Adolescent Substance Abuse Needs and Services Planning Final Report

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This report was prepared by the Public Health Institute for the Alcohol and Drug Policy Institute and Charles and Helen Schwab Foundation. The report was written by Dorie Klein, Patricia Shane and Giselle Barry.

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EXECUTIVE SUMMARY

Alcohol and other drug treatment for youth is currently at a turning point, both in California and in the nation as a whole. Services are emerging rapidly in response to needs that are being made visible as a public policy priority. Initiatives to improve treatment effectiveness and build capacity through collaborations are being supported at the federal level and through the private philanthropic sector. However, the system is still in its infancy, and, unless progress is maintained, youth who need treatment will continue to go without help, struggling with alcohol and other drug problems as well as complex difficulties with their families, education, and the legal system.

This report is the product of an initiative to develop a comprehensive system of care for adolescents with alcohol and other drug (AOD) problems in California. The report was commissioned by the Alcohol and Drug Policy Institute (ADPI), created by the County Alcohol and Drug Program Administrators Association of California, the association of administrators for alcohol and drug services in the 58 counties in the state. The report was sponsored by the Charles and Helen Schwab Foundation, a private charitable organization that stewards a philanthropic vision of building partnerships to improve lives through direct service and partnership in grantmaking initiatives. One of the foundation's key program areas is substance abuse, in which it advocates for building organizational capacity, expanding treatment for adolescents, and supporting systems change in the funding and provision of care.

The preparation of this report by the Public Health Institute (PHI) team began in early 2003, through consultation with the Board of Directors and Executive Director of ADPI, and with the Charles and Helen Schwab Foundation's Substance Abuse Program Officer. The next phase in the report preparation was a series of expert panels, held in mid-2003, designed to draw upon the expertise of policymakers, practitioners, administrators and researchers in adolescent AOD treatment, prevention, mental health, child welfare, juvenile justice, education and health care. In the final phase, the PHI team produced a draft report, which was reviewed by the ADPI Board of Directors, Schwab Foundation managers, and members of the County Alcohol and Drug Program Administrators Association of California at a retreat in mid-2003.

The organization of the report follows the identification by ADPI and the Schwab Foundation of four key areas of focus in the issue of adolescent substance abuse: establishing the need for adolescent AOD treatment; describing the current system and its limitations; identifying elements of a model treatment system; and identifying current and potential revenues for financing the model.

The first chapter of the report, Definition of the Problem, focuses on the prevalence and incidence of AOD use and AOD-related problems among youth, based on information about the general adolescent population, information from the public sectors serving AOD-involved youth, and national data on youth entering treatment. National and state-level information from household and school-based surveys of the general population are summarized. They reveal numbers that, while differing according to each survey's method, show that as many as one in four older high school students in California reports recent binge drinking, and a similar number report the use of an illicit drug. Because youth with AOD-related problems often present to juvenile justice, child welfare and other services, available survey or surveillance data from these sectors are also presented. For example, there is some evidence that rates of substance use disorder may be one-third in some juvenile justice populations of youth, estimated to be far greater than would be found for all youth. The chapter's following section describes data from national databases characterizing youth entering substance abuse treatment, including the predominance of marijuana and alcohol use, and of juvenile justice referrals. The chapter concludes with estimates of the need for treatment. The Center for Substance Abuse Treatment reports that one in 10 adolescents who need substance abuse treatment actually receive services, and of those, only 25% receive enough treatment.

Chapter 2, Description and Analysis of Current Treatment System and Services, describes the current treatment system and services in California, issues and needs recently identified in the field, and efforts to expand the system and develop statewide standards of care. It is estimated that of almost 400 publicly funded AOD treatment programs, nearly 150 are serving youth. Information in the California Department of Alcohol and Drug Program's (ADP) database--the California Alcohol and Drug Data System (CADDS)-- and findings from a survey of 20 selected counties by the report's

authors, both suggest that, of youth entering treatment, approximately 80% receive outpatient care. In the survey, over half the counties report also offering school-based "early intervention." Just under one-third of the sampled counties report having short-term residential treatment, and one-fourth report having long-term residential treatment. The numbers of admissions of youth in the CADDS system in the past five years has almost doubled, rising from 11,000 to 20,000, although it should be noted that the database does not receive information from a number of youth services, including those primarily outside ADP's funding stream. Over half the youth admitted to treatment in CADDS are referred by juvenile justice, followed by school referrals. Family and self-referral are far less frequent portals to treatment. Marijuana and alcohol are identified as the primary problem substances. One-fourth of the youth admitted to treatment are reported as having had prior treatment. Discharge data, although not complete, indicates that half of all the youth leaving treatment have left without satisfactory progress. Information on clients' assessed needs, services delivered, treatment models or approaches, and funding is not collected in CADDS. Results of the authors' survey of a sample of county administrators and youth treatment providers are presented on systemic resource needs and treatment delivery issues widely identified by the field. The chapter concludes with the recent history of initiatives by ADP and a statewide workgroup to develop youth treatment guidelines and draft standards.

Chapter 3, Treatment System Design, builds on the unmet needs and emerging opportunities identified in earlier sections, and addresses in detail the attributes of a model AOD treatment system for youth in California. It suggests systemic principles, including broadening access to care, and implementing the principle of "no wrong door" to treatment, through the creation of "open doors," enabling all adolescents ready access to care in an environment free from stigma and recrimination. The chapter recommends that procedures for early identification of AOD problems and linkages to the treatment system should be developed in schools and other settings where youth receive services. Throughout the network of youth-serving agencies, evidence-based protocols for screening, assessment and referral should be collaboratively adopted. Related components crucial for broadening youth's access to

treatment are initiatives to reduce the stigma of receiving AOD treatment, and disseminating information about its availability and effectiveness.

Broadening access will require creating a continuum of care to address youths' multiple assessed needs within such domains as education, family relationships and mental health, as well as AOD abuse. It will also require placing AOD treatment for youth within the framework of public health, drawing on health promotion elements. The continuum of care should allow for continuity of care and the placement of youth in at clinically appropriate level of treatment, with "stepped up" and "stepped down" referral as indicated in the American Society of Addiction Medicine's Patient Placement Criteria. The delivery of treatment should be community-based, in the least restrictive setting possible, and accessible to youth and their families in each region of the state.

Chapter 3 next proposes re-designing youth AOD treatment to improve its effectiveness, building on the findings in the emerging scientific literature, primary research conducted by the report's authors, and the experts' input collected for this project. A key principle for treatment design is that the services must be driven by the needs of adolescents and their families. Treatment plans must respond to the individual client's comprehensively assessed needs, and the services that are planned and delivered must address multiple domains. Treatment models should be developmentally appropriate to youth as they transition from childhood to adulthood. Interventions that have been evaluated and found to be effective are noted. Such interventions feature the involvement of parents, family members and caregivers. They seek to engage and retain clients through a trust-based "therapeutic alliance." Treatment goals include outcomes and benchmarks that can be measured. A continuum of care includes follow-up services to sustain gains. At all levels of care, the interventions should be gender-specific, and culturally appropriate to the diversity of California youth and their families. The settings for care should maximize elements of physical and emotional safety, and include settings accessible to youth with special service needs, including youth not living at home and those with emotional disorders.

The chapter then focuses on the importance of developing program standards and performance monitoring. The potential roles of state standards for programs and

staffing are discussed, including the development of staff proficiency with respect to knowledge of adolescent development as it affects treatment. To monitor and evaluate program performance, a minimum youth-specific data set will be required, both to hold agencies accountable and to support policy development and future capacity building. A database that covers client needs, service delivery, program performance and client outcomes will require system-wide utilization of common measures. To this end, development of youth-appropriate measures for inclusion in the California Outcome Measuring System (Cal-OMS) is recommended. The chapter concludes with recommended steps and policy considerations for strategic planning of the treatment system, including examples of initiatives in other systems of care that may serve as guides.

The final chapter, Financing, turns to current youth AOD treatment funding streams and potential opportunities to support the model system outlined in the previous chapter. Current funding is inadequate to meet the requirements previously identified in the report, as well as being insufficiently flexible to support the comprehensive services required to address youths' needs. Revenue streams within the AOD sector itself are discussed, such as treatment funds allocated to the county AOD administrations through the state ADP, and funding streams within Drug Medi-Cal, the state's Medicaid program to provide AOD treatment. Opportunities for youth treatment within Drug Medi-Cal, and within Mental Health Medi-Cal, are explored, including those that may be provided within the federal Medicaid program of Early Periodic Screening, Diagnosis and Treatment (EPSDT). Other health-related funding streams, such as California's Healthy Families public health insurance program, are considered.

Relevant revenues in other public sectors are described, particularly those that have been utilized for AOD youth treatment within child welfare, including the funding of group homes as settings for residential treatment, and those within juvenile justice, such as grants to probation for services to institutionalized and adjudicated youth, and to high-risk youth in the community. School services, including school-based prevention and new broader federal programs that may include early intervention, also are addressed. Opportunities for sharing existing or expanded resources between

AOD treatment and these sectors are identified. Some strategies that would support combined funding, including advocacy of regulatory changes, are suggested.

The last section of the chapter notes the potential for future new revenues in both the public and private sectors. This discussion draws upon national and state-level initiatives to develop new sources for funding both public youth AOD services and privately financed AOD treatment. It is suggested that a model AOD treatment system for youth would include the fiscal participation of the private insurance sector, which funds the health care of over 60% of California's adolescents. The chapter concludes with elements for making the important fiscal argument that comprehensive treatment of youth would be effective from the societal viewpoint of future cost avoidance.

It is the authors' hope that this report contributes to the burgeoning movement to create a system of AOD treatment for youth, one that is designed above all to meet their needs and the needs of their families.

Acknowledgments

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We would also like to thank the individuals who participated in our expert panels, who are listed in Appendix I. Their generosity with their time and their valuable insights on designing adolescent treatment are very much appreciated.

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Introduction

This report is the product of an initiative to develop a comprehensive system of care for adolescents with alcohol and other drug (AOD) problems in California.

The report was commissioned by the Alcohol and Drug Policy Institute (ADPI), a nonprofit institute created by the County Alcohol and Drug Program Administrators Association of California (CADPAAC) in order to develop statewide policy initiatives in the substance abuse field. Its mission is to advance the field through knowledge development and information dissemination. The strategic planning processes of both ADPI and CADPAAC, including the association's youth committee, have identified the expansion and enhancement of treatment for adolescents as urgent priorities.

The report was sponsored by the Charles and Helen Schwab Foundation, a private charitable organization that supports the identification of critical social policy issues and the development of approaches and programs to meet social needs. One of its focal areas is substance abuse, including the creation and expansion of adolescent services. The foundation funded the report as part of its initiative to encourage systemic change in substance abuse treatment delivery.

The preparation of this report began in early 2003, through consultation with the ADPI Board of Directors and Executive Director, and with the foundation's Substance Abuse Program Officer. These individuals also responded to a formal survey of values and priorities in youth AOD treatment developed by PHI.

The next phase of report preparation was a series of expert panels held in mid-2003 throughout California. Three regional panels (Southern California, Bay Area and Northern/Central California) and a state-level panel (Sacramento) were held in order to draw upon the expertise of policymakers, practitioners, administrators and researchers in adolescent AOD treatment, prevention, mental health, child welfare, juvenile justice, education and health care. The participants' names and affiliations are included in Appendix I. In addition, semi-structured telephone interviews were conducted with a sample of county AOD administrators and treatment providers in the summer of 2003.

The PHI team developed a draft report which was reviewed by the ADPI Board of Directors, the foundation's Substance Abuse Program Officer, and members of the CADPAAC Youth Committee at a two-day retreat in late 2003.

The organization of the report follows the identification by ADPI and the Schwab Foundation of four crucial elements: establishing the need for adolescent AOD treatment; describing the current system and its limitations; identifying elements of a model treatment system; and identifying current and potential revenues for financing the model.

Alcohol and other drug treatment for youth is currently at a turning point, both in California and in the nation as a whole. Initiatives to improve treatment effectiveness and build capacity through collaborations are being supported at the federal level and through the private philanthropic sector. However, the system is still very much in its infancy, and, unless progress is maintained, youth needing treatment will continue to go without help, struggling with difficulties with their families, schools and the legal system.

It is our hope that this report will contribute to the burgeoning movement to create a system of AOD treatment for youth, one that is designed above all to meet their needs and the needs of their families. This will not be a short-term initiative, but is likely to take many years of sustained innovation, dedication and patient investment by many individuals and organizations. The reward will be ensuring that all young people with substance abuse problems have the opportunity to overcome these challenges so they may live productively and contribute to society.

Chapter 1
Definition of the Problem

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Adolescents' use of alcohol and other drugs (AOD) increases their risk of experiencing problems in different aspects of their life. This chapter presents estimates of alcohol and other drug use and indicators of the need for treatment in both the general youth population and in special adolescent populations in California. This chapter also reports on substance use patterns for adolescents who are entering treatment.

For the information on youth needs, this chapter draws on the most widely used national and state survey and surveillance data. The definition of prevalence and depth of AOD treatment need for youth is broadly drawn. Chapter 3 focuses on the model treatment capacity that arises from these estimated needs.

Specifically, this chapter highlights:

- The prevalence and incidence of AOD use and AOD-related problems;
- AOD use patterns and characteristics for adolescents entering treatment; and,
- Estimating the need for adolescent treatment.

A. PREVALENCE AND INCIDENCE OF ALCOHOL AND OTHER DRUG USE AND RELATED PROBLEMS: GENERAL POPULATION

National

At the national level, three major surveys provide estimates of the prevalence and incidence of AOD use in the general youth population: the National Survey on Drug Use and Health (NSDUH), Monitoring the Future (MTF) and the Youth Risk Behavior Survey (YRBS).

National Survey on Drug Use and Health

Results from the 2002 National Survey on Drug Use and Health (NSDUH) household telephone survey indicate that, for youth aged 12 to 17 in the sample, 17.6% report current alcohol use, or having used alcohol in the past 30 days.[1] Fully 10.7% of youth report current binge drinking (having five or more drinks on the same occasion at least

once in the past 30 days). Two percent of youth report "heavy" alcohol use, defined as five or more drinks on the same occasion on at least five different days within the past 30 days.

For other drugs, 11.6% of the sampled youth report "current drug use," that is, having used an illicit drug at least once in the previous month.[2] This includes 8.2% reporting marijuana use. And 5.7% of youth used any illicit drug other than marijuana, which includes cocaine, methamphetamines and inhalants.

When examining subpopulations of the survey, males and females were found to have comparable rates of reporting past-month alcohol use (17.4% of males and 17.9% of females). The rates of reported current other drug use also are similar, with 12.3% of males and 10.9% of females indicating illicit drug use in the past 30 days.

Monitoring the Future

The 2002 Monitoring the Future survey collected data from national samples of 8th, 10th and 12th grade students on substance use and a variety of other behaviors and attitudes. In the 2002 survey, the proportions of 8th, 10th and 12th graders who report drinking alcohol in the past 30 days are 19.6%, 35.4% and 48.6%, respectively.[3] Twelve percent of 8th graders, 22.4% of 10th graders, and 28.6% of 12th graders report consuming five or more drinks in a row in the last two weeks. The percentage of 12th graders who report "being drunk" (as opposed to simply having consumed a drink) is 30.3%, and the percent who report past-month daily alcohol use is 3.5%.

For other drugs, findings are that 10.4% of 8th graders, 20.8% of 10th graders and 25.4% of 12th graders report having used an illicit drug in the past 30 days.[4] Eight percent of 8th graders, 17.8% of 10th graders and 21.5% of 12th graders used marijuana. Almost 12% of 12th graders used illicit drugs other than marijuana. And 6% of 12th graders report past-month daily marijuana use.

Youth Risk Behavior Survey

The Centers for Disease Control (CDC) conducts the Youth Risk Behavior Survey (YRBS) among a sample of students in grades 9 through 12 every two years to monitor health

risk behaviors that contribute to social problems among youth, including alcohol and other drug use. The 2001 YRBS finds that 47.1% of surveyed students report having consumed alcohol in the past 30 days.[5] Almost 30% of students report "current heavy drinking," or having had more than five drinks of alcohol on more than one occasion. Twenty-four percent of surveyed students had used marijuana.

Overall, male students (33.5%) were more likely than female students (26.4%) to report heavy drinking. Male students (27.9%) were also more likely than female students (20%) to report past-month marijuana use.

White and Hispanic students (50.4% and 49.2%, respectively) were significantly more likely than Black students (32.7%) to report current alcohol use.

Asked about AOD-associated health risk behaviors during the 30 days preceding the survey, 13.3% of students report having driven a car or other vehicle after drinking alcohol. Almost 31% of students report having ridden more than one time during the past month with a driver who had been drinking alcohol.

Differences can be seen in the prevalence of AOD use reported in the three surveys. It should be noted that the surveys differ considerably in terms of populations covered, methods of sampling, questionnaire design and wording, and form of survey administration. Reported rates of substance use tend to be highest in the YRBS and lowest in the NSDUH. This may be due to the fact that the NSDUH is conducted by telephone while youth are at home, while the other two surveys are administered in writing in classrooms. It should also be noted that school surveys do not include school dropouts and non-attendees, segments of the youth population that have been found to have higher rates of substance use. Also, the requirement for prior parental consent may exclude many youth with higher rates of substance use from participating in a survey.

California

At the state level, data on the prevalence and incidence of youth AOD use are more limited than at the national level. This section presents findings from the major school survey, as well as several other efforts to estimate adolescent AOD use in California.

California Student Survey

The California Student Survey (CSS) is the primary statewide survey of alcohol and other drug use among California public and private secondary school students, administered to students in grades 7, 9 and 11 in a randomly selected representative sample of schools.

For the 2002 CSS survey, a little over 10% of 7th graders, 29.3% of 9th graders and 40.7% of 11th graders report having had at least one alcoholic drink in the previous 30 days.[6] And 21.4% of 11th graders report having at least one drink in the past three days. Binge drinking in the past 30 days is reported by 3% of 7th graders, 13% of 9th graders and 26% of 11th graders.

Past-month use of any drug was reported by 6% of 7th graders, 16% of 9th graders and 25% of 11th graders. Four percent of 7th graders, 13.5% of 9th graders and 23% of 11th graders report marijuana use. Among 11th graders, 14.6% report the use of marijuana in the past three days.

For AOD use at school, 3.5% of 7th graders report current use of alcohol on school property, and 8% of 9th graders and 9% of 11th graders report this. The use of marijuana on school property in the past 30 days is reported by 3% of 7th graders, 6% of 9th graders and 8% of 11th graders.

Responding to questions about drinking and driving, 41.1% of 7th graders, 23.3% of 9th graders and 29.9% of 11th graders report having driven while intoxicated or driving at least once in their lifetime with someone who was intoxicated.

National Household Survey on Drug Abuse, California

Using data from the 2001 National Household Survey on Drug Abuse (NHSDA), the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) prepared state-level estimates for different measures related to substance use or mental health based on an average for the combined years 2000 and 2001. Below are the findings for California.[7]

- In the California sample, almost 15% of those aged 12-17 report alcohol use in the past month, and 9.2% report binge drinking in the past month. Eleven percent of those 12-17 report past-month use of any illicit drug. Eight percent report past-month use of marijuana, and 4.9% report use of any illicit drug other than marijuana. Additionally, based on criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), an estimated 4.9% of 12-17-year-olds report alcohol abuse or dependence in the past year, and 5.4% report other drug abuse or dependence.

California Department of Education

Another source of AOD-related problems is the school system. During the 2001-2002 school year, the California Department of Education (CDE) reported through its DataQuest system that, of 19,209 students ordered for expulsion or mandatorily expelled, 8,133 (42%) were expelled or mandatorily expelled for violations related to alcohol or drugs (including, sale, possession, being under the influence or use).[8]

Annually, the CDE also collects and reports incidents of crimes that occur on public school campuses through the California Safe Schools Assessment (CSSA) reporting system. The results from the 2000-2001 assessment indicate that alcohol and drug offenses were the most commonly reported crime at the high school level. There were just over 12 incidents of drug and alcohol offenses reported per 1,000 students enrolled in California high schools.[9]

Overall in California public schools, there were 4.3 incidents per 1,000 students (25,973 incidents) of alcohol and drug offenses on school campuses. The drug and alcohol offenses include possession of drugs (9,724 incidents), use of alcohol or drugs

(9,658 incidents), possession of paraphernalia (3,173 incidents), possession of alcohol (1,406 incidents), sale and/or furnishing of drugs/alcohol (1,531 incidents) and possession of alcohol/drugs for sale (481 incidents).[10]

B. PREVALENCE AND INCIDENCE OF ALCOHOL AND OTHER DRUG USE AND AOD-RELATED PROBLEMS: SPECIAL POPULATIONS

There is limited information regarding the prevalence of substance use among special populations of adolescents, including those being served in the various public sectors, such as juvenile justice, child welfare, mental health and continuation schools. Because these systems do not always address AOD issues among youth or assess their AOD-related needs, it is often difficult to estimate the number of youth who might need AOD treatment. It also can be difficult to establish any primary presenting AOD problems for youth being admitted into service systems outside of AOD, where the official diagnoses may be for non-AOD conditions. Below are highlights from the limited studies that have been conducted.

A recent analysis of data from sampled youth within San Diego County in five different county sectors (AOD treatment, mental health, juvenile justice, child welfare and public school-based services for severely emotionally disturbed [SED] youth) indicates that there are relatively high rates of substance use disorders among adolescents in these systems, as determined in diagnostic interviews with DSM-IV criteria.[11]

Figure 1.1 Special Population Substance Use Disorders[12]

	Alcohol and Drug	*Juvenile Justice*	*Mental Health*	*SED*	*Child Welfare*
Substance Use Disorders - Lifetime	***82.6%***	***62.1%***	***40.8%***	***23.6%***	***19.2%***
Substance Use Disorders - Past Year	***42.6%***	***36.9%***	***22.9%***	***16.0%***	***11.0%***

As indicated in the table above, lifetime substance use disorders were more prevalent for sampled youth in the AOD and juvenile justice systems than in the mental health, child welfare and school-based SED systems. Overall, 31% of total sample youth met

the criteria for an alcohol disorder diagnosis and 26.6% of sample youth met the criteria for a marijuana disorder.

Past-year substance abuse disorders were also more prevalent among sample youth in the AOD and juvenile justice systems. Eighteen percent of the total sample met criteria for an alcohol use disorder, while a smaller 11.3% met the criteria for a marijuana disorder.

Of the sampled youth, 39.5% overall met the criteria for at least one substance use disorder in their lifetime and 24.1% met the criteria within the past year. Rates of substance use disorders were significantly higher for older youth. Males and females were similar in regard to patterns of diagnoses, although males were more likely to meet the criteria for marijuana abuse or dependence.

These data on substance use disorder diagnosed in samples of youth in public sectors in one jurisdiction in the state are important and have many implications for treatment planning. These findings should serve as the foundation for future investigation, but it would be premature to generalize about the total special populations of youth in these sectors statewide based on findings from a single study.

Juvenile Justice

The majority of youth entering treatment in California and in the nation are referred through the juvenile justice system. This will be discussed further in Chapter 2. Surveys in the juvenile justice system often find considerably higher rates of substance abuse among its population than would be found in the comparable general youth population. For example, a recent major study reports that half of male and almost half of female detainees in the Cook County (Chicago) juvenile hall had a substance abuse disorder as diagnosed using DSM-IV criteria.[13]

At the national level, the Arrestee Drug Abuse Monitoring Program (ADAM) surveillance system of the National Institute of Justice tests juvenile detainees for illicit drugs in five jurisdictions. Preliminary urinalysis results from 2002 indicate that approximately 60%

of these detainees tested positive for drugs. In four sites, female detainees were also tested, and almost 46% of cases were positive for drug use.[14]

With respect to AOD-related arrests, the Office of Juvenile Justice and Delinquency Prevention reports that drug violations have increased by almost 150% in the past several years.[15] In 1998, juvenile courts handled approximately 192,500 delinquency cases in which a drug offense was the most serious charge. These offenses accounted for 11% of all cases heard during the year.[16] During 1998, of delinquency cases involving detention, 23% were drug-related.[17] There are no national-level or statewide databases that collect uniform AOD information from juvenile probationers.

Child Welfare

As noted by the Child Welfare League of America (CWLA), few state child welfare management information systems track substance abuse data on the children and youth they serve.[18] In 1997, CWLA conducted a survey of state child welfare agencies to determine policies, programs and data collection efforts in place to help AOD-involved families. Only three of the 47 states that responded were able to provide an estimate of the number of children and adolescents in out-of-home care who had a substance abuse problem. The three states' responses averaged 8% having a substance abuse problem. Upon examination of state risk assessment protocols for child welfare investigations, the findings were that 35 states do not address alcohol or drug use by the children and youth themselves. And 39 states did not have a written policy requiring foster care providers to report a youth's AOD use to the child welfare agency.

In California, the Department of Social Services has recently begun collecting data on the specific conditions of its clients, including AOD use or prior AOD treatment. The intent is to have these data contribute to a new health "passport" that will be used to measure outcomes and accountability of child welfare services in California. The database will include every child in the state found to be the subject of abuse or neglect. These data will help to determine the AOD treatment needs of youth in the child welfare system, a segment of the adolescent population that is likely to be particularly vulnerable to AOD-related problems.

Mental Health

In fiscal year 2001-2002, 177,251 out of 595,405 individuals served in public sector mental health agencies were children or youth, according to the California Department of Mental Health. Of these youth, only 1,163 were diagnosed with any substance use disorder. These low rates are explained as follows: "Although the percentage of consumers with a primary substance abuse diagnosis is low, many have co-occurring substance problems that are the focus of clinical attention, and are diagnosed separately as a secondary diagnosis."[19]

While the mental health system is acknowledged to be admitting a large number of adolescent clients with AOD problems, it is very likely that, because of financial exclusions and constraints of clinical assessments, these problems are not reflected in the diagnoses reported in current data collection systems.

Continuation Schools

According to a recent analysis by the California Student Survey (CSS), students in continuation high schools are considerably more likely than 11th graders in comprehensive high schools to use AOD regularly or heavily.[20] They were twice as likely to report using marijuana in the past 30 days and 1.5 times likelier to report having consumed alcohol in the past six months. Continuation students were also twice as likely as the comprehensive school 11th graders to report binge drinking, and three times more likely to be recent weekly users of drugs.

One-quarter of the continuation students surveyed had used marijuana at school in the past 30 days, and over half report attending school while under the influence (3.5 and 2 times the comprehensive school 11th grade rates, respectively). These findings support the observation that students outside of mainstream school settings are at greater risk of more severe AOD use than traditionally enrolled students.

Hospital Emergencies

Data on emergency room episodes related to drug use is collected from hospitals across the country by the Drug Abuse Warning Network (DAWN). A drug episode is

defined as an emergency department (ED) visit caused by or related to the use of illegal drugs or the non-medical use of a legal drug.[21] In 2001, there were 61,695 total ED drug episodes involving patients ages 12-17, or 10% of all such episodes. The total number of drug mentions in the adolescents' episodes was 97,091.

C. ALCOHOL AND OTHER DRUG USE PATTERNS AND DISORDERS FOR ADOLESCENTS ENTERING TREATMENT

The previous section discussed the prevalence and incidence of substance use in the general youth population. This section describes the characteristics of youth currently entering treatment, as reported in different national data sets. It is not known to what degree these characteristics may be assumed to represent those among all youth who are in need of treatment. Comparable data for youth entering public AOD treatment in California are reported in Chapter 2.

Treatment Episode Data Set (TEDS)

SAMHSA collects information on the demographic and substance abuse characteristics of annual admissions to alcohol and drug abuse treatment facilities that report to individual state administrative data systems through the Treatment Episode Data Set. Below are national-level findings on youth admitted to treatment facilities.[22]

The number of youth ages 12-17 admitted to treatment facilities in 2000 was 131,176. Of these admissions, approximately 62% involved marijuana as the primary drug used. Alcohol was the next most reported drug of use, with 24% of admissions reporting it (53% involved the use of both alcohol and marijuana). Approximately 16% reported alcohol as their primary substance, with a secondary drug that was not marijuana. This underscores poly-drug use by adolescents, dominated by marijuana and alcohol, among those entering treatment. About half of admissions were referred through the justice system. Seventeen percent were self- or family-referred, and 11% were referred through the education system.

National Survey of Substance Abuse Treatment Services

The National Survey of Substance Abuse Treatment Services (N-SSATS), conducted by SAMHSA, collects data on alcoholism and drug abuse treatment facilities and services

throughout the country. Clients under age 18 made up 8% of all clients in treatment in this database in 2002.

