

THE INTEGRATED CO-OCCURRING TREATMENT MODEL (ICT): A NEW TREATMENT MODEL FOR YOUTH WITH CO-OCCURRING DISORDERS INVOLVED IN THE JUVENILE JUSTICE SYSTEM



In recent years, it has become clear that a majority of youth involved in the juvenile justice system struggle with mental health disorders (Skowryra & Coccozza, 2006; Teplin et al., 2002). New research is also showing that a substantial number of these youth—approximately half of them—also have co-occurring substance use disorders (Hussey et al., 2005; Skowryra & Coccozza, 2006). One study found that 63% of juvenile detainees assessed as having a substance abuse disorder were also co-morbid for at least one mental health diagnosis (Hussey et al., 2005).

It is also becoming clear that for many of these youth, mental health and substance abuse disorders are not the only difficulties in their lives. A recent study (Turner et al., 2004) found that 44% of youth with substance abuse problems had *multiple* co-occurring problems (e.g., substance abuse, internalizing and externalizing problems, illegal activity, and/or victim-

ization), and one review of substance abuse literature (White, White, & Dennis, 2004) concludes that multiple co-occurring problems should be considered an expectation and not an exception for adolescents with substance abuse problems.

Therefore, when we think about treatment interventions for youth with co-occurring mental health and substance abuse disorders who are involved in the juvenile justice system, we need to adopt a perspective that encompasses more than just the various diagnoses that a young person has been given. We need to think holistically about the conditions, contexts, and constraints that impact a young person's life and behavior. This sort of holistic view encompasses not just the problems, but also the assets and abilities that are internal to youth or present in their environments. Thus, instead of using the term "co-occurring disorders," we prefer "multiple-occurring conditions," a term that

acknowledges the complex conditions and contexts that affect youth with co-occurring disorders who are involved in the juvenile justice system.

Integrated Treatment

Adopting a holistic perspective makes it clear that treatment for multiple-occurring conditions must be *integrated*. In general, there are three types of treatment for persons with co-occurring disorders.

Sequential treatment. Services are delivered in succession, one service at a time.

Parallel treatment. Services are provided in the same time period, but by different professionals, often in different agencies or systems, requiring different assessments and different treatment plans.

Integrated treatment. Both mental health and substance abuse services are provided by one provider or provider team in the same program, uti-

lizing one integrated treatment plan.

There is little evidence that sequential or parallel approaches are successful in treating the complete needs of youth—or adults—with co-occurring disorders. Dennis (2004) found that “substance abuse treatment helps to reduce the frequency of use and the number of abuse/dependence symptoms but has only indirect impact on emotional and behavioral problems.” Correspondingly, Geller and colleagues (1998) found that psychiatric treatment alone for mood disorders did not significantly reduce youth’s substance use. In addition, The New Freedom Commission on Mental Health (2003) reported that “if one co-occurring disorder remains untreated, both usually get worse.” In contrast, integrated services, in which the person is treated holistically by one provider or provider team, have been shown to be successful with adults, and are the recommended treatment modality for persons with co-occurring disorders (Mueser et al., 2003).

Integrated treatment for adolescents must be developmentally appropriate, and therefore differs from

integrated treatment for adults. Table 1 summarizes important ways that youth with co-occurring disorders tend to differ from their adult counterparts. These differences impact the conditions and contexts that youth experience, and must therefore be taken into account when designing developmentally appropriate treatment.

Appropriate treatment modalities for youth reflect many of these differences. Treatment for adults with co-occurring disorders has a decidedly individual focus featuring group therapy and support groups as the primary treatment modalities. By contrast, treatment for youth has a developmental and systemic focus, utilizing family therapies and placing an emphasis on system collaboration. Building on these considerations, we have worked on the development and evaluation of a new community-based treatment model designed specifically for youth with co-occurring disorders involved in the juvenile justice system. This model is called the Integrated Co-Occurring Treatment (ICT) model (Cleminshaw, Shepler, & Newman, 2005).

