

reclaiming our future

**A PATHWAY FOR TREATING CO-OCCURRING
MENTAL HEALTH AND SUBSTANCE USE DISORDERS
IN NEW HAMPSHIRE'S ADOLESCENTS AND YOUNG ADULTS**

**A Message from Michael Cohen, Executive Director
NAMI, New Hampshire**

I want to thank the many people who have invested considerable time, thought and energy into this report to address a critical public health issue facing New Hampshire and especially its youth and young adults and their families.

I also want to thank the Endowment for Health who recognized the need and helped fund our initial work in the area of treating adolescents with co-occurring disorders and the New Hampshire Charitable Foundation for their willingness to move the project forward to develop this report, *Reclaiming Our Future: A Pathway for Treating Co-Occurring Mental Health and Substance Use Disorders in New Hampshire's Adolescents and Young Adults.*

As the primary resource for support for families living with mental illness, NAMI-NH staff and volunteers often hear from families with adolescents and young adults who are struggling with severe emotional disorders and co-occurring substance abuse disorder. These families consistently describe difficulty in finding effective treatment for their loved ones and ongoing difficulty going from one provider to another because of the lack of access to coordinated and integrated care.

In 2003, NAMI-NH began an initiative that included the talents of nearly 50 people to improve access and treatment for adolescents and young adults with co-occurring mental health

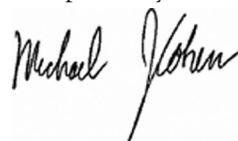
and substance use disorders. Through the award of a planning grant from the Endowment for Health, NAMI-NH convened an Advisory Council of key stakeholders from the state's mental health and substance abuse treatment fields. The Advisory Council worked to identify barriers to improving access to treatment for adolescents and young adults with co-occurring disorders. With the technical support of the Addiction Technology Transfer Center of New England and the coordinating assistance of Westbridge Community Services, NAMI-NH and the Advisory Council held a Stakeholders Conference in January 2005 to develop action items to address the barriers identified by the Advisory Council.

Through a grant from the New Hampshire Charitable Foundation, NAMI-NH was able to move forward with the project to develop a "Blueprint for Change" that provided a framework and specific action steps for addressing the barriers to treatment for co-occurring disorders in adolescents and young adults in the Granite State. A project coordinator was hired and a Project Advisory Group (PAG) was convened, comprised of individuals with broad knowledge of and proficiency in either substance abuse or mental health services and experience working with adolescents and young adults with co-occurring disorders. The PAG developed a work plan for the project and, recognizing the tremendous gains in evidence-based practices in recent years as well as the dramatic advances in our understanding of the causes

and mechanisms of mental health and substance use disorders and their treatments, recommended members to serve on a Scientific Advisory Board (SAB). The SAB was charged with developing recommendations for creating integrated treatment for adolescents and young adults living with co-occurring disorders in New Hampshire.

This report is the culmination of five years of hard work and dedication by many providers of substance abuse and mental illness treatment, policy makers, families living with a child with a co-occurring disorder, researchers, and state officials. Within the report is a description of the breadth of this problem in our state, its devastating effects upon families and the lives of adolescents and young adults, and its toll on societal resources. Most importantly, the report offers solutions and contains specific recommendations for how to address the problem, improve treatment outcomes and enhance the lives of so many young Granite Staters living with co-occurring disorders and their families. As you read the report, please keep in mind that NAMI NH is available to discuss the findings and work with you to implement the recommendations identified in the report.

Respectfully,



Michael Cohen, MA, CAGS
Executive Director

**A Message From Michael Cohen,
Executive Directori**

Executive Summary2

Facing the Challenge4

**The Prevalence of Co-occurring Disorders
in Adolescents & Young Adults6**

**Suicidality Among Adolescents
& Young Adults with Co-occurring Disorders7**

**Factors Increasing the Risk
of Developing Co-Occurring Disorders8**

**Barriers to Accessing Treatment,
Services & Community Supports9**

**A Blueprint for Change:
Recommendations for New Hampshire14**

Investing in Our Future: Changing Lives20

Works Cited22

Appendix I26

Appendix II28

Appendix III29

reclaiming our future

A PATHWAY FOR TREATING CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS IN NEW HAMPSHIRE'S ADOLESCENTS AND YOUNG ADULTS

EXECUTIVE SUMMARY

Throughout New Hampshire and across the nation our young people and their families are facing a crisis.

Nationally, 43% of youth receiving mental health services are also diagnosed with a co-occurring substance use disorder, while among adolescents entering substance use treatment 62% of males and 82% of females have a co-occurring psychiatric disorder. Here in the Granite State, the 2007 Youth Risk Behavior Survey of more than 24,000 New Hampshire high school students found that those students who reported using marijuana and alcohol were twice as likely to also report a range of disturbing moods and behaviors including depression, suicide plans and attempts, and feeling unsafe.

While the presence of co-occurring disorders among young people between the ages of 12 and 24 are well-documented, in New Hampshire, as in much of the United States, treatment systems for mental health and substance use disorders are fragmented and science-based treatments for assessing and treating

co-occurring disorders are used infrequently by providers. Mental health and substance use treatment have developed parallel and uncoordinated systems of care with different funding sources, mandates and treatments. The resulting separate practice patterns have left individuals with co-occurring disorders caught in a “no man’s land” between the two systems.

Without appropriate, integrated treatment for both disorders delivered simultaneously by one provider or team, adolescents and young adults with co-occurring disorders are more likely to have negative outcomes across the lifespan, while being “high utilizers” of societal financial and health resources. Untreated, such individuals are more likely to have frequent psychiatric hospitalizations, over-utilize emergency departments, experience homelessness, have repeated involvement with the juvenile, criminal justice and child protection systems, suffer from chronic health problems, and be unable to live independently.

In 2003, NAMI-NH (National Alliance on Mental Illness—New Hampshire) provided the leadership to undertake an initiative to improve

access and treatment for adolescents and young adults with co-occurring mental and substance use disorders. Partnering with other stakeholders including state and local officials, key state personnel, community-based treatment providers, mental health and substance abuse clinicians, and families living with such disorders, NAMI-NH developed a Project Advisory Group to lead a 5-year-long process to identify and define the problem, propose evidence-based and best practice solutions, as well as a strategy to implement broad system change supporting integrated treatment.

The full report is the culmination of this process. Contained within it is a description of the prevalence of co-occurring disorders among young Granite Staters, the challenges facing them and their families, including barriers to accessing integrated appropriate treatment and support. Drawing upon existing expertise in New Hampshire, the Project Advisory Group convened a Scientific Advisory Board (SAB) comprised of leaders in the mental health, primary care and substance abuse treatment fields to make specific recommendations for implementing consistent, integrated treatment throughout the state.

The SAB has come to consensus upon three key areas and eleven specific recommendations for developing an integrated service approach to meet the needs of adolescents and young adults with co-occurring disorders:

- I. **Establish a working conceptual framework for providers across disciplines that standardizes terminology and identifies practice resources.**

Recommendation 1 Service systems in New Hampshire access existing resources to improve cross-disciplinary communication and treatment integration identified in Appendix I of the report.

Recommendation 2 Service providers use the “Quadrants of Care” model developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) to guide treatment planning based upon symptom severity rather than diagnosis.

- II. **Identify valid screening and assessment tools and evidence-based practices proven effective for adolescents and young adults.**

Recommendation 3 Service providers utilize evidence-based screening and assessment tools such as those identified in Appendix II of the report.

Recommendation 4 Service providers employ evidence-based treatment models for adolescents and young adults such as those identified in Appendix III of the report.

Recommendation 5 Treatment is provided in the most appropriate, least restrictive setting, with progress measured not just in abstinence but also reduction or intensity of symptoms or substance use, and improved functioning.

Recommendation 6 Primary and pediatric care providers routinely screen for mental health, suicide risk and substance use problems, utilizing specific protocols for referrals to necessary treatment providers.

Recommendation 7 Assessments of adolescents and young adults should include, when appropriate, a psychiatric evaluation including determining the risk for suicide.

Recommendation 8 Service providers and systems follow established best practices to ensure access to consistent, quality treatment throughout New Hampshire.

Recommendation 9 Service systems provide ongoing support and training for providers to ensure fidelity to identified screening, evaluation and treatment models.

- III. **Develop strategies to support and assist changes in the system that would facilitate the adoption and implementation of screening, assessment and appropriate integrated treatments.**

Recommendation 10 Assign high level leadership to help initiate, coordinate and implement a plan for integrated treatment state-wide.

Recommendation 11 Develop a plan to implement integrated treatment services for adolescents and young adults with co-occurring disorders in New Hampshire.

The recommendations and action steps described in this report should serve as a guide for improving outcomes for adolescents and young adults with co-occurring disorders and their families. The development of a statewide plan for implementing integrated treatment services for these young people will help reduce the use of costly societal resources. More importantly, such integrated treatment will reduce suicidality, as well as help these young people to complete their education, develop the necessary maturation to live independently, and one day be more successful parents themselves.

While such an endeavor may seem a significant undertaking, New Hampshire’s leaders have already proven themselves up to the task of addressing critical issues facing our young people and families with efficient compassion. Effective leadership and collaborative efforts among stakeholders, families, and providers are proven methods for creating change in the Granite State. This “Blueprint for Change” can help direct such a process, intervening and diminishing the devastating effects that these co-occurring disorders have on our young people and their future.



When one of my younger, surviving sons started to have problems, trying to get him help was as hard as [it had been] with my first two sons. It was like I was starting from scratch... Even my connections with professionals in the field did little to help me. Every step was unclear, complicated and expensive. For other families, with even less knowledge than I, it's even more difficult. There needs to be an easier path to help—we are losing too many of our young people to substance use and mental illness and they are our future!

Charles, whose two older sons died of drug overdoses. He now works at the Adolescent Substance Abuse Program at Seacoast Youth Services as a group facilitator with court-ordered adolescents, most of whom have both mental health and substance abuse issues.

