NC INSTITUTE OF MEDICINE
TASK FORCE ON SUBSTANCE ABUSE SERVICES
February 15, 2008
10:00-3:00
NC Hospital Association

Meeting Summary

Attendees:
Task Force/Steering Committee: Patrice Alexander, Bert Bennett, Sonya Brown, Barbara Boyce, Sherry Bradsher, Carl Britton-Watkins, Jay Chadhuri, Spencer Clark, Chris Collins, April Connor, Leah Devlin, Anne Doolen, Tony Foriest, David Friedman, Robert Gwyther, Paula Harrington, Carol Hoffman, Verla Insko, Larry Johnson, Kevin McDonald, Sara McEwen, Mike Moseley, Paul Nagy, Martin Nesbitt, Thomas Savidge, Jane Schairer, Starleen Scott-Robbins, Gregg Stahl, Flo Stein, Steve Sumerel, David Turpin, Wendy Webster, Cynthia Widford

Interested Persons: Jeremy Brookshire, Karen Chapple, Donna Cotter, Sheila Davies, Kathleen Gibson, Alan Hampton, Denise Harb, Jessica Herrmann, Nidu Menon, Shawn Parker, Brandon Patterson, Shealey Thompson, Mike Vicario, Melanie Whitter, Helen Wolstenholme
Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Jennifer Hastings, Mark Holmes, Pam Silberman, Daniel Shive

WELCOME AND INTRODUCTIONS
Representative Verla Insko
NC House of Representatives

Representative Insko welcomed everyone to the fifth Substance Abuse Task Force meeting. She pointed out that Task Force meetings are now scheduled through August.

RECOVERY SERVICES
Melanie Whitter
Project Director, Partners for Recovery Initiative
Senior Associate, Center for Substance Abuse Treatment
Abt Associates, Inc.

Recovery Oriented Systems of Care (ROSC) are characterized by a person-centered approach to care. The Center for Substance Abuse Treatment (CSAT) in its 2005 National Summit on Recovery defined ROSC as supporting “person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families, and communities to sustain personal responsibility, health, wellness and recovery from alcohol and drug problems.” ROSC provides a comprehensive array of services and supports that can be combined and adjusted to meet an individual’s needs throughout the continuum of care. ROSC requires a full continuum of services across multiple systems of care capable of screening and referring individuals to care (SBIRT model) as well as providing treatment services.

Recovery in the ROSC framework is characterized providing outcomes-driven approaches to care, as measured by the National Outcomes Measures (NOMs). States are currently required to collect NOMs at intake, 30-days, and at discharge to determine how clients are responding to treatment; however there is no requirement to collect NOMs after discharge.

ROSC shifts the focus from getting people into treatment to supporting the process of recovery within the person's environment. This requires ongoing systems improvement and modification based on feedback from people in recovery and their families, NOMs, and other data.

The 2005 CSAT Summit also outlined the key elements and desired outcomes of ROSCs. The first element, person-centeredness, requires access to and participation in individualized and comprehensive services across the lifespan of the recovering individual. These services need to be culturally sensitive and responsive to personal beliefs. True person-centered care requires relationship building between the clinician and the client, as well as client and recovery support system. Anecdotal evidence has shown that these partnerships are positive for both the staff and the patient. Person-centered care also requires the involvement of the recovering individual, their family, and social networks (where appropriate) in the design and implementation of their care.

A second element of ROSC is quality, specifically concentrating on efficiency and effectiveness. Quality in ROSC framework is characterized by an outcomes-oriented integrated services delivery system. Continuity of care from treatment into recovery as well as adequate monitoring and outreach, education and training are essential. Since ROSCs offer a menu of services, it is important to ensure adequate and flexible financing arrangements.

The overarching goal of ROSCs is to broaden the addictions continuum of care by working with a variety of systems to improve the quality of services and, ultimately, the outcomes of individuals and their families.

The ROSC framework is not unfamiliar to addiction treatment; however the framework has not been implemented in a systematic or efficient way. Consequently many states have implemented pieces of the ROSC framework, but lack full integration and adequate patient-centeredness. For instance, many delivery systems have recovery support services built into the treatment system, but lack access to such services prior to or after treatment. This plays into the idea that substance abuse is a chronic condition that requires a chronic care approach to treatment and recovery. This requires a philosophical change in the focus of care to be more responsive to individuals and families.

In ROSCs, treatment is viewed as one of many resources needed for the client's successful integration into the community. No one support structure is more dominant than another. Instead, supports should work together with the client, allowing the client maximum opportunity for choice and control in their own care. Measures of satisfaction

should be collected routinely from people in recovery and, where appropriate, from their families.

ROSC implementation is a priority of the federal government. Federal ROSC activities have included regional recovery meetings to assist with ROSC implementation, three white papers describing ROSCs in states, a conference report addressing emerging peer recovery support services quality indicators, a ROSC tool-kit outlining policies, administrative rules and practice guidelines, and a recovery self-assessment for states to use as they prepare their own ROSCs.