The ICT Model

In the Fall of 1999, through the support and guidance of the Ohio Department of Mental Health (ODMH), the Center for Family Studies at the University of Akron convened an eclectic model development group, including youth, families, and professionals representing expertise in the fields of mental health, substance abuse, and juvenile justice (state and local). The group was charged with developing an integrated treatment approach for youth with co-occurring disorders utilizing a home- and community-based service delivery model. The model development group created the ICT treatment approach based on six major components:

1. System of care service philosophy,
2. Home-based service delivery model,
3. Integrated contextual treatment addressing both mental health and substance abuse disorders,
4. Comprehensive service array matched to need,

TABLE 1. KEY DIFFERENCES BETWEEN YOUTH AND ADULTS WITH CO-OCCURRING DISORDERS

	Youth	Adults
Supports	Legally mandated supports—family, school, juvenile court, child welfare	No mandated supports
Family	More family involvement	Less family involvement
Responsibility	Parent/custodian legally responsible for youth; youth is responsible for his or her behaviors	Fully responsible for well-being and behaviors
Life Tasks	School, life skills, working toward independence	Housing, employment, physical and mental health
Self/Social Cognition	Belief in self as invincible; concrete thinking; interdependent	Increased awareness of self’s vulnerability; abstract thinking; independent
Diagnoses	Substance abuse; emotional or behavioral disorders	Substance dependency; serious mental health disorders
Sobriety	Less likely to consider sobriety as an option; earlier stage of substance use	More likely to consider sobriety as an option
Consequences of Substance Use	Fewer negative experiences; consequences have less impact; rewards of use may outweigh costs	Additive effect of consequences over time; more significant and serious consequences; increasing awareness of costs
Life Focus	Gathering experiences	Preserving life

5. Stage-wise treatment and motivational interviewing strategies focusing on adolescent development, and

6. Risk reduction and resilience-building framework.

Treatment using the ICT model is based on the following principles:

Assessment and treatment integration. Treatment for youth with co-occurring conditions should be integrated, with one provider, one assessment, and one treatment plan.

Treatment salience. Services focus on the most salient presenting symptom, concern, and/or need of the youth and family.

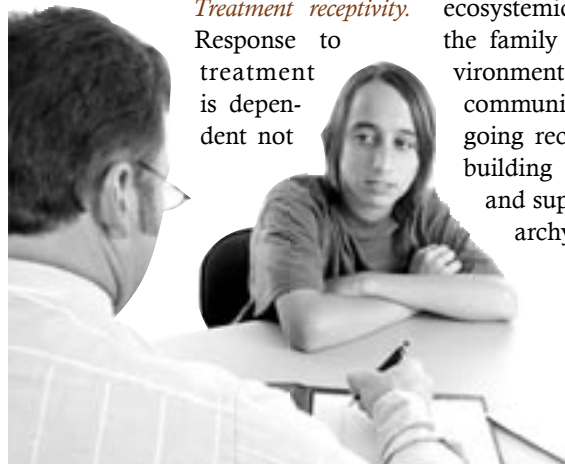
Resource preservation and enhancement. Interventions focus on maintaining the youth's and family's current resources, while building resources and supports where they are needed, with the ultimate goals of individual and family resiliency.

Treatment persistence. Providers are persistent in working with the child and family without giving up on them. When difficulties are encountered, providers are committed to changing the plan rather than rejecting the child and family from services and support.

Family competence. Partnerships are built upon a thoughtful understanding and respect for each family's unique cultural, racial, spiritual, and ethnic traditions, values, and life perspectives.

Cross-system collaboration. ICT providers take a lead role in facilitating the coordination of formal and informal services and supports, as guided by the youth and family.

Treatment receptivity. Response to treatment is dependent not



only on the consumers' motivation and readiness for change, but also their perceptions of the mandates placed upon them, providers' clinical and cultural credibility and trustworthiness, and the quality of the therapeutic alliance.

Interactive determination and contextual functioning. A youth's behaviors are interactively and multiply determined based on his or her mental health, substance abuse, functional environments, and abilities.

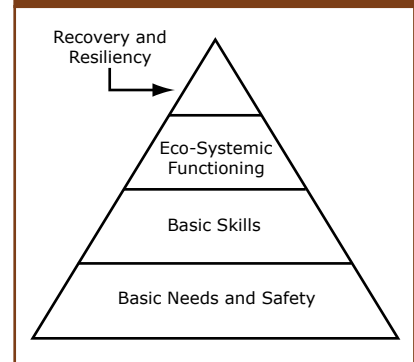
Harm reduction. ICT actively monitors and plans for safety with the goal of reducing harm, risk behaviors, and exposure to risk-generating environments.

Shared responsibility for change. The therapist is accountable for treatment persistence and model fidelity; the youth is responsible for his or her recovery; and the family is responsible for setting the stage for the youth's recovery.