FACING THE CHALLENGE

Throughout the nation and here in New Hampshire the incidence of co-occurring mental health and substance use disorders among adolescents and young adults between the ages of 12 and 24 is a significant public health issue, resulting in tremendous hardship and devastating effects upon their young lives and those of their families. The onset of mental illness in a family member disrupts family life and interrupts the course of cognitive and social emotional development. Combined with a substance use problem, these co-occurring disorders create havoc, disrupting the development of young people, interfering with their ability to complete schooling, establish and maintain healthy relationships, find and maintain employment, and even live independently.

Unfortunately, treatment systems for mental health and substance use disorders are fragmented in the Granite State, as they are in much of the nation. Different philosophies in mental health and substance disorders treatment have resulted in the development of parallel and uncoordinated systems with different funding streams, mandates and treatments. Co-occurring disorders are caught in a “no man’s land” between mental health and substance use treatment systems.

Untreated, co-occurring disorders in adolescents and young adults can

lead to a downward spiral across the lifespan, increasing the likelihood that they will be “high utilizers” of already limited community medical and social resources. Such individuals are more likely to have frequent and/or extended psychiatric hospitalizations, over-utilize Emergency Departments for psychiatric and substance abuse care, have difficulty maintaining housing stability and experience homelessness, have repeated involvement with the juvenile justice, criminal justice and child protection systems, more chronic health problems, an increased vulnerability to HIV infection, exhibit increased rates of depression, suicide and violence, and require a significant and ongoing investment of societal resources and money (New Freedom Commission on Mental Health, 2003).

A recent report from the Institute on Disability at the University of New Hampshire found that among individuals who were frequently hospitalized (at least 10 times over a 10 year span – 1996-2007) with a primary diagnosis of mental illness, 75% had a co-occurring substance use disorder. Similarly, 93% of individuals with repeated hospitalizations for substance use disorders had a co-occurring mental illness. Not surprisingly, the costs for these frequent hospitalizations was high: over the ten years, per patient charges for those with mental illness as the primary diagnosis exceeded \$138,000 for a total cost of \$320

million per 2,310 individuals; among those whose primary diagnosis was substance use disorder, 856 individuals incurred a total cost of \$51 million. The study also found that during the decade studied, ambulatory care rates increased substantially, with the greatest increase occurring among 15–29 year olds whose primary diagnosis was either a mental illness (55%) or substance use disorder (22%) (Antal & Mandrell, 2008).

Early intervention can have a significant positive impact on the lives of adolescents and young adults living with co-occurring mental health and substance use disorders, interrupting the negative course of these disorders and lessening long-term disability. Current advances in brain research indicate that early identification and treatment can sharply improve outcomes and that longer periods of abnormal thoughts and behavior can have cumulative effects, limiting an individual's capacity to recover (New Freedom Commission on Mental Health, 2003). Early detection and treatment are essential to halting the progression of negative outcomes for these young people and their families.

Traditionally, substance use and mental health problems have been treated in separate facilities funded by different systems of care, resulting in clients with co-occurring disorders "falling between the cracks" or bouncing back and forth between treatment facilities which do not adequately meet their complex and

multiple needs. There are three basic models for treating co-occurring disorders: sequential treatment, parallel treatment and integrated treatment. While research is limited, outcomes for clients treated sequentially or in parallel have been poor. More recently developed practices to address co-occurring disorders through integrated treatment have proven more successful, although such services must be both age and developmentally appropriate for use with adolescents and young adults (Roberts, Ogborne, Leigh, & Adam, 1999).

In 2005, the New Hampshire legislature established the Commission to Develop a Comprehensive State Mental Health Plan. The Mental Health Commission's report, "Fulfilling the Promise," identifies integrated treatment for co-occurring mental health and substance use disorders as one of four key priorities for improving the mental health of New Hampshire residents, calling for mental health, medical, and substance use treatment services to be integrated across the state (Mental Health Commission, 2008).

Clearly, young people between the ages of 12 and 24 with co-occurring mental health and substance use disorders present many challenges to the Granite State's systems of care—and face significant barriers in accessing integrated treatment. Yet the devastation that substance use and mental illnesses cause to these young lives and those of their

families, coupled with the societal costs that grow geometrically when such disorders are left untreated, makes it critical that New Hampshire develop a plan to address their distinct needs.

I started using crack in high school. My folks found out and took me to probably every child psychologist in the state—sent me out of state to a residential program twice. They said I had major depression and a substance abuse problem—like I didn't already know that. Then, four years ago, my girlfriend got pregnant, but threw me out because I was using and she didn't like having me using around the baby. So, I got sober, got a restaurant job, got to have my son with me every other weekend. My mom even let me move back in with her. But it got to be too much—I didn't have any health insurance and couldn't afford to go see a doctor about drugs for the depression, so I started using. Now I sleep on my friends' couches when they let me. And I haven't seen my son in over a year. I love him more than anything, but it just wasn't enough.

*Father with co-occurring disorders,
Age 23*

THE PREVALENCE OF CO-OCCURRING DISORDERS IN ADOLESCENTS & YOUNG ADULTS

Both nationally and in New Hampshire, young people with co-occurring disorders are at greater risk of negative outcomes than either those diagnosed with a mental illness or substance use disorder alone. Nationwide, 43% of youth receiving mental health services have been diagnosed with a co-occurring substance use disorder. Among adolescents with significant emotional and behavioral problems, 13% reported substance use. Studies of adolescents entering substance use treatment indicate that 62% of males and 82% of females have a co-occurring psychiatric disorder (Substance Abuse and Mental Health Services Administration, 2002).

In 2007, a self-reported community-based survey (Youth Risk Behavior Survey [YRBS]) of more than 24,000 New Hampshire high school students found that students who reported marijuana and alcohol use in the past 30 days were also more than twice as likely to report a range of other disturbing moods and behaviors, including depression, suicidal ideation, suicide attempts, and feeling unsafe at school (Metzger, 2008).

Since the YRBS is anonymously completed by students, it is not known how many of these adolescents have yet been identified

by the school system, family or other community service provider as having such problems. Too often, adolescents with co-occurring disorders delay seeking treatment until their difficulties have reached such a level of severity that psychiatric hospitalization is necessary or they have become involved in the juvenile justice system. Hospitalization is costly, although more likely to be covered under insurance plans despite the lack of evidence that inpatient treatment relative to outpatient or community-based services is more effective in treating co-occurring disorders. For some adolescents whose involvement in the juvenile justice system is the catalyst leading to the diagnosis of a co-occurring disorder, accessing appropriate community-based treatment is difficult, if not nearly impossible, in many parts of the state.

Mental Illness among Adolescents and Young Adults

National estimates indicate that 20% of children under age 18 have a diagnosable mental illness, 11% experience significant functional impairment and 5% extreme functional impairment due to mental illness. Among 18 to 26 year olds, at least an estimated 2.4 million—or 6.5% of non-institutionalized young adults—have a serious mental illness (GAO, 2008). (The number of all such individuals with a serious mental illness is most likely much higher, as this data does not include homeless, institutionalized or

incarcerated young adults—populations that typically have high incidence rates for mental illness.) Using New Hampshire demographic data from 2005 and assuming similar rates of such disorders, an estimated 56,000 Granite State children, aged 5–19, have a diagnosable mental illness—14,000 of whom, aged 9–17, experience significant impairment due to mental illness (Tappin & Norton, 2007).

Adolescence and young adulthood is the stage of life when psychiatric disorders are most often diagnosed. Depression and disruptive behavior disorders, especially conduct disorders, are typically diagnosed in younger adolescents and often precede and predispose young people to substance abuse. The highest rate for depression across the entire lifespan is between the ages of 15 and 24. Serious and chronic mental illnesses that involve thought disorders such as bipolar disorder and schizophrenia are most commonly diagnosed in late adolescence/early adulthood. Fifty percent of lifetime mental illnesses start by age 14 and 75% by age 24 (Crowley & Riggs, 1999; Hoffman, Estroff, & Wallace, 2001; King, Gaines, Lambert, & Bickman, 2000; National Mental Health Association, 2002; Mental Health America, 2006).

Substance Use Disorders in Adolescents and Young Adults

Substance use rates in New Hampshire are generally higher than

in many areas of the country. In 2003, almost half of New Hampshire high school students reported current alcohol use and one in three reported binge drinking. Among college students, one in five reported abstinence, and over half reported binge drinking. **Drug use among New Hampshire youth age 18–25 ranks among the highest in the country** (New Hampshire Department of Health & Human Services, 2007).

SUICIDALITY AMONG ADOLESCENTS & YOUNG ADULTS WITH CO-OCCURRING DISORDERS

The two leading causes of death among New Hampshire's young people are unintentional injury (52%) and suicide (19%) – with alcohol use playing a key role in both. In one study, 37% of eighth grade females who drank heavily reported attempting suicide compared to 11% who did not drink (New Futures, 2008).

Suicide rates are a dramatic indicator of the impact of mental illness, as well as substance abuse. More than 90% of those who die by suicide have a diagnosable mental disorder and/or underlying substance use disorder. Nationally, suicide is the 11th leading cause of death and the 3rd leading cause of death for those between 10 and 24 years of age. However, in New Hampshire,

suicide is the 2nd leading cause of death in youth between 10 and 24 years of age (National Institute of Mental Health, 2008).

Rates of mood disorders are higher in women and girls, and adolescent girls who experience depression have a high likelihood of developing a substance use disorder. The University of New Hampshire Teen Assessment Program found 84% of females surveyed reported depressed feelings in the past month; 26–29% reported serious thoughts of suicide; and 18% reported attempting suicide (University of New Hampshire Cooperative Extension, 2003).

My life up to two years ago was good. I really screwed up these past couple years. I was admitted to New Hampshire Hospital and Hampstead Hospital for depression. I think weed and the pills I was taking at the time made me depressed, but I don't know for sure. I went to Midway for criminal threatening, and afterwards, I became a huge pill popper. Now I'm sitting in here in placement, waiting for my life to get back on track. Luckily, within two more months I'll be out of here and drug free.

