THE INTEGRATED CO-OCCURRING TREATMENT (ICT) MODEL: AN INNOVATIVE APPROACH TO TREATING YOUTH WITH CO-OCCURRING DISORDERS

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March 23, 2015
Co-Occurring Disorders

- The term “co-occurring” describes two or more disorders or illnesses occurring in the same person.
- Co-occurring disorders also implies interactions between the illnesses that can worsen the course of both (NIDA).
- Each disorder can be established independent of the other and is not simply a cluster of symptoms resulting from [a single] disorder”. (CSAT, 2005)
Youth with Co-Occurring Disorders: Problems are Multiple and Complex

- Multiple problems (5+) are the norm (Dennis, 2005)
- 2/3 of youth and adults seeking substance use treatment also had a co-occurring mental health condition (Chan, Dennis, & Funk, 2008)
- Trauma and victimization in 62 to 80% of youth (Dennis; Hussey)
- Treatment engagement and retention are difficult, and intervention outcomes tend to be poor, (Hawkins, 2009, p.206).
- Gender: higher rates of internalizing disorders and trauma with adolescent girls, and higher rates of externalizing disorders and juvenile justice involvement with adolescent boys
Influence, Interaction, and Manifestation of Multiple Occurring Conditions

- Contexts (Home, School, Peers, Community, etc.)
- Substance Use Disorder
- Mental Health Disorder
- Trauma Factors
- Risk & Resiliency Factors
- Developmental Factors
- Safety Concerns
- Salient Behavior/Symptom

Youth
Family
**Integrated Co-Occurring Treatment**

- ICT utilizes an integrated treatment approach, embedded in an intensive home-based method of service delivery, to provide a set of core services to youth with co-occurring disorders of substance use and serious emotional disability and their families.

- Addresses the reciprocal interaction of how each disorder affects the other, in context of the youth’s family, culture, peers, school, and greater community

- Prioritizes saliency and immediacy of need which may fluctuate from session to session
Core Assumptions

1. Youth with COD often present as complex sets of externalizing, internalizing & substance use symptom patterns and vary in their nature, onset, presentation, interaction and severity; even among youth with similar diagnoses

2. The onset, progression & trajectory of co-occurring disorders is influenced by developmental variables including youth resiliency & risk and protective factors

3. Symptoms and behaviors manifest in, and are influenced by, multiple cultural contexts including home, school and community factors

4. Traumatic stress experiences contribute to impaired emotional and behavioral functioning and to the adoption of risk behaviors, which in turn may lead to further exposure to victimization, violence, and trauma experiences.

5. The stressors associated with co-occurring disorders have a dramatic impact on a youth and family’s resources (emotional, interpersonal, material)

6. Safety concerns and risk behaviors are elevated and need to be actively managed.
ICT Model Components

- Culturally Mindful Engagement and Family Partnerships
  - Intensive Home-Based Service Delivery Modality
  - Multidimensional and Integrated Assessment and Conceptualization
  - Comprehensive and Integrated Treatment Array Matched to Needs and Strengths
  - Cross-System Partnerships and Supports

- Resiliency-Oriented Developmental Perspective
<table>
<thead>
<tr>
<th>Intensive Home-Based Service Delivery Model</th>
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<tr>
<td><strong>Location of Service</strong></td>
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</table>
| **Intensity** | Frequency: 2 to 5 sessions per week  
Duration: 4 to 8 hours per week |
| **Crisis response & availability; active safety planning and monitoring** | 24/7 |
| **Active safety planning & monitoring** | Ongoing |
| **Small caseloads** | 4 to 6 families per FTE; 8 to 12 for team of two |
| **Flexible scheduling** | Convenient to family |
| **Treatment duration** | 3 to 6 months |
| **Systemic engagement and community teaming** | Child and family teaming; skillful advocacy; family partnering; culturally mindful engagement |
| **Active clinical supervision & oversight** | 24/7 availability; field support; individual & group |
| **Program structure and credentials** | Licensed BSW and above; MA preferred  
Program size: 4 to 8; .5 to 1 FTE IHBT Supervisor |
| **Comprehensive service array** | Crisis stabilization, safety planning, skill building, trauma-focused, family-focused; resiliency & support-building interventions; cognitive interventions |
Integrated Assessment and Treatment
Multidimensional and Integrated Contextual Assessment

