, etc.

Additionally, the Reclaiming Futures approach is comprised of a six-step model. More specifically, the elements of the model include:

- Step 1: Screening
- Step 2: Assessment
- Step 3: Service coordination/ multi-disciplinary care planning
- Step 4: Initiation in treatment
- Step 5: Engagement in treatment
- Step 6: Transition, community involvement, and recovery networks

Transition, Step 6, describes efforts to connect youth and families with long-term supports for success and includes restoration (holding young people accountable for court ordered fines and/ or community service); and readiness for whatever is next for the

young person, like education, employment, pro-social activities, re-entry back into the community, and recovery for those with addiction.

IMPLEMENTING RECLAIMING FUTURES

Today, Reclaiming Futures has been implemented in 39 communities across 18 states nationwide. The local Reclaiming Futures sites all are supported by an individual coach; the national program’s office staff and resources (headquartered at Portland State University in Portland, Oregon); a curriculum toolkit; an implementation index and plan; and the Reclaiming Futures national learning collaborative. This collaborative consists of Reclaiming Futures team members from sites throughout the country, and engages all sites in group learning activities, peer coaching, and resource sharing. It is organized by discipline (judges, probation, community, treatment, and project directors) and is convened via regular calls, meetings and webinars. The learning collaborative also convenes as a state cohort within states with multiple sites.

System change at each site is accomplished by ensuring youth progress through the six-step model, making policy changes for better outcomes, sharing leadership across disciplines and partnering agencies, aligning job descriptions with Reclaiming Futures goals, and sustaining and maintaining improvements by institutionalizing the advancements made. The resulting improvements lead to better data on the behavioral health needs of young people coming into the system, better tracking of youth while they are in the system, greater awareness and utilization of evidence-based treatment, and increased community involvement to help these youth become productive members of society.

While Reclaiming Futures is a system change initiative for the juvenile court in general, it has also been effectively implemented in juvenile drug courts, a specialized docket of juvenile court. These courts are

sometimes criticized for being “boutique” because of concerns that they serve a relatively small subset of youth in the system with a disproportionate share of the limited resources available. Reclaiming Futures, through extending screening and assessment beyond the drug court and by increasing community involvement with the juvenile court system as a whole, has provided an opportunity for juvenile drug courts to pilot the model and then spread it throughout the system. Implementation of this model may thus begin in a single court but the intention is to spread its impact from the court to the entire local juvenile justice system, then into the community.

EVALUATING RECLAIMING FUTURES

Independent evaluation by the Urban Institute and the University of Chicago's Chapin Hall Center for Children found that the Reclaiming Futures model works at the implementation level. Surveys of the ten original sites were conducted every six months between December 2003 and June 2006 to determine how adopting the Reclaiming Futures model changed the services offered and the integration of those services within and beyond the juvenile justice system.⁸ Findings indicated that the model is adaptable, flexible, and works in both urban and rural settings. Additionally, Reclaiming Futures pilot communities reported significant improvements in juvenile justice and drug and alcohol treatment services (improved assessment and treatment effectiveness), and positive changes in the way juvenile justice and substance abuse agencies communicate and cooperate. Improvements in family involvement, and young people's involvement in positive activities were also noted.

Since 2007, twelve communities have been funded by OJJDP and the Substance Abuse Services and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) to combine the Reclaiming Futures model with their local juvenile drug court. A recent study looked at this specific implementation and provided the Reclaiming Futures initiative its first youth-level outcome data.⁹ An external evaluation of these sites and Reclaiming Futures funded by OJJDP is currently underway with the University of Arizona, Southwest Institute for Research on Women, through an interagency agreement with the Library of Congress (LOC). One of the external evaluation partners is Chestnut Health Systems of Normal, IL.

The Global Appraisal of Individual Needs (GAIN) is a screening and assessment tool used on every young person coming into both the Reclaiming Futures JTDCs and the SAMHSA CSAT-funded juvenile treatment drug

courts (CSAT-JTDC). It collects several types of data from youth including background demographics and information, substance use, physical health, risk behaviors, mental health, environment risk, legal involvement, and vocational measures. A recent study by Chestnut Health Systems using the GAIN data compared young people in CSAT-JTDC to young people in drug courts using the Reclaiming Futures JTDC model. Research techniques designed to produce an equivalent comparison group were used. The SAMHSA CSAT-funded courts were funded to implement evidence-based treatment for their juvenile drug court. As a result, they are considered relatively effective drug courts compared to the many juvenile drug courts that do not provide evidence-based treatment.