Findings on the adolescents in treatment show that they are most likely to be in private nonprofit facilities, even more so than the total client population (65% and 56%, respectively). They are less likely to be in private, for-profit facilities, which account for 26% of all client admissions, but for only 17% of clients under age 18.[23]

Nearly 60% of the clients under age 18 are in substance abuse-specific treatment facilities, which is fewer than the 68% of total clients. A greater proportion (31%) of minor clients are in facilities combining mental health and substance abuse services than is the proportion (23%) of the total client population. Looking at treatment setting, the great majority of adolescents (88%) are in outpatient treatment, 11% are in residential treatment and 1% are in hospital inpatient treatment.

Drug Abuse Treatment Outcome Studies

Drug Abuse Treatment Outcome Studies (DATOS) are conducted by the National Institute on Drug Abuse (NIDA) to evaluate drug abuse treatment outcomes and emerging treatment issues in the United States. One study, the DATOS-A (Adolescent), has focused on a sample of 1,167 boys and girls ages 11-18 who were admitted to treatment from 1993 to 1995 from four jurisdictions.[24] Included were admissions to residential programs, outpatient programs and short-term inpatient programs. Over half the youth had juvenile justice status at admission and one-third had a prior drug treatment episode. The primary drug was marijuana (47%), followed by alcohol (21%) and hallucinogens (7%). Sixty-three percent met the diagnostic criteria for a mental disorder.

D. ESTIMATING THE NEED FOR ADOLESCENT TREATMENT

There have been several projects at the national level to estimate the need for treatment within the general youth population. Each of the agencies has used its own methodology for determining need. Recent estimates include:

- The Center for Substance Abuse Treatment (CSAT) of SAMHSA estimates that one in 10 adolescents who need substance abuse treatment receives it, and of those who receive treatment, only 25% receive enough treatment.[25]
- According to SAMHSA's TEDS dataset, in 2001 an estimated 1.1 million youth ages 12-17 (almost 5% of this age range) needed treatment for an illicit drug problem. Of this group, only 100,000 (or approximately 10% of youth ages 12-17 who needed treatment) actually received treatment.[26]
- According to SAMHSA's 2002 NSDUH survey, 369,000 individuals ages 12-17 are estimated to have received substance use treatment for alcohol or other drugs in the past year. They were 11% of the total population receiving treatment. They were 13% (254,000) of all those who received treatment for illicit drugs and 9% (227,000) of those receiving treatment for alcohol.
- In the recent NSDUH survey, respondents who had not received treatment were asked whether there was any time during the past 12 months when they felt they needed treatment or counseling for their alcohol or other drug use but did not receive it. Of those 12-17 year olds who responded, 5.7% reported feeling they needed treatment for a drug problem, and 6% reported they felt they needed treatment for an alcohol problem.[27]
- Another DATOS-A project studied a total of 3,382 adolescent patients admitted to short-term inpatient/chemical dependency, therapeutic communities/residential, or outpatient drug-free programs across six cities over time. The study used client self-reports of treatment needs and services received to compare unmet needs for specific services. Findings showed a general decline over time in services received that was only partially offset by decreases in some self-reported service needs. Unmet needs increased significantly over time for certain services, including psychological, family, employment and financial services.[28]
- The California Legislative Analyst's Office reports that, on the basis of an overall review of the field, only 10% of adolescents who need publicly funded treatment receive it, while 17% of adults needing public treatment receive it.[29]

- According to the California Student Survey, 12% of 9th graders and 11.5% of 11th graders report either definitely having felt that they needed help for their AOD use, such as counseling or treatment, or responded "don't know."[30]

This chapter examined the prevalence and incidence of alcohol and other drug use and AOD-related problems in the general and higher-risk populations. Data indicate that in California, as nationally, large numbers of youth are in need of treatment for their use of alcohol and other psychoactive substances. The following chapter will describe the current publicly funded AOD treatment system for youth in California, including its adolescent clients and programs.

[1] Substance Abuse and Mental Health Services Administration. (2003). Overview of Findings from the 2002 National Survey on Drug Use and Health (Office of Applied Studies, NHSDA Series H-21, DHHS Publication No. SMA 03-3774). Rockville, MD.
[2] Ibid.
[3] Johnston, L. D., O'Malley, P. M., & Bachman, J. G. (2003)(a). Monitoring the Future national results on adolescent drug use: Overview of key findings, 2002. (NIH Publication No. 03-5374). Bethesda, MD: National Institute on Drug Abuse. See also: Johnston, L. D., O'Malley, P. M., & Bachman, J. G. (2003)(b). Monitoring the Future national survey results on drug use, 1975-2002. Volume I: Secondary school students. (NIH Publication No. 03-5375). Bethesda, MD: National Institute on Drug Abuse.
[4] Ibid.
[5] Grunbaum, J.A., Kann, L., Kinchen, S., et al. Youth Risk Behavior Surveillance – United States, 2001, June 28, 2002 MMWR 2002:51(No. SS-4).
[6] Skager, R., and Austin, G. (2002). Ninth Biennial California Student Survey 2001-2002 major findings: Alcohol and other drug use grades 7, 9, and 11. Sacramento, CA: California Department of Justice, Attorney General's Office.
[7] Wright, D. (2003). *State Estimates of Substance Use from the 2001 National Household Survey on Drug Abuse: Volume I. Findings* (DHHS Publication No. SMA 03-3775, NHSDA Series H-19). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.
[8] California Department of Education. Expulsion information for 2001-2002. Retrieved November 11, 2003, from http://data.cde.ca.gov/dataquest/expulsion/EdCodeSt.asp?cYear=2000-01&cChoice=EdC
[9] California Department of Education. (2002). California Safe Schools Assessment 2000-2001 results: Promoting safe schools. Sacramento, CA: California Department of Education.
[10] Ibid.

[11] Aarons, G.A., Brown, S.A., Hough, R.L, et al. (2001). Prevalence of adolescent substance use disorders across five sectors of care. Journal of the American Academy of Child & Adolescent Psychiatry, 40: 419-426.
[12] Ibid.
[13] Teplin, L., Abram, K., McClelland, G., et al. (2002). Psychiatric Disorders in Youth in Juvenile Detention. Archives of General Psychiatry, 59: 1133-1143.
[14] Arrestee Drug Abuse Monitoring Program. (2003). Preliminary data on drug use and related matters among adult arrestees and juvenile detainees, 2002. National Institute of Justice, Office of Justice Programs, Department of Justice.
[15] Snyder, H. and Sickmund, M. (1999). Juvenile offenders and victims: 1999 national report. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.
[16] Office of Juvenile Justice and Delinquency Prevention. (2002). Drug offense cases in juvenile courts. OJJDP Fact Sheet. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, Department of Justice.
[17] Office of Juvenile Justice and Delinquency Prevention. (2002). Detention in delinquency cases, 1989-1998. OJJDP Fact Sheet. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, Department of Justice.
[18] Child Welfare League of America. (1998). Alcohol and other drug survey of state child welfare agencies. Washington, DC: Child Welfare League of America.
[19] California Department of Mental Health. (2003). California community mental health performance outcome report: Fiscal year 2001-2002 – A report to the Legislature. Sacramento, CA: California Department of Mental Health.
[20] Austin, G. and Abe, Y. (2002). Continuation schools report: Findings on the use of alcohol, tobacco, and other drugs, from 8th Biennial Survey of California school students in grades 7, 9, and 11. Sacramento, CA: California Department of Justice, Attorney General's Office.
[21] Ball, J., Garfield, T., & Kissin, W. (2002). Detailed emergency department tables from the Drug Abuse Warning Network 2001. Office of Applies Studies, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services: Washington, DC.
[22] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Treatment Episode Data Set (TEDS): 1992-2000. National Admissions to Substance Abuse Treatment Services, DASIS Series: S-17, DHHS Publication No. (SMA) 02-3727, Rockville, MD, 2002.
[23] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. National Survey of Substance Abuse Treatment Services (N-SSATS): 2002. Data on Substance Abuse Treatment Facilities, DASIS Series: S-19, DHHS Publication No. (SMA) 03-3777, Rockville, MD, 2003.
[24] Hser, Y.I., Grella, C.E., Hubbard, R.L., et al. (2001). An evaluation of drug treatments for adolescents in 4 U.S. cities. Archives of General Psychiatry, 58(7): 689-695.
[25] Center for Substance Abuse Treatment. "Treatment Episode Data Set (TEDS)". Substance Abuse and Mental Health Services Administration; National Institute on Drug Abuse. "Monitoring the Future (MTF)"
[Available at www.icpsr.umich.edu/SAMHDA/das.html]
[26] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Treatment Episode Data Set (TEDS): 1992-2000. National Admissions to Substance Abuse Treatment Services, DASIS Series: S-17, DHHS Publication No. (SMA) 02-3727, Rockville, MD, 2002.

[27] Substance Abuse and Mental Health Services Administration. (2003). Overview of Findings from the 2002 National Survey on Drug Use and Health (Office of Applied Studies, NHSDA Series H-21, DHHS Publication No. SMA 03-3774). Rockville, MD.
[28] Etheridge, R. M., Smith, J. C., Rounds-Bryant, J. L., & Hubbard, R. L. (2001). Drug abuse treatment and comprehensive services for adolescents. Journal of Adolescent Research, 16(6): 563-589.
[29] California Legislative Analyst's Office. (2001). Review of health insurance coverage pursuant to Chapter 305, Statutes of 2000 (SB 1764, Chesbro). Sacramento, CA: California Legislative Analyst's Office.
[30] Austin, G. and Abe, Y. (2002). Continuation schools report: Findings on the use of alcohol, tobacco, and other drugs, from 8th Biennial Survey of California school students in grades 7, 9, and 11. Sacramento, CA: California Department of Justice, Attorney General's Office.

Chapter 2
Description and Analysis of Current Alcohol and Other Drug Treatment System and Services

Chapter 2: Description and Analysis of Current Alcohol and Other Drug Treatment System and Services

This chapter describes the emerging and diverse programs for alcohol and other drug (AOD) services for youth in California at the current time. The chapter highlights:

- Overview of existing treatment, including types of programs and characteristics of youth served;
- Issues and needs identified in the field by county administrators and providers; and,
- Efforts to develop a system and standards of care, including program performance and evaluation, and program and staffing certification.

A. OVERVIEW OF EXISTING YOUTH ALCOHOL AND OTHER DRUG TREATMENT SERVICES IN CALIFORNIA

Youth in California are currently being served in a diverse and emerging set of treatment services. There is no unified treatment system, and no single source of data on these services. It is estimated that there is a statewide network of nearly 1,700 publicly funded AOD treatment programs through the California Department of Alcohol and Drug Programs (ADP), of which nearly 400 serve youth.[1]

The largest source of information on adolescent AOD treatment programs and clients is the statewide database maintained by ADP, the California Alcohol and Drug Data System (CADDS).

CADDS is a long-standing management information-oriented reporting system used by AOD county administrations and county-contracted treatment providers. The state is in the midst of transitioning to a more client outcome-oriented reporting system, known as the California Outcome Measuring System (Cal-OMS**,** formerly Cal-TOP), based on proposed federal requirements**.** Both CADDS and Cal-OMS have been designed for ADP-funded programs serving adults.

Note: It is important to understand the contributions and limitations of CADDS, since the following overview of programs and clients draws from its data. The programs most likely to report to CADDS are those that receive funding primarily from AOD treatment dollars via the state ADP and county AOD administrations, and which are regulated by those agencies. Historically, this is a network that serves adults, consisting of a majority of outpatient clinic programs and a smaller number of residential programs which are licensed to admit only adults (although a few have received waivers to admit a very small number of youth).

Other AOD treatment programs, with different primary funding sources and regulatory oversight, including many of those providing services to youth, are less likely to report to CADDS. These include school-based programs, including those which have historically provided prevention and are now expanding to treatment; social service-funded foster care group homes that also are providing AOD services primarily to probation-referred youth; and programs in juvenile justice institutions, juvenile drug courts or community-based probation settings.

In light of the various systems involved in providing formal and informal treatment to adolescents, there is an urgent need for improved data from youth treatment programs to support program performance monitoring and system planning.

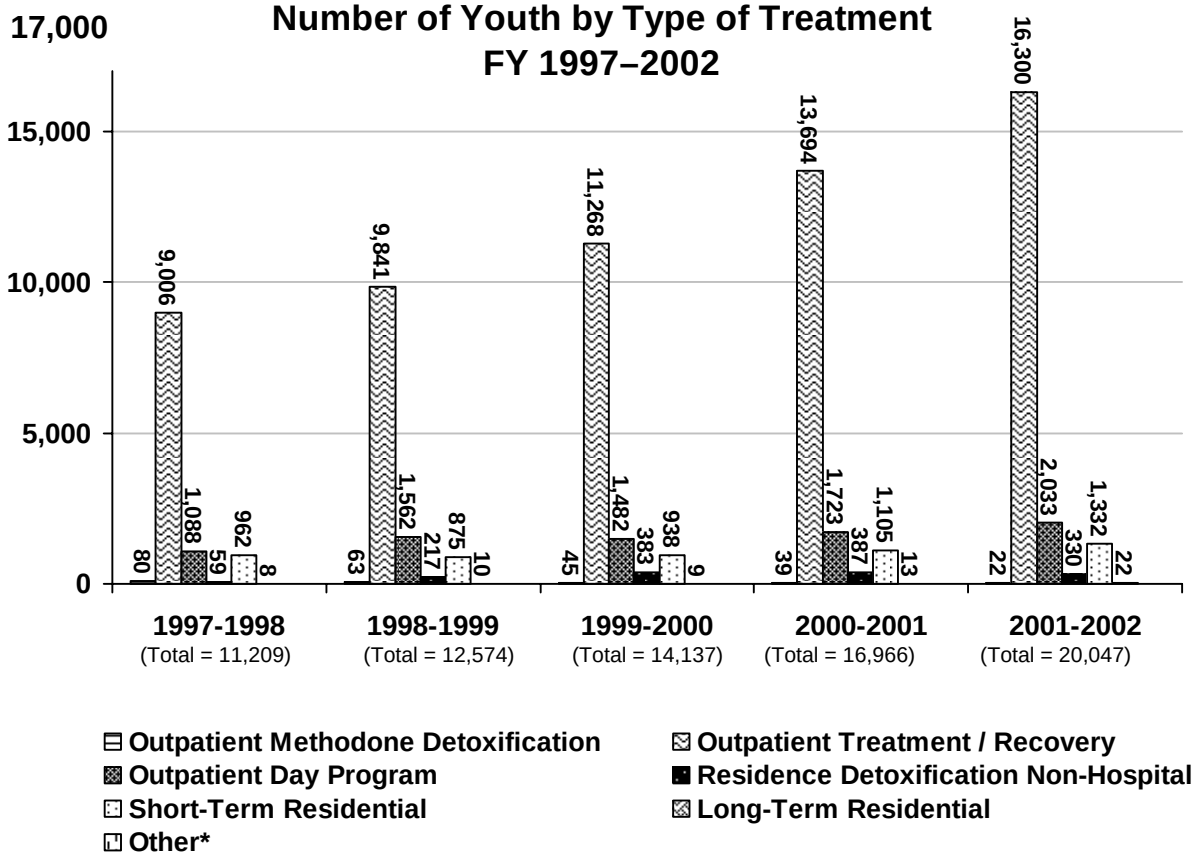
Treatment Statewide and Numbers Admitted

CADDS data for the state were analyzed for youth ages 12-17 admitted to programs over five years, from fiscal year (FY) 1997-1998 through 2001-2002. These numbers constitute total admissions to any episode of treatment during this period, rather than the total number of (unduplicated) youth admitted to treatment. (CADDS does not track unique, individual clients.) Although for purposes of readability this section will refer to "youth admitted to treatment," it should be noted that these are actually "admissions of youth to treatment" and are likely to include youth counted more than once. (As reported below, one-fourth of youth admissions are identified as having had prior AOD treatment, although this treatment may have occurred outside the CADDS system.)

The following statewide program trends and patterns can be identified, as shown in figure 2.1, Number of Youth by Type of Treatment:

- The total number of youth admitted to the CADDS-reporting programs has almost doubled in the past five years, rising from 11,209 in FY 1997-1998 to 20,047 in 2001-02. The numbers increased in each successive year.
- Most youth are being served in programs categorized as falling under the "outpatient" modality. The relative proportion of youth who are in outpatient treatment has remained constant, around 80% for all five years.
- "Day" treatment is the next most common modality of programs based upon total number of youth served. This modality has served between 10% and 12% of the youth in each of the five years.
- The third-ranked modality, serving approximately 7% of those reported to CADDS annually, is "short-term residential treatment." This treatment primarily is provided in foster care group home settings, including nearly 40 of which also are certified by ADP as AOD treatment providers.[2]

Figure 2.1
Number of Youth by Type of Treatment
FY 1997–2002



* Other Includes: Outpatient Methadone Maintenance, Outpatient Detoxification, Residence Detoxification Hospital

Looking across the 58 counties in California, there are considerable variations in the number of clients admitted under age 18 being reported to CADDS, as shown in figure 2.2, CADDS Youth Admissions.

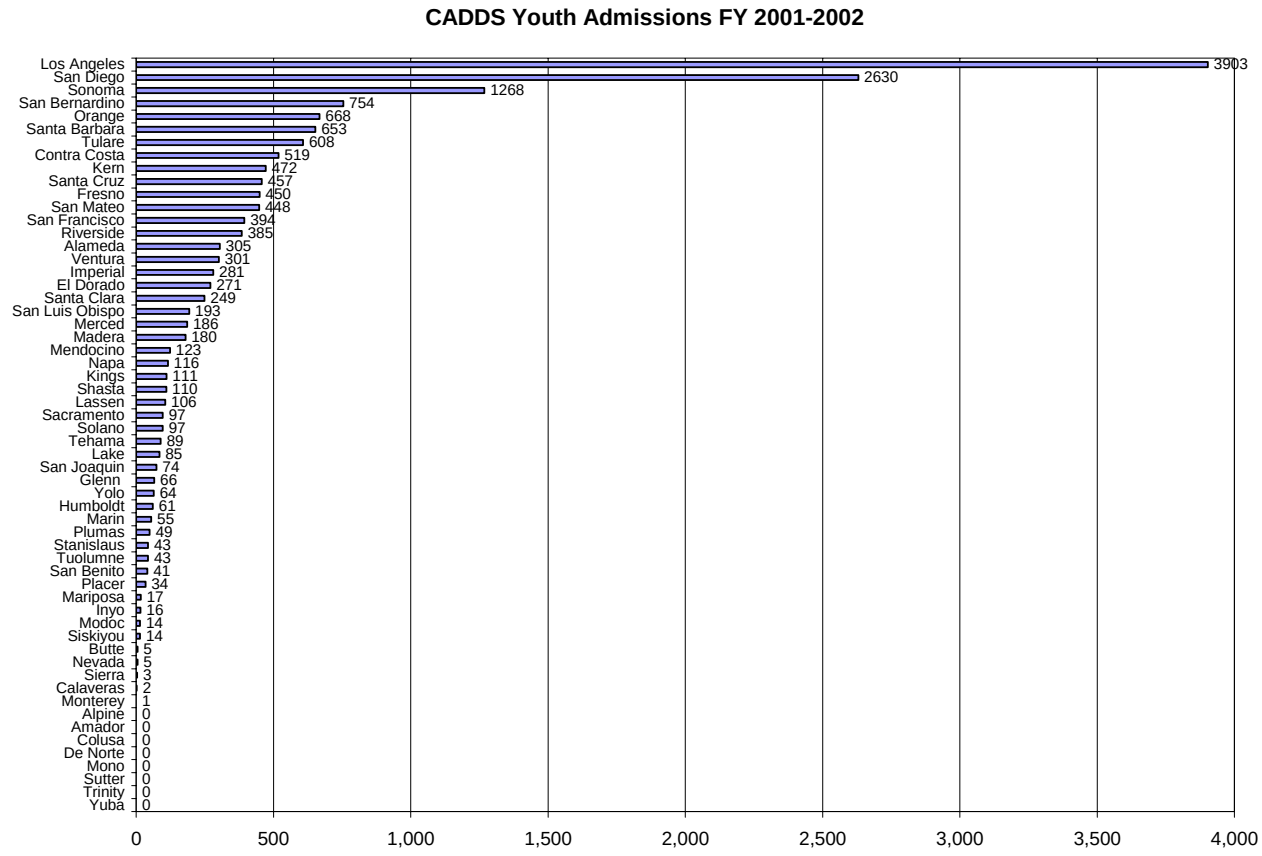
As might be expected, programs in the state's most populous county, Los Angeles, report admitting the largest number of clients under age 18, followed by the next largest county, San Diego, with Orange and San Bernardino counties also at the high end. However, some of the state's less populous counties (e.g., Sonoma, Santa Barbara, Tulare and Santa Cruz) report admitting relatively large numbers of youth. These counties may have more developed youth programs, in some instances after having secured early or supplemental funding (such as the state's Baca/Adolescent

Treatment Program (ATP) funds, grants from the Substance Abuse Mental Health Services Administration, or the Robert Wood Johnson Foundation). These counties may also have pulled into their CADDS reporting systems a relatively large number of their youth programs (e.g., school-based AOD services, juvenile court or probation programs and foster care group homes). At the other end, CADDS reports that several counties admitted no youth to treatment during this period. These include some very small counties whose current state youth AOD treatment funding levels may be insufficient to operate intra-county programs. However, these counties may have AOD treatment programs serving youth but do not currently participate in CADDS. Thus it is premature to draw conclusions about which counties may be under-serving youth based on these data.

Figure 2.2

CADDS Youth Admissions

FY 2001-2002

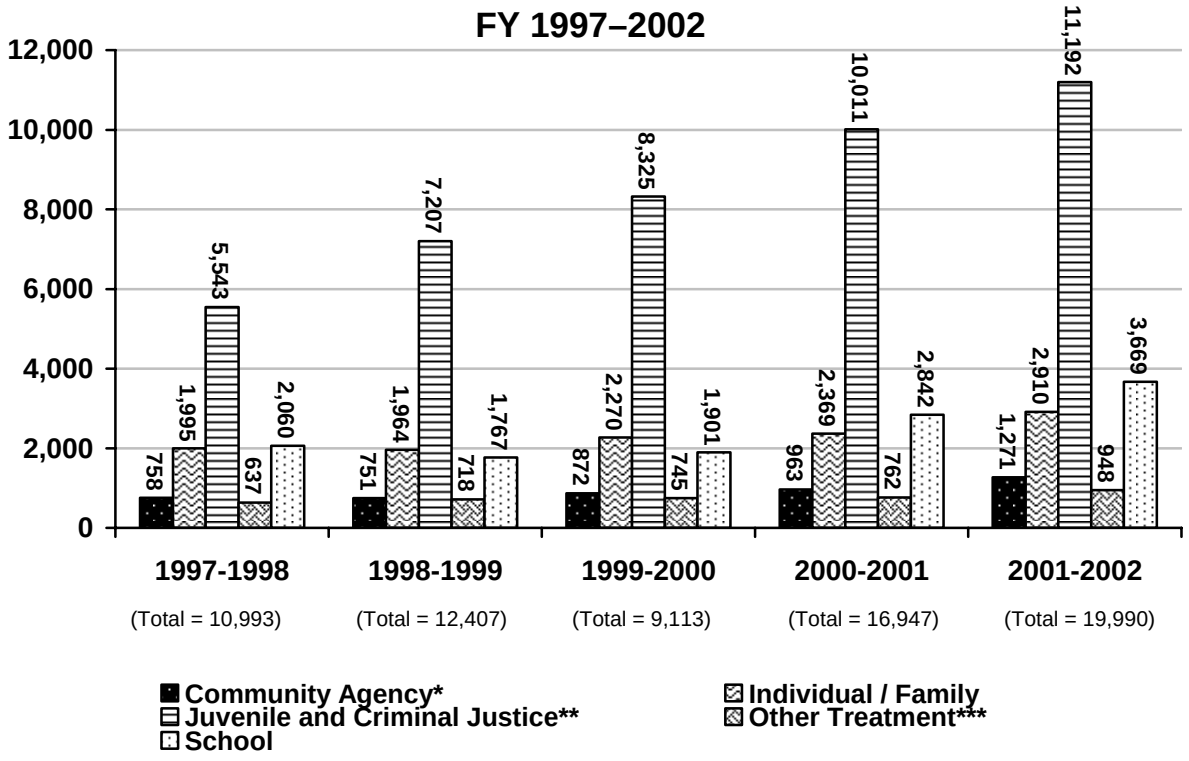


Referral Sources to Treatment

The juvenile justice system is the dominant referral source for adolescent clients admitted to treatment programs.

- In 2001-2002, 56% of the youth in CADDS-reporting programs were referred from juvenile justice, up from 49% in 1997-1998. Schools appear to be a potentially growing source of referral. Family and self-referral appear to be infrequent portals to treatment (see figure 2.3, Source of Referral).

Figure 2.3
Source of Referral
FY 1997–2002



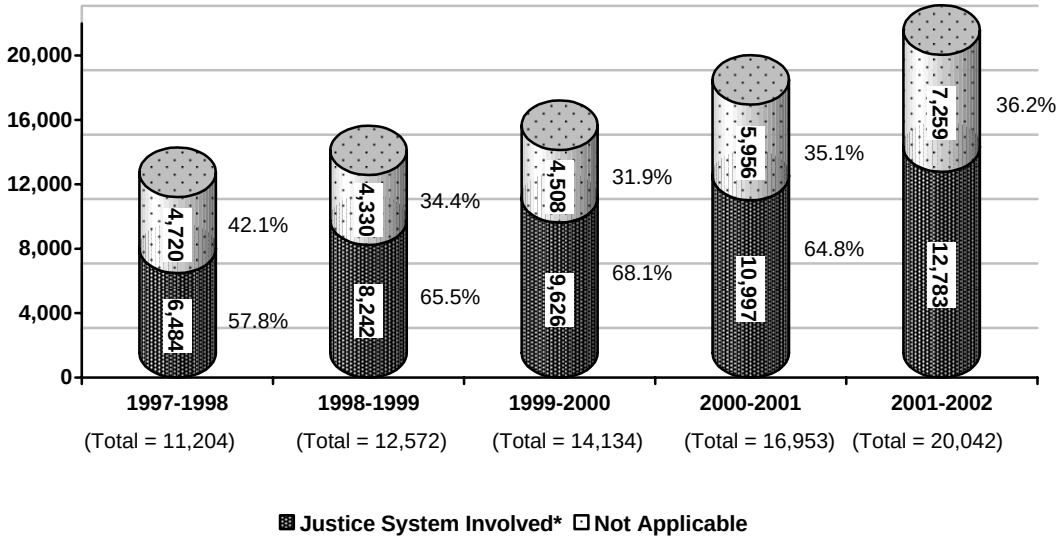
*Community Agency includes: Employer/Employee Assistance Program, Other Community Referral

**Juvenile and Criminal Justice includes: Court/Criminal Justice, Court/Probation, Substance Abuse and Crime Prevention Act of 2000 (SACPA), SACPA Parole

***Other Treatment includes: 12-Step Mutual Aid, Care Program, Other Health Care

- The dominance of juvenile justice as a pathway to treatment is bolstered by the reports from 20 county AOD administrators in a 2003 telephone survey.[3] Three-fourths of the administrators identify juvenile justice as either the largest referral source, or tied with schools for the largest. These administrators also report that schools are the second most common referral source; half the administrators rank it as the second largest, and one-fourth rank it as the largest or as tied with juvenile justice for the largest. The most commonly reported third-largest source of referrals is the family or the youth him- or herself.
- The dominance of juvenile justice as a referral source is further confirmed by a sample of youth AOD treatment providers in the 20 counties with whom telephone surveys were conducted in mid-2003 (see "Issues and Needs Identified in the Field," page 37, and appendices II and III). For the 18 responding providers, two-thirds rank juvenile justice as their largest referral source, with schools a distant second (under one-third).[4]
- CADDS data also are reported on the youths' legal status when admitted to treatment, as shown in figure 2.4, Legal Status. One-third of the admitted youth are identified as having a juvenile justice involvement. (The difference between this proportion and the higher proportion *referred* by justice may reflect the fact that some justice-referred youth are not formally adjudicated and hence "legally involved," or it may be the result of inconsistent reporting practices.)