The research base for ROSCs is slowly growing; however project proponents believe that there is enough evidence supporting the effectiveness of ROSCs to move forward. There is hope that CSAT will convene another summit in 2009 that will move ROSC research forward. Current research has shown that the inclusion of preventive strategies (e.g., recovery management checkups) can reduce relapse and re-admission. An individual's age and stage of addiction at the time of treatment initiation is also important in the duration of treatment. Individuals receiving treatment at younger ages and earlier stages of addiction tend to have longer recovery careers than older and more dependent individuals. The use of mutual aid groups, such as AA, in the ROSC framework can also improve recovery outcomes. Long-term recovery is enhanced by individual choice and commitment to treatment which is facilitated by an integrated system of care. The ROSC principles of care integration and community-based treatment result in lower total medical costs compared to non-integrated, independent care models.

About eight states are in the beginning stages of ROSC implementation with another 30 implementing various ROSC components. Connecticut began promoting a recovery-oriented service system in 2002 and is considered the leader in ROSC development. Connecticut began by developing core values and principles that would embody their delivery system. Taking these principles, they established a three phase conceptual framework to guide implementation. Key aspects of this framework required building competencies and skills at all levels of the system, changing program and service structures, and aligning fiscal resources and administrative polices to support the new system goals. Connecticut has completed the first two implementation phases which addressed consensus building, identifying barriers and incentives, gathering baseline data, obtaining community investment, skills training, and development of fiscal supports. Throughout the process the state has monitored and evaluated the implementation process and made adjustments as necessary. Connecticut has been aggressive in seeking additional funding through ATR, SBIRT and mental health transformation grants. They have also partnered with Yale University to develop tool kits and Brandeis University to develop financial incentives. The Connecticut model also utilizes peer and volunteer networks.

The Connecticut model uses a variety of outcome measures including the NOMs and Washington Circle Group outcomes and performance measures. They are also developing satisfaction measures using patient input and incentives for performance and reporting.

ROSC implementation must begin with the development of a mission for reform. ROSC implementation is a multi-year process that takes ongoing systems improvement and broad consensus building with partners and stakeholders. Implementation also requires an understanding of the strengths and weakness of the existing system. The ROSC framework does not create new systems but rather enhances the strengths of what currently exists.

Comments:

Employers should play a key role in the maintenance of recovery. The employment outcome measure only shows whether a person is employed at a particular time. We need to look beyond providing employment opportunities and instead help individuals maintain employment. Employers are an integral part of the Wyoming ROSC model where they set up trusts to help finance ROSC.

The NOMs assessments seem to be looking at per treatment success which seems to run counter to the ROSC which promotes integrated, chronic care across many service systems. What happens to people when they exit the system? Ultimately, leaving the system should be considered a system failure. In the ROSC model, a discharge represents a move from one level of care to another and not a complete departure from the treatment system. As a substance abuser is never fully recovered, the goal of recovery is to maintain abstinence and activities of daily living (ADLs). This requires the individual to stay in the system between acute episodes. A primary barrier to this type of chronic care may be the lack of reimbursement for follow-up care. It will also require working with the medical professions to help them understand how people in recovery need to be treated differently.

EVIDENCE BASED STRATEGIES FOCUSED ON CHILDREN AND ADOLESCENTS REVISITED

Flo Stein (Nidu Menon, PhD declined)
Chief
Community Policy Management
NC Division of MH/DD/SAS

Adolescent alcohol and drug use occurs early, develops quickly, and often is not limited to one substance. Further complicating adolescent substance use is that it occurs in the context of rapid developmental change. Adolescent substance abusers are also rather heterogeneous, and require and individual treatment focus (amenable to the ROSC framework).

Almost 1-in-5 high school students first used alcohol before the age of 13. Seventeen percent had started smoking and 8 percent had tried marijuana by this age. Rates of past month substance use are significantly higher with 37.7, 22.5 and 19.2 percent of high school students reporting alcohol, cigarette and marijuana use respectively. A recent trend in illicit drug use among high school students has been the migration away from

more heavily enforced drugs to prescription drugs. In 2007, 17 percent of high school students reported ever using non-prescribed prescription drugs.

Middle school students are more likely to sniff glue or aerosols which can be debilitating due to brain damage. The rate of illicit prescription drug use is also on the rise among middle school students.

Even though only a small proportion of adolescents who try alcohol or drugs will develop substance abuse problems, a large and increasing proportion of adolescents are being exposed to or are using alcohol and other drugs by their final year in high school. As such, we must get all adolescents involved in prevention (either universal, selected or indicated) because almost all are exposed. Selected prevention efforts are focused on groups with elevated risk such as drop-outs and children of parents who use. Indicated prevention programs focus on individuals who are currently using but not yet abusing alcohol or other drugs. Since almost 40 percent of 12 to 17 years olds in North Carolina reported having consumed alcohol in the past 30 days, there are over 275,000 adolescents in North Carolina in need of selective or indicated prevention programs.

Of this group of using adolescents, 54,188 meet the diagnostic criteria for substance abuse treatment services. However, only 3,279 (or 6.1%) of these adolescents actually received treatment. This is due, in part, to the low amount of treatment available. The low rate adolescent treatment penetration has changed little over the years.