A comparison was made between the two groups on the number of days and the respective change in days that the youths experienced problems in the year before treatment and the year after treatment. While living in the community, Reclaiming Futures JTDC young people had a larger increase in days abstinent from drugs and alcohol than the young people in the comparison group (a 42% increase in the number of days abstinent in the year following involvement with Reclaiming Futures vs a 24% increase for those in CSAT-JTDC). Young people involved in Reclaiming Futures JTDC also showed higher reductions of crime; illegal activities were decreased by 65% compared to 45%. Higher crime reductions were seen in violent and substance-related activities.

After controlling for the intake differences, Reclaiming Futures JTDC clients reported receiving more substance abuse services, including significantly more days of residential treatment and a trend toward more intensive outpatient treatment days marking an important contribution of this effort. This supports the claim that the Reclaiming Futures model promotes more treatment than JTDC. However, additional findings indicated that Reclaiming Futures JTDC clients had fewer family services; this result is less than desired and warrants additional exploration.

In summary, this evaluation revealed that Reclaiming Futures JTDC increased days of alcohol and drug abstinence by 42%, reduced teens' illegal activity by 65%, and significantly reduced the costs of crime to society. It also increased the amount of services that young people get, with the exception of family services.

This research study had several strengths, including a large sample size (JTDC N=1,934 and Reclaiming Futures JTDC N=811), standardized intake and follow-up measures, data collection at multiple sites, and multiple sources of data on service utilization (i.e., from staff records and self-report). However, we need

to acknowledge some important limitations, including having compared two groups receiving treatment (via Reclaiming Futures JTDC or JTDC) and not using a no-treatment control group.

To address some of the questions raised in this analysis, the authors recommend further analysis of referral sources and an expanded array of outcomes. Additional areas of exploration include even more rigorous analysis of data to determine which young people would most likely benefit from JTDC as normal vs. Reclaiming Futures JTDC. More research also is needed to determine specifically which aspects of Reclaiming Futures JTDC cause its beneficial outcomes so that they can be replicated.

Co-occurring disorders among young people in juvenile justice settings are not exceptions – they are the expectation, and young people should receive evidence-based treatment that addresses their co-occurring needs. The Reclaiming Futures JTDC model has potential to increase drug and alcohol abstinence, reduce young people’s illegal activity, and reduce the cost of crime to society.

Note: In addition to the long-term generous support of the Robert Wood Johnson Foundation, the initiative has received additional investments to spread its model from the Office of Juvenile Justice and Delinquency Prevention; the Center for Substance Abuse Treatment; the Kate B. Reynolds Charitable Trust; The Duke Endowment; and the State of North Carolina, Department of Public Safety. The national office of Reclaiming Futures is housed in the Regional Research Institute of the School of Social Work at Portland State University. For more information on Reclaiming Futures, please visit www.reclaimingfutures.org. For the full article on this research to be published in the coming months, please contact Michael Dennis at mdennis@chestnut.org.

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2014 STAFF OF THE RESEARCH AND TRAINING CENTER FOR PATHWAYS TO POSITIVE FUTURES

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PROJECTS AND STAFF:

CAREER VISIONS tests an approach to career planning and employment for young adults, ages 21-25, who are receiving SSE or extended special education services.

Jo-Ann Sowers, Principal Investigator; Adrienne Scavera, Graduate Research Assistant.

BETTER FUTURES tests a comprehensive intervention to assist young people in foster care with serious mental health conditions to prepare to participate in post-secondary education.

Sarah Geenan and Laurie Powers, Co-Principal Investigators; Pauline Jivanjee, Project Advisor; Lee Ann Phillips, Project Manager; Nick Wings-Yanez, Graduate Research Assistant.

ACHIEVE MY PLAN studies the efficacy of an intervention to increase young people’s participation and engagement in their mental health treatment planning teams, and to build organizational capacity to support youth engagement.

Janet S. Walker and Laurie Powers, Co-Principal Investigators; Celeste Moser, Project Coordinator; Jared Best, Graduate Research Assistant; Celina Ataras, Research Assistant; Heather Rowlett, AMP Coach.

TRANSITION POLICY CONSORTIUM will develop an inventory that assesses the level of community support for transition services with a specific emphasis on measuring collaboration and continuity of care between the child and adult mental health systems.