Figure 2.4
Legal Status
FY 1997–2002

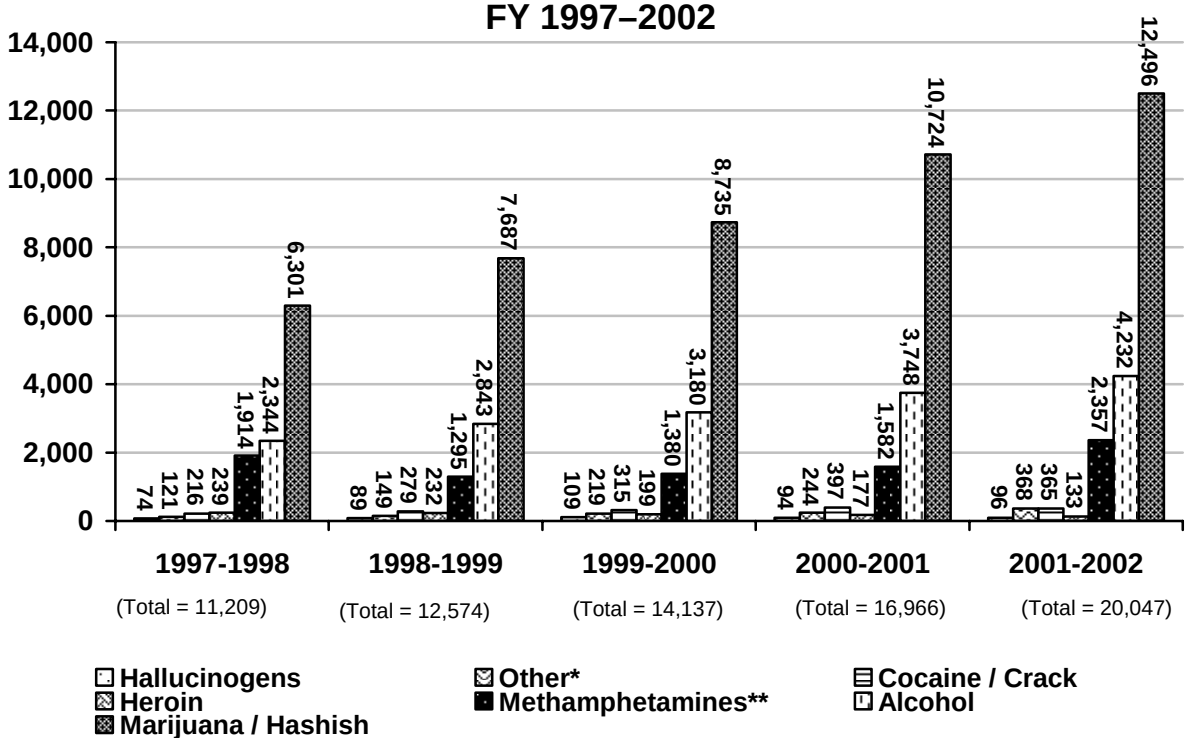


* Justice System Involved includes: Diversion, Incarcerated, Parole by California Department of Corrections, Parole by Other, Probation

Clients' Alcohol and Other Drug Use and Prior Treatment

The data from CADDS identifying the "primary AOD problem" underscores the prevalence of alcohol and marijuana use among adolescents admitted to treatment. Figure 2.5, Primary AOD Problem, suggests that, for youth admitted into reporting programs, marijuana is by far the most frequently identified substance used, followed by alcohol as a distant second. It should be noted that, given the actual prevalence of adolescent alcohol use compared to marijuana, there may be a bias in favor of an illegal rather than a legal substance being formally identified as a youth's primary problem.

Figure 2.5
Primary AOD Problem
FY 1997–2002

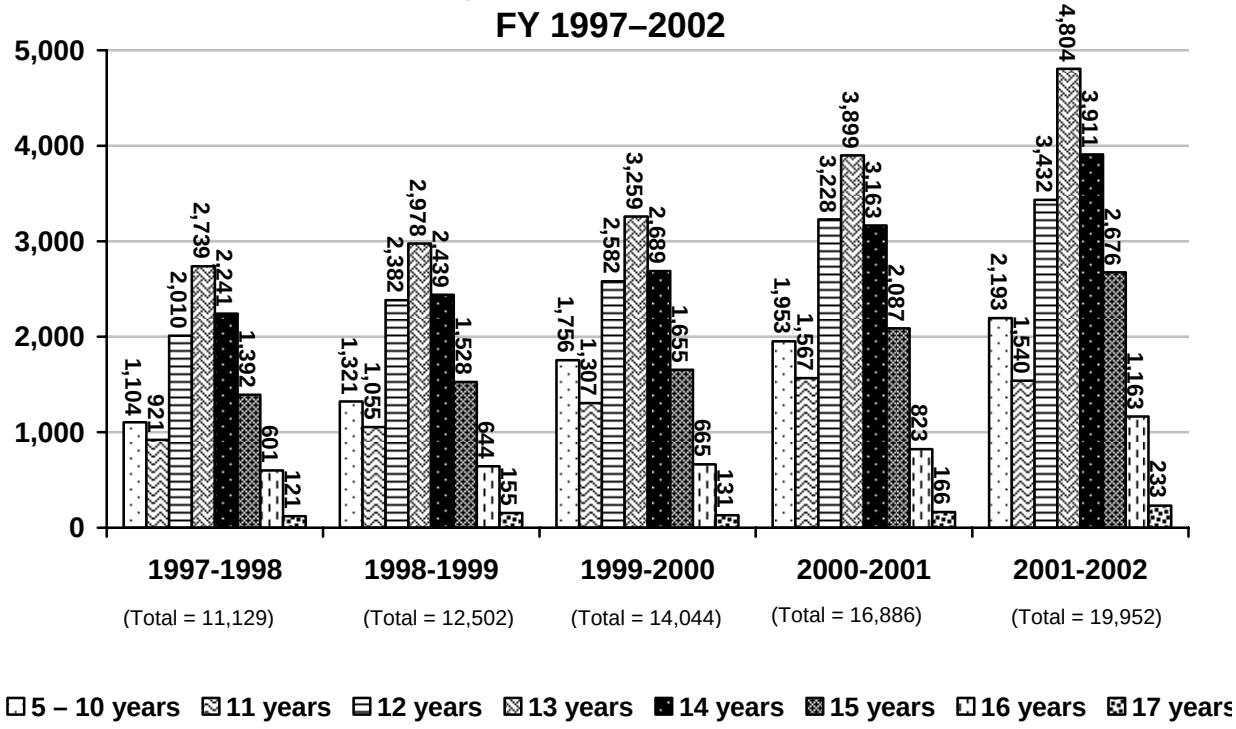


* Other includes: Barbiturates, Inhalants, Non-Prescription Methadone, Other, Other Opiates/Synthetics, Other Sedatives/Hypnotics, Other Tranquilizers, Over the Counter, PCP, Tranquilizers

** Methamphetamines include: Methamphetamines, Other Amphetamines, Other Stimulants

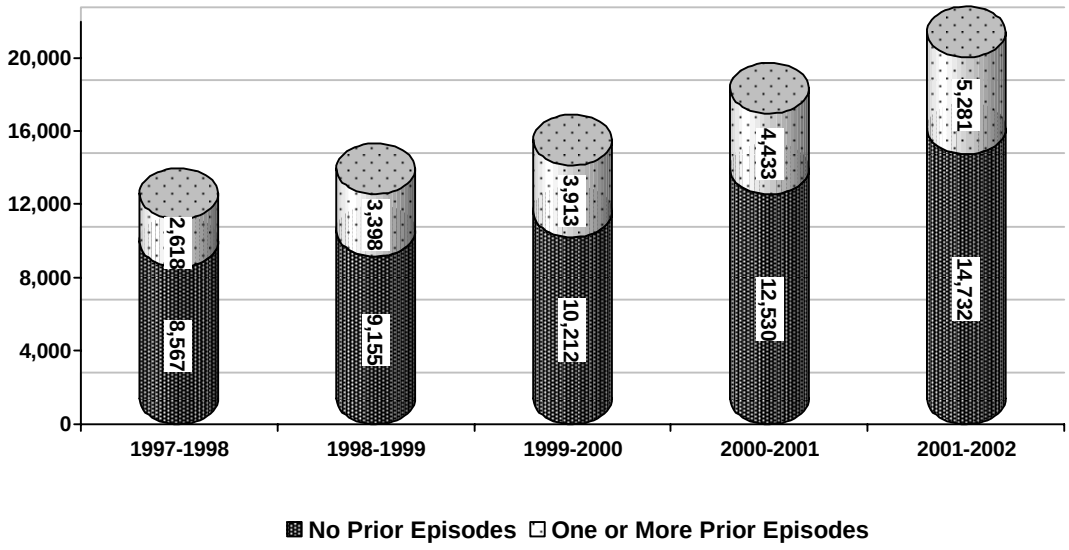
CADDS data forms report the age of first use of the primary problem substance for all clients admitted, although reporting criteria vary. Alcohol use is reported as the age of first *intoxication*; for all other drugs, the age of first *use* is reported. In either case, this age may or may not be the age of first regular or problematic use. Figure 2.6, Age at First AOD Use, shows that the reported age of first use peaks at 13, with ages 12-14 the mode.

Figure 2.6
Age at First AOD Use
FY 1997–2002



Fully one-fourth of the admitted youth are identified at admission as having had a prior treatment episode, or more than one, as shown in figure 2.7, Number of Prior Treatment Episodes.

Figure 2.7
Number of Prior Treatment Episodes
FY 1997–2002



Discharges from Treatment Statewide

Data were also analyzed for discharges of adolescent admissions to programs reporting to the CADDS system. The number of admissions of minors with reported discharges in the CADDS system between 1997 and 2002 was found to be smaller than the total number of admissions of minors during the period. This may be partly due to some admitted youth continuing in treatment at the end of the period. However, it also appears that all reportable discharge information for youth is not being comprehensively or uniformly entered into CADDS. For example, as evidenced in figure 2.8, Number of Youth Discharged with Discharge Status, there is discharge status information for fewer discharged admissions than there is treatment length of stay information for them, shown in figure 2.9.

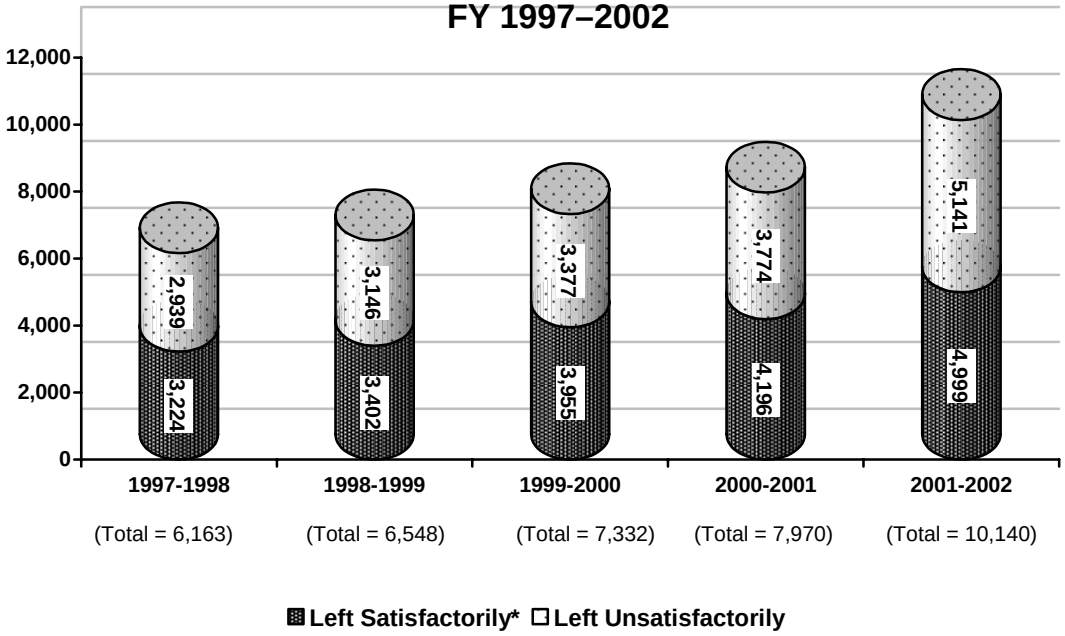
For purposes of analyzing discharge status and length of stay in treatment, the decision was made to separate information for the different modality types, in order not to mix variables that are likely to differ in meaning by modality type. Discharge status may have a different meaning in community-based non-residential programs compared to residential programs with largely court-mandated admissions. Patterns

for lengths of stay are also likely to differ significantly for non-residential, short-term residential and long-term residential modality types. Because of the disparity between the discharge data and the admissions data, the decision was made to analyze data for the modality type with the largest number of admissions with discharge data, i.e., non-residential treatment, including outpatient, "day" and outpatient detoxification.

As shown in figure 2.8, Number of Youth Discharged with Discharge Status, the number of discharges of clients admitted to non-residential treatment while under 18 with discharge statuses reported has increased. By FY 2001-2002, there were 10,140 such reported discharges with status available, an increase of 39.2% over 1997-1998. However, the number of non-residential discharges with status reported for 2001-2002 is still just over half the total of non-residential admissions for the year (18,333), as discussed earlier.

Of clients with discharges and discharge status reported for non-residential care in 2001-2002, half (49.2%) left treatment satisfactorily, either completing or having made progress since admission; 50.7% left treatment unsatisfactorily. This proportion has remained relatively unchanged since 1997.

Figure 2.8
Number of Youth Discharged with Discharge Status**
FY 1997–2002



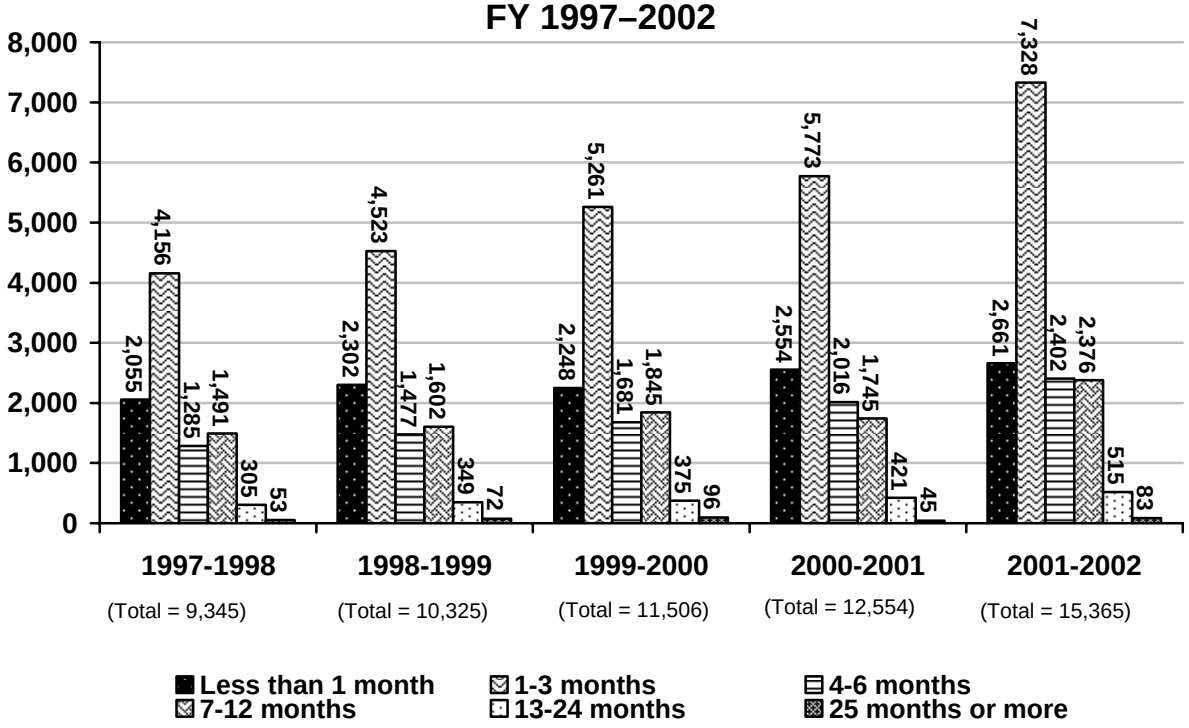
* Left Satisfactorily includes two categories: Completed Treatment and Left Treatment Satisfactorily.

** Non-residential only

With respect to lengths of stay in treatment for discharged non-residential clients, these data are available for 15,365 youth for 2001-2002 (a larger number than the number available with discharge status). This is shown in figure 2.9, Length of Stay. For these clients:

- About half (48%) had remained in treatment for one to three months (30-90 days), the modal stay among clients reported;
- 17% had stayed in treatment less than one month (0-29 days);
- Similar proportions had stayed in treatment for four to six months (16%) and seven to 12 months (16%); and,
- 3% had been in treatment for 13-24 months, and fewer than 1% for 25 months or more.

Figure 2.9
Length of Stay
FY 1997–2002



Program Types in a Sample of Counties

It is important to identify the types of programs in the emerging network of AOD services for youth. Because CADDS does not adequately address this information, data are reported from the 20-county telephone survey conducted in mid-2003.

The AOD administrators in these 20 California counties – which range in size from Los Angeles to Alpine – report having the following AOD treatment available to youth in their county as of mid-2003:

- 80% offer outpatient treatment;
- 55% offer school-based "early intervention;"
- 40% offer intensive outpatient or "day" treatment;
- 30% offer short-term residential treatment; and,
- 25% offer long-term residential treatment.

It should be noted that under current funding and licensing, the only setting for residential youth AOD treatment is either a child welfare-based group home or an adult residential AOD treatment program that has a state waiver to admit a very small number of youth. Several counties also report having AOD programs located in juvenile halls or juvenile justice camps or ranches, which they may be categorizing or reporting as either residential AOD treatment or outpatient AOD treatment for youth in institutional care. Several counties also report providing AOD services at their children's emergency shelter, which also houses out-of-home youth. One county plans to provide AOD services at a group home following the same model. No counties report having publicly funded AOD detoxification for youth, nor having very short-term residential care for crisis intervention. One county has a "clean and sober" school coordinated with school-based treatment, serving youth referred by probation, the school district or a treatment program. A majority (60%) of counties report having some aftercare available, although, except for 12-step meetings, aftercare is not usually available to youth in all programs.

The organizations providing youth AOD treatment in these 20 counties are either the counties themselves or county-contracted organizations. In the bigger counties, services tend to be primarily contracted out, although some large county AOD administrations operate their own programs. In smaller and rural counties, where fewer private organizations exist, government tends to provide the treatment services. Most contracting organizations are private nonprofits, although a few for-profit corporations are in operation. These community-based organizations (CBOs) often are small and regional, although statewide and even national private agencies are present and may be growing in visibility.

Many of the contracting youth AOD treatment organizations also provide other services. This includes adult AOD treatment; many CBOs have long-standing roots in adult AOD services. Other organizations exclusively serve youth, including some that have long done youth prevention work. An increasingly common model is for established behavioral health care agencies to provide youth AOD treatment alongside mental health services, including those to the "dually diagnosed," with co-occurring disorders. In larger counties, organizations may as their core mission serve particular

ethnic communities, such as Asian Americans. This is less common in very small or rural counties, with the exception of American Indian services. However, medium-sized counties report increasingly targeting services to Latino youth and families.

Demographics of Youth Admitted to Treatment

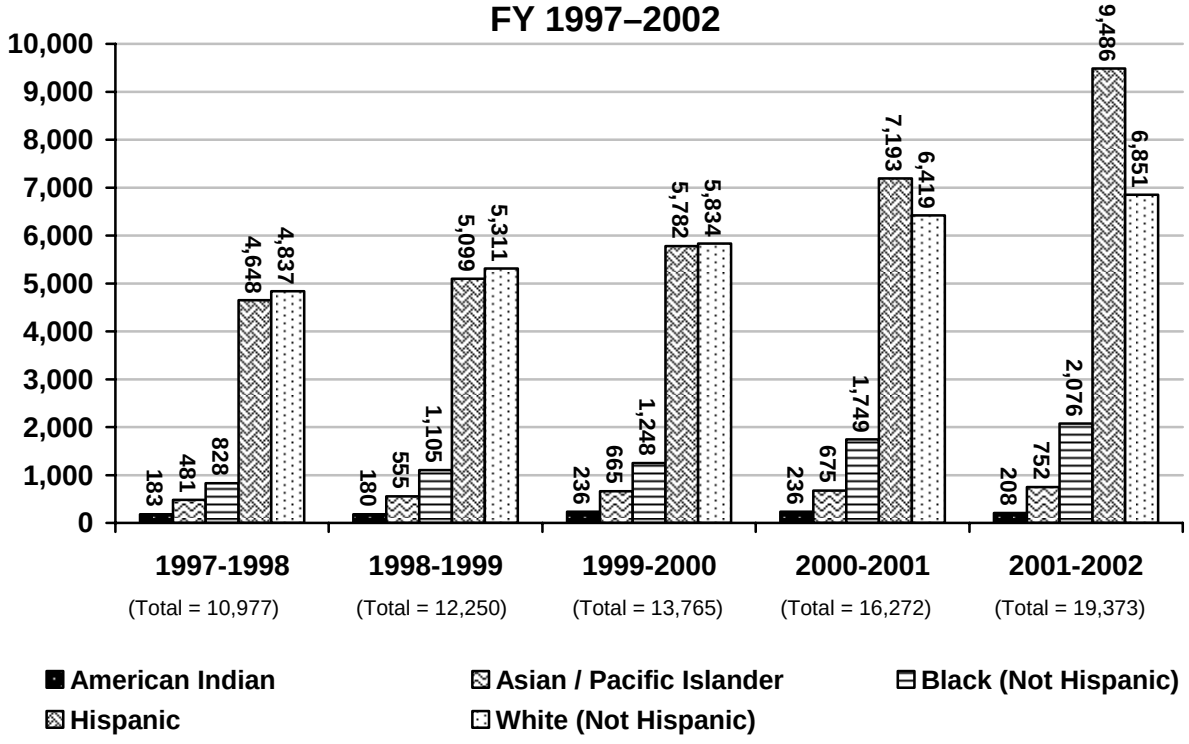
The ethnicity of California youth being admitted to programs reporting to CADDS between 1997 and 2002 can be characterized as follows, as shown in figure 2.10, Race/Ethnicity.

- A growing number and proportion of youth being admitted are Hispanic (or Latino), who as of FY 2001-2002 comprise just under half the youth admitted.
- White non-Hispanic (or Anglo) youth, although their absolute numbers are rising, have dropped from being the largest to the second-largest ethnic group; as of 2001-2002 they are just over one-third of admissions.
- Black non-Hispanic (or African American) youth are increasing in both absolute numbers and as a proportion of all youth; whereas in 1997-1998 they were 7%, in 2001-2002 they were over 10% of youth admitted.
- The number of Asian (or Asian American) and Pacific Islander youth, and American Indian youth, remain small, although they appear to be slowly increasing.

Any conclusion about which ethnic groups are being adequately admitted to treatment, or comparatively under-served, would require further detailed exploration. As noted, CADDS does not include all programs. Second, there is no information on the criteria or quality of CADDS data on client ethnicity. Most important, assessing the treatment needs and admissions contexts for each ethnic group is a complex undertaking requiring that a number of factors be taken into consideration. First is the number of youth in each ethnic group in the general population statewide. For example, the number of Latino youth is growing rapidly. Another factor is the question of differences within groups. For instance, youth categorized as Asian American and Pacific Islander actually belong to very diverse cultural and economic groups. There also is the need to look at the population of each ethnic group within individual counties, since counties' local treatment capacities relative to their populations differ

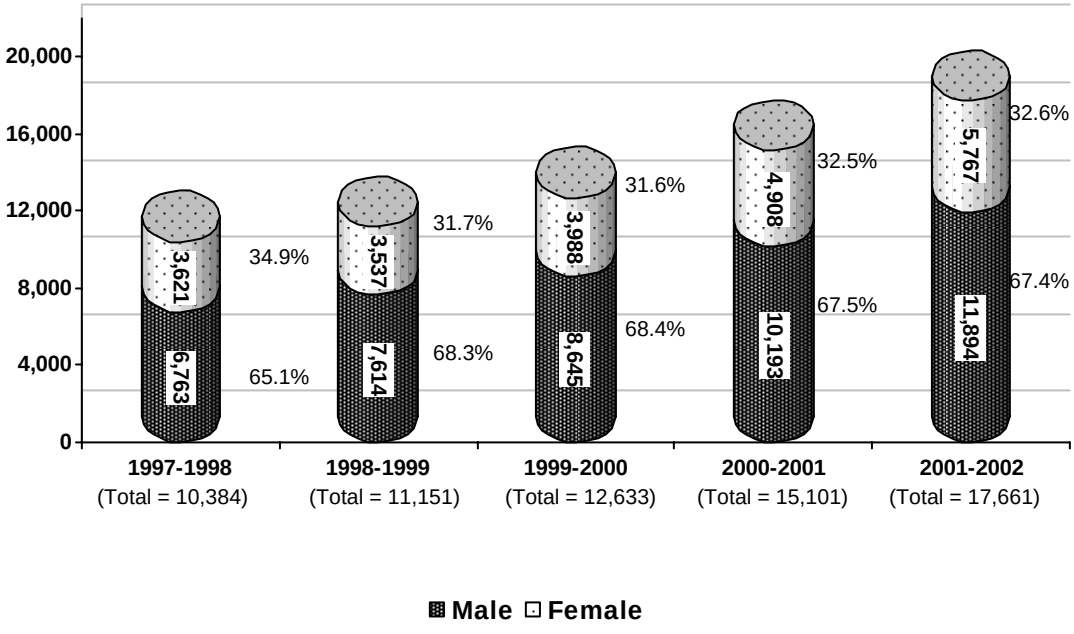
from the statewide relative capacity, as noted earlier. For example, rural American Indian youth may live in smaller counties with quite limited treatment capacity. Next to be considered are the data on prevalence and patterns of substance use and potential treatment need for each group, as measured in existing surveys with ethnic-specific data, as suggested in Chapter 1. For example, in some surveys using certain criteria, white and American Indian youth tend to report higher prevalence and incidence of AOD use than Asian American, African American and Latino youth. Finally, there are contextual factors for public treatment admission for the different ethnic groups. These factors include an ethnic group's relative representation in juvenile justice or child welfare populations, which might lead to public identification and referral, and its relative access to private treatment as an alternative. For instance, African American youth are highly over-represented in justice and welfare populations; furthermore, due to economic factors, they and Latino youth may have less access to privately financed care than do white Anglo youth.

Figure 2.10
Race / Ethnicity
FY 1997–2002



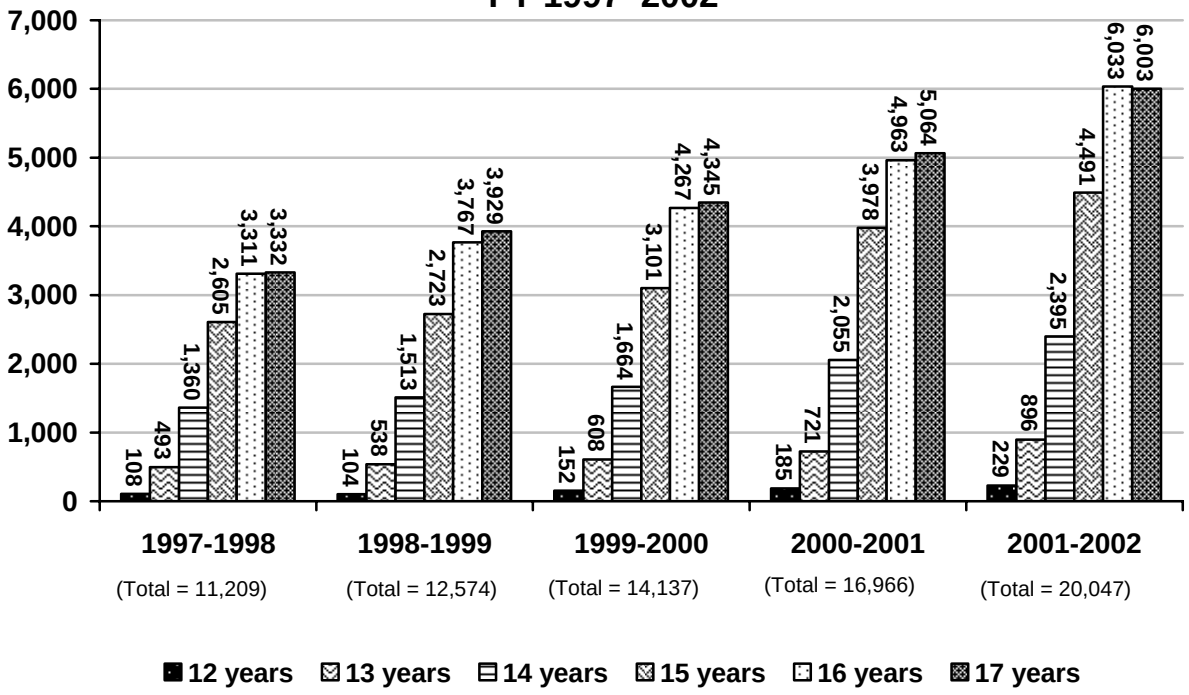
With respect to gender, as shown in figure 2.11, Gender, although the absolute number of girls being admitted to programs reporting to CADDS has risen, girls fairly constantly represent about one-third of all clients, from a high of 34.9% in 1997-1998 to a low of 31.6% in 1999-2000. Yet girls may increasingly be at equal risk with boys for AOD use, as noted in Chapter 1. Treatment programs and juvenile justice institutions historically have been developed to serve males, with females admitted, if at all, as an afterthought. Therefore, girls may very well be under-represented in admissions.

