Outline

– 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)
Outcome Improvement with Post-treatment Continuing Care

- 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
Cost of Program

– 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
Summary

– 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