Nancy Koroloff and Janet Walker, Co-Principal Investigators; Adrienne Croskey, Graduate Research Assistant.

FINDING OUR WAY furthers the development of a culturally specific self-assessment tool for American Indian/Alaskan Native young people.

Developed for youth ages 13-19, the tool will be modified to include issues relevant to transition.

Barbara Friesen and Terry Cross, Co-Principal Investigators; L. Kris Gowen and Pauline Jivanjee, Researchers; Abby Bandurraga, Graduate Research Assistant.

eHEALTH LITERACY is a developmental project that will contribute to a knowledge base about the ways youth and young adults use the internet to find information about mental health care, conditions, symptoms, or medications. The information will be used to develop and test an eHealth literacy curriculum.

L. Kris Gowen, Principal Investigator.

RECOVERY OUTCOMES is a secondary analysis of large national data sets. This project will analyze data from the System of Care National Evaluation related to young people’s recovery outcomes.

Eileen Brennan, Principal Investigator.

MEDIATORS OF STIGMATIZATION will analyze data from nationally representative samples of youth and young adults, and use this information to identify potentially effective anti-stigmatization strategies.

Janet Walker, Principal Investigator.

TRANSITION TRAINING COLLABORATIVE will develop graduate and undergraduate course modules appropriate for individuals who plan to work with transition-aged youth, as well as modules for in-service delivery.

Eileen Brennan and Pauline Jivanjee, Co-Principal Investigators; Claudia Sellmaier, Graduate Research Assistant; Goutam Saha, Coordinator of Multimedia Services.

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Partial Acknowledgement: The development of this paper was supported by the Center for Substance Abuse Treatment (CSAT); Substance Abuse and Mental Health Services Administration (SAMHSA) contracts 270-12-0397 and 270-07-0191; as well as the Office of Juvenile Justice and Delinquency Prevention (OJJDP); Department of Justice (DOJ) contracts 2013-DC-BX-0081, 2012-DC-BX-0128 and LCFRD11C0007 done through an interagency agreement with the Library of Congress (LOC).

AUTHORS

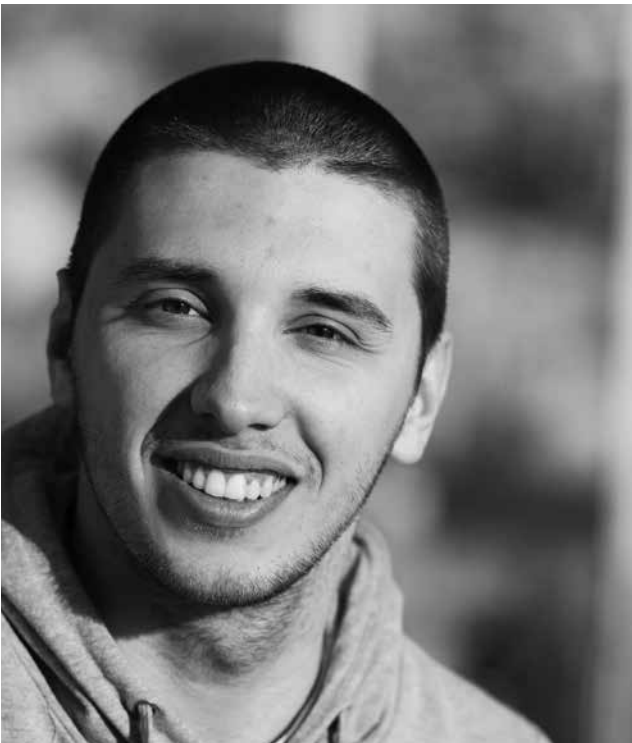
Susan Richardson is National Executive Director for Reclaiming Futures. Formerly, she was a Senior Program Officer in the health care division of the Kate B. Reynolds Charitable Trust in North Carolina, where she led a three-year effort involving the state's juvenile justice and treatment leaders to adopt the Reclaiming Futures model by juvenile courts in six North Carolina counties.

Jim Carlton has worked at the Reclaiming Futures national program office since its inception in 2000. He has served as Deputy Director since 2004.

Laura Nissen served as founding Executive Director of the Reclaiming Futures national program office. In 2014 she assumed the role of Dean of the School of Social Work at Portland State University.

Michael Dennis is Senior Research Psychologist and Director of the Global Appraisal of Individual Needs (GAIN) Coordinating Center (GCC) at Chestnut Health Systems in Normal, Illinois.