Figure 2.11
Gender
FY 1997–2002



The majority of youth admitted to AOD treatment (60%) are between the ages of 16 and 17, as graphed in figure 2.12, Age at Admission. Relatively few 12- or 13-year-olds (5% combined) are being admitted. The age distribution has not changed between 1997-1998 and 2001-2002, although more youth of all ages are being admitted.

Figure 2.12
Age at Admission
FY 1997–2002



B. ISSUES AND NEEDS IDENTIFIED IN THE FIELD

The current AOD treatment network for youth is rapidly emerging and faces considerable challenges. To understand these issues and needs, the PHI research team conducted a telephone survey of county AOD administrators in 20 counties, and with a sample of providers in those counties, in mid-2003. The 20 counties were selected because they had received small amounts of youth AOD treatment funds from the state -- the first such funding -- beginning in the mid-1990s (Baca/Adolescent Treatment Program funds).[5] Hence, these counties and their providers might be expected to have relatively longer experience with youth treatment compared with all counties in the state. The counties included nine large counties, seven medium-sized counties and four small counties. A survey was developed to include questions on issues of concern identified by the national literature, the Alcohol and Drug Policy Institute and the authors' prior work in the field.[6] [7] *Note: quotes are from survey respondents (see appendices I and II).*

The major treatment issues and needs discussed in this section are:

- Funding needs;
- Collaboration and case management needs;
- Screening, referral and placement needs;
- Family involvement concerns;
- Need for comprehensive assessment; and,
- Treatment models and components emerging to date.

Funding Needs

One major treatment issue identified by all policymakers and practitioners, including both administrators and providers interviewed in the survey, is funding inadequacy.

While the details of financing, both current and potential, are discussed in Chapter 4, the following points are highlighted here to place existing treatment in context.

- Despite much successful securing, prioritizing, blending and leveraging of funds in a number of counties and provider organizations, there are near-universal strong concerns about the need to increase overall funding amounts, make funding more long-term and reliable, and make categorical funding streams more flexible with respect to the services covered.
- Given recent government budget crises, there is concern that the state did not make an ongoing commitment to dedicating monies for youth AOD treatment, that counties may have to reduce whatever additional modest general fund commitments they were able to once make, and that even AOD administrative support will be reduced.
- Because of the greater information available on adult AOD service needs compared to that available for youth, coupled with the historic commitment of the adult recovery community, as well as the current policy emphases on diverting adults to treatment (e.g., Proposition 36), there is worry that youth will remain “at the bottom” in terms of funding priorities, compared to adults. This

reveals "a stark disconnect" between youths' needs and what services are funded.

- There is near-universal agreement that current funding does not pay for core direct AOD treatment services that are both clinically indicated for most adolescent clients and nationally recommended as components of evidence-based practices. The core services mentioned include outreach and early identification, services to the youth's family (including telephone and home-based services), individualized counseling, case management, multidisciplinary team collaboration and continuing care. They also include such strength-based approaches as skill building, tutoring and mentoring, therapeutic recreation and cultural activities.
- There also is no funding for systemic development, such as planning; resource and interagency protocol development; staff skills building; cross-training with other agencies that serve the clients; curriculum or manual development; standards development; and evaluation.
- Funding limits and restrictions make it difficult to serve youth adequately. Counties and providers point to concrete examples such as their inability to bill for telephone outreach that can draw in clients and their families, or individual counseling sessions unless an assessment is being completed, or group sessions if fewer than a minimum number are attending, or meeting with outside service providers to do case management, or releasing staff for training time.
- Counties and providers also note that the existing revenue streams require burdensome reporting procedures in order to bill for services and to meet each agency's programmatic licensing or certification standards. There is concern that any future requirements to track clients' outcomes and evaluate program performance will add new tasks without reducing old ones, with no additional resources.
- Providers also express concern about how cutbacks may result in government pressure to remain productive despite shrinking dollars, such as having to reduce the intensity of care or planned length of stay regardless of individual clients' needs, simply to be able to serve all clients who attempt to access care.

- Counties express their own concern that, in an era of diminishing resources, programs may be reluctant to re-refer inappropriate clients or plan shorter courses of treatment to youth who would benefit from them, because of financial disincentives to do so.

Collaboration and Case Management Needs

Collaboration and case management needs are identified in the field as key issues in youth alcohol and other drug treatment. Survey respondents also noted:

- Youth entering AOD treatment in the overwhelming majority of instances have multiple service needs. Referrals to and advocacy with other agencies on behalf of the adolescent client are both important treatment functions.
- Since most youth are referred into treatment by another system, such as juvenile justice, education or child welfare, treatment often must be monitored by the referring system.
- Youths' recovery frequently requires that the treatment provider help the parents or caregiver to receive family counseling or other publicly funded services.
- Many youth admitted to treatment require continuing care, or "stepped down" or "stepped up" care, which may involve collaboration with other treatment organizations.
- From a systemic viewpoint, few organizations have the capacity to provide all treatment-related functions, at all levels and settings, with the desired standard of excellence. Most localities benefit from coordinating and sharing resources, requiring case management.
- If AOD treatment is not present in state and local collaborations of agencies serving youth, its voice will be missing amidst the voices of juvenile justice, law enforcement, education, mental health, health care and child welfare.

Counties and providers show a clear understanding of the need to develop collaboration. In the survey, when asked for their recent major accomplishments in the

arena of youth treatment, many county AOD administrators identified such collaborative efforts as "treatment in the juvenile facility," "entering the alternative schools," "relationship with mental health and public health" and "multi-agency training."

Policymakers and practitioners in California identified a number of specific barriers to collaboration and case management in the youth AOD treatment sector.

- Partnerships with juvenile justice agencies, while increasing in number and offering great benefit to legally involved clients, reveal conflicts over public safety versus rehabilitative missions, punitive versus therapeutic sanctions, and which system gets to determine the treatment placement, setting, intensity and planned length of stay. Such partnerships are complicated by the enormous power of the court.
- Partnerships with schools, while reportedly increasing in some areas, and having enormous potential to serve youth in an accessible setting, also reveal conflicts between academic versus treatment missions and disciplinary versus therapeutic responses. School district politics and the need to overcome local reluctance to publicly identify with AOD problems present additional challenges.
- Partnerships with youth mental health, while strong and growing in some behavioral health settings, also reveal conflicts over the different diagnostic criteria and treatment goals for the youth served and the different paradigms and techniques of care. Mental health's advantage in funding and staffing also affects relationships.

Collaboration and case management is addressed in Chapter 3 in the context of designing a model system, and in Chapter 4 in the context of funding.

Screening, Referral, Initial Assessment and Placement Needs

The functions identified as needed for screening, referral, initial assessment and placement of youth into AOD treatment include:

- Conducting outreach to families, youth, organizations and communities;

- Developing hotlines, centralized access or intake units and interagency referral protocols;
- Screening youth for AOD issues in schools, courts, juvenile halls, shelters and other settings; and,
- Instituting protocols for standardized initial assessment and placement of prospective clients in the optimum level and setting of care, with ongoing reassessment and stepped-up or stepped-down care.

These issues are explored at length in Chapter 3.

Most counties and providers report working to develop such functions. They are aware that, in their absence, there will be low levels of referrals to youth AOD treatment despite apparent high needs in some communities; AOD problems will remain a low priority for other youth service agencies; these agencies will remain ill-equipped to screen for the problems; and/or the visibility of youth AOD treatment will remain low.

Furthermore, there is awareness that many jurisdictions are assessing needs that cannot yet be met, given the current treatment capacity. While many are understandably uneasy about identifying individuals' treatment needs that then cannot be addressed, others point out that acquiring the data on overall levels of need is crucial to advocating for a system of care.

Few counties have developed countywide screening and referral, or centralized AOD access units serving youth. Most areas continue to have fragmented referral and placement relationships, often based on criteria of convenience rather than the client's interest. The individual provider often conducts assessments solely after admission. County AOD administrators obviously have a major role to play in determining the proper place for each treatment program in the county's referral network. However, referring agencies have tended to develop their own criteria for placement rather than delegating this role to the AOD system.

Often the most appropriate placement for a youth does not exist. Many county AOD administrators report having few early intervention programs for youth, sparse

outpatient care sites, no intensive outpatient or day treatment for "higher end" youth, no publicly funded detoxification or crisis intervention, and no local residential treatment for those unable to live at home. Furthermore, few counties have community-based youth AOD services at all these levels that are culturally appropriate to the diverse backgrounds of the youth, for example, with respect to ethnicity, gender and age. However, organizational pressures—financial, legal and political—may lead to problematic placements even when alternatives exist.

Family Involvement Concerns

Youth AOD treatment is distinctive from adult treatment in the key roles played by adult parents or caregivers. This encompasses family influence on a youth's problems and issues, parents' positions on referral and consent to care, and family members' participation in treatment and aftercare.

There is near-universal agreement that family involvement is a crucial component of care at all stages. In the words of one county AOD administrator, "Therapists don't cure [youth], families do." Most providers report encouraging the involvement of parents or other adult caregivers, and a few require it. The form and intensity of family involvement varies, from parental consent to active involvement in multi-family groups to peer "parenting support." One area of concern is the need to develop systemic capacity to deliver other publicly funded services to family members who need them, in coordination with the child who is in treatment.

Providers and administrators report a common set of barriers to family involvement:

- Parents' lack of awareness of a youth's developing troubles;
- Parents' fear and shame concerning behavioral problems or legal involvements;
- Family poverty, instability or undocumented status;
- Cultural or linguistic differences between families and providers;
- Transportation difficulties between home and the treatment site;
- Family and community acceptance of adolescent AOD use; and,

- Parents themselves abusing alcohol or other drugs, or suffering from other personal dysfunctions or family conflicts.

Need for Comprehensive Assessment

The ongoing assessment of youths' AOD treatment needs differs in important ways from that for adults, including the need for a comprehensive assessment that addresses:

- Physical and emotional safety;
- Age-appropriate mental and physical health;
- Legal and social service statuses;
- Age-appropriate AOD-related use patterns, problems, symptoms and consequences;
- Emotional and cognitive development;
- Family relationships;
- Educational achievement and learning disabilities;
- Gender and emerging sexual identity;
- Cultural identity;
- Peer relationships and role models;
- Life skills and transition to adult self-sufficiency; and,
- Pro-social interests and activities.

There is widespread agreement that all these domains are crucial. However, few providers or counties report being able to assess adolescents in all these areas due to the following factors.

- Many comprehensive assessment protocols require considerable program investment and staff training;
- Few common assessments adequately address strengths or assets as well as pathologies or deficits;
- Some assessments are inappropriate for younger clients, females or different ethnic groups;

- Many lengthy assessments provide little opportunity to develop rapport; and,
- Certain assessments are required by funding or collaborating agencies.

Treatment Models and Components Emerging to Date

In the emerging youth AOD treatment system in California, there is a great deal of diversity in philosophy and approach. Only a few county AOD administrators report encouraging that particular models be utilized, or requiring them in county-run services. Within individual community-based organizations, providers' models range from nationally endorsed and standardized evidence-based practices to unwritten and eclectic "homegrown" practices. Chapter 3 addresses the need for evidence-based practices and program performance monitoring to improve treatment effectiveness.

Certain trends in treatment models can be noted.

- Whereas more formal models were once mostly used in "higher-end" treatment, more recent programs at all levels are adopting elements of models from nationally circulated manuals and training.
- In some areas, there appears to be movement away from the former heavy reliance on the peer-support "social model" in outpatient settings and the peer-confrontation "therapeutic community" in residential settings.
- There also appears to be some reconsideration of the appropriateness of peer-based group self-help such as 12-step recovery for all youth, especially as the sole form of aftercare.
- Despite interest in exploring evidence-based practices, resource-related barriers exist with respect to training and implementation.
- There also is a trend toward adopting more clinically based, behavioral health models, especially in "dual diagnosis" settings for youth with co-occurring substance abuse and other mental health disorders.
- There are barriers to the adoption of such a behavioral health model in many AOD programs due to limited professional staff and resources.

- There are philosophical and practical concerns among many managers and staff from within an AOD recovery paradigm about the wisdom of universally adopting a behavioral health mode. While the professional, individualized and integrated nature of the model is lauded (especially for the many troubled or traumatized youth coming into AOD treatment who require such approaches), there is concern about pathologizing AOD-involved youth with the "mental illness" label.
- There are concerns among policymakers and practitioners about how to integrate the traditional, strength-based approaches of community prevention into youth AOD treatment.

Treatment components currently offered can be characterized as follows:

- With the exception of early intervention programs, most providers report conducting initial assessments for each client, often incorporating or adopting standardized screening or assessment instruments. These are reported to be the basis for client treatment plans that are as individualized as is possible within the program's structure. The data are rarely systematized or aggregated.
- A small but growing number of providers report conducting reassessments with youth at periodic intervals, at discharge, or even after discharge, to assess client progress; other programs depend on staff observations, collateral reports or drug testing.
- Programs' treatment models vary, including whether to have uniform versus individual goals, mostly negative versus positive sanctions, and an abstinence or sobriety orientation versus one focused on "reduced use."
- Most providers report relying primarily on group counseling sessions as the key format for delivering treatment, although many express concerns about its efficacy and express a strong interest in providing more individual counseling.
- Many providers report theoretically being able to make referrals to outside agencies for clients requiring services, but many appear to have little case management capacity and report trying to develop as many services in-house as possible. Referrals to or on-site visits from public health and prevention programs are mentioned as particularly successful.

- Despite overall awareness of the multiple service needs of AOD-involved youth, many providers and county AOD administrators report gaps in their specific knowledge of which services are most needed by clients and which referrals are being made. This may be because of the failure to systematize data on assessed client needs or gaps in case management.
- For continuing care, most programs continue to rely on 12-step meetings; some have developed their own teen-oriented Alcoholics Anonymous or Narcotics Anonymous programs out of concern that adolescents will not participate in or benefit from adult-oriented community meetings.
- Some programs report developing innovative "open doors" as portals to treatment, such as a group for youth with family AOD problems, or an urban safe haven characterized by the program manager as "the door [that] is open for any kid."
- Other programs report developing supportive follow-ups for youth to gradually step down from high-end treatment, such as a transitional house and adjoining coffee house for vocational training.

C. EFFORTS TO DEVELOP A SYSTEM AND STANDARDS OF CARE

The last section of this chapter describes recent efforts and concerns voiced during the move to develop a statewide system of youth AOD treatment, including expanding capacity and creating guidelines and standards for care. This may be seen as a bridge between the needs and issues identified in the previous section, and the model treatment system design described in Chapter 3.

In the last several years, the state of California has taken steps to develop a system of AOD treatment for youth under the authority of California Department of Alcohol and Drug Programs (ADP). ADP has given counties modest amounts of funds to be used for youth treatment in a variety of ways at county direction; a statewide evaluation of these efforts; and a state-level development of program guidelines and planned eventual program standards.

The County Alcohol and Drug Program Administrators' Association of California (CADPAAC) has also taken steps to develop such a system by prioritizing youth treatment in its current strategic plan and having its new Alcohol and Drug Policy Institute (ADPI) commission this report.

The state's efforts consist of:

- Funds for youth treatment (discussed in Chapter 4);
- A statewide formative and process evaluation of county programs[8];
- A summative final evaluation of these programs and efforts[9];
- The Youth Treatment Guidelines, originally published in 2000[10] and revised in 2002[11];
- A Youth Treatment Standards Development Workgroup that has advised the state on the original guidelines and worked on revisions[12];
- An internal draft document called the Youth Treatment Certification Standards, intended by ADP to be appended to its requirements for all AOD treatment programs applying for certification[13]; and,
- Recommendations for revisions to these draft youth-specific Treatment Certification Standards by the Youth Treatment Standards Development Workgroup.[14] [15]

The Youth Treatment Guidelines of 2000 contain[16]:

- Recommended practices in publicly funded youth AOD treatment, comprising the main section of the report;
- Excerpts from the American Society of Addiction Medicine's (ASAM) clinical criteria for placing youth in different levels of AOD treatment;
- A review of youth AOD screening and assessment tools by the University of California, Los Angeles; and,
- State statutory and regulatory guidance on client physical safety.

The 2002 Guidelines consist of recommended practices in publicly funded youth AOD treatment, including many recommended revisions from the workgroup[17].

The draft Youth Treatment Certification Standards are intended to set a "floor" for health, safety and minimal programmatic regulations with which youth AOD treatment programs must comply if they wish to be ADP-certified.

The areas addressed in the 2002 Guidelines are:	*The areas addressed in the ADP internal draft Youth Treatment Certification Standards to date are:*
• ***Guiding principles***	• ***Admission***
• ***Screening and assessment***	• ***Assessment***
• ***Target population***	• ***Family involvement***
• ***Outcomes***	• ***Supportive and recreational services***
• ***Service components***	• ***Youth development***
• ***Service coordination and collaboration***	• ***Staffing***
• ***Culture and language***	• ***Staff criminal background clearance***
• ***Health and safety issues***	
• ***Legal and ethical issues***	
• ***Administration***	

The Youth Treatment Standards Development Workgroup, which met monthly or quarterly between early 2000 and late 2002, has been an important focus of statewide energy in encouraging the development of youth treatment, bringing common concerns to the surface and building a potential network of practitioners and policymakers from around the state. Its accomplishments primarily arose from the commitment and enthusiasm of participants, and there were limitations due to the absence of a specific commitment or mandate given to the group by the state. While most original members were county AOD administrators or invited state officials, the

group was expanded to include numerous providers and other youth treatment experts. The Public Health Institute facilitated, staffed and documented the workgroup from mid-2000 to its conclusion.[18]

In addition to working on language for the revised treatment guidelines, and later for the draft standards, the group held lengthy discussions of such important issues as:

- The feasibility of counties and providers implementing recommended practices in publicly funded programs in different regions at different levels of care;
- The identification of areas of statewide consensus, lack of consensus and "red flags" for implementation;[19] [20]
- Certification not being required for an AOD treatment program to receive ADP-derived public funding (except under Proposition 36), although some county AOD administrators report requiring contracted providers to be ADP-certified;
- Treatment components for early intervention, outpatient, intensive outpatient and residential levels of care, including case management; and,
- Cultural and gender issues.[21]

Program Performance, Evaluation and Data

Recent and current statewide evaluations of youth AOD treatment in California[22] [23] have revealed the lack of available program performance and client-oriented data collected across the state.

National and state efforts currently underway could enhance the potential collection and capacity for analysis of such data, including the Substance Abuse and Mental Health Services Administration's (SAMHSA) Program Performance Partnerships proposal and California's responsive California Outcome Measuring System (Cal-OMS). However, at this time there are no plans to include youth in Cal-OMS (which is an adult-oriented database), or to include assessment and outcome treatment measures that are appropriate to youth at either the national or state levels. The CADDS statewide reporting system is similarly adult-oriented, and, as suggested above, it is not

designed to monitor either client-oriented outcomes or program performance measures.

The National Institutes of Health and SAMHSA have begun to support scientific evaluations and technology transfers related to identifying and promoting evidence-based practices in youth AOD treatment, as have, to a lesser extent, private foundations such as the Robert Wood Johnson Foundation and federal juvenile justice agencies.

While many practitioners and policymakers acknowledge the need for data on client needs and program performance, few to date have turned their attention to what would be required. There also is the natural reluctance to embrace additional reporting burdens, and the potential for negative evaluation findings. Balancing that is the understanding that agencies will increasingly be held accountable for documenting the achievement of promised results with public monies. Further dialogue is needed.

Staffing and Program Certification

One of the most important and difficult issues to address is the credentialing of staff and programs. California's ADP is in the process of slowly revising its overall AOD treatment licensing and certification standards, which have always primarily applied to adult outpatient and residential facilities. ADP also is preparing for the first time to endorse the state certification of AOD treatment counselors.

The following discussion touches on current issues in staff training and standards, and program standards.

The first area of concern is preparatory and in-service training of the workforce. The following points have been made by individuals during the various statewide initiatives highlighted earlier:

- The proposed credentialing requirements address the workforce needs of the adult treatment system, and may not be appropriate for staff in youth services.

- Currently there are no youth-oriented curricula or training courses for AOD counselors, including the national protocols. These would need to be developed before youth-specific competencies could be required of the workforce.
- All staff working with youth should receive basic training in core areas, although they need not all become experts in each area.

The following were identified by the workgroup as core youth-specific training areas for the workforce:

- ***Assessment***
- ***Family dynamics, including cross-cultural ones***
- ***Adolescent psychological development, including gender and sexuality, personal and group identity, and life skills***
- ***Adolescent substance use patterns and AOD-related concerns***
- ***Physiological and developmental effects of alcohol and other psychoactive drugs on adolescents***
- ***Common mental health diagnoses and interventions with youth***
- ***Common adolescent health issues, emergency procedures, suicide risks, victimization, reproductive rights, infectious diseases and medications***
- ***Staff-client relationships and boundary-setting with youth***
- ***Treatment client confidentiality, minors' informed-consent issues, child welfare regulations and safety and abuse issues***
- ***Cross-systems service referral and follow-up procedures for youth***

With respect to the next area of concern, certification and credentialing of staff for youth AOD treatment, input was sought from county AOD administrators and providers in the mid-2003 telephone survey to supplement information gathered over the course of the workgroup, as well as from earlier program site visits and statewide process

evaluation activities by the authors.[24] The following is reported as characteristic of staffing experiences to date:

- Youth AOD treatment programs often find it difficult to retain qualified or experienced staff because other fields, including mental health and civil service agencies, offer higher salaries.
- There may be few opportunities for career advancement within youth AOD treatment in many programs and regions.
- Persons working in substance abuse services often feel professionally unrecognized or socially stigmatized, including in comparison to mental health staff.
- Many programs have historically relied on staff recruited from adult AOD treatment programs and recovering communities, some of whom may lack the formal qualifications that would allow for a high level of professional credentialing or for state licensing. Furthermore, these individuals may lack the expertise to work with youth.
- Many formally professionally qualified and licensed clinicians (e.g., in mental health) have little training or experience in delivering substance abuse treatment. Furthermore, they may lack expertise concerning AOD services for youth.
- There may be individuals with expertise in serving AOD-involved youth in other systems, such as mental health, juvenile justice, prevention, education or social services, without AOD certification or mental health licensing.
- There is a potential lack of fit in requiring AOD certification for counselors and clinical qualifications or licenses for their supervisors, since these professional paths, disciplinary paradigms and areas of expertise are very separate.

Practitioners on workforce development have made the following observations:

- Recruiting sufficient numbers of qualified staff to deliver youth treatment is crucial, and will require a significant investment in new funding for competitive salaries.

- Special workforce development initiatives may need to be developed for counties and programs serving rural or low-income ethnic communities.
- Programs, counties and the state should prioritize innovative ways to improve staff retention and encourage professional development.

Another area of discussion in the state-level effort has been the proposed requirement that staff working in youth AOD treatment be cleared for criminal background prior to engagement. In workgroup discussion and recommendations to the state ADP, the following points have been made:

- Youth require a higher level of protection than adult clients with respect to potential abuse by or danger from all adults who have contact with them in a program, especially in more restrictive settings or intensive levels of care.
- Checks for criminal convictions or open investigations should include all serious violent offenses, as well as offenses involving victims under 18, comparable to the Department of Social Services' requirements.
- Checks ideally should be made for all prospective staff and volunteers in advance of their having contact with clients, with a rapid automated statewide procedure put in place, and a process for programs to apply for a state exemption to hire an individual despite a disqualifying conviction.

The final area of state effort to be discussed here is program standards. After considerable state-level meetings on adult and youth treatment standards development, and consideration of the issues addressed by the workgroup, salient points that have been raised include the following:

- California currently lacks the procedures to implement and enforce an adequate program for state certification of AOD treatment programs that admit youth. These procedures would include health and safety standards and minimum programmatic requirements. The development of such requirements, and their possible relationship to other national and state credentialing procedures, should be considered a high priority. At the state level, this effort must be an interagency one.

- The existing certification and licensing regulations for adult AOD treatment, including residential and outpatient programs, do not appear to be an appropriate basis for youth program standards. This is also the case for the proposed internal ADP revisions to these regulations. The appropriate response is to separate state youth treatment certification and licensing from this adult-oriented regulatory process.
- The efforts of the Youth Treatment Standards Development Workgroup, the two versions of the Youth Treatment Guidelines, and the proposed Youth Treatment Certification Standards could be the basis for re-initiating a youth-specific state AOD treatment certification discussion.

This chapter has described the types of programs and participants in AOD services currently offered to youth in California, the issues and concerns reported by experts in the field, and recent statewide efforts to expand treatment and develop standards. It has highlighted the rapid advances, present trends and considerable unmet need that exist. By presenting a snapshot of this moment in time, this chapter sets the stage for the consideration in Chapter 3 of the design of a model AOD treatment system for youth in California.

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[1] California Department of Alcohol and Drug Programs, Research Department, Retrieved March 2004.
[2] Katherine Jett personal communication, June 16, 2003
[3] Semi-structured telephone interviews were conducted with a sample of county AOD administrators in the summer of 2003. Respondents were asked a series of questions related to the nature, availability and provision of substance abuse treatment to adolescents in his/her county. Several of the aggregated responses are highlighted throughout this chapter. See list of participants in Appendix II and survey questions in Appendix III.
[4] Ibid.
[5] The 20 counties were Alpine, San Diego, Santa Barbara, San Luis Obispo, Alameda, Los Angeles, Orange, Contra Costa, Fresno, San Bernardino, San Francisco, Santa Clara, Humboldt, Imperial, Mendocino, Sonoma, Glenn, Santa Cruz, Sierra and Tehama.
[6] Klein, D., Shane, P., et al. (2001). Interim year one report of the Adolescent Treatment Project evaluation. Report to the California Department of Alcohol and Drug Programs. Oakland: Public Health Institute.
[7] Klein, D., Shane, P., et al. (Unpublished) (2003). Final report of the Adolescent Treatment Project. Report to the California Department of Alcohol and Drug Programs. Oakland, CA: Public Health Institute.
[8] Klein, D., Shane, P., et al. (2001). Interim year one report of the Adolescent Treatment Project evaluation. Report to the California Department of Alcohol and Drug Programs. Oakland: Public Health Institute.

[9] Klein, D., Shane, P., et al. (Unpublished) (2003). Final report of the Adolescent Treatment Project. Report to the California Department of Alcohol and Drug Programs. Oakland, CA: Public Health Institute.
[10] California Department of Alcohol and Drug Programs. (2000). Youth treatment guidelines. ADP Publication 8566. Sacramento, CA: California Department of Alcohol and Drug Programs.
[11] California Department of Alcohol and Drug Programs. (2002). Youth treatment guidelines. Revised August 2002. Sacramento, CA: California Alcohol and Drug Programs.
[12] Klein, D., Shane, P., et al. (2001). Interim year one report of the Adolescent Treatment Project evaluation. Report to the California Department of Alcohol and Drug Programs. Oakland: Public Health Institute.
[13] California Department of Alcohol and Drug Programs. (2002, unpublished). Youth treatment certification standards. Sacramento, CA: California Alcohol and Drug Programs.
[14] Klein, D., Shane, P., et al. (Unpublished) (2002). Annotated youth treatment guidelines 2000 suggested revisions. Report to the California Department of Alcohol and Drug Programs. Oakland, CA: Public Health Institute.
[15] Klein, D., Shane, P., et al. (Unpublished) (2003). Final report of the Adolescent Treatment Project. Report to the California Department of Alcohol and Drug Programs. Oakland, CA: Public Health Institute.
[16] California Department of Alcohol and Drug Programs. (2000). Youth treatment guidelines. ADP Publication 8566. Sacramento, CA: California Department of Alcohol and Drug Programs.
[17] California Department of Alcohol and Drug Programs. (2002). Youth treatment guidelines. Revised August 2002. Sacramento, CA: California Alcohol and Drug Programs.
[18] Klein, D., Shane, P., et al. (Unpublished) (2003). Final report of the Adolescent Treatment Project. Report to the California Department of Alcohol and Drug Programs. Oakland, CA: Public Health Institute.
[19] Klein, D., Shane, P., et al. (2001). Interim year one report of the Adolescent Treatment Project evaluation. Report to the California Department of Alcohol and Drug Programs. Oakland: Public Health Institute.
[20] Klein, D., Shane, P., et al. (Unpublished) (2002). Annotated youth treatment guidelines 2000 suggested revisions. Report to the California Department of Alcohol and Drug Programs. Oakland, CA: Public Health Institute.
[21] Klein, D., Shane, P., et al. (Unpublished) (2003). Final report of the Adolescent Treatment Project. Report to the California Department of Alcohol and Drug Programs. Oakland, CA: Public Health Institute.
[22] Klein, D., Shane, P., et al. (2001). Interim year one report of the Adolescent Treatment Project evaluation. Report to the California Department of Alcohol and Drug Programs. Oakland: Public Health Institute.
[23] Klein, D., Shane, P., et al. (Unpublished) (2003). Final report of the Adolescent Treatment Project. Report to the California Department of Alcohol and Drug Programs. Oakland, CA: Public Health Institute.
[24] Klein, D., Shane, P., et al. (2001). Interim year one report of the Adolescent Treatment Project evaluation. Report to the California Department of Alcohol and Drug Programs. Oakland: Public Health Institute.