I. Symptom Patterns and Diagnoses: youth who meet the criteria for both Mental Health and Substance Use diagnoses

II. Contextual Functioning: Degree of functional impairment per life domain

III. Developmental and Cognitive Functioning: (cognitive functioning, emotional & behavioral maturity)

IV. Risk and Recovery Environments: Environmental risk and recovery conditions (e.g. trauma, safety, negative influences, family conflict, poverty)

The youth’s functioning and COD patterns are determined by integrating these areas in context of the other and as a collective whole.
Contextual Assessment

School + -

Peers + -

Family + -

Youth + -

Informal Supports + -

Community + -

Work + -

+ = Protective Factors
- = Risk Factors
Resource Framework

Conservation of Resources Theory
(Stevan Hobfoll)

- First, act to prevent or limit resource loss

- Begin initiation of resource building interventions once there is reasonable stability

- Target resources not (just) illness: “target ... the resources and conditions that facilitate healthy functioning.”
ICT Treatment Foci

Build Protective Factors: Pro-Social Recovery Environments, Asset Building, Supports

Establish Positive Connections & Functional Success through Relational Supports and Strategic Accommodations

Solidify Structure, Supervision, & Monitoring

Build Adaptive Skills & Emotional Coping Across Settings; Psycho-education

Engagement; Readiness to Change

Resiliency & Recovery

Safety, Stabilization, Risk & Symptom Reduction

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Youth and Family Need Hierarchy (Shepler, 1991, 1999)
Target Outcomes

- Living at home or in a permanent home setting
- Attending and achieving at school/work
- Reduced involvement in the JJ system
- Reduced use/no use of substances
- Reduced mental health symptoms
- Participating in positive family, peer, and community life
- Accessing resources and natural supports as needed to maintain gains and prevent recidivism
Dually certified agency; dually licensed supervisor

2 to 4 FTE clinical staff either dually licensed or dually trained, with mix of SU and MH expertise on the team

Consultation, training, and technical support:
- Initial core training and ongoing booster trainings
- Provide weekly consultation and coaching of ICT Team

Years 3+:
- ICT Supervisor Monitors Fidelity
- Consultation negotiated based on need
- Yearly fidelity review

ICT is typically funded through a combination of Medicaid, insurance, and cross-system funding.
Lessons Learned

- For integration to be effective, needs to occur at the policy, funding, and treatment levels
  - Resolve infrastructure issues prior to implementation (integrated funding and paperwork requirements)

- Collaboration with key system partners is essential (especially Courts & Schools)

- Education of referral sources about prevalence of youth with co-occurring disorders and need for integrated treatment

- Intensive clinical supports are needed to help manage risk and safety (active safety planning and monitoring, and 24-hour on-call availability)

- Ongoing treatment and supports may be needed
Realistic Outcomes and Expectations

- Think trajectory of wellness not cure
- Chronic relapsing disorder, requiring multiple treatment attempts over time (White and Dennis)
- Williams and Chang (2000) found that the average rate of sustained abstinence after treatment, across 53 adolescent substance use treatment outcome studies, was 38% at 6 months and 32% at 12-months.
- Tomlinson et al (2004) abstinence at 6 months: 26% in SUD-only group; 13% in SUD and Psychiatric Disorder group
- Measure what you do: risk reduction across life domains
  - Track multiple outcomes
- Conversation with key stakeholders about realistic outcome expectations
Phase One
Initial Model Development: U. of Akron, 1999
Expert panel; focus groups; youth and family

Phase Two
Pilot Implementation: 2001-2005
Model refinement; small comparison study

Phase Three
Multiple Site Implementation: 2005-Present (9 active sites currently)
Initial research study: 2005-2008
Model refinement