Kate Moritz is a Projects Manager at Chestnut Health Systems' Global Appraisal of Individual Needs (GAIN) Coordinating Center (GCC).





Transition-Age Youth A parent perspective

When my children were young it was clear. My role was defined. I provided safety, shelter, food and loving guidance for them to grow. Later, our lives were complicated by unanticipated mental health and substance abuse needs. So, how does one prepare to successfully assist youth to gain the tools and support necessary to move to another stage of life when faced with such challenges? What supports, services, policies and/ or programs need to be put in place in order to be successful and promote recovery?

I am sharing my experience and thoughts here to help contribute some possible answers to those questions.

So, let's talk about support. I want to start with support for self. We, too often, leave this conversation until the end. Yet it is the foundation to all other conversations about support. If you have a transition-age youth, regardless of circumstance, it can be a challenging time. If you add the extra needs of your child(ren) with mental health and substance abuse issues, you need co-navigators. Connecting to other caregivers who have experienced and/ or are experiencing similar conditions can be immensely helpful and expose you to avenues of assistance that you might not know about when transitioning to new service systems.

When your child nears legal adulthood, what once worked in the past regarding accessing services, qualifications for receiving services, and levels and degrees of allowed family involvement, all drastically change. When our child was younger, we might have been

active members in our child's treatment and recovery process, and information was freely shared. We now find that those rules have changed and another layer of permissions is necessary. We may still have financial liability without the ability to participate in treatment decisions. Family supports and family inclusion may not be available. Payment options can shift, as can the direction of treatment. While you may have been an expert in the child serving systems, your child and you are entering into a "new to you" cadre of services – adult services. When we needed to access services within an adult system for my youngest son it was the guidance of another seasoned parent that was most helpful. She was able to tell me what to expect. She was able to assist me in finding ways to learn about the treatment model being used so that I could support my son in his recovery. Those avenues were not made available through the service system itself. Take care of yourself and enlist others to help you do that.

As for supports for young emerging adults, finding ways to connect them with healthy groups that allow them to have social outlets and shared experiences, and to develop skills is equally important. It is best that the support be provided by other young adults in recovery that can and do "talk the talk" and "walk the walk" of recovery. There are a number of youth-in-recovery groups and with a little work you can find them through schools, faith-based organizations, online, or in resource directories. Your older child's choice for a group that works for him or her may be different than yours. It is more important that the group is providing a place for your emerging adult to find support for her

or his ongoing recovery and helping to link her or him to resources than it is for the group to make sense to you as the caregiver. My youngest son, who is just passing out of the transition-age realm and is in long-term recovery from a dual diagnosis, uses one set of supports; meanwhile, my oldest son uses a totally different set of supports. Support what works for the individual.

What about services? Services for transition-age youth need to have a recovery orientation. Often times people assume that because children have received services in the past, they are automatically going to require the same or similar services as an adult. Youth in transition need to be provided with thorough and ongoing assessment to see where they are at on the continuum of need. This has to start early enough to prepare for the eventual “launching” of the young adult. Those services need to include a youth-informed plan that includes education and skill building; employment support; and independent living options. They also need to be coordinated. If your social worker/ clinical worker/ housing authority/ business rep/ natural supports are not all on the same page with you and your child, success is difficult. One essential service is having someone to ensure coordination happens. In an ideal situation, every family that needs it should have a designated person to fulfill that role based on the youth and family plan. If the plan is to transition to independent living with no needed systems support then working toward that plan all through the transition-age years starts at adolescence. If the plan is to make sure all the systems-level supports and services are in place as the young person enters adulthood, then that is reflected in the plan and supported as well.

That really leads us to policy change. Policies that prevent us from playing an informed, active participatory role need revision. Policies that are in place with the Affordable Health Care Act need to be understood and utilized so that services can be obtained. The parity law states that to the degree certain services and supports are allowed for a physical health issue, the same has to be allowed for a behavioral health issue. So, for example, if you have a broken leg and you get treatment and then get physical therapy in the recovery stage, you should be able to get treatment and then recovery supports for a mental health and/ or substance abuse issue. Every child- and adult-serving system should have a transition-age specific set of policies and procedures to ensure that their needs are being met. Those policies should include comprehensive assessment of all the domains to determine what the young adult needs to be able to live in the community; have gainful employment; and obtain needed education and affordable, safe housing. Those policies and their effectiveness

should be measured on a regular basis and adjusted and changed as needs arise.

