Youth Residential Treatment- One Step in the Continuum of Care

Dave Sprenger, MD

- Nature of substance abuse disorders
- Continuum of care philosophy
- Need for prevention and aftercare
- Cost-effectiveness of prevention and aftercare

Substance Abuse is a Chronic Illness

- Addiction is a complex neurobehavioral disease and is chronic, often strongly related to history of psychological trauma
- People sometimes require different levels of treatment in different stages of disease
- Residential treatment is best considered a step in treatment, rather than a cure

Continuum of Care Philosophy

– Substance use disorders (SUDs) are on a severity spectrum, from “at risk” use (more than 4 drinks at a time or 14 drinks/week for males) to heavy use (usually to severe intoxication, affecting several life domains)

– Interventions range from prevention to brief counseling in a doctor’s office to inpatient treatment

American Society of Addiction Medicine Levels

- Level 0.5 – Prevention
- Level I – Outpatient counseling (individual or group)
- Level II – Intensive outpatient or day treatment
- Level III – Residential treatment ranging from low clinical intensity (III.1) to medically monitored or managed treatment (III.9)
- Level IV – Medically managed inpatient treatment

What constitutes aftercare?

- “Aftercare” increasingly referred to as “continuing care” to emphasize that SUDs are chronic, must be managed long-term and are not “one size fits all”
- Continuing care (aftercare) can be at any of the ASAM levels

Why is post-residential continuing care necessary?

- Transitions in care level, such as discharge from residential treatment, are high-risk time periods
- Adolescent post residential abstinence rates in the absence of no, or limited continuing care:
  - 3 months: 40%
  - 12 months: 20%
- With **assertive** continuing care (ACC, a type of post-residential aftercare):
  - 3 months: 55%
  - 12 months: 30%

→ Abstinence rates lower in rural communities

Abstinence Rates Do Not Tell the Whole Story

- In older research, success usually only considered in terms of abstinence
- Other outcomes are important for health and quality of life
- Evidence of positive effect of assertive continuing care on other outcomes (even absent abstinence):
  - Decreased substance use (significant)
  - Staying out of jail, or another YRTC (significant)
  - Mental health (good)
  - School attendance (some)

- Improvement in 3 month abstinence outcomes of 38% (40% abstinence → 55%)
- Improvement in 12 month abstinence outcomes of 50% (20% → 30%)
- Net positive improvement greater when considering other outcomes

What is Assertive Continuing Care (ACC)?

- ACC is evidence-based and practice based (NREPP, SAMHSA)
- Based on behavioral reinforcement theory, i.e. making recovery more rewarding than substance abuse
- Creating an expectation of abstinence, or at least improved function, across youth social domains, including home, school, and probation
- Requires comprehensive analysis of potential triggers and recovery elements (so things don’t fall through cracks) including academic, transportation, recreational skill development, and addressing deficits

Some Potential Triggers for Relapse

- Conflict with parent
- Conflict with boyfriend/girlfriend
- Conflict with other peers
- Conflict with teacher
- Struggling with school/work
- Depression, anxiety, or other untreated medical illness
- Sadness, anger, or other strong emotions
- Peer pressure
- Substance use in the home
- Ongoing abuse
- Exposure to reminders of past abuse
- Boredom
- Lack of access to treatment
- Physical pain

Other Elements of ACC

- Based upon aggressive case management, as opposed to passive follow-up
- Client participation in treatment plan (especially goal setting) is important
- Some visits at patient's location in community, including home and school
- Working with family is important (unless unsupportive of youth's recovery)

Incorporating ACC Into Tribal and Urban Indian Current Practice

- ACC is used in addition to other continuing care modalities including individual and group substance abuse and mental health counseling, or into different levels of care (IOP, day treatment)
- Urine drug screens
- Free SAMHSA youth ACC manuals exist

- Most of the cost of ACC is time for a case manager and training
- For most programs, ACC may be accomplished with existing staff (EBP recommends Bachelor, or Master’s level)
- ACC cost for 90 days is $1,500-$4,500 compared with $50,000 for YRTC already spent
- Considering comparative cost and outcome improvements of >50%, ACC good investment

Role of YRTC Aftercare Coordinators

- YRTC aftercare coordinators will work closely with health program staff and others in community, ACC case manager could be main POC for aftercare coordinator
- Focus will be on “warm handoff” done through aftercare coordinator visits, and/or tele-videoconferencing

Other Continuing Care Options

- Larger programs with many YRTC referrals may want to consider intense outpatient, or even transitional living center/group home
- Tele-videoconferencing can bring group therapies together
- Use of social media and text messaging in adolescent recovery

A Word on Prevention

- Youth substance abuse prevention can take many forms
- One of the best researched and most cost-effective prevention and outpatient programs is Adolescent Community Reinforcement Approach, which is philosophically related to ACC

- Our health programs can provide good, effective and low cost continuing care services which will greatly enhance sustained recovery in our youth
- Encourage program directors and behavioral health directors and other community leaders to research and develop an Assertive Continuing Care, or similar program