Student at Odyssey NH Academy

FACTORS INCREASING THE RISK OF DEVELOPING CO-OCCURRING DISORDERS

Recent advances in the understanding of brain development have confirmed that cognitive maturation continues well into one's twenties, with some research indicating that executive functions (reason and decision-making) are not completely developed until age 30. Adolescence is well-recognized as a developmental stage defined by emotional swings, variations in impulse control and the ability to self-regulate and make decisions. However, modern society expects that, once one has become age 18, adulthood begins and one will act accordingly. Yet, with brain development still continuing during the twenties, adolescence truly does not end at the age of majority. Both mental illness, often first diagnosed in young adults, and substance use disorders can affect and often delay maturation, in essence prolonging adolescence. This combination of lack of maturity and co-occurring disorders increases the risk of adverse outcomes, such as suicide, homelessness, criminal justice system involvement, inability to complete schooling, and victimization for these young people.

Criminal Justice System Involvement

Nationally as well as in New Hampshire, there is a strong

relationship between young people with co-occurring mental health and substance use disorders and involvement in the criminal justice system. Statistically, young adults who struggle with substance use, mental illness, or co-occurring disorders are at an increased risk of becoming involved in the criminal justice system (GAO, 2008). An estimated 85% of all state prison inmates have a history of substance use (Minard, Merrow, Stapleton, & Gagnon, 2002). A December 2005 point-in-time count conducted in the state's county correctional system found an average of 25% of all county inmates were receiving psychotropic medications (New Hampshire Association of Counties, 2006). This figure did not include inmates with a mental disorder diagnosis and who were not taking medication at the time, nor did it include those inmates not yet evaluated. Of 2,630 inmates sentenced to NH Department of Corrections facilities, 20% have been diagnosed with a serious mental illness. *A Mental Health Needs Analysis* in 2004 found that 30.6% of bookings at NH State Prison had a history of mental health problems, a need for follow-up medication, a need for monitoring, or past or present suicidality (New Hampshire Department of Corrections, 2004).

Among juveniles, in the U.S. nearly two-thirds of incarcerated youth with substance use problems have at least one other mental health disorder. Of these, nearly 33% have a mood or

anxiety disorder and as many as 50% of substance abusing juvenile offenders are diagnosed with Attention Deficit Hyperactivity Disorder or ADHD (Northeast Addiction Technology Transfer Center, 2006).

Nationally, nearly 20% of youth in the juvenile justice system have serious mental health problems and a significant number have co-occurring mental health and substance use disorders (Office of Juvenile Justice and Delinquency, 2004). A study on the New Hampshire Juvenile Justice System found that, in 2001, a total of 123 adolescents were committed to the state's Sununu Youth Services Center (SYSC) for juvenile offenders—73% of whom were diagnosed with a disability. Among these, 37% were diagnosed as emotionally disturbed, 22% with ADHD, 24% with learning disabilities, and 14% with speech and/or language disabilities. Twenty-five percent (25%) of the girls in the SYSC population and 75% of the boys had a history of substance use (Skibbie, 2004). More recently, the rate of mental illness among the state's juvenile justice population has been estimated to be as high as 68-80% (Vance, 2008).

In New Hampshire the per capita arrest rate for juvenile drug offenses is among the top ten in the country. Between 1996 and 2002, drug charges against New Hampshire's juveniles increased by 60%. In response to the significant rates of drug use in juvenile

offenders, six of New Hampshire's 36 district courts established juvenile drug court programs. This initiative, supported by a grant from the Robert Wood Johnson Foundation, confirmed that substance use, mental health disorders, co-occurring disorders and juvenile crime are closely linked. Indeed, **78% of the juveniles who participated in the drug court project had a mental health issue identified either before or during the program** (Morrow, Tappin, & McGlashan, 2006).

Victimization and Trauma

Too often adolescents and young adults with co-occurring disorders have trauma histories. Especially among the juvenile justice population and young women, a history of abuse is both a risk factor as well as a complication for treatment. Both nationally and in New Hampshire studies of youth and adults with co-occurring mental health and substance use disorders have alarming rates of trauma histories. Victims of physical and/or sexual violence are at increased risk of significant mental health and substance use problems (New Hampshire Coalition Against Domestic & Sexual Violence, 2007). **Current estimates among the state's SYSC population indicate that 60–70% of the boys and 70–90% of the girls have histories of physical and/or sexual abuse and are suffering from Post-Traumatic Stress Disorder, or PTSD** (Vance, 2008).

While individuals with substance use disorders overall demonstrate high rates of trauma histories, females tend to be two to three times more likely to have such histories than do male substance abusers (Najavits, Weiss, & Shaw, 1997). Women who abuse alcohol are more likely to suffer from depression and other mental health disorders. Up to 89% of substance-abusing women report trauma histories including one or more forms of abuse (Clark, 2001). Among girls with substance use disorders, up to 70% report having been sexually abused before the age of 17 and one out of five under age 16 reports experiencing dating violence (National Institute on Drug Abuse, 1994; Silverman, Raj, Mucci, & Hathaway, 2001)

BARRIERS TO ACCESSING TREATMENT, SERVICES & COMMUNITY SUPPORTS

Accessing treatment for either a mental health or substance use disorder alone can be challenging in the Granite State. The stigma associated with both disorders impedes adolescents and young adults and their families from seeking treatment before a crisis arises that requires either more intensive interventions such as hospitalization or involvement with the criminal justice system. Workforce shortages in both disciplines are yet another challenge,

making treatment access difficult and nearly impossible in some parts of the state. Lack of integrated treatment for co-occurring disorders and funding for essential science-based services further impedes treatment access and outcomes. In addition, the absence of a distinct statewide effort and/or leadership to make it a priority means that the problem does not get addressed.

Stigma

The stigma associated with both substance abuse and mental illness is pervasive and creates obstacles for individuals with co-occurring disorders to access treatment. The American Medical Association, National Institute of Mental Health, and the National Alliance for Mental Illness have all recognized that substance dependence and mental health disorders are defined by organic, physical conditions comparable to other chronic diseases, such as diabetes, asthma or hypertension. Yet, while years of research document the biological nature of these disorders, and the efficacy of treatment has been proven, neither is generally treated as the chronic disease that it is.

Despite the advances in brain research and decades of community-based treatment, public opinion, policy, practice and revenue streams too often reflect the view that substance abuse and mental illness are the result of an individual's moral or personal failings. Public and private insurance policies, service

delivery systems, and society continue to reflect the common misperception that substance dependence and mental health disorders are not real diseases and therefore less deserving of treatment or funding (Northeast Addiction Technology Transfer Center, 2006; Hoffman, Estroff, & Wallace, 2001; Substance Abuse and Mental Health Services Administration, 2008). Recent passage of national mental health parity legislation may eventually help improve access to care for those with insurance, but changes in public perception and opinion will be necessary to remove barriers to care for all members of society.

For individuals with other chronic illnesses, it is expected that over the course of their lifetime, treatment regimens will need to be reviewed and adjusted. If a patient does not fully adhere to their physician's recommendations, they are not refused further treatment, even if the result has been a negative health consequence. Instead, they are viewed as needing further intervention and a renewed approach to help them better manage their illness.

Yet, a young adult who struggles with substance use disorder and/or mental illness and does not take prescribed medications, misses appointments, or uses alcohol or drugs is labeled "non-compliant," blamed for the treatment failure, and may even be discharged from treatment altogether. Even with insurance parity recently passing at the national level, there still exists

pervasive bias against both disorders. Despite this recent legislative success, the jury is still out as to whether or not managed care companies that develop insurance coverage plans will face up to the need to comprehensively address these illnesses and provide adequate coverage to those who live with them.

Workforce Shortages: Finding Treatment Resources

Locating mental health or substance abuse treatment professionals or programs can be a challenge in many parts of the Granite State. Finding a provider or collaborating providers equipped to handle co-occurring disorders in adolescents is even more difficult. Add to that the additional licensing requirements for professionals who work with children and the likelihood of accessing community-based, integrated professional care becomes extremely bleak.

Among the recommendations in the report of the state's Mental Health Commission is assuring that New Hampshire has an adequate mental health workforce. With a significant portion of the state's North Country already designated as a Mental Health Professional Shortage Area (MHPSA) by the federal Health Services and Resources Administration (HRSA), accessing treatment locally can be very difficult and frequently requires significant travel. Additionally, of the state's ten counties, two have no child psychiatrists and two have just

one apiece (Norton, Tappin, & McGlashan, 2007). Due to population shifts alone, without the development and implementation of a plan to address the declining workforce, the state will have an acute shortage of mental health professionals in 15 years time (Mental Health Commission, 2008).

Additionally, among the state's ten community mental health centers, staff turnover rates exceed 20% on a regular basis. Reasons most often cited are job stressors, inadequate pay and the shortage of professionals, leading to relatively easy employment mobility (Antal & Mandrell, 2008). High staff turnover and a statewide direct care vacancy rate of 6.81% negatively impacts the quality of service provision as well as creating additional administrative burdens and costs in recruiting and training new staff. Improving community mental health workforce retention and development is one of five recommendations in the state's plan for restoring the mental health system in New Hampshire (New Hampshire Department of Health & Human Services, 2008).

In the substance abuse treatment field, again, there are high turnovers in staff due to inadequate pay, job-related stress and stigma. Licensed Alcohol and Drug Counselors (LADCs) and Master Licensed Alcohol and Drug Counselors (MLADCs) are in high demand and frequently move between programs. By 2010, the demand for addiction professionals and licensed treatment

staff with graduate-level degrees is projected to increase by 35% (National Association of State Alcohol and Drug Abuse Directors, 2003).

Funding and Insurance Barriers

Funding for mental health and substance abuse treatment varies significantly based upon a young person's access to insurance, involvement with ancillary services such as child protection or special education, and their age. Many private insurance plans will provide some, usually capped, coverage for both mental health services and substance abuse treatment. Young Granite Staters who live in New Hampshire or are full-time students can now remain on their parents' insurance policies until age 26, if their parents work for a New Hampshire-based employer.

Private insurance is the primary payor for hospital care related to mental health or substance use disorders in the state, although private insurance coverage for such treatment has not increased substantially over the last five years, despite significant service provision increases. Indeed, clients seeking hospital services for mental health and/or substance use disorders were less likely to have their treatment visits covered by insurance than those seeking other medical services combined. The Institute for Disability's recent report found overall a decrease in private insurance coverage for mental health or substance use disorder related

hospitalizations, an increase in private insurance treatment limitations (such as a pre-approved list of treatment options) and a significant increase in the cost of benefits (Antal & Mandrell, 2008).