Effective programs need to be available so that whether you live in an urban-based community or a remote, rural setting you can easily access them. The delivery method might be different but the core components can remain. Those supportive programs have to include whole-person thinking by addressing those issues that support ongoing recovery, housing, employment, nutrition, etc. Protocols vary with cultures, and responding to the needs of these differing groups in ways that are most effective, respectful and helpful is important. I come from a tribal community and we have specific ceremonies that define entry into stages of life with roles and responsibilities that accompany those stages. So if you have a transition plan that is not informed you could be working at cross purposes. For example, there is an expectation that a young person will spend some of the transition-age period serving and learning from an elder. If you know that, you can work to make that a part of the plan and perhaps link it to specific skills that may aid in ongoing recovery efforts.

We want to do what works. We want to have some degree of assurance that what we are doing will work and will get us closer to meeting our goals. We need to learn what practices have some degree of success so that we can, together, with the young adult, make informed decisions about the best course of action. There are those practices that have “evidence” and have been proven to be effective. There are also practices that communities and families have found to be helpful. They may not have the body of “proof” but nonetheless can be helpful or a good fit for your young person. My oldest son participates in our traditional ceremonies. He obtained and maintained a long-term recovery through these practices. Those practices are not currently supported or considered evidence-based but they work for him and that is what matters to us.

Ultimately, for me, emerging adults need safety, housing, food, and loving guidance along with opportunities to learn and practice providing for themselves.

AUTHOR

Shannon CrossBear is a beautiful, powerful, spiritual Ojibwe/ Irish woman whose purpose is to demonstrate and promote gentle healing. Health issues within Ms. CrossBear’s family of origin and community cement her commitment to improving conditions for children. She expresses her commitment to healing through her work in the world.

The Patient Protection and Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA):

Addressing Co-Occurring Substance Use Disorder Services for Transition-Aged Youth



Substance use, which almost always begins in adolescence, is the most expensive public health problem in the U.S. today. Youth with mental health conditions are more likely than other youth to have a substance use disorder (SUD)¹ and substance use may indicate an undiagnosed mental illness. Reasons for this higher risk include attempts to self-medicate to alleviate distressing symptoms, lower impulse control, greater difficulty resisting peer pressure, and acting-out or defiant behaviors.²

Access to quality services that address both mental health and SUDs has been hampered by limited insurance, and lack of 1) knowledge about services, 2) available services, and 3) incentives for quality standards for treatment. In 2012, only about 10 percent of 1.6 million youth aged 12 to 17 needing SUD treatment in a specialty facility received treatment. Over half of those people aged 12 years and older who sought SUD treatment did not receive it because of cost or lack of insurance, or not knowing where to go. The rest were hindered by stigma, transportation issues, time constraints, and a perceived lack of readiness to get help.³ For those who got treatment, few received services that met evidence-based practice standards, or integrated mental health and SUD treatment.⁴ Implementation of the Patient Protection and Affordable Care Act (ACA), along with the Mental Health Parity and Addiction Equity Act (MHPAEA), has the potential to greatly improve access to and quality of services for youth and young adults.

ACA: BENEFITS FOR MENTAL HEALTH AND SUD SERVICES

Thomas McLellan, former Science Advisor and Deputy Director of the White House Office of National Drug Control Policy, and CEO and founder of the Treatment Research Institute believes that ACA will have the most profound effect on addiction as an illness, revolutionizing SUD treatment.⁵ Fully implemented on January 1, 2014, ACA guarantees coverage for mental health and SUDs as an essential health benefit (EHB) and recognizes these disorders as chronic illnesses, paving the way to coverage of services available for other chronic conditions.

ACA⁶ firmly places mental health and SUDs in the medical arena by including their 1) treatment as an EHB, 2) definition as chronic diseases, and 3) screening in medical settings. ACA further improves access to quality care for youth and young adults with co-occurring disorders by:

1. allowing young adults to be covered by their parents' insurance until age 26 (this provision has been in effect since September, 2010);
2. facilitating coverage for vulnerable, low income young adults not covered by a parent's insurance policy through Medicaid coverage to age 26 and outreach to help youth obtain coverage in states;
3. prohibiting denial of coverage for pre-existing mental health, behavioral health, or substance use conditions;

4. eliminating annual and lifetime limits that would deny access to treatment;
5. incentivizing use of the most effective practices and providing coverage for medication and non-medication effective practices; and
6. supporting prevention, early detection and referral by medical providers and school-based health centers.