Failure to treat adolescent substance abuse can lead to a variety of adverse consequences such as psychiatric disorders, neurological impairment due to "huffing" and risky sexual practices. Continued substance use in adolescence has also been linked to delayed cognitive and social-emotional development.

Family and environmental factors play a significant role in adolescent substance abuse. Family dysfunction and community disorganization can both increase the risk for problem behaviors. Almost 50 percent of addiction may be genetically linked. Children of parents with substance use disorders are at increased risk of developing substance use disorders themselves. Other adolescent groups with distinctive treatment needs include homeless or gang involved youth, youth with mental health or painful chronic physical ailments, abused or neglected youth, and youth involved with the justice system.

The essential elements of a care system for adolescents differ from those of the adult system. Adolescent systems must incorporate assertive outreach to reach kids that do not want to be found. There are some successful examples of youth outreach programs but overall few such programs exist. Kids require trust and dependability which makes outreach difficult and resource intensive. The ROSC model can be utilized to reach out to other natural and community supports such as athletic coaches. Athletes tend to use more drugs than teenagers who are not, particularly younger student athletes. This is a good group for outreach because coaches can touch many more students. Similar to the adult system, the adolescent system requires a comprehensive continuum of care with continuous recovery management.

Since teenagers are still trying to learn to be adults they need their own adolescent-specific treatment services. Such services include targeted sessions that are gender and culturally focused, and programs that are focused on skill and competency acquisition. Peer influence can also play a significant to both positively influence children who are currently using and to support those children that are not using.

North Carolina has adopted an adolescent continuum of care based on the ASAM guidelines. Service definitions have been created but system capacity is lacking. As it currently stands, there is no capacity for continuity of care for adolescents. There are currently no services for children with co-occurring disorders in the state. There are currently only 8 adolescent substance abuse regional residential programs, 2 of which are only 2 years old. These programs are localized and high specialized with most having about six intensive inpatient beds with long waiting lists. These intensive inpatient programs are not needed everywhere, but the current supply is grossly inadequate (possibly double current number of programs).

Ms. Stein also presented information regarding the Description of Provider Survey results conducted by UNCG's Center for Youth, Family, and Community Partnerships. The survey was sent to adolescent substance abuse counselors (not programs) to obtain information about the use of evidence-based practices (EBPs) in North Carolina. Overall, 123 providers across 35 counties responded.

Over 85 percent of survey respondents did not have any form of substance abuse certification. Of those certified, most were Licensed Clinical Addiction Specialists (8.9%), Certified Substance Abuse Counselors (5.7%), and Certified Clinical Supervisors (4.1%).

Survey respondents were asked whether they use any of the 14 SAMHSA model/promising treatment programs for adolescents. Although the majority of providers were screening adolescents, only 37% were using evidence-based assessment tools. Over half of respondents reported not using any evidence-based treatments. Of those who did, Cognitive-Behavioral Therapy, Motivational Interviewing, and Behavioral Therapy were the most common. When asked what barriers prevent the use of EBPs, most providers cited a lack of training opportunities. Other common barriers include inability to bill for EBP coaching/training and lack of practical fidelity monitoring instruments. Almost 5 percent of providers said that they cannot fit EBPs into existing service definitions which leads to a perception problem. Not all EBPs fit into existing services definitions, but many do.

The Global Appraisal of Individual Needs (GAIN-Q or GAIN-I) is the SAMHSA preferred assessment tool. Over one-fifth of survey respondents reported that they desired more training with this instrument.

Summary results of the survey show that EBPs are grossly underutilized across the continuum of services. There is also a need for increased training and greater workforce

capacity of certified substance abuse specialists. In response, MHDDSAS with SAMHSA/CSAT grant funds has started offering introductory and in-depth training and technical assistance for a variety of screening, assessment, and treatment EBPs.

Comments:

Providers are not currently required to use EBPs. And those that are using them need to understand that one model cannot address every need. Programs need multiple models to treat diverse needs.

Workforce problems are a big issue. We are not treating much of the need now and when we do, we are doing it with untrained people. Recommendations are needed to fix this problem.

DISCUSSION OF POTENTIAL RECOMMENDATIONS

Open discussion began with the presentation of an integrated care schematic that visually depicts the interplay between prevention strategies, outpatient and primary care services, specialized substance abuse service, and recovery supports. Often times these pieces are treated as separate systems but the goal is to create comprehensive care integration in which the primary care system can provide screening, counseling and brief treatment or refer patients into more intensive treatment. There is also the expectation that patients will move back down the service spectrum as needed.

The Task Force began discussion of recommendations to be included in the interim report. Only those issues discussed through the current meeting will be included as interim recommendations. Other issues will be addressed in subsequent meetings and will be included in the final report. Draft recommendations, compiled by the Steering Committee, were handed out and discussed one-by-one. Task Force members commented on recommendation content, structure and appropriateness for inclusion as an interim rather than a final report recommendation. Task Force members were also invited to email other edits/changes to the NCIOM.

Revised recommendations based on Task Force member comments will be distributed and discussed at the March Task Force meeting.