

## Meeting Notes

**Vermont Department of Health Division of Alcohol and Drug Abuse Programs**  
Adolescent and Young Adult Treatment Provider Meeting at the  
7<sup>th</sup> Annual Vermont Conference on Addictive Disorders  
October 5, 2012

### In the Room

1. Craig Smith, Valley Vista
2. John Mann, Valley Vista
3. Aleda Stith, Northeast Kingdom Human Services
4. Terry Kelleher, Behavioral Health and Wellness of Lamoille
5. Gwen Koenig, Rutland Mental Health
6. Annelise Ulrich, Rutland Mental Health
7. Karen Macaulay, Rutland Mental Health
8. David O'Brien, United Counseling Service of Bennington
9. Patricia Marshall, United Counseling Service of Bennington
10. Mitch Barron, Centerpoint Adolescent Treatment Services
11. Kayla Tatro, Northwestern Counseling and Support Services
12. Howard Hood, Central Vermont Substance Abuse Services
13. Mary Gratton, Northwestern Counseling Services
14. Barbara Cimaglio, VDH, ADAP
15. Marcia LaPlante, VDH, ADAP
16. Jackie Corbally, VDH, ADAP
17. Amy Danielson, VDH, ADAP

### On the Phone

18. Corinna Stewart, Counseling Services of Addison
19. Doug Norford, Rutland Mental Health
20. Robin Rieske, VDH, ADAP, Prevention Consultant, Brattleboro
21. Julia Davenson, Youth Services of Windham County
22. Brenda Gooley, DCF, Central Office
23. Justin Tauscher, Spectrum Youth and Family Services
24. Annie Ramniceau, Spectrum Youth and Family Services
25. Bert Klavens, Washington County Youth Services
26. Kerri McClaury, VDH, ADAP, Young Adult Advisory Team (YAAT)
27. Emily Hawes, Clara Martin Center

\*\* Please let me know if I missed someone ([amy.danielson@state.vt.us](mailto:amy.danielson@state.vt.us))

### Welcome and Introductions

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#### Barbara Cimaglio

- Vermont has only a few dedicated adolescent treatment providers
- It is challenging to provide robust services to adolescents given that so few providers in Vermont have a sole focus on treating adolescents
- Core questions

- How do we get sufficient focus on adolescent treatment in all of our agencies?
- Who do we partner with so we can bring the expertise of the adolescent substance abuse field to your agency in a meaningful way?
- We are not going to grow more adolescent specialty providers, however, we CAN grow the adolescent treatment expertise
- We need to consider co-occurring issues, partnering with DMH, DCF and others, healthcare reform
- We hope that this group will be forward thinking
- And that you will challenge your administration, as well as us as the administration locally and statewide so that we can rise to this challenge
- The 18-25 year old population clearly is the population with the highest drug use
  - Speaks to the need for more prevention, earlier intervention, and appropriate treatment
- We hear from Valley Vista, these kids are so sick when they get here, how can we do more sooner?
- We are hopeful and we want to do things differently in FY' 14
- I will go on the record for saying that it is appalling what has happened with the deterioration of the system. If you don't spend your money it is moved somewhere else. This has had a negative effect which we want to counteract
- We need your help and your organization's help to understand how to place more focus on adolescents and young adult substance abuse treatment for FY' 14
- We really appreciate you being here

**Corinna Stewart, Counseling Services of Addison County**

I represent the youth and family service program which integrates an adolescent substance abuse program into our broader mental health and family support program

**Doug Norford, Rultand Mental Health**

I am interested in learning some good ideas of how to enhance our program

**Robin Rieski, Prevention Consultant, Brattleboro**

I am concerned about lack of treatment services in Brattleboro, and have been talking with parents, SAPs, treatment providers about what we might do to shore up more support for youth in this area

**Brenda Gooley, DCF, Central Office**

I am a liaison for Family Services to the Hub and Spoke effort

**Justin Tauscher, Spectrum Youth and Family Services**

I am looking to help identify any holes in the treatment system and to understand how to enhance and pair services with other providers

**Emily Hawes, Clara Martin Center**

I am looking forward to creativity and planning around providing services to these groups

**Mary Gratton, Northwestern Counseling Services**

The St. Albans area is currently giving Valley Vista a lot of business. We provide services from Richford to Isle La Motte—a very large area. We have schools reaching out to use for support. We have a meeting in a few weeks with 3-4 different high schools up in the corners of Vermont to try to figure out how we can help these kids. Both the schools and the parents are asking for help.

**Aleda Stith, Northeast Kingdom Human Services**

I work with both adolescents and young adults. I collaborate with Northeast Kingdom Youth Services and Elm Street Transitional Living Program, work with homeless youth in the community, and I do a lot of outreach work

**David Obrien, United Counseling Service**

We are under resourced to keep up with adolescent services, these services are the bottom rung of all the demand that comes in and we aren't being proactive—we are taking care of business as it comes in. We are trying to be more intentional and link to other partners.