My teenage son has bipolar disorder and takes a number of psychotropic medications. You think when you have insurance that you will be okay, but the co-payments for just his prescriptions cost over \$100 a month. And that's with the pharmacy by mail service where you pay two months co-pay for three months of pills. I can barely afford the co-pays for his meds. I don't know how folks without insurance can afford to have a mental illness.

Working single mother

The New Hampshire Healthy Kids Program, through which families can access either Healthy Kids Gold (Medicaid) or Healthy Kids Silver (insurance for children the cost of which is based upon family income and size), provides coverage until age 19. Children covered by Healthy Kids Gold are eligible for mental health services and inpatient substance abuse detoxification services, but not outpatient substance abuse treatment. Those children covered by Healthy Kids Silver are eligible for both inpatient substance abuse detoxification services and outpatient substance abuse treatment, as well as mental health services, although there is an annual cap of 20 total visits for both mental health and substance abuse outpatient visits (National Mental Health Information Center, 2003). However, beyond the issue of coverage limitations, the state has no discrete inpatient detoxification programs for adolescents and truly integrated treatment for co-occurring disorders for young people is virtually non-existent in most areas.

For those adolescents who receive services either through the children protection, juvenile justice, or educational systems, once they reach age 18, or graduate from high school, these services end. This problematic circumstance is further compounded by the fact that half of all lifetime cases of mental illness begin by age 14 and three-quarters by age 24 (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005).

Just as many of these young adults may be entering a period of even greater need for services, they are thrust out into the adult world, lacking the resources necessary to maintain their health.

Young adults age 19–24 who do not have private insurance may qualify for Medicaid if they have a disability, such as severe and persistent mental illness. Qualifying for Medicaid benefits does not, however, provide most individuals in New Hampshire with access to substance abuse treatment services. The state's Medicaid Plan only covers substance abuse detoxification and treatment for pregnant women. Additionally, as the state's immigrant population grows, it is important to note that except in the case of refugees or those who have been granted asylum here in the U.S., an individual must be a Legal Resident or Naturalized Citizen for at least five years in order to be eligible for either NH Healthy Kids or Medicaid (National Immigration Law Center, 2002).

The state's Bureau of Drug and Alcohol Services does provide funding to community-based, non-profit treatment and detoxification programs for individuals without insurance or financial resources, but waiting lists for these programs are usually long. Accessing crisis social detoxification beds frequently requires that an individual phone the program daily to ensure their place on the list. Services are provided on a sliding fee scale based upon one's

ability to pay. Most of the state-funded substance abuse treatment programs do not provide treatment for co-occurring disorders.

Those young individuals who qualify for Medicaid and have a severe emotional disorder can receive mental health treatment at one of ten community mental health centers in the state. Due to funding constraints, even those community mental health centers that have substance abuse treatment professionals on staff do not routinely provide integrated treatment for individuals with co-occurring disorders, especially for adolescents. Often adolescents are referred to the state-funded substance abuse treatment programs for such assistance.

Local Service Coordination

While the desire of most communities is to meet the needs of its youth, school personnel operate in one manner, mental health providers in another, access to residential treatment is lacking, and the various systems do not work together despite significant expenditure of effort and resources. Too often, this lack of coordination among community systems leads to youth with co-occurring disorders who are untreated or who receive inappropriate care. This, in turn, results in negative outcomes for these young people: increased school drop-out rates, difficulty maintaining employment, poor socialization skills, criminal justice system involvement, homelessness, and

early pregnancy—while drifting to a wayward and marginal adulthood (Johannessen, 2008).

Even with medical insurance coverage, New Hampshire's treatment system for adolescents with co-occurring disorders is very limited. Although some providers may claim to offer such services, what exists is not well integrated and is limited to mental health centers, outpatient providers, prevention and residential treatment programs. While the state has proven treatment resources available, the access to that care is dependent upon court involvement for residential treatment programs due to their cost and eligibility requirements, as well as payment structures for community and private mental health treatment. Distance from treatment resources also hampers utilization – for example, there is only one Intensive Outpatient Program for youth in the entire state. Access is further limited by the lack of staff trained in evidenced-based treatment models (Johannessen, 2008).

Adolescents with co-occurring disorders may access after-school prevention programs, not because they have been identified as having mental health and/or substance use problems, but because they have an interest in the activities offered. Rarely, however, do these programs have formal relationships with treatment providers to help assure continuity and access to care. Often the result is that a young person moves through multiple systems

without any coordination, let alone integration, of treatment (Johannessen, 2008).

Statewide Leadership

Until recently, within the state government structure itself mental health and substance abuse services were separate entities housed in different organizational divisions, resulting in minimal service coordination and collaboration. Substance use services were actually divided into three different offices addressing policy, prevention and treatment, the first of which (policy) came under the New Hampshire's Department of Health & Human Services (DHHS) Office of the Commissioner. The latter two offices (prevention and treatment) were housed within the DHHS Division for Public Health Services. The state's Bureau of Behavioral Health, responsible for the oversight and ultimate provision of community-based mental health services, was part of DHHS' Division of Community Based Care Services. While the reasons for this were largely funding driven—with each treatment system receiving different federal funding streams—it helps to point out how the dichotomy in mental health and substance abuse treatment has been ingrained within the state's very structure.

As of July 2008, DHHS reorganized its services, creating a single Bureau of Drug and Alcohol Services, now part of the Division of Community Based Care Services, along with the

It is an optimistic time as evidence-based screening, diagnostic and effective treatment technologies are emerging for children and adolescents. Yet, the tragedy is that the gap between what we know and what we actually deliver is widening for many children and adolescents in New Hampshire owing to the rural nature of the state and significant areas of under-service.

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Bureau of Behavioral Health, Bureaus of Developmental Services, Elderly & Adult Services, Homelessness and Housing Services, and the Disability Determination Unit. Additionally, DHHS is co-locating the new Bureau of Drug and Alcohol Services and the Bureau of Behavioral Health in the Main Building of the downtown State Office Park, enhancing the ability of both offices to coordinate efforts and develop integrated services.

In addition to requiring mental health and substance use services, families with young members struggling with co-occurring disorders are often involved with multiple agencies, such as the Division for Children, Youth & Family (DCYF), as well as the educational, criminal (juvenile and adult) justice systems and primary care. Each system is able to provide varied supports and treatment access, depending upon the age and diagnoses of the individual. Yet, there is currently no coordination mechanism or leadership position to help ensure that treatment is truly integrated. These separate entities, linked by the common goal of improving outcomes for adolescents and young adults, can interweave their services and funding streams to ensure access to a system of care that can meet the singular needs of this population and their families.

The recent changes at DHHS, combined with the fact that the Main Building is also home to the Department of Corrections (DOC) and DCYF is located in the nearby Brown

Building, are a positive first step in creating system change and moving forward to develop fully integrated treatment for adolescents and young adults with co-occurring mental health and substance use disorders.

A “BLUEPRINT FOR CHANGE”: RECOMMENDATIONS FOR NEW HAMPSHIRE

Recognizing the extent of the problem of co-occurring disorders for New Hampshire’s adolescents and young adults and the challenges they face is only the first step toward developing a continuum of treatment that is accessible for all Granite State families. Through the support of the Endowment for Health and the New Hampshire Charitable Foundation, the National Alliance on Mental Illness-New Hampshire (NAMI-NH) and its partners developed a Scientific Advisory Board (SAB) to help define the problem in New Hampshire and develop recommendations for the state.

The members of the Scientific Advisory Board brought to this critical initiative a wealth of expertise and knowledge in the fields of substance abuse, mental health care, psychiatry, psychology, treatment and public policy, service delivery, adolescents and young adult development, and the treatment of co-occurring disorders. The group collaborated for six months to develop its recommendations for better understanding and addressing of the needs of adolescents and

young adults in New Hampshire with co-occurring disorders.

The Scientific Advisory Board's ultimate goal was to create a "Blueprint for Change" to assist New Hampshire treatment systems in developing an integrated service approach to meet the needs of its adolescents and young adults with co-occurring disorders.

To do so, the SAB developed specific recommendations in the following areas:

- I. Establish a conceptual framework for providers across disciplines to work from, standardizing terminology and identifying resources;
- II. Identify valid screening and assessment tools and evidence-based practices proven effective for adolescents and young adults;
- III. Develop strategies to support and assist changes in the system that would facilitate the adoption and implementation of screening, assessment and appropriate integrated treatments.

True integrated services are essential to best serve the needs of adolescents and young adults with co-occurring disorders. The costs related to not integrating treatment for individuals with co-occurring disorders has been great for youth and young adults in New Hampshire in terms of increased hospitalizations, juvenile and criminal justice and child protective services involvement, homelessness,

interrupted education, under/unemployment, and the devastating effects upon their families. A well coordinated and integrated treatment system will treat the whole person and ensure that entry into any one system of care can provide access to all needed services.

In developing its recommendations, the Scientific Advisory Board used the following definitions for the levels of integrated service delivery for people with co-occurring disorders (Co-Occurring Center for Excellence, 2006):

- **Minimal Coordination/ Consultation**—Service provider is aware of co-occurring conditions or treatment, but has no contact with other providers or has referred a person with co-occurring disorders to another provider with little or no follow-up;
- **Consultation**—Two or more service providers are involved in treatment and the transfer of medical or clinical information about the client's status has occurred;
- **Collaboration**—A more formal process of sharing responsibility for treating a person with co-occurring disorders. Formal agreements, memoranda of understanding, contracts, or expectations exist between providers that clarify specific treatment areas;
- **Integration**—Expertise from one or more providers, from both the

substance abuse and mental health disciplines, are combined to develop a single treatment plan that addresses both disorders simultaneously. Formal interaction and cooperation between disciplines is part of the ongoing reassessment and treatment process.

Issue Area I:

Establish a Conceptual Framework

In reviewing the current system of care for adolescents and young adults with mental health and/or substance use disorders in the state, the Scientific Advisory Board quickly recognized that amongst treatment providers there does not exist a consistent conceptual framework that would ensure continuity of care across systems and throughout the state. Mental health and substance abuse service providers do not have a common treatment language, sometimes using similar terminology, but not necessarily the same definition for those terms. Additionally, the state lacks a cohesive single source for resources and other treatment information related to integrated care.

