PARTNERING WITH MENTAL HEALTH: BUILDING AN INTEGRATED YOUTH SYSTEM OF CARE

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Average Past Month Use
by 12 to 17 Years Old, 2013/2014

- Non-Medical Marijuana States: 5.99%
- Medical Marijuana States: 8.52%
- Recreational/Medical Marijuana States: 11.31%
Average Past Month Use by 18 to 25 Years Old, 2013/2014

- Non-Medical Marijuana States: 16.43%
- Medical Marijuana States: 22.54%
- Recreational/Medical Marijuana States: 27.86%

RMHIDTA, 2016
Colorado High School Students’ Lifetime Marijuana Use, 2013

With few exceptions, regions with lowest rates of use have fewest medical marijuana centers (total 168). Regions with highest rates of use have most medical marijuana centers (total 327).

Sources: 2013 Colorado Healthy Kids Survey; Colorado Department of Revenue, MED Licensed Medical Marijuana Centers.
ADDITION: DOES AGE AT FIRST USE MATTER?

• 9% percent of people who try marijuana become addicted

• 17% of youth who begin marijuana use before age 18 become addicted

• Daily users before age 17 have increased risk of later dependence and use of other drugs

NIDA, 2014; Silins, et al., 2014.
THE IMPLEMENTATION PROCESS

- Determining the system integration model
- Defining the delivery system
- Defining the core tasks of youth integration
- Developing unified documentation and tools
  - Unified screening tool
  - Unified ASAM assessment
- Defining a comprehensive training program
- Piloting the project
- Defining outcomes to measure client improved client functioning and quality of care
THE INTEGRATION MODEL PROCESS: WHAT WERE OUR CORE VALUES?

– The lens of our consumers: Is this framework client-focused?
– Will this result in better outcomes for our consumers?

The two questions we asked with every model:
– “Is this culturally competent?”
– “How will this benefit our clients?”
BEHAVIORAL HEALTH INTEGRATION DELIVERY SYSTEM DESIGN

Hybrid Approach

Adopting of the best elements of both models

Comprehensive, Continuous, Integrated System of Care (CCISC)
Minkoff and Cline 2004, 2005

SAMHSA Evidence-Based Treatment Kit
Substance Abuse Mental Health Services Administration

SAMHSA Evidence-Based Treatment Kit
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Act
Plan
Do
Study
COMMON ELEMENTS OF THE TWO MODELS

- No Wrong Door
- Client Driven- The client and his/her needs are the primary concern in treatment, which is aligned with the ASAM
- Co-occurring needs are the norm not the exception
- One individualized treatment plan which is client- focused and client- driven
- There is limited research on what model is the “best” integration model, each model allows the flexible inclusion of EBPs and cultural competencies.

MODEL DIFFERENCES

- Staff trainings and competencies in addressing dual diagnosis issues
  - The EBP Kit includes an integrated specialist,
  - Behavioral Health Homes utilize interdisciplinary teams and
  - CCIS trains all staff in core competencies.
THE HYBRID MODEL DESIGN

• Some sites may offer specialty Substance Use only or Mental Health only services.
• Other sites may offer both specialty services at the same site.
• All sites will be capable of assessing Co-Occurring Disorders.
• Each program works with a specific cohort of co-occurring disorder needs. All sites can provide basic COD services, but clients may need to be transferred to another site that has more specialized services to meet their needs.
6 INTEGRATION LEVELS: SAMHSA-HRSA

Level 1 – *Minimal Collaboration*: Providers work in separate facilities, have separate systems, and rarely communicate about cases.

Level 2 – *Basic Collaboration at a Distance*: Providers have separate systems at separate sites, but engage in periodic communication about shared patients. Providers view each other as resources.

Level 3 – *Basic Collaboration Onsite*: Professionals have separate systems, but share facilities. Proximity supports at least occasional face-to-face meetings and communication improves and is more regular.

Level 4 – *Close Collaboration in a Partly Integrated System*: Providers share the same site and have the same system in common such as scheduling or charting. There are regular face-to-face interactions among primary care and behavioral health providers, coordinated treatment plans for difficult patients, and a basic understanding of each other’s roles and cultures.

Level 5 – *Close collaboration in a Fully Integrated System*: Professionals share the same sites, vision, and systems. All providers are on the same team and have developed an in-depth understanding of each other’s roles and areas of expertise.
INTEGRATION GUIDING PRINCIPLES AND VALUES FOR THE YOUTH SYSTEM OF CARE

INTEGRATION VALUES:
- Improved client experience
- Ongoing quality improvement
- Reduce redundancies and increase efficiency

GUIDING PRINCIPLES:
- Development across the life span
- Acuity/Intensity (Level of Care)
- Clinical competency

TRIPLE AIM:
- Improved patient experience
- Improved health of populations
- Decreased per capita costs
YOUTH SYSTEM OF CARE WORK GROUP ACTIVITIES/MILESTONES

**Inventory of Programs**
- Describe F&C programs and services in MHD/SUTS
- Mapping of programs
- Identify gaps in services/programs
- Identify EBPs and PPs (MHD Level of Care work group)

**Screening and Assessment**
- Review, examine and evaluate assessment and screening tools
- Examine whether to adopt existing tools or create SCC version of screening and assessment tool
- Joint QI review of tools
- Recommendation of tools to steering committee

**Welcome and Access to Services (Call Center)**
- Describe Call Center functions for F&C (MHD/DADS)
- Review screening and assignment process
- Discuss points of convergence and divergence
- Identify technology and staffing needs

**Training**
- What are the core competencies needed to work in an integrated care model?
- Develop job description for dual diagnosis/co-occurring treatment provider
- What core trainings and elective trainings are needed to develop providers who can work in an integrated care model?