Phase Four: Increase Research Support
ICT Comparison Study

- Real world study: Utilized naturally occurring comparison groups from a specialized co-occurring court
  - Due to ethical concerns, randomization into groups was not allowed

- All youth received the co-occurring court’s intensive probation program

- Compared ICT to traditional non-integrated services (TAU)

- ICT group had significantly more problems at admission than TAU group

## Positive Results: Improvement Over Time

### All Youth Considered Together
- Substance use variables (GRAD; Drug Screens)
- Mental health variables: (Ohio Scales; GRAD)
- Family/Parenting (GRAD)
- Pro-Social Activities (GRAD)
- Educational Functioning (GRAD)

### ICT Did Better than TAU
- Substance Use Variables (GRAD; Drug Screens)
- Mental Health Problem Severity: (GRAD only)
- Pro-Social Activities (GRAD)
- Pro-Social Peers (GRAD-Parent Rating)
- Family/Parenting (GRAD-Youth Rating)
ICT showed a significant decrease in substance use, as measured by the GRAD Substance Use/Abuse Scale, as compared to TAU (p < 0.001)
ICT showed a significant decrease in mental health problem severity, as measured by the GRAD Personality/Behavior Scale, compared to TAU (p < 0.014)
ICT: Preliminary Data (July 2009- June 2013)

- Examined data for COD youth from the Behavioral Health/Juvenile Justice program (BHJJ)
- Used data from Summit County (Akron, OH).
- Compared COD youth who received ICT to COD youth who received TF-CBT
## ICT: Preliminary Data (2009-2013)

<table>
<thead>
<tr>
<th></th>
<th>ICT (n = 29)</th>
<th>TF-CBT (n = 83)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Male</td>
<td>72%</td>
<td>77%</td>
</tr>
<tr>
<td>% White</td>
<td>48%</td>
<td>25%</td>
</tr>
<tr>
<td>Age</td>
<td>16.3</td>
<td>15.4</td>
</tr>
<tr>
<td>Ever talked about suicide</td>
<td>31%</td>
<td>22%</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>14%</td>
<td>5%</td>
</tr>
<tr>
<td>Age first use (alcohol)</td>
<td>13.2</td>
<td>12.9</td>
</tr>
<tr>
<td>Age first use (marijuana)</td>
<td>12.3</td>
<td>12.7</td>
</tr>
</tbody>
</table>
## ICT: Preliminary Data (2009-2013)

<table>
<thead>
<tr>
<th>Measure</th>
<th>ICT</th>
<th>TF-CBT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past 30 day alcohol use (Intake)</td>
<td>1.5 days</td>
<td>.8 days</td>
</tr>
<tr>
<td>Past 30 day alcohol use (Term)</td>
<td>1.0 days</td>
<td>.4 days</td>
</tr>
<tr>
<td>Past 30 day marijuana use (Intake)</td>
<td>5.6 days</td>
<td>4.1 days</td>
</tr>
<tr>
<td>Past 30 day marijuana use (Term)</td>
<td>4.0 days</td>
<td>2.1 days</td>
</tr>
<tr>
<td>Problems related to alcohol/drugs (OH Scales - W) (Intake) (0-5)</td>
<td>2.2</td>
<td>1.2</td>
</tr>
<tr>
<td>Problems related to alcohol/drugs (OH Scales - W) (Term) (0-5)</td>
<td>1.2</td>
<td>.8</td>
</tr>
</tbody>
</table>
ICT: Preliminary Data (2009-2013)

Ohio Scales Functioning

- Score
- Intake
- Termination
- ICT
- TF-CBT
ICT: Preliminary Data (2009-2013)

Ohio Scales Problem Severity

Score

Intake

Termination

ICT

TF-CBT
ICT: Preliminary Data (2009-2013)

TSCC: Anger

<table>
<thead>
<tr>
<th>Score</th>
<th>Intake</th>
<th>Termination</th>
</tr>
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<tbody>
<tr>
<td>ICT</td>
<td></td>
<td></td>
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<tr>
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<td></td>
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</tbody>
</table>
ICT: Preliminary Data (2009-2013)