**Mitch Barron, Centerpoint**

I am interested in discussing the practices that are working well in some parts of the state and to find ways to share, generalize, build these practices in other parts of the state

**Terry Kelleher, Behavioral Health and Wellness**

One of the biggest problems we have is engaging youth who don't think they have a problem- getting youth to access services

**Annelise Ulrick, Rutland Mental Health**

We have coordinated with DCF, schools and Family and District Court to develop an IOP for kids in the community who have both legal issues and problems at school. I would like to increase access to services for kids who need higher levels care

**Karen Macaulay, Rutland Mental Health**

In the mental health side we see the impact on the kids of parents' drinking and drugging. My concern is the lack of support for kids.

**Jackie Corbally, ADAP**

- I have a professional and personal interest in figuring out where we are going in the future with serving the needs of youth and young adults
- At ADAP we are working on the Hub and Spoke initiative.
  - We need to have the conversation around 18-25 year olds and how they will engage in a Hub or a Spoke; what are the services that we need to have in place to meet the needs of these young people in the Hub and Spoke model?
  - Also, how do the 17 and 18 year olds fit in to the Hub model, do they fit in, or not? If they don't how do we give them the same access to services that their older counterparts will get by coming into a Hub?
- This meeting is a starting point. More meetings to come.
- This is a remarkable turnout for this meeting

## **Data Slides**

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**Barbara Cimaglio** There has been an increase in the rate of heroin and opioid use among 18-25 year olds in Vermont. We are also seeing this jump nationally. This is a very worrying trend.

**Craig Smith**- at Valley Vista less than 5% our admissions come from referrals from the preferred provider system. We are an ASAM driven system, I assume that everyone else here and on the phone has embraced the ASAM criteria for placement. It is also true for the adult system- about 5% come for referrals from the preferred provider system. During these future meetings hopefully we will examine this. Other referrals come from DCF, Drug Courts.

**Barbara Cimaglio**- Our goal is to create a system, a system from prevention to recovery that includes families and communities. We want you to help us from your vantage point to identify means to create a system of care from prevention through recovery, as system that will be easy for people to connect to. As in general in Health Care reform- we are concerned with people bouncing around from place to place without being connected- we want to provide a coordinated system of care that avoids people receiving care randomly.

**Carinna Stewart**- we have low number adolescents registered as being in substance abuse treatment, however in the Department of Mental Health data we have some of the highest saturation of emotionally and behaviorally challenged youth. A lot the substance abuse treatment at CSAC happens within the context of the family and it is fully integrated within behavioral health treatment. It continues to be an area of frustration for us to capture the number of adolescents who are being treated for substance abuse within CSAC. It is also frustrating to have two systems, VDH and DMH, not truly collaborating as funding sources. Another piece- how many kids are receiving a level of treatment in the schools? When you look at the core functions and what folks doing in schools, they are performing everything except a formal assessment, and in some cases we are having them do the formal assessment. But not through ADAP grant money. Other programs may not have substance abuse treatment fully embedded in behavioral health treatment and therefore more numbers are showing up in substance abuse treatment.

**Barbara Cimaglio**- It is my understanding that Medicaid reporting can record up to 10 diagnoses. I would be interested to know if someone comes in the mental health door but has as substance abuse issue- is that being reflected in the Medicaid data? This is an important topic to understand in light of health care reform and the goal of better integrated care.

**David O'Brien**- Maps of numbers in treatment: it would be interesting to separate outpatient and residential. In our agencies these clients are being seen in specialized children's treatment services. The number is definitely underreported in our area. If you separate things out you might see that the higher proportion is in residential in Bennington county.

## **Discussion**

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**Jackie Corbally-** We at the State recognize the expertise and creativity that exists in you and your agencies when it comes to serving these populations. We want to take advantage of this as we look to FY'14. This is an opportunity for us to learn and for you. What are your promising practices? Are there promising practices you would like to implement but haven't have the recourses or buy-in?

**Mitch Barron-** Funding comes in boxes and the administration comes in boxes or with restrictions. We no longer try to fit the kids or young adults into the boxes. We worked hard to put together services for family and clients, not programs. We provide a range of services and supports, at school, in the home, at the agency that total an IOP service level. No more boxes or programs. That lens has allowed us to grow services in lots of different ways. Last year we saw 645 kids and families. About 300 walked into the clinic door. The others did not. We brought services to them. In Burlington we have a strong college campus base- we are in partnership with three of our local colleges. We provide service when their needs exceed what their college counseling services can provide. There is no wrong door. We have multiple points of access with flexible service design and in this way remove the obstacles to treatment for most people.

**Rutland Mental Health-**Court diversion or DCF- referrals we get through the courts system completion rate is higher. Having negative consequences help. If kids are in DCF custody, receiving treatment can be a motivational tool to be reunited with their families. You can go to Valley Vista or you can go to Woodside—you decide.

**Jackie Corbally-** We are looking to remove the boxes. When a family or person is looking to access treatment, are they able to get those services in the community or in the state regardless that they are a certain age? How many of you are connected to your primary care doctors in the community?