Recommendation 1:

Service systems in New Hampshire access existing resources.

Recognizing that nationally there has been tremendous progress over the past two decades in developing practices for the assessment, evaluation and treatment of co-occurring mental health and substance use disorders, the Scientific Advisory

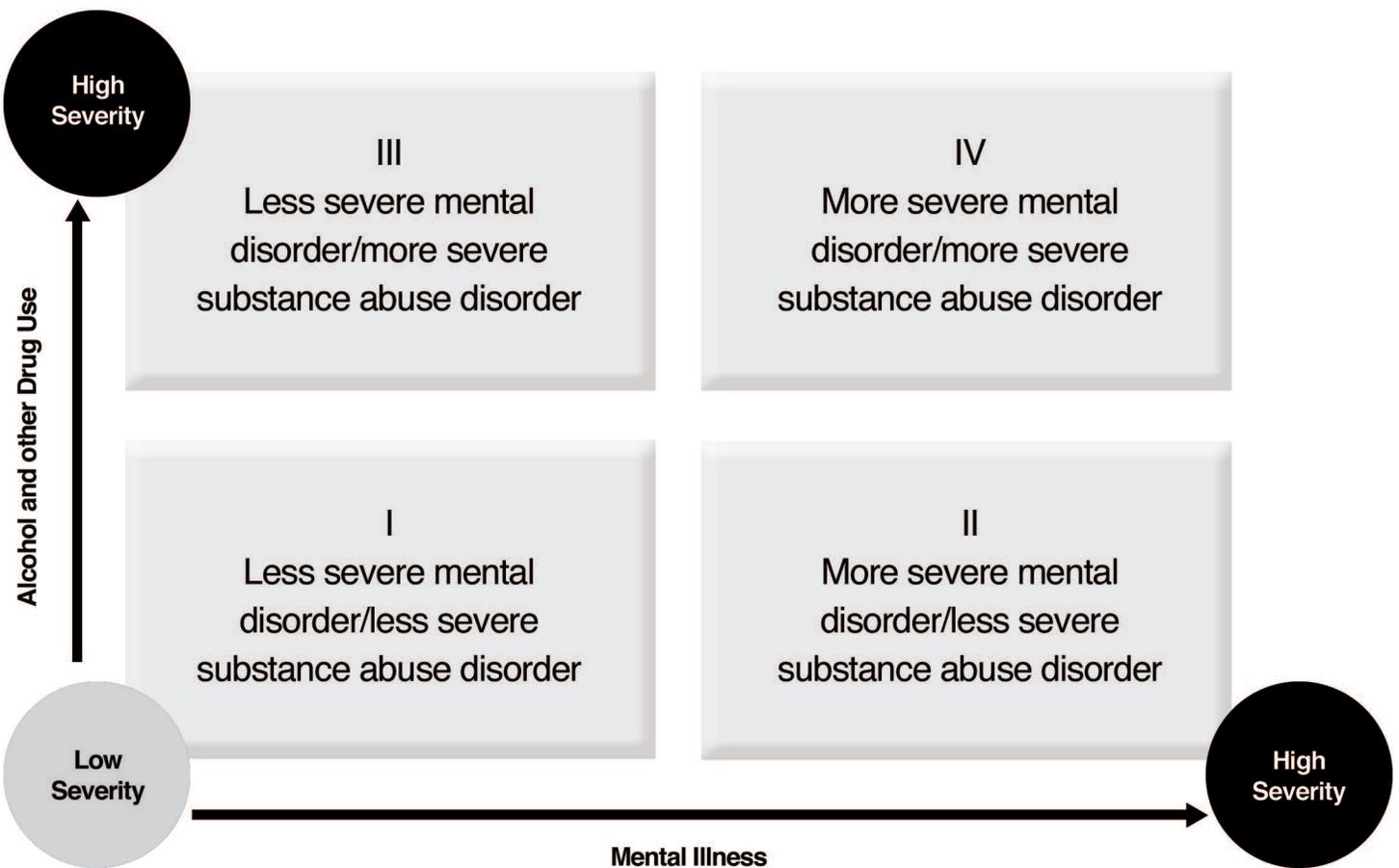
Board recommends that service systems in New Hampshire access and use these existing, proven resources. In particular, the Substance Abuse and Mental Health Services Administration's Co-Occurring Center for Excellence (COCE) has recently published eight papers that define terms, conceptual models and provide a summary of research on co-occurring disorders. The SAB recommends that New Hampshire providers, including primary care providers, use the terms, models and concepts defined in the

COCE's overview papers. A listing of resources for establishing a consistent conceptual framework for providers in New Hampshire can be found in Appendix I.

Recommendation 2:
Service providers use "Quadrants of Care" model to guide treatment planning.

The Scientific Advisory Board also recommends that New Hampshire service providers use the severity of symptoms for young people with

co-occurring disorders to help guide treatment planning. The "Quadrants of Care" model classifies patients into four categories based on relative symptom severity, not diagnosis. This quadrant framework provides a structure for fostering consultation, collaboration, and integration among substance abuse and mental health treatment systems and providers in order to deliver appropriate care to every client with co-occurring disorders (Center for Substance Abuse Treatment, 2005):



It is important to note that adolescents and young adults at different points in time can be classified in different quadrants and therefore need to be directed to different levels of care that correspond with their current level of need. The model directs services from simple consultation with other agencies, to collaboration among agencies that together provide multiple services, to integration of services, where treatment for both disorders are combined and delivered simultaneously (Co-Occurring Center for Excellence, 2007).

Issue Area II: Identify Valid Tools and Evidence-Based Practices

The tools and evidence-based practices recommended for use by the Scientific Advisory Board are described in Appendices II and III. In order to ensure that these screening, assessment and treatment instruments would be appropriate for use in New Hampshire, the SAB weighed the following factors in developing its list of recommended instruments:

- New Hampshire providers' and systems' familiarity and comfort with the instrument;
- Logistics and cost of the instrument;
- Logistics and cost of the training in its use;
- Applicability across adolescent and young adult populations;
- SAB members' professional experience working with the instruments.

Screening tools are quick question and answer formatted instruments that are either self-administered or administered by a professional. The purpose of screening is to determine if an individual needs to be referred for a more thorough assessment. Screening tools can be used in a variety of settings including primary health care and other community service venues.

Assessment tools are used to identify and clarify the existence and intensity of substance abuse and/or mental health disorders, and to direct and guide a treatment plan. Accurate assessment requires the use of proven instruments, trained clinicians and, as with any disease, must be ongoing. Re-evaluation/re-assessment periodically as patients' progress is a vital component of treatment and considered essential to best practice.

Evidence-based practice (EBP) is a term that denotes a practice or instrument based on research findings and expert or consensus opinion about available evidence, and is expected to produce a specific clinical outcome, measurable by change in client status.

Evidence-based thinking is a process by which diverse sources of information are synthesized by a clinician, expert, or group of experts in order to identify or choose the optimal clinical approach (Co-Occurring Center for Excellence, 2007).

Recommendation 3:

Service providers utilize evidenced-based screening and assessment tools.

The Scientific Advisory Board recommends screening and assessment instruments (Appendix II) that have been identified as either evidence-based or through the use of evidence-based thinking determined to be a promising practice.

Recommendation 4:

Service providers employ evidence-based treatment models for adolescents and young adults.

The Scientific Advisory Board has developed a list of treatment models (Appendix III) that have been demonstrated to be successful with adolescents and young adults with co-occurring disorders and best suited for use in New Hampshire. While research on the suggested models is limited, these recommendations are based on the best available evidence. Current and future research on these models will provide additional guidance as to which approaches are most efficacious with which populations.

Recommendation 5:

Treatment is provided in the most appropriate, least restrictive setting.

Regardless of the stage or intervention chosen, the Scientific Advisory Board recommends that treatment should always be initiated in the most appropriate, least restrictive setting. Individuals who are in treatment and are either not progressing or not adhering to

treatment need to be considered for alternate therapies, more intense treatment or stepped up community supports. As with any chronic disease, the road to better health is bumpy and service providers and clients, along with the client's family and support systems, must work together to achieve the best results. SAB members also caution that treatment success is more nuanced than an absence of symptoms or change in behaviors. For an adolescent or young adult with a substance use disorder, abstinence is a goal of treatment. However, progress can also be measured in reduction in frequency or intensity of use and improved functioning. Mitigation of behaviors or symptoms associated with mental health disorders is also a sign of improvement. An individual's improved functioning in school, in relationships, occupationally, or improved sense of well-being are all important positive outcomes even when a "cure" is not achieved.

Recommendation 6:

Primary and pediatric care providers routinely screen for mental health, suicide risk and substance use problems.

Basic screening instruments can and should be utilized in primary and pediatric care settings at routine visits to determine if adolescent and young adult patients may require referral for further assessment by mental health and substance abuse providers. Several tools can easily be made part of initial intake

procedures with data collected by patient advocates, medical assistants and nurses. Referral systems need to be established between local primary care, mental health, and substance abuse providers.

Recommendation 7:

Assessments of adolescents and young adults should include, when appropriate, a psychiatric evaluation including determining the risk for suicide.

When working with adolescents and young adults, the Scientific Advisory Board strongly recommends assessments include psychiatric evaluations. Depending upon the severity of a possible mental disorder, a psychiatric evaluation by an appropriately trained psychiatrist or psychiatric nurse practitioner should be conducted as early as possible. Ideally, those with experience and training in assessment and treatment of substance use disorders should do the evaluation. Medication, if needed, can be a vital component in treatment and the delay in its administration can setback or even derail an entire treatment plan.

Recommendation 8:

Service providers and systems follow established best practices.

Scientific Advisory Board members emphasize that clinicians and service delivery systems treating adolescents and young adults with co-occurring disorders must always:

- Employ a recovery perspective, adopting a multi-problem

viewpoint combined with a strength-based approach;

- Employ the Quadrants of Care Model that considers the level of severity and the integration of systems required;
- Address specific real-life, psychosocial problems early in treatment by engaging other key service providers, including primary care providers, educational systems, and youth development agencies;
- Take into account cognitive and functional impairments;
- Engage families and other social/natural support systems to maintain and extend treatment effectiveness;
- Orient treatment from the client perspective—a client-centered approach;
- Recognize the development (cognitive and emotional) stage of the individual.

