Substance Use Disorder Continuum of Care: Engaging the Community

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PROGRAM DIRECTORS' MEETING

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Outline

Nature of substance use disorders

Continuum of care philosophy

Importance of community involvement

Effectiveness of aftercare

Effectiveness of prevention

Substance Abuse is a Chronic Illness

Addiction is a chronic, complex neurobehavioral disease

Addiction is not “one size fits all”

Residential care is considered the most intense level of addictions treatment (except withdrawal management is better considered medical management)

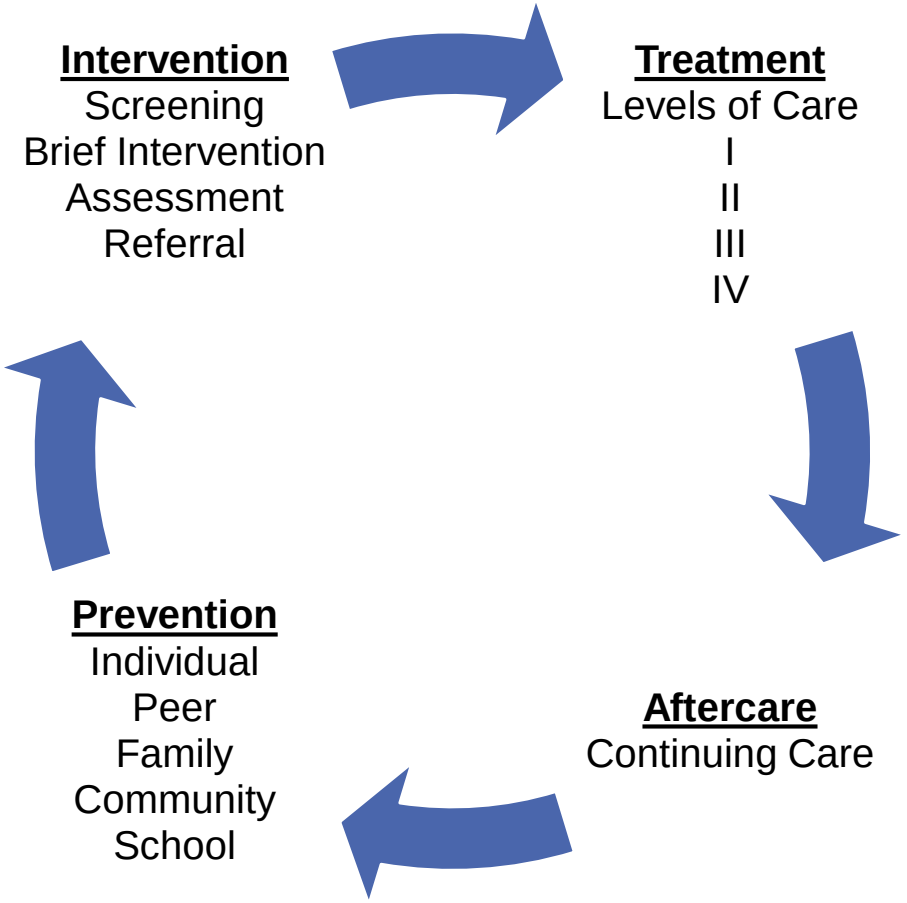
Continuum of Care Philosophy

Substance use disorders (SUDs) are on a severity spectrum

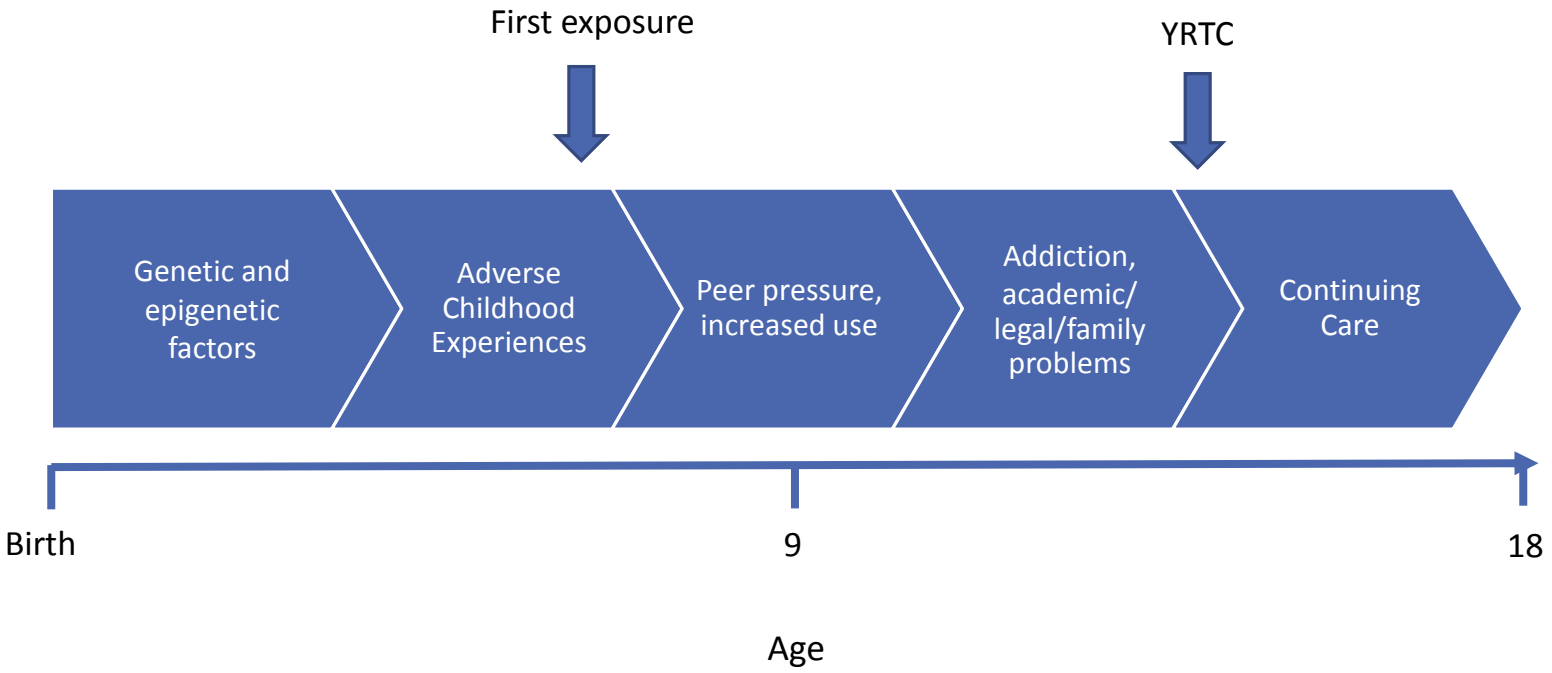
For example, for alcohol use in adult males from: **“at risk”** use (more than 4 drinks at a time or 14 drinks/week for males) to **heavy** use (frequent, severe intoxication, accompanied by legal, medical and family problems)