**Corinna Stewart-** Yes for kids under 18. No if over 18-these clients don't see themselves as having their own primary care doctors. This population is difficult in that way

**Mitch Barron-** we provide services in the primary care clinics.

**Jackie Corbally-**What are the services that you think are crucial for these age groups to have?

**Mary Gratton (12-18)** Need Transportation and Case Management. It is almost a relief when they enter the drug court in St. Albans because we know that they will get wrapped with services. There is no one going with these kids to their meetings to their school meetings, to facilitation healthcare visits, gynecological visits for young women

**Craig Smith-** 18-25 year olds. Psychiatric need is huge. And transportation.

**Aleda Stitch-** Case management need is huge. I go on home visits with DCF. More Family work/family therapy. Wrapping the family with services  
The homeless in St. Johnsbury receive case management but it is not well coordinated

More collaboration in general is needed- I am doing a lot of outreach with schools, primary care doctors—just trying to get people to talk

**David O'Brien-** Our greatest hope is in collaborating with specialized children's services. We have begun that. We have a relatively new therapist from another program I have asked her to collaborate with the specialized children's services to provide more supports for outpatient clients. We also will work with diversion. We are hoping to build, but have the same challenges as others.

**Barbara Cimaglio-** What can we do at the state level to support you. Challenge of opening a case. If you had one place to open a case, multiple services could be recorded without having to go through a lot of different paper work. Would this integration at the administration level help?

**Corinna Stewart-**yes, yes, yes

**Barbara Cimaglio-** I know full well that some of the barriers will be administrative

**Corinna Stewart-** It would help if you allowed some early intervention and treatment to occur before the assessment or urine screen happens. With this group it helps to become their ally first. Help them find housing, work, etc, than address the treatment piece. Have an **Open Light** level in which you do case management piece and outreach before you open them fully for treatment.

Also, it would help to not have to close a case after 30 days of not seeing a client. We do not have to do this in Mental Health. It is inherent to the population that they fall off the map—then they come back. This is an administrative nightmare.

**Barbara Cimaglio-** this is a federal requirement. I think we will let the feds now that we will become out of compliance with this. I know that other states have already done this. We will look into moving it to 60 days.

**Mitch Barron-** I like Corinna's idea of **Admission Light**, or **Open Light**. Allow client to be admitted based on a screening for a certain amount of time. In addition, I think of developmentally matched services 12-13, 14-16, 16-18, 17-19 are populations, not 12-18. We have exploded around parent skills training parent interventions, THEN family therapy. I want to see fewer parents say you are 16 or 18, get out of the house. We want to give families resources and still to avoid this so that it doesn't become a cliff, and we are picking up the pieces after this. We are bringing an SBIRT model into one of our high schools- it will change the way the school responses to their substance abuse issues. Bring promising practices- to appropriate settings.

**John Mann-** I like what has been said. I think in the outpatient world- the **Light Outpatient** idea is good. In the real world you end up doing the assessment twice anyway- once for the record and the second time to find out what is going on. At Valley Vista, Centerpoint is an easy step-down for us. If client is going to a place with fewer

services we are often trying to build services in the community- which is difficult. Often IOPs do not exist. Case Management is critical, especially if a mentor like relationship is established with youth or young adult. About 90% of young adults who come to Valley Vista do not understand their eligibility for level of care. Medication follow-up is difficult- help primary care doctor be comfortable with this- create a support for the doctor. Develop community flow chart- how to track a case through the system at the community level. Take a collaborative look- so providers aren't shooting in the dark.

**Corinna Stewart-** Adolescent population who need Buprenorphine- can primary care providers prescribe for their adolescent clients? I think primary care doctors would do this if they knew that they could take care of only their patients.

**Jackie Corbally**—any doctor can provide Buprenorphine if register with DEA after taking an online training (takes 8 hours).

**Barbara Cimaglio-** We are eager to get more medical providers, especially for young adults for the Hub and Spoke initiative.

**Howard Hood- Light Admission-** We do early intervention services. Kids can come in who need early intervention- If they qualify for the brief intervention- we can give them up to 7 session, family, group, some case management. This is our second year providing this. I have done marketing to let people know we have this to offer. For 12-18, family engagement is an expectation, even for the screening. We do a lot of family therapy. Big issue is parity with mental health. We work with criminal justice, community justice center, DCF. Start the assessment right at the court house. At Mental Health, you can bill for emergency case management, and open a case without a lot of paperwork. We can't do this in substance abuse. We do not have a way to make these services self supporting.

**Annelisse Ulrich-** Good coordination with Family Court and DCF. We need the outreach in the community to increase awareness at the school level for need for treatment. Court pretty much mandate youth to treatment- we call our program I-Track. The problem we have is that we are not reaching youth before they get into trouble. Need funds for educational outreach in schools. Reach youth and the families before the youth get into trouble. Schools are referring youth to our services who have been suspended.