Chapter 3
Treatment System Design

Chapter 3: Treatment System Design

Adolescent substance use and abuse are highly prevalent problems in California, as shown in Chapter 1. The substantial unmet need and limited capacity to provide treatment services, as well as other areas where improvements would advance the field, specifically in treatment effectiveness, client retention and staff professionalism, were discussed in Chapter 2.

This chapter describes the principles and topics that should be addressed in designing a treatment system in California that would meet the needs of youth. The discussion includes the following areas:

- Principles for developing a model system;
- Broadening access to treatment;
- Promoting early identification and screening;
- Conducting clinical assessment, referral and placement;
- Creating a continuum of care;
- Principles for improving treatment effectiveness;
- Incorporating multiple assessment domains;
- Making treatment developmentally appropriate;
- Community-based treatment settings;
- Delivery of evidence-based treatment;
- Utilization of program standards and performance monitoring; and,
- Strategic planning for the treatment system.

Some of the areas covered in this chapter include recommendations or policy directions derived from a number of sources, including: (a) the rapidly emerging scientific literature on alcohol and other drug (AOD) treatment for youth; (b) primary research conducted for the past several years by the authors; and (c) input collected for this report from a broad array of California stakeholders and experts (see appendices I and II).

This chapter concludes with calls for further collection of information and continuing discussion by stakeholders and other experts. In some instances the task of specifying policy directions will be linked to future research or advances in the quality of available data. The chapter begins with a section that looks at overall treatment system design issues. It then moves to consider those design issues within treatment. Next it addresses standards and monitoring. Finally, the topic of systems-level strategic planning is discussed.

The organization and content of this chapter reflect the fact that multiple approaches will be required to close the "treatment gap," defined as the distance between estimated unmet need and current treatment capacity and utilization. These approaches include:

- Reconsidering access and potential pathways to AOD treatment for youth;
- Initiating substance abuse screening in a broad array of settings;
- Disseminating information to the public about the availability and effectiveness of treatment;
- Expanding adolescent treatment capacity and redesigning services to meet clients' needs;
- Developing and implementing youth-specific standards of treatment that reflect research findings and best practices;
- Implementing performance monitoring at the systems level to support treatment improvement and collaborative data-driven planning; and,
- Developing a strategic plan, involving stakeholders, and establishing the authority and funding necessary to create a model system.

A. MODEL DEVELOPMENT: AN ALCOHOL AND OTHER DRUG TREATMENT SYSTEM FOR CALIFORNIA'S YOUTH

> *"Treatment providers must develop a vision and a plan for treatment improvement, capacity expansion and excellence."*[1]

Principles for Developing A Model System

Principle 1. *The model should broaden access, implementing the "no wrong door" principle* (see next section). The framework for service delivery should move beyond the current limited pattern of providing treatment for youth referred by other agencies, a pattern that is largely demand-driven and reactive. The drive toward needs-driven access should encompass:

- Early identification and screening of youth in a range of settings (see "Broadening Access," below);
- Public information and cross-training with other providers of youth services; and,
- Commitment to a continuum of care within treatment, as well as case management and cross-referral with other youth services (see "Creating A Continuum of Care," below).

Principle 2. *Public information strategies and community awareness should be developed to reduce barriers to access and reduce stigma.* This must include:

- Making treatment accessible, appropriate and acceptable to adolescents and their families (see "Making Treatment Developmentally Appropriate," below); and,
- Increasing the available treatment choices so that there are to provide diverse modalities and levels of care, programs for specific populations with special needs, and programs in a range of settings (see "Community-Based Treatment Settings," below).

Principle 3. *A needs-driven treatment design should be developed.* The current capacity to deliver treatment services that derive from adult models and limited funding streams should be changed to:

- A system where both overall and individual treatment planning are, above all, responsive to the needs of youth and their families, with programs that are

youth-centered and family-focused (see "Principles for Improving Treatment Effectiveness," below); and,

- Ensure that treatment elements include assessment, case management and responsibility for providing access to needed services, including but not limited to AOD treatment (see "Incorporating Multiple Assessment Domains," below).

Principle 4. *A model system should place AOD treatment for youth squarely within the framework of health and public health.* The treatment system must move beyond the many current treatment elements that are influenced by correctional approaches or juvenile justice sanctions and commit itself to:

- Utilize the growing body of evidence that demonstrates that health and public health approaches are the most effective methods of reducing harmful AOD use and its consequences for adolescents; and,
- Draw on adolescent health promotion elements. Youth require a holistic and strength-based approach to further their development (see "Making Treatment Developmentally Appropriate," below). Many AOD-involved youth who enter treatment are not diagnosed with a chronic, relapsing disorder. Therefore, a public health-derived, health-promotion paradigm may offer an appropriate alternative.[2]

Principle 5. *A model system should include a framework for the delivery of AOD services over a more extended period of time, and should work with youth to manage the common occurrence of relapse.*[3] This new paradigm must move beyond the current pattern of a single provider delivering a stand-alone treatment episode to include:

- Follow-up and continuing care for all youth who are transitioning out of formal treatment or between different treatment settings (see "Creating A Continuum of Care," below);
- Recognition that continuity of care is an important contributor to treatment effectiveness and needs to be integrated into system design; and,
- Provision for ongoing access to re-entering treatment, aftercare and continuing support for those adolescents who are diagnosed with AOD dependencies. This

includes long-term management of the condition as would be provided for youth diagnosed with other chronic health problems such as asthma or diabetes.[4] [5]

Principle 6. *The model system should include referral networks and on-site services linked to schools and other settings that routinely see youth and their families, such as after-school programs, neighborhood centers and locations near transportation hubs.* These referral and service locations should be available in each region of the state. Each school district, in particular, must have protocols for screening and referring youth to the local AOD treatment system.

Principle 7. *The system should be structured to deliver treatment to youth in the least restrictive setting that ensures their physical and emotional safety.* The system should:

- Create intensive levels of care that would allow youth in treatment to remain safely with their families and in their communities. This is increasingly recommended by child welfare policymakers and required in laws determining the placement of children in care; and,[6] [7] [8]
- Ensure that placement in a level of care for AOD treatment is made on the basis of clinical assessment (see "Conducting Clinical Assessment, Referral and Placement," below) rather than as part of a juvenile justice sanction, so that youth are not court-ordered to AOD treatment in out-of-home residential or institutional settings.

Principle 8. *The model AOD treatment system should have a central position in the larger world of comprehensive health, education and social services for youth.* Substance abuse treatment providers should play a proactive role in the planning and delivery of adolescent services. This will require:

- Adopting evidence-based and consistent protocols and standards for identification, screening, initial assessment, referral and placement. This would move beyond the current pattern of incomplete linkages and local protocols based on custom;

- Integrating AOD treatment into comprehensive community-based networks in partnership with multiple agencies and organizations;
- Developing county- and state-level authority for youth AOD treatment and related services that includes the power to establish services, enforce standards, ensure funding and provide accountability to stakeholders, including consumers (see "Program Standards and Performance Monitoring" and "Strategic Planning for the Treatment System," below);
- Utilizing current fiscal challenges as catalysts to propose the restructuring of services and service delivery practices to expand and enhance care, move beyond the current patterns of categorical funding (see Chapter 4) and improve accountability across agencies and service sectors; and,
- Assigning a high priority within state- and county-level AOD treatment to serving adolescents, moving beyond the de facto current pattern that prioritizes adults.

Broadening Access: The "Doors" to Treatment

> *"The laws, regulations, funding and research have historically supported an adult-driven system. As a result, children and youth with substance abuse issues have predominantly been identified and dealt with through other systems, including the juvenile justice, mental health and educational systems."*[9]

The principle of "no wrong door" means that access for youth in need of AOD treatment should be expanded through a broad array of entry points.[10] Wherever a youth is initially identified as having a probable substance abuse problem, there should be the capacity to initiate an appropriate sequence of interventions to screen, assess and refer the youth for needed services.

This will require AOD treatment providers to collaborate with professionals who work with youth in schools, clinics, social service agencies and the juvenile justice system. Protocols need to be developed at state, county and local levels. Cross-training on AOD abuse screening and other issues facing youth are needed. Interagency linkages and memoranda of understanding are necessary for the appropriate referral of youth.

> *"Substance use disorders (SUDs) span all youth care sectors, and SUD assessment and treatment should be a prominent consideration with regard to both policy and practice."*[11]

Treatment systems that operate within the framework of "no wrong door" are characterized by the following:

- Continuous direct access to a system that can easily be utilized, without outside assistance, in a geographically accessible place, during flexible hours;
- Direct access to treatment services for youth and their families;
- Self-referral opportunities for youth and their families; and,
- Greater awareness of local treatment options, including outreach to school- and community-based civic organizations.

Another crucial strategy should be to develop public awareness and community campaigns around treatment (as noted in Principle 2) with youth and families in diverse populations and communities.

These outreach initiatives must be accompanied by an increase in the local availability of treatment for youth, and facilitated entry into treatment. When an adolescent or family member "knocks on any door," a timely response should be available.

> *"Screening for drug problems in primary care settings, at school, and mental health programs will help in the early identification and treatment of drug use disorders in youth."*[12]

There should be a "front door" that youth feel comfortable entering.

- The "front door" symbolizes a place that adolescents are willing to enter without stigma or shame.
- This means that the door to treatment services must be youth-appropriate and user friendly.
- AOD treatment settings should operate in physical environments that are well designed, beneficial and welcoming (also see "Making Treatment

Developmentally Appropriate" and "Community-Based Treatment Settings," below). These could be locations designed for other programs utilized by teens, such as after-school centers.

- Placing AOD treatment in the framework of health (see Principle 4) will also encourage youth or parents to present for services.

These initiatives must simultaneously be accompanied by a redesign of treatment to make it responsive to its consumers: AOD-affected youth and their families.

The gateways resembling "back doors" should be changed.

- As a consequence of current treatment referrals of youth from the juvenile justice system, a public image has been created whereby deeply troubled youth are forced to enter treatment through a hidden "back door," an image that stigmatizes AOD treatment and its clients, and associates it with coercion and probation supervision.
- It is crucial to afford youth in juvenile justice open-door access to referral to treatment. However, referral patterns should be changed to negate the "back door" image.
- Court-involved youth should have entry through the same "front door" as other youth.
- This means moving away from court-ordered treatment and toward court referral to an appropriate clinical placement.
- This will require working with the judiciary and probation to shift juvenile placement criteria and to develop new protocols based on treatment criteria.

Reliance on what resemble "locked doors" should be reduced.

- This refers to the metaphor for treatment provided within institutional settings, perceived as operating with "locked doors."
- Group homes are currently the only publicly funded 24-hour or residential settings available to deliver AOD treatment to youth. These settings may be

perceived as restrictive rather than therapeutic by youth, most of whom are ordered there by the juvenile court.

- Capacity should be developed to provide alternatives for intensive or "day" treatment outside residential or institutional settings.
- AOD treatment for youth, including those with juvenile justice involvement, should be delivered in the least restrictive setting possible, in open community-based settings where youth can easily come at hours tailored to their needs. Alternatives to institutional settings should be developed for the placement of youth with many co-occurring concerns.

Conducting Clinical Assessment, Referral and Placement

System-wide screening, initial assessment, referral and initial placement practices, including screening tools, initial assessment protocols, referral procedures and placement decision criteria, should be implemented in accordance with standards or guidelines that are collaboratively developed by the multiple agencies involved. These guidelines should incorporate the following:

- The best practices known in the field as they emerge in the national research;
- Means to advance agencies' capacities to fund and implement these practices and protocols;
- Promotion of early identification of AOD problems and timely intervention;
- Use of standardized, validated and youth-specific screening and assessment tools and placement criteria and protocols
- Sequential processes for screening, initial assessment based on the screening, subsequent referral and contingent initial placement
- Prior to placement in an AOD treatment program, a youth should have been screened for AOD problems, found to have a "positive" screening result, and subsequently referred for an initial AOD-oriented clinical assessment;
- The AOD problem should serve as the *primary* basis for any admission to AOD treatment. Although youth may have multiple issues, including both contributing or co-occurring problems and consequences of AOD abuse, the

model system for youth should place AOD abuse at its center. Whatever clinical tools and protocols are used for the screening, initial assessment, referral and initial placement in AOD treatment, a youth must "score" positively on the basis of his or her AOD abuse;

- A youth's comprehensive service needs, as initially assessed, should guide the referral and placement in the appropriate AOD treatment setting and level of care. Ideally, the initial clinical assessment function should be independent of any specific treatment provider;
- To the greatest degree possible, the family or adult caregivers should be involved in the initial assessment, and in the placement and following in-depth assessments;
- The emotional and physical safety of the youth should also be factors in screening and initial assessment, referral and placement decisions; and,
- After receiving screening and initial assessment information, the admitting treatment provider should conduct a more in-depth, multi-dimensional assessment as part of the intake and treatment planning (also see "Incorporating Multiple Assessment Domains, below").

"Accurate assessment should cover the many issues associated with teen substance abuse – and treatment should match the complexity and severity of the problems revealed by the assessment."[13]

"The assessment of adolescent drug and alcohol involvement remains a complex clinical and practical process. It requires the careful and skillful implementation of procedures across a wide range of service systems and providers. ... Because problem identification, triage, and referral, level-of-care decisions, treatment provision, and treatment outcome are predicated upon an adequate appraisal of the assets and liabilities the youth brings to an intervention setting, multidimensional, comprehensive assessment using standardized

measures is necessary at various stages of the assessment process and within each service system."[14]

Subsequent reassessments are necessary to inform discharge planning, to monitor client outcomes and to measure aspects of program performance.

- The initial treatment placement should be at the least intensive, least restrictive level of care that is clinically appropriate to the youth's assessed treatment need. This guideline will help to ensure that:
  - Higher levels of care will be reserved for the youth who need them;
  - Placement criteria originating from other domains, such as a juvenile justice assessment of a youth's potential risk to public safety, will be addressed as separate and distinct from the assessment of need for AOD treatment;
  - The public sector costs of a treatment episode will be as low as possible; and,
  - The scarce resources that exist will be directed to developing a full continuum of care in the community.

Creating A Continuum of Care

A comprehensive continuum of care is best developed across two dimensions:

- One dimension is *across* AOD treatment and other multiple service sectors, allowing for simultaneous cross-referral of a youth to the most appropriate type, setting and level of care.
- The second dimension is *within* AOD treatment, allowing for unrestricted entry and re-entry of youth over time to more or less intensive and/or restrictive levels and different settings as needed.

The continuum of care should reflect the array of levels and settings within the youth-specific Patient Placement Criteria as recommended by the American Society of Addiction Medicine (ASAM).[15]

This continuum should include continuing care that provides relapse prevention, support and monitoring.

> *"Treatment requires continuity of care, including acute and follow-up strategies, management of any relapses and satisfactory outcome measurements."*[16]

The continuum should also include professional therapeutic counseling services to the youth and his/her family as needed (see "Model Development: Treatment Design Issues," below). The continuum should include facilitated referrals and formal linkages between AOD treatment and services to address the youths' mental health, physical health, education and legal needs.

B. MODEL DEVELOPMENT: TREATMENT DESIGN ISSUES

This section addresses aspects of a model system that relate to internal treatment design.

Creating a model system will require redesigning AOD treatment to improve its effectiveness with youth. This will include implementing a treatment approach that addresses youths' multiple issues, including their family relationships and educational needs. A youth-sensitive treatment approach will respond to and enhance clients' age-appropriate development. These approaches will foster increased client engagement, retention and attainment of treatment goals.

Improving treatment in these ways will require instituting standards of program excellence that draw on evidence-based practices, and initiating performance monitoring based on those standards. Workforce development also will be a crucial element of this initiative.

Principles for Improving Treatment Effectiveness

Nine key principles to improve youth AOD treatment are listed below.

Principle 1. Treatment of each client should match his/her assessed needs, and treatment should match the complexity and severity of the assessed problems (see "Conducting Clinical Assessment, Referral and Placement," above).

Principle 2. Services should be planned and delivered to address all domains of the youth's life (see "Incorporating Multiple Assessment Domains," below), in an "authentically connected referral network."[17]

Principle 3. The treatment model must be developmentally specific to adolescence (see "Making Treatment Developmentally Appropriate," below).

Principle 4. The involvement of the youth's parents, family members and adult caregivers must be central to the AOD treatment model.[18]

Principle 5. A "therapeutic alliance" must be built between the youth and the program staff based on mutual trust and partnership.

Principle 6. Follow-up services should be part of treatment planning and discharge planning in order to maintain treatment gains in the months and years following treatment (as noted in "Creating A Continuum of Care," above).

Principle 7. The program must provide interventions that are acknowledged as appropriate and effective for gender and cultural identity issues.

> *"There is currently a lack of material that identifies basic issues regarding gender-specific services, treatment needs, etiologies of behavior and suggestions for policy and practice in treatment and service settings, including institutions, residential and community based."*[19]

Principle 8. Program staff must have expertise in adolescent development and its relationships to family dynamics and AOD abuse. Staff also should have knowledge of the symptoms and appropriate treatment referrals for co-occurring disorders in youth.

Standards for training and proficiency, as well as clinical supervision, must be established (also see "Program Standards and Performance Monitoring," below).

> *"Most individuals who have co-occurring mental health and substance use problems are not receiving effective treatment. Efforts to improve the care provided to persons who have co-occurring disorders should focus on strategies that increase the delivery of effective treatment."*[20]

Principle 9. Ongoing program evaluation should provide the basis for continuous treatment improvement and the effective targeting of resources.

Incorporating Multiple Assessment Domains

A thorough assessment should be conducted for each youth, including the specific domains that have been identified as relevant to adolescents. Research-identified core domains for assessment are listed below:[21] [22]

- Alcohol and other drug use, severity indicators, patterns of use, age of onset and treatment history;
- Parenting and household situation, immediate and extended family profile and history, economic status, family relationships and communication;
- Educational status and history, any learning issues;
- Mental health: any symptoms, types and severities of any disorders, medication and treatment history;
- Physical health: any significant medical history;
- Peer relationships, relationships with significant adults, community profile;
- Personal skills and aptitudes;
- Any faith, spiritual or cultural affiliations or identities;
- Sexual activity and history, and gender identity and orientation;
- Illegal or injurious activity involvement, patterns and consequences;
- Abuse or victimization history, stressful life events and trauma; and,

- Involvement with social services or juvenile justice and history of placements.

General steps for conducting and using the assessment include the following:

- Each youth should be assessed for the core domains and any additional domains that may apply.
- Each domain assessed should then be considered for appropriate goals within the treatment plan.
- Each treatment goal should then have outcomes that can be measured through reassessment.
- Hence, the planned and delivered services will be matched to the specific needs assessed for each youth.
- A thorough assessment includes standardized tools that have been validated for youth, clinical observations and a professional evaluation of the youth's assets as well as problems.
- A facilitated referral will be made and case management will ensure that the needed services are delivered.

Making Treatment Developmentally Appropriate

Creating services that are appropriate to adolescents' developmental stages is a priority in youth AOD treatment design. AOD treatment models and practices must move away from reliance on adult-derived paradigms and acknowledge the substantial developmental differences between adults and adolescents, as well as the developmental differences among youth at different stages of adolescence.

Treatment interventions, activities and materials should reflect that fact that youth:

- Are at an earlier stage of cognitive development than adults;
- Tend to move from more concrete thinking to abstract thinking as they mature;
- Are transitioning from the earlier, family-based identity, through a period of peer-group identity, ultimately toward an individual identity;

- Are likely to have less-developed verbal skills than they will have as adults;
- Usually require tangible, immediate and positive goals and incentives;
- May be minimally responsive to didactic or negative treatment approaches; and,
- Are likely to benefit from action-oriented plans and pro-social activities.

Developmentally appropriate treatment for youth:

- Is relevant to the substances commonly used (alcohol and marijuana);
- Responds to the youth's characteristic use patterns (e.g., bingeing and opportunistic use);
- Addresses the high rates of co-occurring internal problems (depression, anxiety, traumatic distress), and external problems (attention deficit, hyperactivity, conduct disorder); and,
- Incorporates medical and behavioral evidence on biological and cognitive development.

Recognizing the developmental issues of youth in the design of a model treatment program also means:

- The screening and assessment tools selected should have validity when utilized with youth (see "Conducting Clinical Assessment, Referral and Placement," above).
- The assessment, treatment goals, services delivered and outcome benchmarks should incorporate the multiple domains that are crucial to youth (see "Incorporating Multiple Assessment Domains," above).
- Treatment for the adolescent should always integrate the active participation of family members or adult caregivers in therapeutic activities, unless this is clinically counter-indicated or logistically impossible. Support services for parents are also crucial.
- A key consideration in making a treatment placement is ensuring that the adolescent is as physically and emotionally safe and healthy as possible (see

"Conducting Clinical Assessment, Referral and Placement," above). It is equally vital in treatment and discharge planning. Many youth entering AOD treatment also require professional therapeutic counseling to address their history of abuse or victimization and/or current trauma.

- The treatment and discharge plan should address the life and social skills necessary for the youth to successfully transition into independence as a young adult. Inside the treatment setting, especially if it is a restrictive one, youth will benefit from opportunities to achieve competency in decision making.

"Many group care settings provide so much structure that youth are not able to exercise much discretion or learn to take responsibility for themselves. This structure comes at a cost to the development of youth."[23]

- The treatment and discharge plan should also assess the youth's personal strengths and capabilities, and arrange for promotion of his or her recreational and cultural interests in order to build a basis for future economic self-sufficiency and satisfaction with pro-social activities. "Strength-based" treatment elements are likely to improve client engagement, retention and long-term benefits.
- Treatment and discharge plans should assess and encourage supportive relationships and other social or spiritual sources of resiliency and positive identity. Treatment routines should incorporate opportunities for the youth to spend time with these mentoring individuals or groups.

This means that treatment must incorporate differential and complex developmental issues into therapeutic methods, program structures and routines, treatment goals and discharge planning, and the curricula and materials utilized with youth. There should also be intensive training of staff on adolescent development, its relationship to AOD abuse, and its effects on the course of treatment.

Community-Based Treatment Settings

Principles of model development described earlier included developing services in local neighborhoods, strongly linked to schools, and delivering care in the least restrictive setting possible (see "Principles for Improving Treatment Effectiveness," above).

Settings for AOD treatment for youth should:

- ***Be non-restrictive and community-based wherever possible, including at the more intensive levels of care***
- ***Consider co-location with after-school programs and other youth centers***
- ***When in a restrictive environment, minimize any punitive or correctional elements, and maximize elements of safety and privacy, so as to avoid re-traumatizing youth***
- ***Always strive for a "youth-friendly" and developmentally appropriate appearance***
- ***Include separate spaces for girls, to ensure that they receive safe, equitable and gender-specific treatment***
- ***Incorporate linguistically and culturally sensitive elements in order to engage the families of under-served youth***
- ***Develop settings suited for youth with special service needs or access issues, such as those with gay, lesbian, bi-sexual or transgender identities; runaway and street youth; those with serious emotional disorders; and severely addicted or alcoholic youth***

Most youth will not be assessed as clinically requiring treatment in a setting that provides 24-hour care. However, there is the need to develop publicly funded, state licensed, residential youth AOD treatment in California for those youth who do clinically require residential care, and for youth who need treatment but cannot safely live at home or in the community.

As noted in Chapter 2, publicly funded residential AOD treatment services in California are currently delivered in group homes or in correctional facilities such as juvenile halls, camps and ranches. These institutional facilities are not designed to provide treatment. There also is emerging evidence that large facilities, when compared to family-type homes, are not optimal settings for youth to thrive.[24]

> *"There is no substantial evidence to support the necessity or value of large centralized emergency shelters or residential treatment centers for most children involved with child welfare services. The costs of these placements are so much higher than other placements, yet their efficacy appears to be no greater. Therefore, their use cannot be justified on a cost-benefit basis if any other levels of care can provide a safe place for children."*[25]

AOD treatment should be provided for youth identified with AOD problems who are currently in restrictive environments such as social service and juvenile justice facilities. There should be screening and referral to link them to assessment and treatment in a qualified program with professional counseling staff. Ideally, this program would be in a community-based setting.

Implementing these changes will require moving away from juvenile justice-based AOD treatment programs that rely on peer self-help groups inside institutions, the use of correctional staff to deliver AOD treatment services, and court-ordered residential AOD treatment placement as a punitive sanction.

Delivery of Evidence-Based Treatment

Recently, national scientific evaluations of AOD treatment and treatment outcomes for youth have become a visible priority for the federal government. Promising programs -- both clinical research experiments and "real world" community-based programs -- are being developed to provide replicable curricula or formal manuals, which then can be shared with the field through training and technology transfer networks. Manuals have been developed to advance the fields' access to treatment approaches and interventions.[26]

Thus, at this time, a treatment redesign initiative is poised to take advantage of advances in the dissemination of knowledge about the needs of youth entering treatment, new treatment models being developed, and the identification and adoption of effective treatment practices and components.

Effective interventions to date include:[27] [28]

- ***Family-Based Interventions: Structural-Strategic Family Therapy, Parent Management Training (PMT); Multi-Systemic Therapy (MST), Multi-Dimensional Family Therapy (MDFT)***
- ***Motivational Enhancement Therapy (MET): A client-centered approach, used as a stand-alone, a brief intervention or integrated with other intervention modalities; helpful in addressing ambivalence or resistance and strengthening motivation for change***
- ***Cognitive-Behavioral Therapy (CBT): Based on learning theory, often utilizes motivation-enhancing techniques, may include a functional analysis on attitudes, thinking/coping strategies, problem solving and communication skills***
- ***Behavioral Therapy Approaches: Based on operant behavioral principles giving or withholding rewards or utilizing sanctions to modify or extinguish unwanted behaviors***
- ***Community Reinforcement Therapy: Combines principles and techniques derived from behavioral, cognitive-behavioral, motivational and family therapy, often using incentives to enhance treatment outcomes***

Common elements found to be effective in the treatment of AOD-affected youth are:

- The use of empathic, supportive, motivationally enhancing techniques;
- Behavioral and cognitive behavioral approaches;

- Emphasis on comprehensive assessment and targeted interventions in a range of domains related to substance abuse (see "Multiple Assessment Domains," above);
- Individualized therapeutic interventions; and,
- Inclusion of the family in treatment.

C. PROGRAM STANDARDS AND PERFORMANCE MONITORING

Chapter 2 discussed the historic lack of overall statewide youth AOD treatment program standards in California, and the state's recent initiative to develop guidelines for existing services. By tracing the fragmented and inadequate funding streams for these services, Chapter 4 will outline why the program requirements that are in place are so disparate and often incompatible.

Chapter 2 also addressed concerns that have arisen in the state's attempts to develop youth-specific program certification standards, and issues surrounding the lack of youth-specific counselor credentialing standards. In addition, gaps in data on program and client performance were identified.

This section addresses the role of program standards, including staff requirements and performance monitoring, including the necessary elements and uses of information, in the context of developing a model AOD treatment system for youth.

Utilization of Program Standards

The goal of standards at the systems level is to achieve a rich mix of high-quality services successfully delivered to youth who need care, through a service network that is appropriately integrated at the state and county levels. This network is likely to be characterized by a combination of: 1) directly provided, publicly funded county-level treatment, 2) county-contracted private service providers, 3) interagency memoranda of understanding and funding mechanisms that link AOD treatment with other community-based youth services, and, 4) facilitated referrals and case management that occur in a variety of sites. Thus, standards at the systems level must address access to, as well as accountability for, the quality of services.

Standards at the systems level should also address:

- Appropriate, standardized tools and uniform protocols for screening and initial assessment, which are designed for adolescents and are multi-dimensional, and which work in a variety of youth-service and school-based settings (see "Conducting Clinical Assessment, Referral and Placement" and "Multiple Assessment Domains," earlier in this chapter);
- Treatment placement decisions based on documented clinical criteria, or placement protocols based on the American Society of Addiction Medicine's Patient Placement Criteria (see "Conducting Clinical Assessment, Referral, and Placement, above"); and,
- Comprehensive, integrated and developmentally appropriate treatment approaches and networks which are capable of linking youth and their families to needed services, and which can provide a continuum of care (see "Principles for Improving Treatment Effectiveness," above, and the following sections).