**Outcomes and Evaluation**
- How will we know we have improved outcomes for clients
- Identify outcomes and indicators
- Review and examine outcome and assessment tools
CONTINUUM OF CARE – DEVELOPMENTAL PERSPECTIVE

Child Needs & Concerns

Promotion

Prevention

Early Intervention

Intervention

Community/Social Systems

Family

School

Child

Childhood

Prenatal; Birth - Five

School-Age Children

Adolescents

Transition Age Youth – Young Adults
MENTAL HEALTH & DRUG USE

Mood & Anxiety Disorders Among Respondents with Marijuana Dependence (NESARC)

- Any Mood Disorder: 61%
- Any Anxiety Disorder: 20%
- Depression: 49%
- Dysthymia: 47%
- Mania: 20%
- Hypomania: 4%
- Panic w/ Agoraphobia: 24%
- Panic w/o Agoraphobia: 3%
- Social Phobia: 10%
- Specific Phobia: 9%
- Generalized Anxiety: 5%
THE REFERRAL AND TREATMENT FRAMEWORK: THE 6 QUADRANT MODEL
CONTINUUM OF CARE: PRIMARY MENTAL HEALTH

Least Intensive

- Prevention and Early Intervention
- School Linked Services

Outpatient
- General
- Ethnic Specific
- KidConnections Network (Birth-Five)

Intensive Outpatient (IOP)

Katie A Services *

Full Service Partnership Child/TAY

Wraparound *

Residential Treatment *

Most Intensive

TBS Therapeutic Behavioral Services
Includes Intellectually Disability
CONTINUUM OF CARE: PRIMARY SUBSTANCE USE

Least Intensive

Early Intervention

Outpatient School Treatment Services

Outpatient Clinic Treatment Services

Intensive Outpatient

Residential Treatment

Most Intensive

Recovery Services
CONTINUUM OF CARE: INTEGRATED TREATMENT

- Least Intensive
  - Early Intervention
  - Outpatient School Treatment Services
  - Outpatient Clinic Treatment Services
  - Intensive Outpatient*
  - Residential Treatment*

- Most Intensive
  - Recovery Services
COORDINATION WITH MENTAL HEALTH

• Referrals are based on the Referral and Treatment Framework
  – The screening tool
  – Unified assessment with an ASAM framework
• Mental Health’s four co-occurring disorder providers: Building SUD competency
  – Clinical provider meeting attendance
    • Training: Calibrating the ASAM and Level of Care
    • Service coordination- building processes
    • Case consultation
  – Joint chart review during initiation of services
PILOTING INTEGRATION

- Juvenile Hall Integration
  - Pilot tested Integrated Screening Tool
  - Pilot tested Integrated Assessment Tool

- Four Mental Health COD Treatment System Providers

Target Population
- Youth Ages 6-18 with Full Scope Medi-Cal or Drug Medi-Cal
- Youth can be served in home, at school, in clinic or community
- Treatment of co-occurring mental health (low, moderate to high severity) and (low severity) substance use disorders

Parameters
- 4.5 hours of service per month
- Average of 8 months length of stay
INTEGRATED TREATMENT

SUD Providers

Target Population
- Youth and TAY up to age 25 with DMC
- Service provided in the home, school or community
- Treatment of co-occurring mental health (low, moderate severity) and substance use disorders (low to high severity)

Parameters
- Up to 24 hours per month
- Average 6 month LOS
DEVELOPING INTEGRATED TOOLS

- Unified Screening Tool – Trauma, Mental Health and Substance Use
  - AC-OK
  - SB2I with Mental Health questions

- Unified, Integrated Assessment
  - Inclusion of Title 9 Specialty Mental Health and Title 22 Drug Medi-Cal Substance Abuse Services requirements
  - Inclusion of American Society of Addiction Medicine (ASAM) Criteria
  - Leaving out the kitchen sink
UNIFIED SCREENING TOOL – TRAUMA, MENTAL HEALTH AND SUBSTANCE

• TOOLS WE ANALYZED
  – CRAFFT
  – CAGE
  – AC-OK
  – AST (Alaska Screening Tool)
  – COJAC
  – GAINS short screener
AC-OK-COD ADOLESCENT SCREEN