Therefore, appropriate interventions range from brief counseling in a doctor’s office, to residential treatment

Continuum of Care Model



Natural Course of Adolescent Substance Use Disorders



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.7)
Level IV	Medically managed inpatient treatment

So, what is 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 lower ASAM levels, including 1.0, to 3.1 (group homes), or stated differently it can just about any validated substance use disorder treatment, delivered in any non-residential setting

Why is post-residential continuing care necessary?

First, in any clinical setting, transitions in care level, such as discharge from residential treatment, are high-risk time periods

Second, the research shows adolescent, 12 month post-residential abstinence rates are much improved with high quality continuing care:

- No continuing care → 20%
- Continuing care → 30%

Despite the dismal outcomes, here is the good news:

- Continuing care improves outcomes by 50%
- Recent research has shown that recovery, at levels less than complete abstinence, can be enough to turn someone's life around

How can our programs provide continuing care?

The CAO has offered Assertive Continuing Care (ACC) training to all full scope tribal and urban Indian health programs ($17,000 value). There are 17 that will be participating

ACC is a well-researched and evidence-based continuing care modality (NREPP, SAMHSA)

Based on behavioral reinforcement theory, i.e. making recovery more rewarding than substance abuse

It begins with a comprehensive analysis of potential triggers and recovery elements (so things don't fall through cracks) including academic, transportation, recreational skill development, and addressing deficits

Address the triggers, build on the development of healthy activities

Some Potential Triggers for Relapse Addressed by ACC

- 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

A Few Other Elements of ACC

Requires 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 (white on rice)

Working with family is important (unless unsupportive of youth's recovery)

How Much Does ACC Cost?

Most of the cost of ACC is time for training (which CAO is providing) and clinical staff time spent on therapy and case management

For most programs, ACC may be accomplished with existing staff

ACC cost for staff time for 90 days is $1,500-$4,500 (avg $3k), compared with $50,000 for YRTC already spent

Considering comparative cost and outcome improvements of >50%, ACC good investment

What is the 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 to the community, and/or tele-videoconferencing

Effectiveness of Prevention

Research has consistently found a return on investment of 4:1 for substance use disorder prevention activities

Many opportunities exist for potentially effective prevention activities at both the community level and the clinical level

One of the Best Early Community Interventions

One of the best established early prevention programs is Family Spirit, which was developed by Johns Hopkins University specifically for Indian Country

It pairs a paraprofessional with a pregnant woman at risk. The paraprofessional provides support and guidance to the young mother

The CAO has offered Family Spirit training for all full scope health programs (about $24k value). This year, nine programs have accepted the training

Family Spirit Effectiveness

From the John Hopkins School of Public Health website (http://www.jhsph.edu/research/affiliated-programs/family-spirit/proven-results/research-findings/):

Maternal Outcomes

Decreased maternal depression

Decreased substance use

Fewer behavior problems in mothers

Child Outcomes

Fewer behavior problems in children to age 3 (externalizing, internalizing, and dysregulation)

- Predicts lower risk of substance use and behavior health problems over life course

One of the Best Primary Care Based Prevention

Screening, Brief Intervention and Referral to Treatment (SBIRT) is the best established method

Essential elements of SBIRT include:

- Screening using a validated instrument (NM-ASSIST preferred)
- For those that score in “at risk” range, Brief Intervention is offered in the primary clinic, by any trained clinical staff
- For those that score in the “clinical” range, Referral to Treatment is recommended

SBIRT

Now reimbursed by both Medicare and Medi-Cal

Complete requirements for obtaining Medi-Cal reimbursement are found at the following Provider Manual webpage:

http://www.dhcs.ca.gov/services/medi-cal/Documents/prev_m01o03.pdf

SBIRT Training

78 Tribal & Urban Indian healthcare program staff became SBIRT-certified during the Providers' Best Practices Conference in May 2015

SBIRT Training offered again on November 30, 2016 in the John Moss Federal Building, Sacramento

Summary

Our health programs can provide good, effective and low cost continuing care services which will greatly enhance sustained recovery in our youth and effective prevention services that will make our communities healthier

Successful recovery can only be achieved by the community supporting the entire continuum of care