Utilizing a risk and protective factor framework, ICT focuses on reducing risk behaviors and exposure to risk-generating people and environments while simultaneously fostering resilience and building developmental assets. Thus, the main goals of ICT are harm and risk reduction, reasonable functioning in major life domains, symptom reduction, relapse prevention, and ongoing recovery and resiliency. To achieve these goals ICT focuses on four main treatment areas: 1) basic needs, safety, and risk factors; 2) individual symptom reduction, recovery, and functioning; 3) ecosystemic functioning, including the family system and recovery environment, school functioning, and community functioning; and 4) ongoing recovery and resiliency, and building community connections and supports. A family need hierarchy (Shepler, 1991; Shepler & Cleminshaw, 1999) is utilized to assess and prioritize the youth's and family's needs (see Figure 1).

Strategies and interventions are matched

FIGURE 1.
FAMILY NEED HIERARCHY



to the most basic need first. Treatment focus progresses to more complex needs once the primary needs are met. A flexible array of individual and family therapies, skill building, crisis stabilization, case management, and wraparound planning are utilized to comprehensively impact family functioning and the youth's mental health and substance abuse needs.

The model has been field-tested in the community with a group of youth with co-occurring disorders who were juvenile court-involved. This pilot study compared 56 adolescents receiving ICT to 29 youth who received usual services in the community. Results indicated that the ICT youth responded more favorably. The recidivism rate for the youth receiving usual services was 72%, while it was only 25% for the ICT youth. In a separate analysis of the youth receiving ICT, functional and behavioral improvements were also noted. While these findings are promising, the results must be interpreted with caution as a true experimental design was not utilized and the number of youth studied was relatively small.

While there is an increased recognition of the prevalence and the need for services for youth involved with the juvenile justice system that have co-occurring disorders, much more research is needed to further our understanding of the special needs of these youth. The ICT model is one promising practice that was developed to address the unique needs of these youth and their families.

References

Cleminshaw, H., Shepler, R., & Newman, I. (2005). The Integrated Co-Occurring Treatment (ICT) model: A promising practice for youth with mental health and substance abuse disorders. *Journal of Dual Diagnosis, 1*(3), 85-94.

Dennis, M. (Spring, 2004). Traumatic victimization among adolescents in substance abuse treatment. *Counselor: The Magazine for Addiction Professionals, 5*(2), 36-40.

Geller, B., Cooper, T. B., Sun, K., Simmermann, B., Frazier, J., Williams, M., & Heath, J. (1998). Double-blind and placebo controlled study of lithium for adolscent bipolar disorders with secondary substance dependency. *Journal of American Academy of Child and Adolescent Psychiatry, 37*, 171-178.

Hussey, D., Drinkard, A., Murphy, M., & Ols, K. (March, 2005). *Year-one outcomes from the Cuyahoga County Strengthening Communities Youth (SCY) Project*. Poster presentation at the 2005 Joint Meeting on Adolescent Treatment Effectiveness. Washington, D.C.: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

Mueser, K. T., Noordsy, D. L., Drake, R. E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford.

New Freedom Commission on Mental Health. *Achieving the promise: Transforming mental health care in America. Final report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: Author.

Shepler, R. (1991). Integrating home-based practice: A transdisciplinary model for treating multi-need families. In P. Cibik, S. Gwatkin, C. Pastore, & R. Shepler (Eds.), *A practitioner's guide to home-based services: A resource manual* (pp. 311-331). Akron, OH: The Center for Family Studies, The University of Akron.

Shepler, R. N., & Cleminshaw, H.



(1999). Community-based intervention for families. In L. VandeCreek and T.L. Jackson (Eds.), *Innovations in clinical practice: A source book* (pp.413-430). Sarasota, Florida: Professional Resource Press.

Skowrya, K., & Coccozza, J. (2006). *Blueprint for change: A comprehensive model for the identification and treatment of youth with mental health needs in contact with the juvenile justice system: Executive summary*. The National Center for Mental Health and Juvenile Justice Policy Research Associates, Inc. and Office of Juvenile Justice and Delinquency Prevention.

Teplin, L., Abram, K., McClelland, G., Dulcan, M., & Mericle, A. (2002). Psychiatric disorders in youth in juvenile detention, *Archives of General Psychiatry, 59*, 1133-1143.

Turner, W. C., Muck, R. D., Muck, R. J., Stephens, R. L., & Sukumar, B. (2004). Co-occurring disorders in the adolescent mental health and substance abuse treatment systems. *Journal of Psychoactive Drugs, 36*,455-462.

White, M. K., White, W. L., & Dennis, M. L. (Spring, 2004). Emerging models of effective adolescent substance abuse treatment. *Counselor: The Magazine for Addiction Professionals, 5*(2), 18-21.

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