Gender: _____ Age: ______________ Last grade completed____________

During the past year have you:
1. Felt really sad, lonely, hopeless; stopped enjoying things, wanted to eat more or less, had problems sleeping, or doing what you need to at home or at school? Yes No
2. Heard voices or seen things that others don't hear or see? Yes No
3. Drink alcohol or used other drugs more than you meant to? Yes No
4. Burned or cut yourself? Yes No
5. Have you experienced a very bad thing happen (a traumatic event) where you continue to feel scared, worried, or nervous or even had nightmares that bothered you after it was all over? Yes No
6. Tried to stop drinking alcohol or using other drugs, but couldn't? Yes No
7. Been prescribed medication for your feelings? Yes No
8. Got in trouble with the law, school, or parents, or lost friends because of your drinking alcohol or using other drugs, and continued to use? Yes No
9. Drank alcohol or used other drugs to change the way you feel? Yes No
10. Had thoughts about hurting yourself or wanting to die? Yes No
11. Tried to kill yourself? Yes No
12. Have you ever been afraid of your parent, caretaker or a family member? Yes No
13. Have you ever been hit, slapped, kicked, touched in a bad way, cursed at, yelled at or threatened by someone? Yes No
14. Changed your friends or planned your free time to include drinking alcohol or using other drugs? Yes No
15. Needed to drink more alcohol or use more drugs to get the same buzz or high as when you first started using? Yes No
AC-OK SCORING

**Scoring:** Remember, one (1) “Yes” answer on any of the three (3) domains (Substance Abuse, Mental Health, and Trauma) indicates that an additional assessment(s) is needed in that domain.

Substance Abuse: 3, 6, 8, 9, 14, 15
Mental Health: 1, 2, 4, 7, 10, 11,
Trauma 5, 12, 13
CRAFT- AMERICAN ACADEMY OF PEDIATRICS, 2011

During the past 12 months, did you:
  – Drink any alcohol (more than a few sips)?
  – Smoke any marijuana or hashish?
  – Use anything else to get high?

YES TO ANY-

Have you ever ridden in a CAR driven by someone who was high or had used alcohol or drugs?

Do you ever use to RELAX, feel better about yourself or fit in?

Do you ever use alcohol or drugs ALONE?

Do you ever FORGET things you did while using?

Do your family or FRIENDS ever tell you you should cut down?

Have you ever gotten in TROUBLE while you were using?
In the past year, how many times have you used tobacco?
- never
- once or twice
- monthly
- weekly or more

Alcohol?
- never
- once or twice
- monthly
- weekly or more

Marijuana?
- never
- once or twice
- monthly
- weekly or more

STOP if answers to previous questions are “never.” Otherwise continue-
In the past year, how many times have you used...

Prescription drugs that were not prescribed for you (like pain meds or Adderall)?
- never
- once or twice
- monthly
- weekly or more

Illegal drugs (such as cocaine or Ecstasy)?
- never
- once or twice
- monthly
- weekly or more

Inhalants (like nitrous oxide)?
- never
- once or twice
- monthly
- weekly or more

Herbs or synthetic drugs (such as salvia, K2 or bath salts)?
- never
- once or twice
- monthly
- weekly or more
THE IMPORTANCE OF SHINING A LIGHT ON TRAUMA

- Teens who experience physical or sexual abuse are three times more likely to report substance use than those without a trauma history.
- Up to 59% of youth with PTSD subsequently develop substance abuse issues.
- By age 17, 40% of youth have been exposed to family violence
- More than 70% of teens in treatment report a history of trauma.
- Youth of color are more likely to experience violence than their white counterparts (42.1 per 1,000 in the population versus 46.1)
A UNIFIED YOUTH ASSESSMENT TOOL

Why use the ASAM framework?
• It covers all the required elements for Title 22 and Title 9
• It’s comprehensive
• It’s required in the 1115 Waiver
• A youth can be served in both systems without having to be re-assessed within a year
  • It’s customer friendly
  • It frees staff for more face-to-face work with clients
  • It allows work to begin more quickly when there is a referral
# ASAM: The 6 Dimensions of Multidimensional Assessment

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<th>Acute Intoxication and/or Withdrawal Potential</th>
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BIO-PSYCHO-SOCIAL ASSESSMENT:

DIMENSION 4 – READINESS TO CHANGE - MENTAL HEALTH AND SUBSTANCE USE

Dimension 4 looks at issue-specific

- Motivation
- Stage of change on the continuum
- Resistance to treatment
DIMENSION 5 – RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

Relapse triggers - objects and situations  
Difficulty dealing with negative emotions  
Chronic stress  
Psychosocial difficulties  
Difficulty coping with cravings  
Coping skills  
Medication compliance
INTEGRATED TREATMENT TRAINING PLAN BUILDING A COMPETENT DUAL DIAGNOSIS WORKFORCE

- Clinical Provider Meeting
- Integrated Treatment Training Plan
  - Co-Occurring Capable Training
  - Co-Occurring Enhanced Training
OPPORTUNITIES FOR SYSTEMS CHANGE

• Title 9 Specialty Mental Health Services & Title 22 Drug Medi-Cal Substance Abuse Services
• Funding streams and client-centered treatment
• Forms and policy/procedures/protocols
• Change management
• 42CFR and sharing information
• Developing competency
• Developing communication habits and patterns
Comments & Questions