One approach to implementing such standards for AOD treatment programs is to prioritize and systematize licensing and certification in a state agency-level forum. This might take the form of a joint state commission or other multisector body that would identify minimum treatment standards and bring into alignment the current disparate licensing, certification and funding requirements. Such standards would address health and safety areas, as well as clinical programmatic requirements. These state efforts could build on youth behavioral health care standards developed by national program accreditation organizations.

Another important arena for state-level activity is the commitment to professionalizing the youth AOD treatment workforce, including the credentialing of counselors. To date, the work accomplished on AOD counselor credentialing is adult-oriented and hence not the ideal basis for youth-appropriate staff standards.

The AOD-oriented credentialing of staff for youth treatment must address the issue of how to integrate potentially diverse disciplinary backgrounds and qualification levels of staff. Program staff should have the proficiency to deliver a full spectrum of services to

meet clients' assessed treatment needs. Staffs' individual expertise should be complementary. Staffing composition must provide for clinical supervision of all counseling by qualified professionals.

It is recommended that a training curriculum specifically for youth AOD counselors be developed. Although California plans to require AOD counselor certification, a developmentally appropriate, youth-focused AOD counseling curriculum is not yet available. In its absence, any certification would be reliant on adult curricula.

Utilization of Performance Monitoring

The goal of performance monitoring at the systems level is to continuously develop and refine treatment outcomes, measure them in valid and reliable ways, and support functional improvement, all at the client-, program- and system-wide levels. This will require innovative change to shift away from current service patterns that often provide a single episode of time-limited treatment with little capacity to evaluate outcomes. The shift toward system building will require a planned, ongoing system of data collection and analysis to support continuous quality improvement and provide the basis for performance monitoring.

> *"Effective system builders structure the quality improvement process to reflect the system's values and goals, and key stakeholders, including families and youth, are involved in the design and implementation of quality improvement through committee structures, participation in focus groups, involvement in targeted assessments and the like."*[29]

Outcomes and measures should include:

- *Performance Indicators*: These should consist of relatively simple measures of service delivery to clients and overall program and system operations (e.g., referrals received, screenings and assessments conducted, continuing care services offered and utilized).

- *Client Outcomes*: These should include the trajectories of clients as they move through time, to identify changes in multiple dimensions[30] [31] (see "Multiple Assessment Domains," above).
- *Benchmarking*: This provides the basis for monitoring individual program performance and assessing change against its own historical performance, and for comparisons across programs or sites. By integrating and establishing standards for performance indicators and client outcomes, benchmarking can provide tools for monitoring program performance statewide for all programs delivering AOD treatment services and for specialized treatment programs that serve specific subgroups of clients.

It is recommended that a statewide youth AOD treatment data infrastructure be developed in accord with consensus-formulated guidelines that include:

- A minimum data set of measures of client need in domains derived from standardized assessments developed for youth; and,
- Complementary indicators of appropriate service delivery and utilization, and feasible client outcome measures, which emerge from the domains of client need.

The uses of program monitoring data should include:

- *Support for Data-Driven Accountability*: Develop a system of accountability in state and county agencies and provider organizations that incorporates performance monitoring. Both the proposed federal Substance Abuse and Mental Health Services Administration (SAMHSA) Performance Partnership Grant system and the emerging state California Outcome Measuring System (Cal-OMS) should include clients under the age of 18 who are receiving AOD treatment services, with appropriate client outcomes and program performance indicators.
- *Support for Data-Based Collaborative Planning*: Move toward an infrastructure of interagency planning and policymaking that is supported by the analysis of shared data collected across service systems.

- *Support for the Creation of Incentives*: Develop incentives to improve the capacity of providers, their efficiency in delivering services, and the commitment to meet standards of accountability.
- *Support for Feasibility Initiatives to Overcome Barriers*: Identify current barriers to the reporting of operational, clinical and fiscal information that could be collected and analyzed to improve performance, and construct regional or local pilot programs and innovations to mitigate these barriers.

D. STRATEGIC PLANNING FOR THE TREATMENT SYSTEM

The final and crucial piece in designing an AOD treatment system for youth in California is the strategic planning process employed to accomplish the task. This planning process currently is in its early stages.

The first steps began with the planning and implementation of the project, including the commissioning of this report by the Alcohol and Drug Policy Institute (ADPI) of the County Alcohol and Drug Program Administrators' Association of California (CADPAAC), and the Charles and Helen Schwab Foundation. A consensus is emerging on the unmet needs in the current treatment network.

> *"A fractured system of care, limited access to individualized treatment, an isolating over-reliance on restrictive care, and insufficient resources are causing the vast gap between provided treatment and children's needs."*[32]

The initial steps in the strategic planning process have included the development of this report, the convening of expert/stakeholder panels, (see Appendix I) and a retreat for ADPI, CADPAAC and the Schwab Foundation held in December 2003. This was followed by the development of specific policy recommendations that were presented by the Schwab Foundation to the California legislature in April 2004. Future efforts will include the development of strategic and tactical collaborations among policy stakeholders and advocates.

It is recommended that strategic planning:

- ***Create a strong, inclusive statewide alliance among county AOD administrators, but de-emphasize a county-by-county perspective***
- ***Identify opportunities for system building with other providers of youth services at the county, regional and state levels***
- ***Utilize language that capitalizes on the goals and vocabularies shared with other youth-serving sectors***
- ***Manage changes and crises as opportunities for the creation of alliances***
- ***Initiate a dialogue in the statewide policy arena to identify fiscal and administrative barriers to a youth AOD treatment system***
- ***Make costs associated with the status quo, and the consequences of inadequate and fragmented AOD services, and identify ways that a more integrated and fully funded system would result in future cost avoidance***
- ***Seek incentives for agencies and organizations to advocate for and participate in system changes***

The tools for strategic planning include:

- Interagency outreach to foster goals and agendas across youth service delivery systems;
- Cross-training with staff in other systems to properly identify, screen and refer adolescents to AOD youth treatment, and to refer them for other services;
- Cross-training with other systems to facilitate the translation and application of research findings into practice across youth-serving sectors;
- Improving treatment effectiveness, including the adoption of evidence-based practices; and,

- The promotion of program standards, staff proficiency and performance monitoring for youth AOD treatment.

Issues for Strategic Planning

In the strategic planning process the following issues can be anticipated to arise:

- What are the respective roles of CADPAAC and the California Department of Alcohol and Drug Programs (ADP) in creating statewide interagency executive leadership and helping to develop legislative leadership to legitimize, expand and enhance youth AOD treatment?
- What role should counties, county AOD administrators and CADPAAC take in steering strategic planning, in relation to other potential stakeholders?
- What role should youth, families and potential consumer advocates take in the strategic planning process, in relation to official policymaking stakeholders?
- What should be the respective roles in strategic planning for different treatment provider organizations and various practitioners' associations?
- What is the potential role of ADP in advancing the youth AOD treatment system's accountability and its own authority at the state level? Which of the recommendations that are being made fall within the state's purview (e.g., setting system-wide standards, workforce credentialing, program licensing and certification)? Are there other national public or private organizations (e.g., SAMHSA, Joint Commission on the Accreditation of Healthcare Organizations) that could help to set such standards?
- Should a gubernatorial appointment be proposed that would create a state-level youth "czar" to provide the leadership, authority and credibility necessary to achieve systemic change?
- What are the potential roles of ADP and CADPAAC in advocating for federal and state funding flexibility and revenue changes needed to address adolescents' need for treatment?
- What is the appropriate degree of decision-making authority that should reside at the community level? What statutory, administrative or fiscal changes are

needed to provide a youth AOD treatment system with a community-level locus of services?

At the national and state level, initiatives are underway to build capacity, improve treatment effectiveness and create strategic partnerships. Policy strategies devised for other initiatives may have value for redesigning and improving the delivery of youth AOD treatment systems. These include the following:

- The Children's System of Care (SoC) is a publicly endorsed model designed for seriously emotionally disturbed children. Nationally, SoC principles specify that services should be family focused, culturally competent, interagency, community based, accessible, coordinated, individualized, least restrictive and accountable.[33]
- Reclaiming Futures is a national program of the Robert Wood Johnson Foundation to promote leadership in building community solutions to substance abuse and delinquency. Its focus is to develop and implement new models for comprehensive care networks involving AOD treatment and juvenile justice.
- Strengthening Communities–Youth (SCY) is a national Center for Substance Abuse Treatment (CSAT) initiative to help communities increase capacity, apply evidence-based and cost-effective methods, and provide gender-specific, culturally appropriate treatment to youth and their families. Emphasis is on providing a continuum of services and developing a management information system to track youth throughout the system.
- Washington Circle Adolescent Subcommittee, established by CSAT in 2002 as an offshoot of the adult-focused committee, is developing performance measures for adolescents with substance use disorders. Included will be administrative service data, process data and outcome data prioritizing those that are linked to clients' improved functioning. The subcommittee will consider how to use such measures in an accreditation process, including measurement specification, cost and auditability.

This chapter has described elements of a model system, presented the array of factors that must be addressed to advance the model system, and suggested future steps in

system design. Chapter 4 will focus on current funding limitations and will describe in detail the financing issues that will be crucial to support a model AOD treatment system for youth.

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[1] Bever, J.E., Brannigan, R., & Nissen, L.B. (2003). Reclaiming Futures - Treatment improvement self-study workbook: A current capacity and needs assessment tool. Portland, OR: Robert Wood Johnson Foundation.
[2] Brindis, C., Morreale, M., & English, A. (2003). The unique health care needs of adolescents. The Future of Children, 13(1): 117-135.
[3] Shane, P., Jasiukaitis, P., & Green, R.S. (2003). Treatment outcomes among adolescents with substance abuse problems: The relationship between comorbidities and post-treatment substance involvement. Evaluation and Program Planning, 26(2003): 393-402.
[4] Physician Leadership on National Drug Policy. (2002). Adolescent substance abuse: A public health priority. Providence, RI: Brown University, Center for Alcohol and Addiction Studies.
[5] McLellan, A.T., Lewis, D.C., O'Brien, C.P., et al. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. Journal of the American Medical Association, 284(3): 1689-1695.
[6] Kavale, K.A. and Farness, S.R. (2000). History, rhetoric, and reality – Analysis of the inclusion debate. Remedial and Special Education, 21(5): 279-296.
[7] Marty, D.A. and Chapin, R. (2000). The legislative tenets of client's right to treatment in the least restrictive environment and freedom from harm: Implications for community providers. Community Mental Health Journal, 36(6): 545-556.
[8] Barth, R.P. (2002). Institutions vs. foster homes: The empirical base for a century of action. Chapel Hill, NC: University of North Carolina, School of Social Work, Jordan Institute for Families.
[9] Alcohol and Drug Policy Institute. (2002). Adolescent substance abuse treatment system of care: Concept paper. Irvine, CA: Alcohol and Drug Policy Institute.
[10] Center for Substance Abuse Treatment. (2000) Improving substance abuse treatment: The national treatment plan initiative. Changing the conversation. DHHS Publication No. (SMA) 00-3480. NCADI Publication No. BKD 383, U.S. DHHS, SAMHSA, CSAT.
[11] Aarons, G.A., Brown, S.A., Hough, R.L, et al. (2001). Prevalence of adolescent substance use disorders across five sectors of care. Journal of the American Academy of Child & Adolescent Psychiatry, 40: 419-426.
[12] Wu, P., Hoven, C.W., & Fuller, C.J. (2003). Factors associated with adolescents receiving drug treatment: Findings from the National Household Survey on Drug Abuse. Journal of Behavioral Health Services Research, 30(2): 190-201.
[13] Bever, J.E., Brannigan, R., & Nissen, L.B. (2003). Reclaiming Futures - Treatment improvement self-study workbook: A current capacity and needs assessment tool. Portland, OR: Robert Wood Johnson Foundation.
[14] Meyers, K., Hagan, T.A., Zanis, D., et al. (1999). Critical issues in adolescent substance use assessment. Drug and Alcohol Dependence, 55(3): 235-246.
[15] Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.F., & Friffith, J.H., eds. (2001). ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders,

Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc.

[16] Physician Leadership on National Drug Policy. (2002). Adolescent substance abuse: A public health priority. Providence, RI: Brown University, Center for Alcohol and Addiction Studies.

[17] Pires, S.A. (2002). Building systems of care, A primer. Prepared for the National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center. Washington, DC: The Georgetown University.

[18] Riggs, P.D. (2003). Treating adolescents for substance abuse and comorbid psychiatric disorders. Science & Practice Perspectives, 2(1). Washington, DC: National Institute on Drug Abuse, National Institutes of Health.

[19] Prescott, L. (1998). Improving policy and practice for adolescent girls with co-Occurring disorders in the juvenile justice system. Delmar, NY: The National GAINS Center.

[20] Watkins, K., Burnam, M.A., Kungt, F.Y., et al. (2001). A national survey of care for persons with co-occurring mental health and substance use disorders. Psychiatric Services, 52(8): 1062-1068.

[21] Bever, J.E., Brannigan, R., & Nissen, L.B. (2003). Reclaiming Futures - Treatment improvement self-study workbook: A current capacity and needs assessment tool. Portland, OR: Robert Wood Johnson Foundation.

[22] Meyers, K., Hagan, T.A., Zanis, D., et al. (1999). Critical issues in adolescent substance use assessment. Drug and Alcohol Dependence, 55(3): 235-246.

[23] Barth, R.P. (2002). Institutions vs. foster homes: The empirical base for a century of action. Chapel Hill, NC: University of North Carolina, School of Social Work, Jordan Institute for Families.

[24] Ibid.

[25] Ibid.

[26] Manuals from the Cannabis Youth Treatment studies and the Adolescent Treatment Models studies may be found at www.chestnut.org; also see Stevens and Morral, 2002 for descriptions of adolescent treatment models. Stevens, S. and Morral, A., eds. (2002). Adolescent substance abuse treatment in the United States: Exemplary models from a national evaluation study. Drugs and Society. New York, NY: Hawthorn Press.

[27] Drug Strategies. (2002). Treating teens: A guide to adolescent drug programs. Washington, DC: Drug Strategies.

[28] National Institute on Drug Abuse. (1999). Principles of drug addiction treatment: A research-based guide. NIH Publication No. 99-4180. National Institute on Drug Abuse, National Institutes of Health.

[29] Pires, S.A. (2002). Building systems of care, A primer. Prepared for the National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center. Washington, DC: The Georgetown University.

[30] Dennis, M. (2002). Treatment research on adolescent drug and alcohol abuse: Despite progress, many challenges remain. Invited commentary in Connection newsletter. Academy for Health Services Research and Health Policy. Washington, DC: Academy for Health Services Research and Health Policy.

[31] Shane, P., Jasiukaitis, P., & Green, R.S. (2003). Treatment outcomes among adolescents with substance abuse problems: The relationship between comorbidities

and post-treatment substance involvement. Evaluation and Program Planning, 26(2003): 393-402.

[32] Gardner, P. (2001). Unmet mental health needs cause failure across youth-serving institutions. Youth Law News. 22(1).

[33] Holden, E.W. (July, 2002). The national evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program. Presentation given at the Center for Substance Abuse Treatment conference, Baltimore, MD.

Chapter 4
Financing

Chapter 4: Financing

This chapter focuses on current and potential funding streams used to deliver alcohol and other drug (AOD) treatment for youth, and critical issues in eligibility, coverage and funding levels. It addresses public funding within the AOD sector as well as revenues from other service sectors that are relevant for the delivery of AOD services to adolescents. The chapter concludes with recommendations for potential future financing directions, including combined funding strategies, reallocation, and possible new sources of public and private revenue.

> *"Having health insurance does not necessarily ensure that adequate substance abuse treatment services will be available to an adolescent. Even adolescents who have access to healthcare, either through private or public insurance, are not receiving adequate substance abuse treatment services."*[1]

At this moment in U.S. history, the systems of public and private financing of behavioral health care are in flux. The emergence of a youth AOD treatment system at this time presents a unique opportunity to establish adequate, appropriate and reliable funding mechanisms.

Currently, a patchwork of funding streams is used to support AOD treatment services to youth. Existing funding streams include the following:

- Public AOD treatment funds, including federal block grants, state general funds and Drug Medi-Cal (D/MC);
- Public mental health funds, including Mental Health Med-Cal;
- Healthy Families/State Children's Health Insurance Program (SCHIP), another publicly funded health care insurance;

- Child welfare funds, including payments to group homes;
- Juvenile justice funds, including those targeted for interagency efforts;
- School services;
- Maternal, child and adolescent health;
- Local general funds; and,
- Private funds, including insurance.

This chapter discusses the current state of these funding streams and then highlights opportunities for utilizing several of them to fund youth AOD treatment.

A. PUBLIC FUNDING FOR ALCOHOL AND OTHER DRUG TREATMENT FOR YOUTH

Alcohol and Other Drug Treatment Funds

> *"Total public spending for drug and alcohol treatment and prevention programs in California is approaching more than $1 billion annually, in a 'system' that operates primarily through county governments, schools and prisons. The system is fragmented, with more than 15 separate identifiable funding streams, and no single focal point for decision-making about treatment programs. This fragmented pattern resembles a patchwork quilt of funding, with each new piece leading to a new and largely separate planning process which is not informed by previous efforts."*[2]

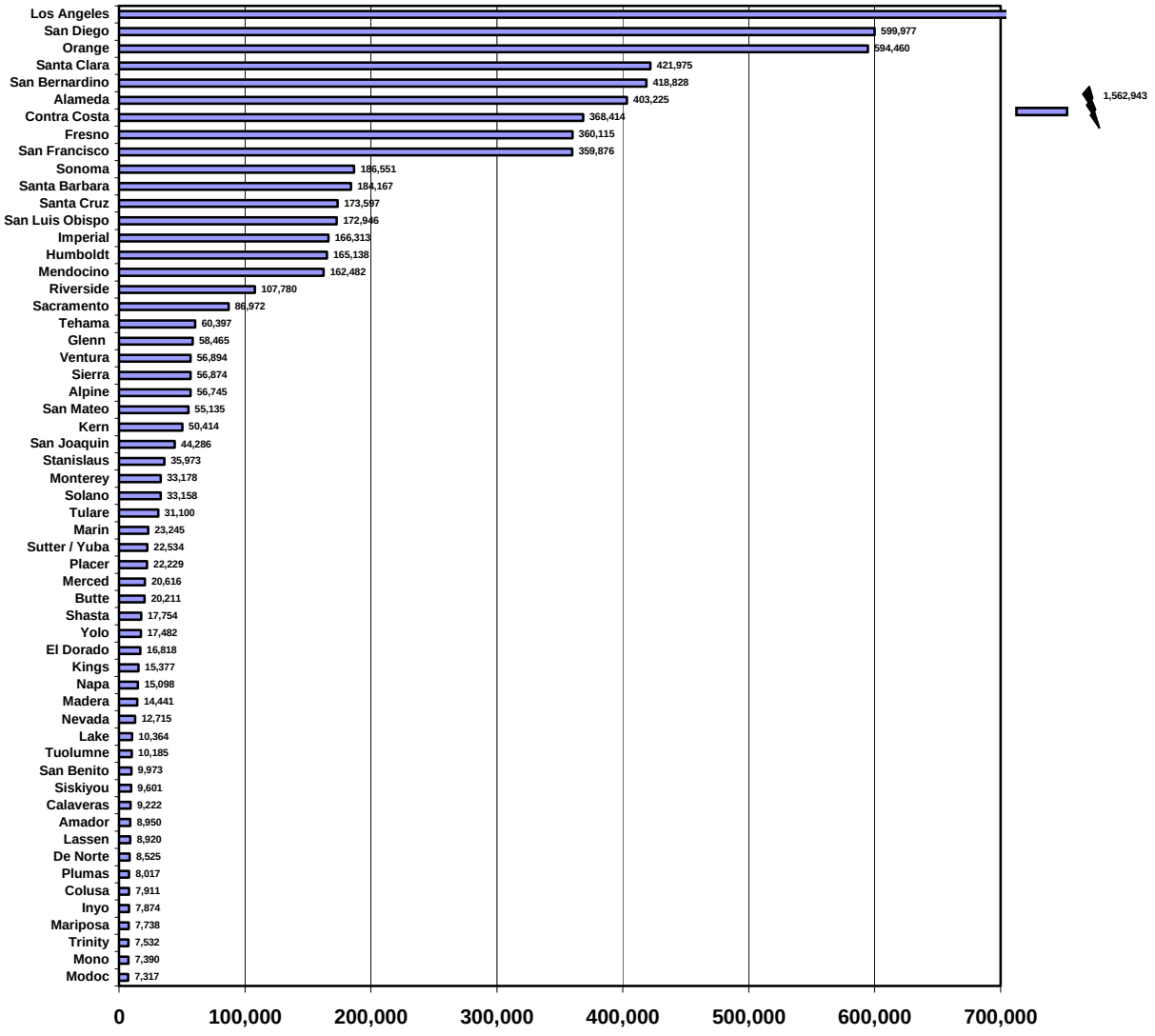
Public funding of AOD treatment for youth and adults has been influenced by multiple factors.

- Services have been developed as a system for adults. Only in the past several years have the needs of youth begun to be addressed.
- Most clients are low-income and a large proportion is referred from the juvenile justice system.
- In recent years, the public sector has funded a growing proportion of AOD treatment compared to private funding.
- Within the public sector, AOD treatment budgets are shrinking relative to justice system budgets and mental health treatment budgets.[3]

At the state level, public funds directly earmarked for AOD treatment come through the California Department of Alcohol and Drug Programs (ADP). Funding comes from the federal Substance Abuse Prevention and Treatment block grant; the state general fund for designated programs; federal and state shares of Drug Medi-Cal costs; and other special programs supported by federal funds, earmarked fees or a mixture of sources.

Two ongoing state ADP funding streams recently have been allocated specifically for youth treatment, funded through a mix of federal block grant and state general funds: 1) the 20-county Baca/Adolescent Treatment Program (ATP) monies, and 2) the 58-county Youth Treatment funds. The total amount appropriated for these funds combined has been very small, under $8 million in fiscal year (FY) 2001-2002. Annual amounts vary by county, and range from slightly more than $1.5 million (Los Angeles) to under $10,000 (13 counties). These varying but uniformly modest amounts are shown by county for FY 2001-2002 in figure 4.1, ADP Youth Treatment Funding.

Figure 4.1
ADP Youth Treatment Funding
FY 2001–2002



While the money from the block grant and state general fund for youth AOD treatment is small, it is groundbreaking, as it represents the first funding of a youth-dedicated program in a treatment funding stream previously serving adults.

Counties also report funding youth AOD treatment through other sources:

- Allocations from their amount of the general federal block grant for treatment;
- County general funds;
- Drawing on Drug Medi-Cal for eligible youth, as discussed below;
- Time-limited interagency grants from ADP and the state Workforce Investment Board (7 counties);
- Grants from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT); and,
- Grants from private sources such as the Robert Wood Johnson Foundation.

In the survey the authors conducted of county AOD administrators from the 20 Baca/ATP counties, the FY 2003-2004 percentage of total AOD treatment monies allocated to youth, as compared to adults, (including all sources accessed by the AOD administrators, according to their estimates), are reported as:

- 75% of counties (15 counties) spent less than 20% of AOD treatment money on youth;
- 25% of counties (5 counties) spent 20% - 40% of AOD treatment money on youth; and,
- No county spent more than 40% of AOD treatment money on youth.

In these 20 Baca/ATP counties, the actual dollar amounts spent on youth AOD treatment in FY 2003-2004 (including all sources accessed by the AOD administrators, according to their estimates) ranged from under $100,000 (four counties) to $100,000-$500,000 (three counties) to over $500,000 (10 counties, including Los Angeles). It should be noted that the 20 counties in this sample tended to include

many of those with more developed youth treatment programs than are found in many other counties in the state.

Drug Medi-Cal

Drug Medi-Cal (D/MC) is the mechanism in California (Title 22, California Code of Regulations) used to pay for eligible AOD treatment services for individuals enrolled in Medi-Cal, the state's version of the federal Medicaid public health insurance program (Title XIX, Social Security Act).

The coverage of AOD treatment under Medi-Cal, like the Medicaid coverage of AOD treatment in most states, has been influenced by the following:

- The lack of a federally mandated Medicaid AOD benefit for adults;
- An orientation toward acute medical care that is incompatible with most AOD treatment (e.g., the federal mandate requires "medically necessary" care including inpatient, hospital outpatient and physician services);
- The state having wide discretion in how broadly to cover adult services apart from acute medical care (e.g., states' "optional" services being "clinic-" based outpatient services and/or "rehabilitative" services);
- The historic image of Medicaid as welfare, rather than an entitlement like Medicare or insurance like Healthy Families (discussed below);
- Modest funding levels of the state's share, currently at 47% including the state-required county match (the remaining 53% is the federal share);
- State flexibility in order to contain costs; and,
- Low reimbursement rates for AOD treatment providers, even compared to already low Medi-Cal reimbursement rates for medical and mental health care providers.

The administration of Medi-Cal client enrollment, provider certification and service reimbursement is complex:

- The federally designated single state agency is the California Department of Health Services (DHS).

- DHS has in turn delegated state agency-level authority over Drug Medi-Cal to ADP.
- At the county level, Drug Medi-Cal is administered through county AOD departments.
- Clients enroll in Medi-Cal through county social services departments.

Client eligibility criteria are also complex:

- An individual must be "categorically" eligible according to federal law (includes all youth under 21).
- The countable income level of the youth's parent(s) must not exceed a certain percentage of the federal poverty level as set by the state (for children ages 6-18, 100% of the federal poverty level; for youth 19-20, about 65% of the federal poverty level).
- There is an assets test for youth and adults ages 19-20.
- As of October 1, 2003, clients 19 or older must re-qualify every six months.
- While individuals without documented citizenship or immigration status are eligible, under state law they currently can receive only certain limited medical services, not including Drug Medi-Cal.

Drug Medi-Cal (as developed for adult AOD treatment services) is characterized by the following:

- It is designed to reimburse providers for AOD treatment services delivered outside the scope of the primary physical health care provider, with no service delivery coordination required.
- It is carved out of the current managed-care Medi-Cal organizations that exist in most counties, which permit participation by the traditional "safety net," special population, community-based and rural AOD service providers.
- Reimbursement to providers is on a fee-for-service basis, with no utilization controls or quality controls.[4]

- A physician must designate that the services provided are medically necessary.

California's Drug Medi-Cal is currently authorized by the state under its option as a clinical model, not a rehabilitative model. Due to the limitations of adult D/MC, a 2002 statutory initiative proposed shifting D/MC from a clinical model to a rehabilitative model under the state option granted by the federal Medicaid law. However, to date, the state has not appropriated its share of Medi-Cal funds for implementation.

The current model has important restrictions in terms of:

- The kinds of providers who are eligible to be certified as Medi-Cal providers under D/MC;
- Treatment services that may be reimbursed include:
  - Outpatient "drug-free" services, including individual assessment and treatment and discharge planning; group counseling with specified minimum contact hours and group numbers, with optional on-site case management included; on-site collateral family services; crisis intervention; medical supervision; and drug screens;
  - Day care habilitative services for youth under 21 and pregnant or postpartum women;
  - Perinatal residential treatment for pregnant and postpartum women and their children; and,
  - Narcotic treatment, used for methadone maintenance (outpatient "non-drug-free").
- Services that have not been included for reimbursement include: outreach and screening; at-home and telephone services; ongoing individual counseling; and aftercare.

It should be noted that the services excluded from Drug Medi-Cal's outpatient reimbursement scheme are widely accepted as vital for youth AOD treatment.

Drug Medi-Cal EPSDT

> *"States overall have not made optimal use of Medicaid as a financer of mental health and substance abuse services for children. Although a number of states have structured their Medicaid benefits to allow reimbursement of innovative services delivered in a child's home, school, or other site, many others still emphasize traditional inpatient and clinic-based services in their coverage policies. …States should focus on the mandatory EPSDT benefit, in particular, as a means of supporting prevention, early intervention and treatment activities."*[5]
>
> *"In theory, EPSDT has the potential to significantly increase the access of Medicaid-eligible adolescents to substance abuse treatment; in practice, the benefit is underutilized."*[6]

Children under 21 (as youth are defined under Medicaid) who are enrolled in Medicaid have a federally mandated benefit, Early Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT has particular relevance to youth AOD treatment services. It will be discussed here in the context of Drug Medi-Cal and in the section below in the context of Mental Health Medi-Cal.