Recommendation 9:

Service systems provide ongoing support and training to ensure fidelity to treatment models.

The SAB recommends that systems support and maintain ongoing fidelity to treatment models. New Hampshire currently lacks an integrated system of providers with the skills necessary to assess and treat the complexities of co-occurring disorders in young people. Cross-system collaborations are often ineffective, with conflicting philosophies about what to treat and

how to do so. Assessment and treatment models currently in use with adults do not necessarily work well with teens. Fidelity to adolescent-specific, evidence-based practices is an essential component to achieving the best outcomes for adolescents and young adults with co-occurring disorders. Cross-training, staff development and adequate supervision for both mental health and substance abuse providers must be supported to assure a workforce that has adequate and appropriate skills to treat co-occurring disorders in an integrated manner.

Issue Area III: Changing the System to Serve New Hampshire's Youth

There is wide recognition in both the substance abuse and mental health fields that adolescents and young adults will benefit from an integrated approach to all phases of care. Despite overwhelming evidence and agreement that integrated services would improve outcomes in New Hampshire, few such programs exist. There are multiple reasons for this profound gap between what is widely accepted as a better way and the current state of services:

- Over time, mental health and substance abuse services developed and continue to operate separately;
- Training, education, licensing boards and certification processes run parallel and independently;
- The state's current scope of service for MLADCs does not allow these providers to treat co-occurring

disorders, further limiting access to treatment;

- Models and treatments approaches are different with limited cross-disciplinary training;
- Financing mechanisms do not support integrated treatment;
- Stigma is pervasive for both substance abuse and mental health disorders, limiting access to treatment.

Moving toward a more integrated system of care for co-occurring disorders in adolescents and young adults will require thoughtful and concerted attention to addressing the factors that created and sustain separate service delivery systems. State leaders and service providers need to be deliberate in implementing practice changes to better serve young people with co-occurring disorders.

Recommendation 10:
Assign high level leadership to carry any plan forward.

The SAB recognizes that without a designated leader to help initiate and coordinate planning, its recommendations may be implemented piecemeal in different areas in the state. To truly affect change, the state must assign a leadership role to a high level individual who is cognizant of the issues, has expertise in both the mental health and substance use treatment systems, and is familiar with the challenges facing young

Fidelity to adolescent-specific treatment is key. I have witnessed the challenges of helping staff maintain the use of evidence-based practices. It is common for all of us to revert to that which we know, even after learning new and more effective ways of doing our work. Direct observation of clinical work by trained supervisors, combined with financial and logistical support for outcome measurement systems, will go a long way in helping to develop a competent delivery system that will meet the definition of true integrated care for teens with co-occurring disorders.

*Barry S. Timmerman, LADC,
LCMHC, Scientific Advisory
Board Member*

Granite Staters living with co-occurring disorders.

Recommendation 11:
Develop a plan to implement integrated services for young people with co-occurring disorders.

The following steps and interventions are recommended by the SAB to improve services for adolescents and young adults with co-occurring disorders.

- a) Determine the necessary elements that must be added to treatment programs to give equal consideration to both mental health and substance use disorders in assessment and treatment efforts (see Appendix II);
- b) Evaluate workforce patterns to determine if additional staff with the appropriate knowledge and skills (MLADCs, LADCs, licensed mental health counselors, ARNPs, psychiatrists, psychologists) may be required to meet the expected demand for treatment;
- c) Support the implementation of the strategies to improve workforce retention and development in the community mental health system, as outlined in the state's strategic plan (New Hampshire Department of Health & Human Services, 2008);
- d) Develop similar strategies to improve workforce retention and development in the substance abuse treatment field, including ensuring adequate resources to pay

and maintain qualified staff, as well as investing in ongoing training;

- e) Support increased access to qualified providers, such as MLADCs, who are trained in the recommended screening and assessment tools and treatment models;
- f) Identify and address intra-agency structures or policies that may be barriers to delivering or evaluating integrated care, such as billing, data collection, or language representing a more narrow treatment philosophy;
- g) Assure that licensing and accreditation boards thoroughly address how the recommended practice changes discussed here will impact licensing status and educational requirements;
- h) Establish recommendations for training across both disciplines to ensure providers have the knowledge and skills necessary for consistent, integrated service delivery;
- i) Develop an implementation plan, allowing for training and supervision time on an ongoing basis; consider how dissemination of the model might occur throughout the state over a multi-year period;
- j) Adopt inter-agency memoranda of understanding to define collaboration and continuity of care;
- k) Investigate the “medical home

model” as a vehicle for accessing integrated and coordinated care that is based on the principles identified in this report.

INVESTING IN OUR FUTURE: CHANGING LIVES

The Scientific Advisory Board readily acknowledges that changing systems is difficult, even when strong evidence exists to support the need for change. Change also requires funding for treatment, service coordination and outcomes evaluation. The current system supports reimbursement for limited treatment. Effective treatment for adolescents and young adults with co-occurring disorders is essential and yet is rarely reimbursed.

Mental health and substance use disorders in young people have far-reaching impact at many levels, beginning with the family and extending to school, the criminal justice system and the community at large. Due to the lack of integrated treatment, young people with co-occurring disorders tax all of the above systems and enter adulthood with poor coping skills and a lifetime of challenges ahead of them. Because adolescents and young adults are in the midst of major developmental changes, physically, emotionally and cognitively, the combination of mental illness and substance abuse can have a rapid and severe impact on their development. **However, early assessment and intervention are proven techniques for**

interrupting the devastating course of co-occurring disorders.

Fortunately, a significant pool of resources and treatment models has been developed to address co-occurring disorders in adolescents and young adults over the past decade (see Appendix III). **If New Hampshire’s service systems wish to serve this population successfully, they must utilize these new treatment technologies and have the leadership and dedication to design an effective service delivery system.**

Better collaboration between the mental health, substance abuse and primary systems of care, providers, and among state agencies would result in:

- Improved outcomes for adolescents and young adults with co-occurring disorders in the state—and a reduction in the devastating effects of such disorders upon New Hampshire’s families;
- Increased access to integrated care for young Granite Staters living with co-occurring disorders;
- Development of protocols for using existing funding streams to augment service delivery and more effective service coordination;
- Reduction in duplication of effort and enhancement of services provided;
- Decreased use of costly interventions such as hospitalizations, emergency room admissions, and criminal/juvenile justice system involvement.

Designating an existing leader in the state to oversee this project and bring to the table the necessary parties would be a positive first step in improving collaborative efforts and moving toward an integrated system of care that would better utilize existing funding mechanisms.

Ultimately, there is no question that development and implementation of integrated treatment for adolescents and young adults with co-occurring disorders will require various state agencies, local service providers, primary care physicians, and schools to work together to create a coordinated response to this crisis facing so many young Granite Staters and their families. State and organizational leaders will each have to look beyond “the way it’s always been done” to see where existing relationships can be enhanced and new ones forged. Despite state and federal funding constraints, the Granite State has a long history of “getting the job done the New Hampshire way.” Developing a system of integrated treatment for young people with co-occurring disorders can also be accomplished the New Hampshire way—with commitment, creativity and collaboration.

Research clearly demonstrates that for the individuals with serious mental illness and co-occurring substance abuse disorders, integrated treatment dramatically improves outcomes and is cost effective.

Representative James R. MacKay, Ph.D., Chairman, Commission to Develop a Comprehensive State Mental Health Plan

WORKS CITED

- Antal, P., & Mandrell, M. (2008). Policy Brief: The Changing Dynamics of Hospital Care for Mental Illness and Substance Use in New Hampshire—Implications for Supporting Continuums of Care. Access New Hampshire: Living with Disability in the Granite State, 1(2).
- Center for Adolescent Substance Abuse Research. (2002). CRAFFT. Retrieved September 2, 2008, from Center for Adolescent Substance Abuse Research at Children's Hospital Boston: www.ceasar-boston.org/about/index.php.
- Center for Substance Abuse Treatment. (2005). Substance Abuse Treatment for Persons with Co-occurring Disorders: Treatment Improvement Protocol No. 42. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Clark, H. W. (2001). Residential substance abuse treatment for pregnant and postpartum women and their children: Treatment and policy implications. Arlington, VA: Child Welfare League of America.
- Co-Occurring Center for Excellence. (2006). No. 1—Definitions and Terms Relating to Co-Occurring Disorders. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Co-Occurring Center for Excellence. (2006). No. 2—Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Co-Occurring Center for Excellence. (2006). No. 3—Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Co-Occurring Center for Excellence. (2006). No. 4—Addressing Co-Occurring Disorders in Non-Traditional Service Settings. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Co-Occurring Center for Excellence. (2007). No. 5—Understanding Evidence-Based Practices for Co-Occurring Disorders. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Co-Occurring Center for Excellence. (2007). No. 6—Services Integration for Persons with Co-Occurring Disorders. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Co-Occurring Center for Excellence. (2007). No. 7—Systems Integration Relevant to Co-Occurring Disorders. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Co-Occurring Center for Excellence. (2007). No. 8—The Epidemiology of Co-Occurring Disorders. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Crowley, T., & Riggs, P. (1999). Adolescent Substance Use Disorder with Conduct Disorder and Comorbid Conditions. Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions, NIDA Research Monograph Number 156.
- Dennis, M. (2002). Lighthouse Institute. GAIN-I. Retrieved September 1, 2008, from Chestnut Health Systems: www.chestnut.org/li/gain.
- Dennis, M. (2002). Lighthouse Institute. GAIN-SS. Retrieved August 31, 2008, from Chestnut Health Systems: www.chestnut.org/LI/gain/GAIN_SS/index.html.
- Dennis, M. (2002). Lighthouse Institute. GAIN-Q. Retrieved September 1, 2008, from http://www.chestnut.org/li/gain/GAIN_Q/index.html.
- Friedman, A. S., & Terras, A. (1989). Adolescent Drug Abuse Diagnosis. Philadelphia, PA: Belmont Center for Comprehensive Treatment.
- GAO. (2008). Young Adults with Serious Mental Illness: Some States and Federal Agencies Are Taking Steps to Address Their Transition Challenges. Washington, DC: U.S. Government Accountability Office.