MHPAEA: EQUIVALENCE OF BENEFITS

MHPAEA,⁷ signed into law in 2008, guarantees that mental health and SUD benefits, if provided, be consistent with financial requirements and treatment limitations of medical/ surgical benefits. ACA, by making these services an EHB, guarantees coverage for these services, with the exception of grandfathered small group plans, and the gaps in coverage of low income populations who fall in the 138 percentile of the federal poverty level in states that do not adopt Medicaid expansion. Application to Medicaid and the Child Health Insurance Program (CHIP) were addressed separately by letter⁸ and further guidance is forthcoming on the application of MHPAEA to Medicaid expansion. The



final rules for MHPAEA implementation, published in November 2013, go into effect on July 1, 2014, affecting most plans at the start of the new plan year on January 1, 2015. The final rules clarify that:

1. treatment limits or financial coverage requirements for copays or deductibles that are more restrictive for mental health and SUD services than for medical/ surgical services are prohibited;
2. if plans cover mental health and SUD services, coverage generally includes inpatient and outpatient services, emergency care, and prescription drugs. Within categories such as these, plans can treat preferred and non-preferred providers differently;
3. deductibles for mental health and SUD services cannot be calculated separately from other services in the same category;
4. parity applies to intermediate level mental health and SUD services such as residential treatment and intensive outpatient services;
5. the same type of processes must be employed for management of health and SUD and medical/ surgical benefits, such as determining medical necessity or requiring preauthorization;
6. ACA's prohibition of annual or lifetime dollar limits on EHBs overrules limits allowed under MHPAEA, which only apply to provisions that are not EHBs;
7. federal parity laws do not pre-empt more stringent state parity laws; and
8. medical necessity determinations and reasons for denial of reimbursement or payment of services with respect to mental health and SUDs must be made available to participants and beneficiaries.

HOW ACA AND MHPAEA AFFECT SERVICES FOR CO-OCCURRING DISORDERS

The impact that ACA and MHPAEA will have on mental health and SUDs, and behavioral health treatment can be grouped into six areas.

1. *Essential Health Benefits*. By making mental health and SUD services, including behavioral health treatment, one of 10 EHBs these services must be covered by qualified health plans, with the exception of grandfathered individual and small group plans. This provision will greatly expand access to coverage for youth and young adults who were previously unable to obtain treatment due to lack of insurance coverage.

2. ***Mental Health and Substance Use Disorder Treatment Parity.*** Parity means that benefits for mental health and SUDs cannot be treated differently from benefits for other medical services. While MHPAEA does not require coverage of these services, ACA does. Therefore, together ACA and MHPAEA ensure benefits and parity for mental health and SUD services covered by qualified health plans. However, state differences in coverage of mental health and substance use disorder benefits will need close monitoring.⁹
3. ***Mental Health and Substance Use Disorders as Chronic Disease.*** Identification as chronic conditions assures that the full spectrum of services available for the prevention, identification, treatment, and ongoing management of other chronic illnesses, such as diabetes, will be available to individuals at risk of, with early signs of, or diagnosed with a mental health or substance use disorder. This is critical for SUDs which have been treated as acute illnesses with limited coverage for inpatient or outpatient services, without coverage for early intervention or long term management, which has been demonstrated to yield the best recovery outcomes.¹⁰
4. ***Prohibition of Denial of Coverage for Pre-Existing Conditions.*** Individuals can no longer be denied coverage because of pre-existing mental health or substance use disorders. Consequently, more people may be willing to use their insurance to seek treatment for mental health or substance use concerns since they will not be risking potential loss of coverage.
5. ***Screening and Prevention Services.*** As with any progressive, chronic illness, prevention and early intervention can make the difference between high cost intensive treatment in response to a crisis and low cost problem reduction before the disease progresses. ACA includes new benefits for screening and prevention services, such as depression screening. Support for school-based health centers includes prevention and early intervention services. Ideally, medical practitioners, who will be able to bill for screening and prevention services, will implement evidence-based brief interventions for substance use disorders, such as Screening, Brief Intervention, Referral, and Treatment (SBIRT) and Motivational Interviewing (MI), which have demonstrated success in changing behavior.^{11,12}
6. ***Impact on Quality of Care and Evidence-Based Practice.*** ACA includes incentives and provisions



to improve quality of care and outcomes. Measures to reward quality include financial incentives for 1) improved health outcomes resulting from quality reporting, 2) implementation of best practices and evidence-based medicine, 3) reduction of health disparities, and 4) the risk of non-payment for hospital readmissions associated with the treated condition within 30 days of discharge. Although risk of non-payment is specified for hospital re-admissions, it remains to be seen how these incentives may be applied to intermediate care residential treatment.