EPSDT benefits are described under federal law as follows:[7]

- Comprehensive services are to be provided to "correct or ameliorate physical or mental health defects or conditions."
- The services are aimed at preventive and comprehensive care that is developmentally appropriate and coordinated among providers.
- The "screening" for any condition is to include a "developmental assessment" including youths' functioning around "self-help," "self-care," "social-emotional," and "cognitive" skills; collateral reports and "anticipatory guidance."
- Families with children enrolling in Medi-Cal must be informed in a timely way of their right to request and receive the EPSDT "screening."
- EPSDT must, if requested, pay for "assistance with transportation and scheduling appointments."

- The "diagnosis" can be made by a physician, maternal and child health facility, community health center, "rehabilitation center," or "other practitioner or facility qualified to evaluate" "an individual's health problem." It does not have to be made by a provider who is qualified to deliver all treatments.
- The admitting provider of treatment is to be responsible for "case management" and for arranging "continuing care."
- Memoranda of understanding are needed to ensure "coordination with related agencies" including maternal and child health, vocational rehabilitation, health education counseling, education and social services.

States have generally not met the requirements of EPSDT under Medicaid to date. And, like Medicaid in general, EPSDT does permit states to set up authorization procedures for certain services as part of utilization control and cost containment. Despite the limits of EPSDT coverage to date, this comprehensive, federally required benefit is relatively recent. Therefore, EPSDT should be seen as a funding mechanism with further potential.

EPSDT can be utilized for substance abuse treatment under Medicaid. Services are not specified and, to date, it has been used by the states only on a limited basis.[8]

California's authorization for an EPSDT "Supplement" under Drug Medi-Cal for youth under age 21 dates to 1999 and is restricted to the following:

- Day care habilitative services;
- Under outpatient "drug-free" services, individual counseling (up to 1½ hours per day) may be provided with a prior "Treatment Authorization Request" submitted by the provider showing medical justification and the planned frequency and duration of service, and approved by the state Department of Health Services office, outside the usual ADP D/MC structure.
- Claims for reimbursement for this supplemental service are submitted by the provider to the regional state DHS office, also outside ADP D/MC; and,
- The "individual counseling supplemental service" can be provided by

- The Drug Medi-Cal-certified outpatient clinic itself; or
- A qualified professional (e.g., a licensed clinician) who is certified as an "EPSDT supplemental service provider" for that client.

Drug Medi-Cal EPSDT Opportunities

The EPSDT framework provides opportunities for youth AOD treatment within the context of Drug Medi-Cal.

The advantages of utilizing Medi-Cal for youth AOD treatment include:

- Medi-Cal is the largest single children's health insurer in California. It is estimated that one-third of the children in families that lack private health insurance are eligible. Nineteen percent of adolescents 12-17 in a recent representative statewide survey report being enrolled in Medi-Cal.[9]
- Medi-Cal is a large, relatively reliable funding stream, when compared to block grants or state general fund allocations, with a large federal cost share.
- Medi-Cal is an entitlement, with eligible enrollees having the right to receive complete care as statutorily authorized.

Strategies to consider include:

- Renewing efforts for the state to invoke the "rehabilitative model" option in Drug Medi-Cal and appropriate funds;
- Advocating for full EPSDT coverage for youth even within the current D/MC framework of the "clinical model," using the federal EPSDT regulations as a guide, which implicitly allows case management, transportation, etc. The special services for perinatal women may be a useful precedent; and
- Negotiating with the state to reduce barriers such as prior treatment authorizations, exceptions to reimbursable services, required numbers and frequencies for group sessions, and burdensome paperwork to receive certification and submit claims to multiple state funding authorities (e.g., ADP and DHS).

There are limitations to relying on Drug Medi-Cal as the sole new funding source:

- Current reimbursement rates under D/MC are low and are unlikely to be automatically increased in the current budget climate.
- Some youth AOD treatment providers may be unable or unwilling to meet the requirements for D/MC certification.
- Many youth AOD treatment delivery models may be ill suited to the physical health care orientation of Medi-Cal.
- Many families of youth needing AOD treatment will not qualify for Medi-Cal unless income eligibility requirements are loosened.

"Minor Consent" Drug Medi-Cal

The procedure known as "minor consent" Medi-Cal, or Medi-Cal for "sensitive services," is intended to pay for specified services to youth outside the regular or "full scope" Medi-Cal system, where the usual requirement for parental consent could be a barrier to care.

Minor consent Medi-Cal is characterized by the following procedures:

- Individuals eligible for enrollment are youth over 12 years old and under 21 who live with their parent(s) or guardian.
- The criteria for youths' eligibility do not include their parents' incomes.
- Youth apply to county social services for enrollment, as do other Medi-Cal-eligible individuals, but, unlike others on "full scope" Medi-Cal, they must be re-certified for eligibility every month.
- Upon enrollment, clients are eligible for health services without the usual requirement of parental consent.
- The services must be provided by an agency that is Medi-Cal-certified.

Under minor consent Drug Medi-Cal, certain services are or are not reimbursable:

- Outpatient "drug free" services to youth are covered, including individual assessment, treatment and discharge planning; group counseling, including on-site collateral services; and crisis intervention.
- Like "full scope" adult Drug Medi-Cal, there is no reimbursement for outreach and screening; ongoing or routine individual counseling; at-home or telephone services; day care habilitative or residential (unless pregnant or postpartum); and aftercare.

Important parameters of minor consent Drug Medi-Cal include:

- The relatively generous criteria for client eligibility are balanced by the frequency of required client recertification and by restrictions on services.
- There is the potential barrier for reimbursement by the state for "collateral" family services or assessment involving parents within the "minor consent/ sensitive services" framework.
- All minor consent Medi-Cal is funded by the state, under DHS authority; there is no federal match.

Minor Consent Drug Medi-Cal Opportunities

Minor consent Drug Medi-Cal is a useful funding stream for counties and providers to serve youth in the following circumstances:

- Communities where there are not enough youth with full-scope Medi-Cal-eligible families to support a Medi-Cal-funded youth AOD treatment program.
- Communities where many youth could not receive full-scope Medi-Cal services because of their undocumented status.
- Individual youth whose families do not qualify for Medi-Cal.
- Individual youth who wish to receive treatment without parental consent.
- School-based services where youth are coming into AOD treatment for relatively limited services and without parental involvement.

Another advantage to this funding source is that youth may be reluctant to seek AOD treatment if their families must give prior consent, or may be reluctant to participate in treatment sessions with their families.

B. OTHER PUBLIC FUNDING STREAMS AND OPPORTUNITIES

Mental Health

> *The annual budget of the California Department of Mental Health (DMH) from all sources is $2 billion, including somewhat less than half from the State General Fund. It cannot be ascertained what percent is spent on children and adolescents, but DMH estimates about half, or $1 billion.*[10]
>
> *Over 150,000 children in California, or about 3% of the population under 18, receive publicly funded mental health services each year. The percent of Medi-Cal-enrolled children receiving them is about 5%.*[11]

The public expenditure for mental health care to children in California can be characterized by the following:

- It currently is reserved for children and youth who have been diagnosed with a mental health disorder according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or the International Classification of Diseases, by state regulation.
- It prioritizes diagnosed children and youth who also have been identified as severely or seriously emotionally disturbed (SED) through the state- and federally designed children's mental health "system of care" or via the school- and county-based implementation of the federal Individuals with Disabilities Education Act (IDEA).
- It is a system that has been characterized as requiring youth to "fail first" before they can receive services, rather than as prevention-oriented.
- It is funded through a number of complex federal, state and county revenue streams, including but not limited to Medi-Cal.

- Because of different local needs, resources, historic state funding shares and "maintenance of effort" obligations, county expenditures on a per capita basis vary widely.

There has been a continuous state spotlight on the need to improve mental health services for children, including the need for additional interagency collaboration and systemic integration of care:

- State (and national) discussions of the need for a coordinated "system of care" to serve SED youth began in the 1970s.
- In 1982, state law[12] directed county mental health to coordinate with probation and social services to serve youth placed out of home by child welfare or juvenile justice.
- In 1984, state law and court decisions required mental health to collaborate with school districts to serve youth in special education, who are federally entitled to assessment and treatment.
- As recently as 2001, the Little Hoover Commission wrote a report critical of children's mental health services, as part of a series of reports critical of all state and county services to children and youth, calling for additional integration.
- Many of these discussions, laws, court decisions and reports requiring or recommending collaboration and integration have not included or even mentioned AOD treatment or AOD agencies.

Mental Health Medi-Cal EPSDT

Children enrolled in Medi-Cal, as discussed earlier in reference to Drug Medi-Cal, have access to EPSDT for mental health treatment. The California Department of Mental Health is designated by the California Department of Health Services as the state authority for Mental Health Medi-Cal administration.

AOD treatment for youth is increasingly being integrated into the Mental Health Medi-Cal EPSDT mechanism because:

- Many such youth are dually diagnosed with a co-occurring mental health disorder in addition to a substance use disorder (i.e., substance abuse or substance dependency);
- A greater range of services can be reimbursed, as noted below, compared to those under the clinical model currently authorized for Drug Medi-Cal, as discussed earlier; and,
- Medi-Cal reimbursement rates are higher for mental health services than for AOD treatment, although they are still low in the broad contexts of national Medicaid and general medical care fees.

However, it should be noted that there are several important limitations on the provision of youth AOD treatment under existing Mental Health Medi-Cal funding. Currently, state regulations specify that AOD treatment to youth can be provided under Mental Health Medi-Cal EPSDT only if the substance use disorder (SUD) is diagnosed as secondary to the non-SUD(s), and it is medically necessary to treat the SUD in order to treat the other disorder(s). Current state regulation also excludes youth with primary SUD disorders from eligibility for a SED diagnosis (mentioned above) and receipt of those services.

The services eligible for reimbursement under Mental Health Medi-Cal, including but not limited to EPSDT, are relatively expansive due to the federal rehabilitative model that the state opted for in the early 1990s:

- Services may be provided at home or at other off-site and non-clinical settings.
- Services may be provided by a range of licensed providers.
- Services include case management and arrangement for transportation.
- Youth under EPSDT are eligible for the "specialty mental health services" as a "supplement" if they have an eligible diagnosis (not including SUD) and serious impairment or lack of developmental progress.
- Youth may also be eligible for "therapeutic behavioral services," including intensive, community-based, family-centered "wrap-around" care, if they are at risk of a placement in a higher-level group home (see "Social Service Child

Welfare Group Homes," below) or are to transition from such a placement to a lower level of care, providing there is prior treatment authorization from the Department of Mental Health.

- The state's administrative interpretation of general federal statutes and regulations tends to be broader than it is under the clinical model option currently operative for Drug Medi-Cal, although there is still utilization control.

The provision of services through Mental Health Medi-Cal, including EPSDT, is affected by the following:

- Mental Health Medi-Cal is a managed-care system, not a fee-for-service system.
- Most Mental Health Medi-Cal services are delivered through counties' mental health departments, although some counties have managed-care contracts.
- There are exceptions when there is a need for a "specialty mental health provider" (currently not available for youth with a primary SUD-diagnosis), which involves a carved out fee-for-service reimbursement to the provider.
- There is a reported lack of coordination between most counties' managed-care physical health Medi-Cal providers and Mental Health Medi-Cal providers.
- There is a shortage of Medi-Cal certified and qualified mental health providers for children and youth or primary physicians who can screen, assess and refer.

The expenditures for Mental Health Medi-Cal EPSDT can be characterized by the following:

- Costs are growing rapidly. Although EPSDT is only one revenue stream within all Mental Health Medi-Cal funding for children (over $150 million out of a total that exceeds $500 million per year statewide), in fiscal year (FY) 2003-2004 the budgeted increase for Mental Health Medi-Cal EPSDT over the prior year was $60 million.
- Expenditures vary widely by county. There is a range from literally $0 in several counties, to under $100,000, to $1million-$5 million, to $5 million-$10 million, to over $30 million (in Los Angeles county).

- The funding stream is complex. Despite EPSDT's classification as a federally mandated benefit within Medi-Cal, the state share is capped, with counties receiving amounts from the state based on their historic expenditures, reimbursements from claims submitted to the federal government for its share, and counties' negotiated cost-shares based on recent historic expenditures and annual increases.
- The question of state versus county responsibility is also complex. A state court has ruled[13] that providing all "medically necessary" services under EPSDT is a state obligation, not a county responsibility, despite the re-alignment of mental health funding from the state to the counties earlier in the decade. As the designated state agency, the Department of Health Services is ultimately responsible for decisions its subdivisions, i.e., county departments, make in relation to Medi-Cal.

Mental Health Medi-Cal EPSDT Opportunities

The Mental Health Medi-Cal EPSDT revenue stream has become of particular interest to youth AOD providers and counties in recent years.

Advantages to drawing on this funding source include the following:

- A broader range of services is currently reimbursable under the rehabilitative model of Mental Health Medi-Cal than under Drug Medi-Cal's current clinical option, as noted above.
- There are higher reimbursement rates under Mental Health Medi-Cal EPSDT than under Drug Medi-Cal for comparable services.
- The budget for children's mental health care at the federal, state and county levels has dwarfed that for youth substance abuse services.
- There is a well-established network of advocates from the mental health provider and parent communities who have worked to achieve legitimacy and funding for these services.
- Many AOD-abusing youth also require mental health treatment, or the comprehensive and family-based services permitted under Mental Health Medi-

Cal EPSDT, and already are clients of mental health, juvenile justice or child welfare.

Healthy Families/State Children's Health Insurance Program

Youth in low-income families may be eligible for the state's Healthy Families (HF) publicly funded health insurance program, California's version of the 1997 federal State Children's Health Insurance Program (SCHIP) (Title XXI of the Social Security Act).

Healthy Families provides medical care coverage for children in families with too much income to qualify for Medicaid but who lack employer-based health care coverage or cannot afford private insurance. The program is administered by the state Department of Health Services. Funding for Healthy Families in California for FY 2003-2004 is projected to be over $900 million from all sources, including under $300 million from the State General Fund. The federal cost share is 65%; the remainder is the state's portion.

States have had discretion regarding the implementation of SCHIP. While about half the states chose to expand Medicaid eligibility and benefits to SCHIP-qualifying families, others chose either to develop separate block grant insurance programs or to use a mix of the two. California chose as its model for Healthy Families the health insurance benefits offered to state employees' families through the California Public Employees' Retirement System (CalPERS).

Client eligibility for SCHIP is characterized by the following:[14]

- Youth through age 18 may qualify if their parent(s) earn less than 251% of the federal poverty level, using Medicaid eligibility determination criteria (discussed earlier under Drug Medi-Cal).
- Youth age 19 or older are not eligible.
- Youth living independently may qualify.
- Youth without documented residency or citizenship are not eligible.
- Youth enroll directly at the state level with a mail-in application.
- Enrolled families or youth must pay small premiums and co-payments.

The Department of Health Services has delegated authority for the Healthy Families program to a state board known as the Managed Risk Medical Insurance Board.

Services for youth AOD treatment under Healthy Families are currently constrained by the following:

- Healthy Families is intended to be a managed-care model based on providing all services within a medical health maintenance organization, although this is proving to be difficult to implement in rural areas.
- The current state-mandated minimum AOD treatment benefits for Healthy Families are: inpatient detoxification as medically necessary, a minimum of 30 days inpatient for mental health, and a minimum of 20 outpatient visits per year, with no explicit discussion of what these visits must include.
- A plan may offer a higher level of benefits at its own discretion.

Healthy Families Opportunities

There is great potential for utilizing Healthy Families to expand the availability of AOD treatment for youth. As many as one-third of California's children who have lacked health insurance coverage are estimated to be eligible for HF under its current regulations, even though many do not yet belong (e.g., in one survey only 4% of adolescents were enrolled).[15]

There are political and fiscal advantages to drawing on Healthy Families:

- Because HF requires families to pay modest premiums and co-payments, it is perceived as "insurance" rather than as an "entitlement" or "welfare."
- There is a federally assured 65% match for the SCHIP population.
- A significant portion of the federal funds available for HF has not yet been spent.

There also are political and fiscal limitations:

- Healthy Families, unlike Medi-Cal, is not an entitlement, which means enrollments can be capped and waiting lists and other restrictions imposed, as proposed in California in November 2003.
- Indeed, because of the current nationwide fiscal climate, a number of states have reported considering waiting lists, limiting eligibility periods, reducing benefits or raising deductibles or co-payments.[16]

The current HF benefit for AOD treatment is extremely limited, as described earlier. A renewed effort to expand these benefits should be undertaken.

One strategic direction could be to advocate as follows:

- That the state "carve out" youth AOD treatment for Healthy Families, and make enrollees eligible for these services under Medi-Cal. This could be linked to advocacy to expand Drug Medi-Cal access for youth under EPSDT, as discussed earlier. Or, if Mental Health Medi-Cal EPSDT was the basis for expanded HF service, the current exclusion of substance use disorder (SUD) as a primary diagnosis for eligibility could be changed.
- In the earlier efforts to expand Healthy Families benefits for youth AOD treatment, advocates suggested a more modest approach: limiting the expanded benefit to SUD-diagnosed youth who also have "substantial impairment" as specified, or are at risk for removal from the home, or are a danger to self or others. This language was comparable to the criteria for youth with non-SUD mental health diagnoses to qualify for SED services (explained under "Mental Health Medi-Cal EPSDT," above). The advocates suggested designating as reimbursable those services which are comparable to the ideal ones in EPSDT, including comprehensive assessment, case management, continuing care and levels of care ranging from intensive outpatient treatment to day treatment to residential treatment. They estimated the annual cost as between $1.4 million and $2.4 million to serve 500-900 youth per year.[17]
- Advocacy could draw on national efforts to widen access to AOD and behavioral health treatment for youth through the federal SCHIP program. A meeting

convened by the American Academy of Pediatrics recommended specific levels of care, how to assure access, family involvement and service provider coordination. This consensus statement was also signed by the American Academy of Child and Adolescent Psychiatry, the American Society of Addiction Medicine and other bodies.[18]

Social Services

A variety of youth qualify to receive funding under social services that can legally be used to provide non-medical substance abuse treatment services. Major revenue streams fall under the Social Security Act (SSA).

These include the federal Temporary Assistance for Needy Families (TANF), known in California as Cal-WORKS. In addition to Medi-Cal, youth from low-income families (e.g., those enrolled in Cal-WORKS) may be eligible for TANF-supported services intended to promote family economic self-sufficiency.

Child Welfare

Within social services, the child welfare system spends large sums on services to youth, including youth living in families where alcohol and other drug problems are present. Child welfare has a multi-faceted mission to prevent child maltreatment, maintain or reunify families and attain permanence for children who have been abused, neglected or made dependents of the court. The state Department of Social Services (DSS) handles numerous federal and state programs within this broad mandate.

Youth can be served through child welfare if they are in out-of-home placements (e.g., foster care families or group homes), transitioning from such placements or are at risk of such placements.

Youth at risk of an out-of-home placement or whose families are attempting to reunify may be eligible to receive a range of services, including mental health care, through Title IV-B of the Social Security Act; however, it is a capitated amount.

Youth in foster care may be eligible to receive substance abuse treatment and mental health care through Title XIX, which is run through Medi-Cal, as well as physical health care and EPSDT services through the Child Health and Disability Prevention program operated by DHS. Foster care youth 9 to 20 years old are to be screened by EPSDT once every three years as a county public health responsibility.

Out-of-home foster care youth may be eligible to receive child welfare case management services through Title IV-E, via the current federal funding to support foster care. Youth transitioning from out-of-home placements to adulthood are eligible for federal funds under the 1988 "independent living program" but this is a newly emerging source of assistance.[19]

In practice, youth AOD treatment services provided through the child welfare portal have been limited for several reasons:

- Child welfare caseloads have climbed and there is a chronic shortage of caseworkers; and,
- Until recently, little attention has been paid to the AOD treatment needs of children in the child welfare system because, first, the child welfare system has primarily screened and referred parents for AOD treatment, and, second, the system has not been well-equipped to deal with the needs of adolescents compared to those of young children.

It should be noted that $4 billion per year is spent on child welfare in California, including federal, state and county expenditures. Like so many other public services in the state, child welfare is administered at the county, not the state, level. Funding streams are therefore both large and complex.

> *"Federal policies in the family support and child welfare sector provide funds that may be used for adolescent substance abuse treatment; however, it is often difficult to determine the use of funds for this purpose...In addition, it is difficult to disaggregate the proportion of funds that are used for substance abuse treatment for adolescents, the proportion that go to education and prevention services, and the*

proportion that funds substance abuse services for the adolescents' families. … In general, adolescent substance abuse treatment does not appear to be a high priority in federal family support and child welfare policies. In this policy sector, adolescent substance abuse treatment is competing with many other services that children, youth and families need. … However, the family support and child welfare policies have the potential to make services less fragmented for many adolescents."[20]

Social Service Child Welfare Group Homes

One of the largest roles that social services plays in funding AOD treatment for youth in California is management of its network of foster care group homes. The operating, or "board and care," costs of foster care group homes are a social services responsibility. Licensing of group homes as "community care," and oversight of safety and programmatic compliance, has also been a Department of Social Services responsibility since the 1970s.

These group homes--which have a total capacity of 13,000--have emerged as the de facto setting for the only publicly funded residential youth AOD treatment in California, as noted in chapters 2 and 3 of this report. The state ADP and county AOD departments do not currently have the funding that would otherwise support the full costs of publicly funded 24-hour care.

The parameters for funding of group homes relevant to AOD treatment include the following:

- There are over 150 group home provider organizations in California, both nonprofits and for-profits, with the average organization operating 10 homes and some over 100 homes. Each group home houses between six and 100 children.
- DSS sets group home staffing ratios, staffing levels and allied reimbursement rates through a series of "Rate Classification Levels" (between 1 and 14), without specific reference to AOD treatment staffing or service fee needs.

- County social services are also involved in reimbursement. First, they determine youths' eligibility for Title IV-E of the SSA, which allows federal reimbursement for half the costs for youth in group homes whose families would have qualified for assistance under the federal Aid to Families with Dependent Children (AFDC), which preceded TANF. Second, county social services pay for the remaining costs in combination with DSS, at a ratio of 60-to-40.
- The cost of group homes averages between $3,000 and $6,000 per youth per month, with a wide deviation across levels, between homes at the same levels, and even within homes.
- One large urban county estimates its average total cost per year per group home placement at $65,000.[21]

While group homes are licensed by DSS, they are not licensed as AOD treatment programs by the California Department of Alcohol and Drug Programs, as are adult residential facilities. Important qualifiers are the following:

- Some group homes are voluntarily certified by ADP to provide treatment, as noted in Chapter 2.
- Some group homes seek and receive behavioral health treatment facility accreditation from national health care organizations (e.g., Joint Commission on Accreditation of Healthcare Organizations).

Considerations for Future Social Service Child Welfare and Group Home Funding

Future funding for child welfare and group homes may be influenced by the following:

- There has been ongoing criticism of the financial reimbursement structure for group homes, including Senate Bill 933,[22] which mandated a re-examination of the issue and a report to the legislature.
- Despite agreement that the current reimbursement structure is unduly rigid and fragmented, and not linked to children's needs or targeted outcomes, there is no consensus on funding reforms.[23]

- The Little Hoover Commission has repeatedly criticized California's child welfare system, including its group home system.[24]
- The current statewide "stakeholders" group recommendations for a redesign of child welfare principles for DSS may affect out-of-home placement criteria and the role of group homes by emphasizing earlier intervention and interagency collaboration.[25]
- While group homes are increasingly moving toward providing treatment rather than just board and care, they are also becoming larger. Concurrently, there are systemic moves toward keeping more dependent and delinquent youth in the home or in community-based family-like settings while receiving "day" treatment.
- The emerging federal child welfare system performance measures may also have an impact on placements by stressing children's outcomes.

Juvenile Justice

As was noted in Chapter 1, a large proportion of youth in the juvenile justice system are in need of AOD treatment. Moreover, the juvenile justice system currently is, and is likely to remain, the single biggest pipeline for youth coming into AOD treatment. Yet AOD treatment at its present funding level is unable to adequately serve juvenile justice-involved youth, and is often even less able to serve other youth. While juvenile justice funds have paid for some youth AOD services, in many instances the treatment of these youth has not been paid for by justice monies.

The juvenile justice system spends large sums on processing youth, many of whom have problems related to alcohol and other drugs.

It should be noted that the juvenile justice "system" is shorthand for a network of county, city and state law enforcement, legal and correctional agencies that perform such varied functions as arrest, detention, prosecution, defense, adjudication, placement, supervision and treatment. State agencies responsible for funding and oversight include the state Board of Corrections, the Attorney General's Office (Department of Justice), the Judicial Council (Administrative Office of the Courts), the

California Youth Authority (CYA) and the Office of Criminal Justice Planning. Local funding is primarily centered on county probation departments.

Funds are received by county probation, for services to juvenile offenders or to juveniles at risk of offending, from a variety of federal, state and county sources, all with a variety of objectives.

There are considerable funds dedicated to juvenile offenders who are institutionalized wards:

- The legislature has appropriated over $450 million since fiscal year 1997-1998 to counties to build, expand or improve juvenile halls, camps and ranches; over half these funds are from federal formula grants and must be used to increase institutional capacity.
- The annual budget for the California Youth Authority exceeds $400 million. Some of this may be used for AOD treatment inside CYA's institutions.

Examples of current funding streams for youth through juvenile justice include:

- County probation departments have received nearly $170 million per year statewide from DSS in TANF funds (see "Social Services Child Welfare Group Homes," above) allocated by the federal 1997 Comprehensive Youth Services Act:
  - State allocations to each county have ranged from $20,000 to over $50 million.
  - The legislative intent was to replace Title IV-A-EA under the old AFDC, which paid claims for eligible institutionalized juveniles.
  - The monies can be used locally with considerable discretion; some counties have expended them primarily within juvenile halls or other institutions, while others have set up or expanded community-based programs, with blended or leveraged money from other agencies.
  - A local planning council process is required under the chief probation officer. A RAND evaluation notes that, for 55 responding counties, 95%

report including mental health on the council. AOD services are not mentioned.[26]

- County probation receives Title IV-E federal SSA monies for eligible children placed in foster care and group homes, in order to perform case management and other "field" services; this is under $100 million per year, with half provided by the federal government and the remainder a state-county split.
- The Crime Prevention (Schiff-Cardenas) Act of 2000 has appropriated a large amount of state general funds for counties to use with considerable discretion, aside from some required allocations. In fiscal year 2003-2004, the total appropriation was just under $100 million statewide. The Crime Prevention Act of 2000 required each county to develop a comprehensive multi-agency juvenile justice plan. In some counties, AOD treatment has participated in the planning and has been supported by some of these funds.
- Counties may receive federal "Community Prevention Grants" (Title V), which require local strategic planning by a multidisciplinary board, and a state-county match.
- There are also federal formula grants to the states for delinquency prevention activities, managed through the federal Office of Juvenile Justice and Delinquency Prevention; the state advisory group must allocate these grants to local agencies and meet federal priorities, including, currently, the deinstitutionalization of status offenders and the reduction of disproportionate minority confinement.
- Counties are receiving federal or state drug court grants for juvenile drug courts, portions of which may be used for AOD treatment services.

Examples of recent funding streams which may be reauthorized or replaced include the following:

- Juvenile justice "challenge" grants (Juvenile Crime Enforcement and Accountability programs) were initiated during the 1990s by the state legislature to use federal and state funds to support counties' planned responses to delinquency, broadly targeting both adolescent offenders and youth at risk.

Interventions could include AOD treatment and services to families. After a period in which small planning grants were awarded to all counties in the state, 16 counties were selected to receive over $45 million in 1997. In 1998, an additional $60 million was funded, with a state directive for counties to focus on including community-based organizations in planning, and to target for intervention juveniles placed out of home. In 1999, 17 counties received these monies. Again, coordinating councils, chaired by county chief probation officers, were required to be established.

- The legislature's Repeat Offender Prevention Program was a time-limited demonstration project designed to intervene with those juvenile offenders at greatest risk of recidivating. Collaborative services, with assessment by multidisciplinary teams, were to be provided to youth with problems related to substance use, school performance, family relationships and high-risk behaviors. Eight counties received $14 million over four years.
- Sixty programs in California received over $20 million in one-time money from the federal Juvenile Accountability Incentive Block Grant Program, created in 1999 to promote greater legal accountability of adjudicated juvenile offenders. Some of this funding was directed to after-school, mentoring and treatment programs.

Considerations for Future Juvenile Justice Funding

This may be an opportune moment for youth AOD treatment advocates to initiate a dialogue on collaborative funding with stakeholders and policymakers within the different sectors of the juvenile justice system. For example, the California Youth Authority, like the adult prisons in California and elsewhere, is under fiscal and political pressure to downsize. The same may be true for county juvenile detention and institutional facilities. Probation departments may also feel the pinch of prospective state cutbacks, with larger client caseloads, and they may be eager to divert needy juvenile clients into AOD treatment.