- Godley, S. H., Godley, M. D., Karvinen, T., Slown, L. L., & Wright, K. L. (2006). *The Assertive Continuing Care Protocol: A Clinician's Manual for Working with Adolescents After Treatment of Alcohol and Other Substance Abuse Disorders*. Bloomington, IL: Chestnut Health Systems.
- Grisso, T., Barnum, R., Famularo, R., & Kinscherff, R. (2000). *Massachusetts Youth Screening Instrument—Version 2*. Retrieved September 1, 2008, from National Youth Screening Assistance Project: www.maysiware.com/MAYS12.htm.
- Hoffman, N., Estroff, T., & Wallace, S. (2001, Summer). *Co-Occurring Disorders Among Adolescent Treatment Populations*. Dual Diagnosis Recovery Network .
- Johannessen, E. B. (2008, September 23). CEO. Personal Communication. Odyssey NH.
- Kessler, R., Berglund, P., Demler, O., Jin, R., Merikangas, & Walters, E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replicaton (NCS-R). *Archives of General Psychiatry*, 62, 593-602.
- King, R., Gaines, L., Lambert, E. S., & Bickman, L. (2000). The Co-Occurrence of Psychiatric and Substance Use Diagnoses in Adolescents in Different Service Systems: Frequency, Recognition, Cost, and Outcomes. *Journal of Behavioral Health Services & Research*, 27 (4), 417-430.
- Mental Health America. (2006, November 24). Fact Sheet: Co-Occurring Disorders and Youth. Retrieved July 30, 2008, from Mental Health America: <http://www.mentalhealthamerica.net/index.cfm?objectid=C7DF9472-1372-4D20-C8B4204053F7CD4D>.
- Mental Health Commission. (2008). *Fulfilling the Promise: Transforming New Hampshire's Mental Health System*. Concord, NH: State of New Hampshire.
- Merrow, K., Tappin, R., & McGlashan, L. (2006). *Evaluating Reclaiming Futures: Performance Review 3*. Concord, NH: New Hampshire Center for Public Policy Studies.
- Metzger, J. L. (2008, September). Senior Management Analyst. Personal Communication. NH Department of Health and Human Services.
- Miller, G. A. (1997). Retrieved September 1, 2008, from SASSI Institute: <http://www.sassi.com/sassi/index.shtml>.
- Minard, R., Merrow, K., Stapleton, J., & Gagnon, M. (2002). *Under the Influence: Alcohol, Drugs, Crime, and Treatment in New Hampshire*. Concord, NH: New Hampshire Center for Public Policy Studies.
- Najavits, L. M., Weiss, R. D., & Shaw, S. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. *American Journal on Addictions*, 273-283.
- National Association of State Alcohol and Drug Abuse Directors. (2003). *Recommendations related to closing the treatment gap, NASADAD policy position paper*. NASADAD.
- National Immigration Law Center. (2002). *Guide to Immigrant Eligibility for Federal Programs*, 4th ed. Los Angeles: National Immigration Law Center.
- National Institute of Mental Health. (2008, June 26). *Suicide in the U.S.: Statistics & Prevention*. Retrieved July 30, 2008, from National Institute of Mental Health: www.nimh.nih.gov/publicat/harmsway.cfm.
- National Institute on Drug Abuse. (1994). *Women & drug abuse: You and your community can help*. Bethesda, MD: National Institutes on Health.
- National Mental Health Association. (2002). *Alcohol and Drug Abuse Addiction and Co-occurring Disorders. Advocate Information*. Alexandria, VA: National Mental Health Association.

- National Mental Health Information Center. (2003). *Mental Health and Substance Abuse Services in Medicaid and SCHIP in New Hampshire*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- National Registry of Evidence Based Programs and Practices. (2008). Retrieved August 29, 2008, from Substance Abuse & Mental Health Administration: www.nrepp.samhsa.gov/.
- New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. Rockville, MD: U.S. Department of Health & Human Services.
- New Futures. (2008). *The Scope of the Problem in New Hampshire*. Exeter, NH: New Futures.
- New Hampshire Association of Counties. (2006). *Initial Report: County Corrections Mental Health Initiative*.
- New Hampshire Coalition Against Domestic & Sexual Violence. (2007). *Violence Against Women in New Hampshire: A report from the New Hampshire Coalition Against Domestic & Sexual Violence*. Concord, NH: New Hampshire Coalition Against Domestic & Sexual Violence.
- New Hampshire Department of Corrections. (2004). *Mental Health Needs Analysis*. Concord, NH: State of New Hampshire.
- New Hampshire Department of Health & Human Services. (2008). *Addressing the Critical Mental Health Needs of NH's Citizens: A Strategy for Restoration*. Concord, NH: State of New Hampshire.
- New Hampshire Department of Health & Human Services. (2007). *Overcoming the Impact of Alcohol and Other Drug Problems: A Plan for New Hampshire*. Concord, NH: State of New Hampshire.
- Northeast Addiction Technology Transfer Center. (2006). *Co-occurring Substance Use and Mental Health Disorders in Adolescents: Integrating Approaches for Assessment and Treatment of the Individual Young Person Trainer's Manual*. Providence, RI: ATTC-NE.
- Norton, S., Tappin, R., & McGlashan, L. (2007). *Few and Far Between? Children's Mental Health Providers in NH*. Concord, NH: New Hampshire Center for Public Policy Studies.
- Office of Juvenile Justice and Delinquency. (2004). *Public Law 108-414*.
- Psychological Assessments Systems, Inc. (2003). CASI. Retrieved August 29, 2008, from The Child & Adolescent Screening Inventory: www.casisystem.com/index.html.
- Roberts, G., Ogborne, A., Leigh, G., & Adam, L. (1999). *Best Practices: Substance Abuse Treatment and Rehabilitation*. Ottawa: Minister of Public Works and Government Services Canada.
- Silverman, J., Raj, A., Mucci, L., & Hathaway, J. (2001). *Dating violence among adolescent girls and associated substance use, unhealthy weight control, sexual risk behavior, pregnancy and suicidality*. *Journal of the American Medical Association* .
- Skibbie, M. (2004). *Children with Disabilities in the New Hampshire Juvenile Justice System: A Report to the Division of Juvenile Justice Services, Department of Health & Human Services, State of New Hampshire*. The Institute on Disability, Justiceworks. Durham, NH: University of New Hampshire.
- Substance Abuse and Mental Health Services Administration. (2002). *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*. Rockville, MD: U.S. Department of Health and Human Services.
- Substance Abuse and Mental Health Services Administration. (2008). *The Relationship Between Mental Health and Substance Abuse Among Adolescents*. Rockville, MD: Office of Applied Studies.

Substance Abuse and Mental Health Services Administration. (2005). Substance Abuse Treatment for Persons with Co-Occurring Disorders: Treatment Improvement Protocol (TIP) Series 42. Rockville, MD: U.S. Department of Health and Human Services.

Tappin, R., & Norton, S. (2007). Children's Mental Health In New Hampshire. Concord, NH: New Hampshire Center for Public Policy Studies.

University of New Hampshire Cooperative Extension. (2003). Teen Assessment Program 2001-2002 Multi-Community Report. Durham, NH: University of New Hampshire.

Vance, E. (2008, June 23). Medical Director, NH DHHS Division of Juvenile Justice Services. Testimony before the Criminal Justice/Mental Health Work Team. Concord, NH: Commission to Develop a Comprehensive State Mental Health Plan.

Winters, K. C., & Henley, G. A. (n.d.). Adolescent Diagnostic Interview & Personal Experience Inventory. Los Angeles, CA: Western Psychological Services.

APPENDIX I

SCIENTIFIC ADVISORY BOARD RECOMMENDATIONS OF RESOURCES FOR ESTABLISHING A CONCEPTUAL FRAMEWORK

Substance Abuse & Mental Illness Services Association Co-Occurring Center for Excellence (COCE) Overview Papers

Central to the COCE approach is a series of overview papers and technical reports addressing key co-occurring disorder (COD) topic areas. The overview papers and technical reports summarize the science base for each topic they address and make recommendations for practice, systems, and State and local laws and regulations that support treatment and prevention systems. These papers and reports are used as the basis for all COCE products and services.

No. 1—Definitions and Terms Relating to Co-Occurring Disorders

It is essential to use a common language to develop consensus on how to address the needs of persons with co-occurring disorders. This paper provides definitions of terms associated with substance-related disorders, mental health disorders, co-occurring disorders and programs.

Electronic copy in PDF available at:
http://coce.samhsa.gov/cod_resources/PDF/OP1-DefinitionsandTerms-8-13-07.pdf

For printed copies, order through NCADI at:
<http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17471>

No. 2—Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders

Clients with COD are best served through an integrated screening, assessment, and treatment planning process that addresses both substance use and mental health disorders, each in the context of the other. This paper discusses the purpose, appropriate staffing, protocols, methods, advantages and disadvantages, and processes for integrated screening, assessment, and treatment planning for persons with COD as well as systems issues and financing.

Electronic copy in PDF available at:
http://coce.samhsa.gov/cod_resources/PDF/OP2-ScreeningandAssessment-8-13-07.pdf

For printed copies, order through NCADI at:
<http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17472>

No. 3—Overarching Principles to Address the Needs of Persons with Co-Occurring Disorders

Principles, by their nature, are consistent with a concern for the well-being of the client and his or her loved ones. This overview paper outlines 12 overarching principles for working with persons with COD. These principles are intended to help guide, but not define, systemic and clinical responses.

Electronic copy in PDF available at:
http://coce.samhsa.gov/cod_resources/PDF/OP3-OverarchingPrinciples-8-13-07.pdf

For printed copies, order through NCADI at:
<http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17473>

No. 4—Addressing Co-Occurring Disorders in Non-Traditional Service Settings

Settings outside the substance abuse and mental health system, or settings where service missions do not include a primary focus on COD but where persons with COD are likely to be seen, are the focus of this overview paper. These include primary health, public safety and criminal justice, and social service settings. These settings should be prepared to identify and effectively respond to persons with COD.