ANTICIPATED TREATMENT ACCESS ISSUES

Although ACA establishes conditions of coverage and supports for implementation, access to SUD services may, at least initially, be seriously hampered by untrained medical personnel and insufficient treatment providers.

Physicians and other medical staff rarely receive training in SUDs. Despite requirements, they may be unskilled in screening, or unprepared to follow up on positive findings. ACA includes resources for training and integrating medical and behavioral health provider practices, but it will take time for practitioners to adopt changes successfully.

SUD services are already stretched to capacity, even without the influx of individuals representing the unmet need for services. Long waiting lists often exist for detoxification and treatment, and rural and underserved areas often have no services available nearby. In addition to support for provider training, ACA incentivizes referral to effective specialty providers. The broader availability of insurance benefits for these services may promote their increased availability.

There is some concern that SUD treatment providers may elect to operate as private pay only. ACA includes

incentives for enhanced reimbursement based on quality of care, but also has increased electronic health record (EHR) and reporting requirements that present cost concerns for providers. Challenges with uptake of EHRs and concerns about confidentiality and protection of patient data also cloud the issue of how treatment providers will respond. The success of early identification and treatment referral will depend on sufficient availability of specialty providers who take insurance.

CONCLUSION

For transition-aged youth with co-occurring disorders, ACA provides the means to obtain screening, early intervention, treatment at the appropriate levels of care relative to level of illness, quality care, care coordination, and long term disease management. Together, these factors offer the promise of early intervention before substance use disorders progress to life threatening levels; effective treatment; and ongoing medical and behavioral supports to increase successful long term recovery.

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DATA TRENDS

DISPARITIES IN TREATMENT FOR SUBSTANCE USE DISORDERS AND CO- OCCURRING DISORDERS IN ETHNIC/ RACIAL MINORITY YOUTH

SOURCE

Alegria, M., Carson, N. J., Goncalves, M., & Keefe, K. (2011). Disparities in treatment for substance use disorders and co-occurring disorders for ethnic/ racial minority youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 50(1), 22-31.

Youth who have substance use disorders (SUD) and co-occurring disorders (COD) experience increased difficulty reaching educational, employment, and social goals. Yet some populations experience disparities – differences, such as socio-economic status (SES) or insurance, that cannot be justified by health conditions or treatment preferences – in seeking care for these conditions. For example, it has been demonstrated that ethnic and racial minority youth experience disparities in access to needed SUD/ COD treatment and in overall quality of treatment compared to non-Hispanic White youth.¹ Such disparities may be a result of a number of issues, including health care policies and procedures; how referral and treatment organizations are structured; availability of providers; a lack of culturally appropriate treatment; and historical discrimination against ethnic and racial minority members. This study reviewed literature on racial/ ethnic disparities in behavioral health services for youth in the United States.

METHOD

Alegria and colleagues searched the literature for studies that directly addressed racial/ ethnic differences in behavioral health services for children or adolescents. Literature search sources included PubMed, PsychInfo, Center for Substance Abuse Research, The National Survey on Drug Use and Health, and the National Institute on Drug Abuse-funded Monitoring the Future. Search terms used were: substance use disorders, health services, adolescence, health disparities, ethnicity, poverty, and service disparities. The literature was organized under six categories: 1) federal and economic health care policies and regulations; 2) operation of health care and school-based systems and provider organizations; 3) provider level factors; 4) the environmental context including social and economic forces; 5) the operation of the community system; and 6) patient level factors.

RESULTS

Compared to non-Hispanic Whites, African American adolescents with SUD report seeing specialists less often and also report receiving less

A shortage of healthcare providers is four times as likely in communities with high proportions of African American and Hispanic persons regardless of community income.



Youth in need of care are less likely to be identified for treatment when they live in communities with higher proportions of single-parent families, and higher proportions of racial/ ethnic minority residents.

informal care (i.e., care from family members or other non-professionals) for SUD and COD and Latinos with SUD report fewer informal services for SUD and COD. The authors note many factors and processes leading to these disparities.