TSCC: PTS

Intake Termination

Score

ICT
TF-CBT
ICT: Preliminary Data (2009-2013)

TSCC: Depression

Score

Intake         Termination

ICT

TF-CBT
## ICT: Preliminary Data (2009-2013)

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<thead>
<tr>
<th></th>
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<th>TF-CBT</th>
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<tbody>
<tr>
<td>Attending school more than before treatment</td>
<td>50%</td>
<td>38.5%</td>
</tr>
<tr>
<td>Suspended or expelled (Intake)</td>
<td>64%</td>
<td>68%</td>
</tr>
<tr>
<td>Suspended or expelled (Term)</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>Want to kill myself (Intake)</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Want to kill myself (Term)</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Want to hurt myself (Intake)</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>Want to hurt myself (Term)</td>
<td>5%</td>
<td>11%</td>
</tr>
<tr>
<td></td>
<td>ICT</td>
<td>TF-CBT</td>
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<tr>
<td>--------------------------------</td>
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</tr>
<tr>
<td>Misdemeanor 12 months after Intake</td>
<td>65%</td>
<td>74%</td>
</tr>
<tr>
<td>Felony 12 months after Intake</td>
<td>35%</td>
<td>49%</td>
</tr>
<tr>
<td>Criminogenic Risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>11%</td>
<td>27%</td>
</tr>
<tr>
<td>Moderate</td>
<td>43%</td>
<td>38%</td>
</tr>
<tr>
<td>High</td>
<td>46%</td>
<td>35%</td>
</tr>
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## ICT: Preliminary Data (2009-2013)

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<th>Behavioral Health Need (Intake)</th>
<th>ICT</th>
<th>TF-CBT</th>
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<tbody>
<tr>
<td>Low</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Moderate</td>
<td>10%</td>
<td>45%</td>
</tr>
<tr>
<td>High</td>
<td>83%</td>
<td>47%</td>
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<tr>
<td>Low</td>
<td>0%</td>
<td>15%</td>
</tr>
<tr>
<td>Moderate</td>
<td>41%</td>
<td>45%</td>
</tr>
<tr>
<td>High</td>
<td>59%</td>
<td>41%</td>
</tr>
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Next Steps

- Next phase of development is to increase the research base and conduct further comparison studies of the model, including longitudinal studies to determine the sustainability and durability of the treatment results.
Resources

Briefs:

☐ Providing Effective Treatment for Youth with Co-Occurring Disorders

☐ Prevalence of Youth Drug Use, Mental Health and Co-Occurring Disorder -
  http://www.scribd.com/doc/246378645/Case-Western-Brief-1

☐ Screening and Assessment for Substance Use, Mental Health and Co-Occurring Disorders in Adolescents -

☐ Overview of Evidence-Based Promising Treatment Practices for Youth With Substance Use and Co-Occurring Disorders -
  http://www.scribd.com/doc/254697414/Case-Western-Brief-3

☐ Implementing Treatments for Youth with Co-Occurring Mental Health and Substance Use Disorders: Opportunities and Challenges -

☐ Expected Outcomes in Substance Use Disorder Treatment for Youth -
  http://www.scribd.com/doc/254014789/Case-Western-Brief-4#scribd

Websites:

☐ National Center for Juvenile Justice and Mental Health: http://www.ncmhjj.com


☐ Center for Innovative Practices: http://begun.case.edu/cip/practices/integratedtreatment
National Recognition

- **SAMHSA’s 2010 Science and Service Award**: A national program that recognizes community-based organizations and coalitions that have shown exemplary implementation of evidence-based mental health and substance abuse interventions. Given to McHenry County for its implementation of ICT for their SAMHSA SOC grant.

- **NIATx iAward (2010)** given by the State Association of Addiction Services and NIATx: Family Service and Community Mental Health Center located in McHenry County, Illinois received a 2010 iAward for Innovation in Behavioral Healthcare Services for its successful implementation of Integrated Co-Occurring Treatment (ICT).

- **Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile**: One of the programs highlighted in the National Center for Mental Health and Juvenile Justice/OJJDP monograph
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