Electronic copy in PDF available at:
http://coce.samhsa.gov/cod_resources/PDF/OP4-SpecialSettings-8-13-07.pdf

For printed copies, order through NCADI at:
<http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17655>

No. 5—Understanding Evidence-Based Practices for Co-Occurring Disorders

The advantages of employing evidence-based practices are now widely acknowledged across the medical, substance abuse, and mental health fields. This paper discusses evidence-based practices and their use in treating persons with COD, discusses how evidence is

used to determine if a given practice should be labeled as evidence-based, and gives some brief examples.

Electronic copy in PDF available at:
http://coce.samhsa.gov/cod_resources/PDF/OP5-Practices-8-13-07.pdf

For printed copies, order through NCADI at:
<http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17656>

No. 6—Services Integration for Persons with Co-Occurring Disorders

Services integration refers to the process of merging previously separate clinical services at the level of the individual to meet the substance abuse, mental health, and other needs of persons with COD. The paper examines issues concerning the context, content, approaches, and processes that promote and inhibit services integration.

Electronic copy in PDF available at:
http://coce.samhsa.gov/cod_resources/PDF/OP6-ServicesIntegration-8-13-07.pdf

For printed copies, order through NCADI at:
<http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17732>

No. 7—Systems Integration Relevant to Co-Occurring Disorders

Organizational structures and processes can promote or inhibit systems integration. This paper encourages the use of creative thinking to obtain and effectively use funding and provides examples of successful initiatives in systems integration.

Electronic copy in PDF available at:
http://coce.samhsa.gov/cod_resources/PDF/OP7-SystemsIntegration-8-13-07.pdf

For printed copies, order through NCADI at:
<http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17733>

No. 8—The Epidemiology of Co-Occurring Disorders

The paper is presented in two parts. Part 1 is for non-scientists and explains what epidemiology is and how it can be used by practitioners, administrators and policy

makers. Part 1 also presents highlights from past epidemiological studies of co-occurring disorders and introduces three major national studies that are regularly used as sources for information on the nature and extent of co-occurring disorders in the United States. Part 2 presents detailed technical information on these three studies and is for audiences who are familiar with epidemiologic methods.

Electronic copy in PDF available at:
http://coce.samhsa.gov/cod_resources/PDF/OP8Epidemiology10-03-07.pdf

For printed copies, order through NCADI at:
<http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=17749>

ADDITIONAL RECOMMENDED RESOURCES:

Substance Abuse Treatment for Persons with Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42.

Center for Substance Abuse Treatment. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

This TIP identifies key elements of programming for co-occurring disorders in substance abuse treatment agencies. The elements described have relevance for mental health agencies and other service systems that seek to coordinate mental health and substance abuse services for their clients.

Electronic copy in PDF available at:
<http://download.ncadi.samhsa.gov/prevline/pdfs/bkd515.pdf>

Co-occurring Substance Use and Mental Health Disorders in Adolescents: Integrating Approaches for Assessment and Treatment of the Individual Young Person Trainer's Manual.

Northeast Addiction Technology Transfer Center. (2006). Providence, RI: ATTC-NE.

Trainers' Manual for a two-day course entitled Co-occurring Substance Use and Mental Health Disorder in Adolescents: Integrating Approaches for Assessment and Treatment of the Individual Young Person. Curriculum is designed to assist those who provide training to counselors working with adolescents in substance use treatment programs by addressing the unique challenges

that counselors may have when they consider ways to begin to integrate assessment and treatment approaches to meet more fully the needs of youth with co-occurring mental health disorders.

Copies available for download and purchase at:
http://store.ireta.org/merchant2/merchant.mvc?Screen=PR OD&Store_Code=I&Product_Code=mn1986-DLD1.zip&Category_Code=mn1

APPENDIX II

SCIENTIFIC ADVISORY BOARD RECOMMENDATIONS FOR RECOMMENDED SCREENING AND ASSESSMENT

Instruments Recommended as Screening Tools:

Scientific Advisory Board members recommend five screening tools, several of which are already used in different settings in New Hampshire: GAIN-2, MAYSI-2, SASSI, GAIN-SS, and CRAFFT. The GAIN-SS, POSIT, MAYSI-2 and GAIN-Q are used to screen for both substance abuse and mental health disorders, the others are used for substance abuse specifically. All of these screening tools can be administered in less than 30 minutes.

CRAFFT (Center for Adolescent Substance Abuse Research, 2002) is short, with questions that can be condensed onto a small, credit card sized plastic card. This screening tool is already used in primary care settings in New Hampshire and many providers are comfortable and familiar with CRAFFT.

GAIN-SS (Global Appraisal of Individual Needs-Short Screener) can quickly identify psychiatric disorders, substance use disorders, or crime/violence problems in general populations. It is well suited to primary care settings (Dennis, Lighthouse Institute, 2002).

SASSI (Adolescent Substance Abuse Subtle Screening Instrument) is a brief self-report, easily administered psychological screening measure that is available in separate versions for adults and adolescents (Miller, 1997).

MAYSI-2 (Massachusetts Youth Screening Instrument) is designed for use with the juvenile justice, 12-17 year old population to identify special mental health needs. Administration takes no more than 15 minutes and is a self-administered pencil and paper test (Grisso, Barnum, Famularo, & Kinscherff, 2000).

GAIN-Q (Global Appraisal of Individual Needs-Quick) is an instrument used to identify various life problems among adolescents in the general population. Designed for use by personnel in diverse settings, it can identify a need for a more detailed assessment, those who can benefit from brief intervention, or guide referral or placement decisions (Dennis, Lighthouse Institute, 2002).

Recommended Assessment Tools:

SAB members offer four assessment instruments that can be used with adolescents/young adults who may have co-occurring disorders.

GAIN-I (Global Appraisal of Individual Needs) is a progressive assessment approach based on DSM IV and ASAM (American Society of Addiction Medicine) criteria. The GAIN assesses alcohol and drug dependence, mood, anxiety, PTSD and conduct disorders (Dennis, Lighthouse Institute, 2002).

ADAD (Adolescent Drug Abuse Diagnosis) is designed to assess substance use and other life problems, to assist with treatment planning, and to assess changes in life problem areas and severity over time (Friedman & Terras, 1989).

CASI (Child and Adolescent Screening Inventory) is a computerized assessment instrument for children and adolescents referred to group homes or residential treatment facilities. It is designed to be used by county placing agencies and residential treatment programs with the goal of identifying children at risk for multiple placements and improving treatment outcomes, or as part of a psychological assessment battery for the purpose of developing a comprehensive, effective treatment plan (Psychological Assessments Systems, Inc., 2003).

ADI (Adolescent Diagnostic Interview) with PEI (Personal Experience Inventory). The ADI tests for symptoms associated with psychoactive substance use disorders. The PEI queries substance use consumption history and the way a person functions in society (Winters & Henley).

The GAIN-I is recommended by SAMSHA's COCE (Co-Occurring Center for Excellence) and provides a comprehensive evaluation. However, some funding streams are tied to the use of the GAIN-I, so selection

of which screening and assessment tools to use must be made in context. The SAB members stated strongly that agencies, service systems and providers need several choices when selecting tools to best serve adolescents and young adults with co-occurring disorders.

APPENDIX III

SCIENTIFIC ADVISORY BOARD RECOMMENDATIONS FOR RECOMMENDED TREATMENT MODELS

Recommended Treatment Models

The Scientific Advisory Board offers a list of treatment models that have been demonstrated to be successful with adolescents and young adults with co-occurring disorders. The research on the suggested models is limited. These recommendations are based on the best available evidence. Current and future research on these models and others will provide additional guidance for which approaches are most efficacious for specific populations.

Cognitive Behavioral Therapy (CBT) is well accepted as an effective treatment for adolescents with co-occurring disorders. Both the mental health and substance abuse fields are familiar with CBT (Center for Substance Abuse Treatment, 2005).

Motivational Enhancement Therapy (MET) is often successful in the beginning of treatment to engage clients in the process of treatment, motivating them to identify the problem and develop a plan for change. Typically a second treatment approach is used to carry out the treatment plan (Center for Substance Abuse Treatment, 2005).

Multidimensional Family Therapy (MFT) and **Multisystemic Therapy (MST)** are models that address youth substance abuse using behavioral approaches while focusing on family systems and dynamics. Both models are promising according to studies although expensive to administer. This concern applies to all family centered approaches. Good family work requires well trained, skilled therapists (National Registry of Evidence Based Programs and Practices, 2008).

Adolescent Community Reinforcement Approach (ACRA) incorporates 12 sessions that include family involvement and involves a behavioral approach for developing effective coping strategies and teaches youth

how to use community resources to support positive change. ACRA is considered especially appropriate for rural areas where therapeutic groups are difficult to find (National Registry of Evidence Based Programs and Practices, 2008).

Dialectic Behavioral Therapy (DBT) is more commonly found in mental health services. It is now used to treat a variety of mood disorders and for co-occurring disorders. Family members are involved (National Registry of Evidence Based Programs and Practices, 2008).

Seeking Safety has good reviews, is designed specifically for individuals with trauma histories and substance abuse and recommended for individuals who are 17 and older (National Registry of Evidence Based Programs and Practices, 2008).

The following Treatment Model was provided by a member of the Project Advisory Group and was not reviewed by the SAB prior to publication. It is included here as an additional, evidence-based resource for providers:

Assertive Continuing Care (ACC) is designed to minimize the time between discharge from residential treatment and returning to substance use through home visits and telephone support. These “assertive” methods of reaching clients require that the case manager assume the responsibility for completing continuing care appointments rather than the traditional office-based appointment model (Godley, Godley, Karvinen, Slown, & Wright, 2006).

Copies of the ACC manual are available for download and purchase at:
http://www.chestnut.org/li/Bookstore/Blurbs/Manuals/K107-Assertive_Continuing_Care.html

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This project has gone through numerous phases over the past four years. Please forgive us if we have unintentionally left your name off this list of contributors. Thank you for your work to improve the lives of New Hampshire's adolescents and young adults with co-occurring disorders.

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