Federal and Economic Health Care Policies and Regulations: More than 60% of uninsured children are African American or Hispanic and three fourths of the uninsured are eligible for Medicaid or the State Children's Health Insurance Program (SCHIP). The authors note that since SCHIP increases access to SUD and COD services for minority youth, state and federal health care policies that restrict access to this program may result in healthcare access disparities. Determining ways to increase enrollment in SCHIP among racial/ ethnic children can result in a reduction in racial/ ethnic disparities in meeting behavioral health needs.

Operation of Health Care and School-based Systems and Provider Organizations: Overall, research has found that racial/ ethnic minority youth with behavioral health needs are under-identified by schools although the results of studies vary in terms of whether teachers differ in referral to treatment. Racial/ ethnic minority members also tend to receive less intensive COD treatment when behavioral challenges are indicated, which can result in lower quality of services. It may be that clinicians misidentify treatment need for some subpopulations.

Provider Level Factors: A shortage of healthcare providers is four times as likely in communities with high proportions of African American and Hispanic persons regardless of community income. Additionally, the authors found that unavailability of multilingual provid-

ers for diverse communities can lead to misinterpretations of needs and SUD and COD conditions, resulting in low treatment retention. The authors also note that provider attitudes that do not consider social contexts of marginalization, discrimination, and poverty can lead to misinterpretation of difficulties in treatment engagement and will likely result in low quality care.

The Environmental Context, including Social and Economic Forces: Youth in need of care are less likely to be identified for treatment when they live in communities with higher proportions of single-parent families, increased rates of drug-related arrests, and higher proportions of racial/ ethnic minority residents. Youth are more likely to be identified as being in need when they live in communities with higher average income, greater proportion of persons who graduated from high school, and greater concentrations of treatment facilities. The review found that American Indians and Alaska Natives are particularly underserved with regard to behavioral healthcare.

The Operation of the Community System: The authors found that healthcare disparities were affected by family, friends and the lay sectors within the community. Long-standing barriers to care for communities of color may have led families to develop a tolerance of suffering and formal care may not be sought until children exhibit pronounced difficulties. Fear of coercive treatment based on historical events and collective memory, may be another barrier. A provider's lack of consideration of cultural values, and assessment models that are insensitive to culturally-specific issues may lead to family dissatisfaction with treatment. When parents contend with multiple stressors and competing

demands, ability to support engagement in treatment is limited. Low healthcare literacy may also result in underuse of insurance benefits and poor understanding of treatment protocols, which may lead to lower adherence to treatment plans.

Patient Level Factors: Racial/ ethnic minority youth may prefer individual treatment over group services as increased privacy offers safety for self-disclosure and avoidance of stereotyping. Formal measures for assessing behavioral health conditions may require further validation among various racial/ ethnic groups in order to improve accuracy of need detection. While up to 80% of youth in substance abuse treatment have comorbid mental disorders, different racial/ ethnic subpopulations exhibit different patterns of co-morbidity. The review found that African American, Hispanic, and mixed-race youth are more likely than White youth to have internalizing conditions such as depression and posttraumatic stress disorders. African American and American Indian/ Alaskan Native youth are less likely than their White counterparts to have externalizing problems such as conduct issues or both internalizing and externalizing problems. These different patterns influence use of services, which may not be designed with these variations in mind.

CONCLUSION

The authors conclude that barriers to quality SUD and COD treatment are significant issues for racial/ ethnic minority youth. Disparities could be reduced by adoption of state policies that increase insurance eligibility; increase screening in communities with higher rates of diversity and/ or lower SES; target provider attitudes regarding the social context of discrimination and poverty; and address health literacy. Addressing direct

service issues would require culturally appropriate screenings and treatment adaptations that take into consideration the social and behavioral characteristics of various populations as well as factors that influence health behaviors. Culturally validated measures of treatment need would include variables related to discrimination, ethnic orientation, ethnic mistrust, acculturation, and acculturative stress. Providing care in the native language of patients and addressing parental beliefs regarding needs and services could increase treatment engagement. Some families may fear discrimination, inappropriate care and/ or treatment coercion and turn to self-reliance instead of more formal care, while others may be contending with highly demanding lives that limit ability to support treatment engagement. Further research should focus on how youth and families are dissuaded from service use. Communities that face social exclusion should not have to depend solely on self-reliance and informal help, but should instead be offered competent care for their youth.

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