Meanwhile, juvenile drug courts are prompting new interest in AOD treatment among juvenile court judges, and perinatal AOD treatment programs and the emerging "family" or "dependency" drug courts are helping to educate dependency court judges.

Juvenile justice revenues -- which are considerable, as noted above -- may be perceived as potential funding sources for youth AOD treatment in several ways. First, juvenile justice may directly fund treatment as currently constituted, when linked to juvenile drug courts, or delivered on-site in juvenile facilities, or offered in programs with fiscal participation by probation.

It should be noted that there are potential advantages as well as disadvantages to juvenile justice funding of youth AOD treatment. It could allow access to AOD treatment for the highest-need youth who are already inside institutions. Community-based AOD providers have a tendency to prefer to "cherry pick" less difficult or risky clients, which can result in high-need youth remaining under-served. The disadvantages may include having the juvenile justice system, rather than the treatment sector, determine which youth have access, which services are provided, and which treatment goals are prioritized. This could lead to more coercive or control-oriented programs, which have also been shown to be least effective, as noted in Chapter 3. Another possible disadvantage would be to concentrate AOD treatment inside the juvenile justice system; this might encourage the arrest, detention, formal adjudication and out-of-home placement of youth simply to provide them with access to treatment. This would "widen the net" of the juvenile justice system, and expose more youth to criminalization and institutionalization.

Next, juvenile justice funds may be targets for reallocation. Nationwide movements are underway to divert resources away from juvenile justice and toward behavioral health treatment for legally involved youth. These include assessment centers funded by the federal Office of Juvenile Justice and Delinquency Prevention in several states, including Florida. They also include efforts by private foundations, including the Charles and Catherine T. MacArthur, Annie E. Casey and Robert Wood Johnson foundations, to divert youth out of juvenile justice and into treatment through collaborative demonstration projects, in cities from Chicago to Portland.[27] [28]

There has been discussion of an initiative that could be described as a "Proposition 36 for youth." Proposition 36 did not literally reallocate criminal justice (i.e., prison) funds for community-based treatment; it appropriated additional state general funds.

However, in a short time it appears to have contributed to a decline in imprisonment for drug offenses and a reduction in prison costs. A youth version would require the development of legal and clinical criteria for eligibility, since, compared to adults, few AOD-abusing youth are actually arrested for drug offenses.

There are historic examples of state fiscal disincentives (i.e., state-sanctioned penalties, or "sticks,") for counties to rely on institutionalization for different populations, as well as fiscal incentives ("carrots") for counties to offer community-based treatment. These could be explored for their application to AOD-involved youth at risk of detention and institutionalization. One specific incentive to remove youth from detention or institutionalization in order to provide AOD treatment exists through Medi-Cal. Federal funds for Medi-Cal cannot be used to provide services inside juvenile justice facilities. However, youth can become re-eligible as soon as they are released.[29] [30]This could be the basis for a program of diversion to treatment, or treatment in lieu of detention and institutionalization.

Finally, there could be future juvenile justice cost avoidance from increasing access to community-based AOD treatment. Total justice expenditures could be reduced in the future, as discussed in "Fiscal Arguments for Youth AOD Treatment," below.

School Services

Schools are a vital site for the referral of youth to AOD treatment services and, potentially, for their delivery. To date, school-based AOD services have primarily focused on universal prevention, although a number are providing early intervention, as noted in Chapter 2.

Funding streams are available through the educational system for special programs that may include components of AOD treatment.

The federal Safe Schools and Healthy Students Violence Prevention Act has funded the states through formula grants, and through its discretionary grants it has provided funding for a number of school districts and counties around California to develop services for students, focusing on both the general student body and high-risk

students. One of the required elements for local school districts submitting proposals to the federal government is to address alcohol and drug abuse prevention (universal and indicated forms) and early intervention. Services may (but are not required to) include early-intervention modes of AOD treatment. Another required element is mental health care, prevention and treatment intervention. The federal grant application from the Safe and Drug-Free Schools Office requires partnerships between schools, mental health and law enforcement, with participation encouraged by juvenile justice, family court, community, faith-based organizations and families. AOD organizations are not specified. Additional federal funds are provided through the Safe and Drug Free Schools and Communities Act. California's Department of Alcohol and Drug Programs receives a small portion of these funds, which it forwards to the counties for community-based youth AOD prevention services.

Schools in California also have a statutory obligation to collaborate with county behavioral health in order for the county to provide mental health care for school-referred youth:

- The provision of this care by the county -- not by the school -- is required under AB 3262.
- Most of these students are special education students who are entitled to such care under the federal Individuals with Disabilities Act (IDEA).
- Students who are diagnosed as severely emotionally disturbed (SED), or with several other learning or physical disabilities, are eligible but, as noted earlier in this chapter, youth with primary substance use disorders are excluded from the SED diagnosis.
- The provision of mental health assessment and treatment to failing or high-risk students has been limited in practice: less than 1% of IDEA students are served.
- The dollar sums are considerable: over $500 million per year is spent in California for all IDEA services, and the state pays $100 million per year on county mental health claims under AB 3262.
- The contention and delays over reimbursement by the state to counties for these claims has led many counties to instead utilize Mental Health Medi-Cal for

eligible youth (see earlier discussion in this chapter), although this funding stream is supposed to be second-choice.

Opportunities for school-based service funding that flows through education could include the following:

- Funds for lower-priority general prevention, in particular for programs that lack proven efficacy, could be reallocated for indicated or "tertiary" prevention that targets students at high risk for AOD abuse, including programs offering school-based early intervention or student assistance.
- School-based prevention could also incorporate elements of early intervention, such as after-school programs and teen drop-in centers, which are especially needed to attract self-referred clients through the "open door." One advantage is that prevention funds, unlike treatment funds, can often be used for services such as therapeutic recreation, family outreach and community advocacy. Another advantage is that prevention programs do not appear as stigmatizing as treatment sometimes does for self-referred youth.

Public Health

There is a long-established tradition of providing maternal and child health services through public health at the national, state and county levels. Funding exists for these purposes (e.g., Title V block grants). Although most of these funds have historically been used for perinatal and small children's health, this has begun to change in recent years, as there is growing interest in serving adolescents.

There may be opportunities for collaboration with public health for the provision of AOD services to adolescents. The Adolescent Health Collaborative effort, based at the Public Health Institute and at the University of California San Francisco, is one example. The California Maternal, Child and Adolescent Health (MCAH) Directors' Association has an adolescent health working group. EPSDT regulations explicitly call for collaboration with MCAH to serve eligible youth.

There may also be opportunities for drawing on public health funding through the long-standing programs that provide reproductive health and other counseling services

to teens, including girls. These programs see many youth with, or at risk for, AOD problems, including those from AOD-involved families or peer groups. The Adolescent Family Life Program is based in most counties, and delivers parenting and pregnancy prevention services to 15,000 youth annually, with over $20 million in federal and state funds. There are other public health interventions targeting teens, such as violence prevention, HIV/STD prevention and school-based clinics in high-need communities.

The potential may also exist to provide AOD treatment resources to special populations of potentially high-risk youth through the public health care and linked social services for youth diagnosed with physical and developmental disabilities. California Children's Services is based in all counties and serves youth with physical disabilities; it has a combined federal and state budget of over $500 million. The state's Regional Centers encompass all counties and serve youth with developmental disabilities. Adolescent clients of these centers may be at high risk for unidentified AOD problems, and are unlikely to be adequately served in broad-spectrum treatment programs.

One limitation of strategies reliant on public health as the sole source of service delivery is that relatively few adolescents routinely present to public health agencies for other than for reproductive or STD services or chronic or disability conditions.

Public AOD Treatment Funding for Youth, in Budgetary Context

One important factor in considering the public financing of a model AOD treatment system for youth is the relative size of the current expenditures. Several counties around the state have examined their total local expenditures on services to children as a way to assess their budgetary priorities for children.

Figure 4.2 is drawn from San Diego County's recent analysis of AOD treatment expenditures.[31] It indicates that these expenditures are a very small fraction -- under 1% -- of all monies expended in county agencies on children's and youth services in FY 2001-2002.

Figure 4.2 is included in this report as a suggestive example. Since this analysis is specific to a single county in one year, generalization to other counties and other periods would be premature. However, it is unlikely that San Diego County in 2001-2002 is unique in the small proportion of all youth funding spent on AOD treatment.

Figure 4.2

San Diego Children's FY 2001-2002 Budget: Selected Items[32]

Category	Dollars (in millions)	Percent
Child protection (including child welfare, foster care)	$ 187.8	19 %
Mental health	106.8	11
Juvenile justice and at-risk youth (including custody and placement, supervision and probation programs including substance abuse treatment)	93.0	10
Health and Medi-Cal medical care	54.0	6
Substance abuse prevention and treatment (Substance abuse treatment) **	6.8 (3.5)	< 1 (O.7) < 1 (0.4)
Youth development (including after-school programs, juvenile diversion)	5.3	<1 (O.6)
Other ***	492.8	52
Total ****	$ 947.4	100 %

** Added to table from information in Johnson and McBrayer, 2003, page 35

*** Employment, Income, and Other Family Supports including TANF/CalWORKS and Family Resource Centers ($335.0); Early childhood care including TANF ($116.2); Special Partnership Commission for Proposition 10 ($41.6.).

**** Does not include recreation, housing, and other services that may indirectly be spent on children.

C. POTENTIAL FUTURE FUNDING STRATEGIES AND SOURCES

The future funding for youth AOD treatment in California is likely to depend on strategies of creatively combining existing monies drawn from multiple revenue streams, the reallocation of funds from other public programs or sectors to AOD treatment, and the capture of new funding, including private sector resources. Making progress in any or all these directions will also require that advocates make the case that providing appropriate AOD treatment and comprehensive services to youth will be a cost-effective investment.

> *"Since 1994, the [Little Hoover] Commission has issued reports on state policies for children ... including studies on juvenile justice ... abused and neglected children ... violence prevention. ... It is clear that ... reform [in one area] will not significantly improve services for troubled children and their families. Rather, more holistic reforms are needed to integrate these services to these Californians."*[33]

If financial strategies are to be developed that will advance the youth AOD treatment system design goals outlined in Chapter 3, there will need to be simultaneous pursuit of tasks such as combining funds across sectors, advocating for funding flexibility, reallocating and re-prioritizing resources, and identifying new funding partners and stakeholders. This concluding section of this chapter addresses these tasks.

Issues in Future Collaborative Funding

> *"The practice of blended funding doesn't merely redirect existing dollars but generates new revenue to provide more services to more clients in more programs."*[34]

As many counties and providers of youth AOD treatment are discovering, the existing patchwork of categorical and targeted funds, with all their restrictions, can often be combined or commingled with other revenues. In fact, many public and private grant programs require that recipients contribute, from the recipient's other resources, a match for each dollar received. This stipulation is designed, in part, to ensure that new funding dollars do not -- as commonly happens -- merely supplant or substitute

for funds already available to the recipient, but create new services, or expand or enhance existing ones.

In the survey of the 20 Baca/ATP counties conducted by the authors of this report in mid-2003 (see Chapter 2), it was found that, despite the budget cutbacks, 50% of the AOD administrators report that their youth treatment capacity is increasing. The remainder report that it is decreasing (20%) or unchanged (30%). Strategies used to increase or stabilize funding during a time of budget cuts are often reliant on combining revenues. Examples of such innovations can be found around the state, in places as diverse as Humboldt County, the Northern County regional collaborative that planned the Herlong facility,[35] Santa Cruz County, San Diego County and elsewhere. These projects include elaborate collaborations with funding from SAMHSA's "Strengthening Communities -- Youth," Robert Wood Johnson's "Reclaiming Futures," the Department of Education's Safe Schools and Healthy Students, and state- and federally funded youth mental health systems of care. But innovations also include smaller-scale efforts to combine funding from block grants, juvenile justice money, school contributions, public health collaborations and various forms of Medi-Cal, including EPSDT.

To support and expand such combined and collaborative funding, funding-related objectives should include:

- Modifying restrictive funding stream requirements that are in conflict to achieve greater compatibility;
- Removing funding restrictions and capitations, or increasing discretionary funds, to better meet demonstrable client needs and provide evidence-based practices; and'
- Loosening procedural regulations to give counties and providers more flexibility in the way in which specific goals are met.

There should also be particular advocacy for revenues that will support:

- ***Regional inter-county programs to serve youth in rural or isolated areas***
- ***Interagency programs for youth with multiple and special service needs***
- ***Community-based organizations for youth from underserved population groups***

The specific targets of the funding-related objectives will be the elimination of such barriers as conflicts among statutory authority, intervention goals, client eligibility criteria, program terminology, required treatment components, reimbursable services and rates, staffing standards, fiscal accounting and data reporting.

There also will be organizational challenges to be met in engaging in collaborative partnerships in order to share resources or develop new ones. There is always the pull toward doing "business as usual,"[36] and the usual "turf" and "role" conflicts.

> *"Fiscal incentives for collaborative and/or integrated services have been most successful in the past. They provide motivation for all parties involved, create a voluntary interest in integration, can put some specific protections and requirements on the plan for integration, and can require that certain outcomes be achieved."*[37]

Strategies for collaborative funding need to include "win-win" (not "zero-sum") scenarios, even in the absence of large sources of new money. Incentives should include a range of benefits to participating organizations and agencies at all levels.

Potential New Public Funding: Alcohol Beverage Revenues

There may be opportunities in the next months and years for youth AOD treatment to draw upon new public funding resources, in addition to the existing revenue streams discussed earlier in this chapter.

At the national level (e.g., at the Robert Wood Johnson Foundation), there is ongoing discussion of states raising their alcohol tax levels as an appropriate revenue source for AOD services.

An important precedent in California for imposing taxes to produce revenues for directly related programs is Proposition 99, the 1988 tobacco tax to pay for smoking prevention and related health care.

There have been recent efforts to pass state legislation to impose a tax on alcoholic beverages to fund AOD programs for youth. If this effort is revived, one option is for youth AOD treatment advocates to argue that treatment as well as prevention programs should be supported from such a mechanism. Indeed, one could argue that the need for treatment for alcohol abuse or dependency is a direct consequence of excessive or detrimental alcohol consumption by youth, and hence is a logical recipient of alcohol beverage taxes.

Potential New Private Funding: Private Health Insurance AOD Parity

Planning for the funding of youth AOD treatment requires looking at the needs of all populations of youth, in order to ensure all youth have access to the care they need.

The majority of youth in California live in families with private or employer-financed health care insurance. Fully 64% of adolescents ages 12-17 in a representative sample of households in California are covered by private insurance, compared to 24% by public insurance and 12% uninsured.[38]

But privately insured youth do not necessarily have access to comprehensive AOD treatment. Indeed, coverage in the private sector has been modest and shrinking. Even well-to-do parents quickly run out of privately financed options for their AOD-abusing children and, as a result, they turn to the public sector. This places an enormous potential burden on local agencies that already are struggling to serve publicly insured and other lower-income families.

Within the universe of AOD treatment provision, there has been some discussion in recent years about the commingling of public and private monies. The advocacy of an infusion of private funds into services that have grown increasingly reliant on public funds may be an important strategic direction. Unless the private sector contributes its share for its insured clients, it is unlikely that the public sector will ever be able to adequately meet the AOD treatment needs of youth.

Hence it is important to look at the coverage of AOD treatment benefits for youth in the private sector. In recent years there has been strong nationwide movement toward government expanding behavioral health coverage within private insurance plans to match physical health coverage. However, the momentum, direction and results of this "parity" initiative are still very much to be determined.

> *"In recent years, legislative activity designed to introduce parity in insurance coverage for mental health/ substance abuse (MH/SA) treatment has experienced a resurgence."*[39]

There are some positive signs on the horizon. In 1999, the federal government extended its required coverage of AOD and mental health treatment to achieve parity with its coverage of physical health treatment for federal employees. As of mid-2002, 33 states (and the federal government) had enacted some kind of parity laws. Of these, 19 state plans offered "full parity." The others (including the 1996 federal Mental Health Parity Act, PL 104-204) had various limitations. California's 1999 law is a "partial parity" law. While excluding substance abuse from the mandated offering of mental health benefits, it does require alcohol (but not drug) abuse treatment, but for group- (not individually) purchased policies only.

On the other hand, in the current economic climate, with overall health care costs rising, it should not be surprising to learn that a recent human resource managers' survey found that the share of employers offering mental health benefits to employees (substance abuse services not reported) declined between 1998 and 2002 from 84% to 76%.[40]).

Yet the costs of AOD parity have been shown to be minimal. One study projects an increase in insurance premiums of less than 1% (0.2%).[41] Another study projects a comparable increase in premiums of 0.3%. Unlimited AOD treatment coverage would cost the insurer an additional $5 a year.[42] The California Legislative Analyst Office's review finds that the costs are minimal because, "while substance abuse treatment is relatively expensive on an individual basis, the cost is comparatively small ... when spread out over all enrolled members ... because few members received substance abuse treatment. In addition, in the longer run, there appear to be offsetting savings from avoided future medical care."[43]

The most recent studies, on the actual fiscal and coverage impacts of full parity such as Vermont's 1997 law, do suggest that these costs are minimal, although one reason for this may be the failure to expand access to AOD treatment despite parity.[44] [45] This failure in turn may be linked to AOD treatment advocates' relative invisibility compared to mental health advocates, and a possible stigma still associated with seeking substance use treatment.

The AOD treatment provider network, which historically has been publicly funded, would need to overcome several challenges before it could draw on private resources. These challenges include learning to negotiate the private revenue stream and its billing requirements,[46] and attaining the certifications, licensing and professional staff required by medical insurance.

With respect to parity's relevance to youth AOD treatment, there will need to be reconsideration of the typical private health care insurance benefit package and its appropriateness for youth. Detoxification, limited inpatient stays and the limited number of outpatient visits may ill suit adolescents, few of whom are long-term alcoholics or addicts. Not only may youth not need or not be approved for inpatient stays, but a rigidly predetermined course of outpatient visits may also not meet their needs, or even be logistically accessible.

Hence, advocates for parity of youth AOD treatment -- as opposed to advocates for parity of AOD treatment in general -- may need to join forces with adolescent health advocates. These advocates point out that the acute medical care insurance model does not always address the common health needs of most adolescents.[47] Adolescents are likely to benefit from health care that is oriented to the promotion of good health and the management of health risks.

Fiscal Arguments for Youth AOD Treatment

The final and crucial piece of developing future strategies and sources for youth AOD treatment is the identification and dissemination of the fiscal arguments for treating youth.

A number of specific points can be made to highlight the cost-avoidance and cost-benefit potentials of providing AOD treatment to youth. This discussion will mention several.

The societal costs that could be avoided were there to be timely and comprehensive treatment of AOD-involved youth include:

- ***Diminished school performance and school costs (e.g., lost attendance days)***
- ***Lost employee productivity in young adulthood***
- ***Vanished opportunities for civic participation***
- ***Current juvenile justice costs and future criminal justice costs***
- ***Immediate public health and social service costs of AOD-related injuries and future medical costs of addiction or alcoholism. A recent study found that $1 out of every $7 in health care dollars was for AOD-related care.[48]***

Compared to adults, the cost calculations for youth AOD treatment may look different:

- Youth are relatively rarely acutely ill, or immediate public safety threats, or chronic social nuisances.
- Under an "acute care first" model, or a "high-end chronics first," youth will never be served.
- But youths' lives may also be turned around faster and easier than those of acutely ill, threatening, or chronic adults.
- In any case, the benefits for serving youth will accrue later, but may be even greater, and will in any case require a longer-term view.

Despite the need for a long-term view, nonetheless there are compelling immediate public costs being incurred in the justice, social service and school sectors due to untreated AOD problems among youth.

Average cost nationally to educate a student with a disability: $12,639[49]

Average cost of a typical 30-day juvenile hall stay: $3,500

Average statewide daily juvenile hall census: 11,500[50]

Average annual cost of a California Youth Authority (CYA) placement: $80,000

Average statewide daily CYA census: 4,619

If the argument for Proposition 36, which funded AOD treatment for adult offenders, was premised on both immediately avoiding state prison costs and ultimately reducing all criminal justice costs, this must be true for juveniles.

- Treating individuals at home is far cheaper than treating them in institutions.
- Timely treatment reduces the risk of future legal trouble and diminishes future criminal justice costs.

- If these are true for the 35-year-olds being served under Proposition 36, how much truer would they be for 16-year-olds?

But it is important to look not only at public cost benefits, but at social benefits, as well:

- All children are our future; they are not "someone else's children."
- All children deserve our public investment, now.

  We will all benefit in the future from the investment we make now.

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[1] Physician Leadership on National Drug Policy. (2002). Adolescent substance abuse: A public health priority. Providence, RI: Brown University, Center for Alcohol and Addiction Studies.

[2] Alcohol and Drug Policy Institute. (2003). A planning approach for assessing county-level need, demand and capacity in drug and alcohol treatment services in California. Irvine, CA: Alcohol and Drug Policy Institute.

[3] Gerstel, T. And Shane, P. (2001). Building community solutions to substance abuse and delinquency: Financing collaborative approaches and challenges for building integrated systems. Prepared for the Robert Wood Johnson Foundation Reclaiming Futures Initiative. Oakland, CA: Authors.

[4] Johnson, P. (1999) Substance abuse treatment coverage in state Medicaid Programs. Report to the Forum for State Health Policy leaderhip. Washington, DC: National Conference of State Legislatures.

[5] Alcohol, Drug Abuse and Mental Health Services Administration. (1991). Medicaid financing for mental health and substance abuse services for children and adolescents. Technical Assistance Publication Series Number 2, Financing Subseries Volume 1. Rockville, MD: Alcohol, Drug Abuse and Mental Health Services Administration.

[6] Physician Leadership on National Drug Policy. (2002). Adolescent substance abuse: A public health priority. Providence, RI: Brown University, Center for Alcohol and Addiction Studies.

[7] 42 U.S. Code Section 1396d(r)(5))

[8] Cavanaugh, D. (2002). Financing a system of care for adolescents with substance use disorders: Opportunities and challenges. Prepared for the Robert Wood Johnson Foundation. Washington, DC: Georgetown University.

[9] California Health Interview Survey. (2002). California Health Interview Study (CHIS) Findings. University of California, Los Angeles, Center for Health Policy Research. Retrieved December 30, 2003, from www.chis.ucla.edu.

[10] Little Hoover Commission. (2001). Young hearts and minds: Making a commitment to children's mental health. Sacramento, CA: Little Hoover Commission.

[11] Ibid.

[12] AB 2315, sponsored by then-Assembly Member Lockyer, Chapter 325

[13] TL v Belshe, 1995

[14] Gehshan, S. (2001). Substance abuse treatment in State Children's Health Insurance Programs. Report to the Forum for State Health Policy Leadership. Washington, DC: National Conference of State Legislatures.

[15] California Health Interview Survey. (2002). California Health Interview Study (CHIS) Findings. University of California, Los Angeles, Center for Health Policy Research. Retrieved December 30, 2003, from www.chis.ucla.edu.

[16] National Conference of State Legislatures. (2003). The state of SCHIP budgets and programs. 2003. Denver, CO: National Conference of State Legislatures.

[17] Kaplan, S. (1999). Healthy Families program: Building a better alcohol and drug treatment system for California youth. Sacramento, CA: California Institute for Mental Health.

[18] American Academy of Pediatrics. (2000). Insurance coverage of mental health and substance abuse services for children and adolescents: A consensus statement. October, 2000. Elk Gove, IL: American Academy of Pediatrics.

[19] Reed, D. and Karpilow, K. (2002). Understanding the child welfare system in California: A primer for service providers and policymakers. Berkeley, CA: California Center for Research on Women and Families, Public Health Institute.

[20] Cavanaugh, D. (2002). Financing a system of care for adolescents with substance use disorders: Opportunities and challenges. Prepared for the Robert Wood Johnson Foundation. Washington, DC: Georgetown University.

[21] Johnson, K.A. and McBrayer, S.L. (2003). San Diego children's budget: financial data to improve future returns. San Diego, CA: The San Diego Children's Initiative.

[22] Chapter 311, Statutes of 1998

[23] California Department of Social Services. (2002). Reexamination of the role of group care in a family-based system of care: A Status Report. Report to the Legislature, August 16, 2002. Sacramento, CA: California Department of Social Services.

[24] Little Hoover Commission. (2003). Still in our hands: A review of efforts to reform foster care in California. Sacramento, CA: Little Hoover Commission.

[25] Child Welfare Services Stakeholders Group. (2003). CWS Redesign: The future of California's child welfare services. Sacramento, CA: California Department of Social Services.

[26] Turner, S., Davis, L.M., Steinberg, P.S., et al. (2003). Statewide evaluation of the CYSA/TANF Program: Final report. Prepared for Chief Probation Officers of California. Santa Monica, CA: RAND Corporation.

[27] Bilchik, S. (1998). Mental health disorders and substance abuse problems among juveniles. OJJDP Fact Sheet. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, Department of Justice.

[28] Kamradt, B. (2002). Funding mental health services for youth in the juvenile justice system: Challenges and opportunities. Delmar, NY: National Center for Mental Health and Juvenile Justice.

[29] Burrell, S. and Bussiere, A. (2003). The "Inmate Exception" and its impact on health care services for children in out-of-home care in California. Prepared for The California Endowment. San Francisco, CA: Youth Law Center.

[30] National GAINS Center for People with Co-Occurring Disorders in the Justice System. (2001). Maintaining Medicaid benefits for jail detainees with co-occurring mental health and substance abuse disorders. Fact Sheet Series. Delmar, NY: The National GAINS Center.

[31] Johnson, K.A. and McBrayer, S.L. (2003). San Diego children's budget: financial data to improve future returns. San Diego, CA: The San Diego Children's Initiative.

[32] Ibid.

[33] Little Hoover Commission. (2001). Young hearts and minds: Making a commitment to children's mental health. Sacramento, CA: Little Hoover Commission.

[34] Edelman, S. (1998). Developing blended funding programs for children's mental health care system. A manual of financial strategies. Sacramento, CA: California Institute for Mental Health.

[35] Klein, D., Shane, P., et al. (2001). Interim year one report of the Adolescent Treatment Project evaluation. Report to the California Department of Alcohol and Drug Programs. Oakland: Public Health Institute.

[36] Orland, M.E. and Foley, E. (1996). "Beyond decategorization: Defining barriers and potential solutions to creating effective comprehensive community-based support systems for children and families." Washington, DC: The Finance Project.

[37] Jordan, P. (2003). Integrated services for children and families. Sacramento, CA: California Institute for Mental Health.

[38] California Health Interview Survey. (2002). California Health Interview Study (CHIS) Findings. University of California, Los Angeles, Center for Health Policy Research. Retrieved December 30, 2003, from www.chis.ucla.edu.

[39] Rosenbach, M., Lake, T., et al. (2003). Effects of the Vermont mental health and substance abuse parity law. DHHS Publication SMA 03-3822. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[40] "Money and Medicine" column, *New York Times*, April 20, 2003.

[41] Substance Abuse and Mental Health Services Administration. (1998). The costs and effects of parity for substance abuse insurance benefits. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[42] Sturm, R. (2001). The Costs of covering mental health and substance abuse care at the same level as medical care in private insurance plans. Presentation to the National Conference of Insurance Legislators. Santa Monica, CA: RAND Corporation.

[43] California Legislative Analyst's Office. (2001). Review of health insurance coverage pursuant to Chapter 305, Statutes of 2000 (SB 1764, Chesbro). Sacramento, CA: California Legislative Analyst's Office.

[44] George Washington University Medical Center, The. (2003). Alcohol treatment coverage offered by health insurers in 5 states falls short of legal mandates – press release. Washington, DC: The George Washington University.

[45] Rosenbach, M., Lake, T., et al. (2003). Effects of the Vermont mental health and substance abuse parity law. DHHS Publication SMA 03-3822. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[46] Cavanaugh, D. (2002). Financing a system of care for adolescents with substance use disorders: Opportunities and challenges. Prepared for the Robert Wood Johnson Foundation. Washington, DC: Georgetown University.

[47] Brindis, C., Morreale, M., & English, A. (2003). The unique health care needs of adolescents. The Future of Children, 13(1): 117-135.

[48] Harwood, H., Fountain, D., & Livermore, G. (1998). The economic costs of alcohol and drug abuse in the United States. Fairfax, VA: The Lewin Group.

[49] 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: 2003.

[50] Little Hoover Commission. (2001). Young hearts and minds: Making a commitment to children's mental health. Sacramento, CA: Little Hoover Commission.

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Appendix III
Telephone Survey Questions

The survey consisted of both structured (multiple-choice) and open-ended questions, administered in a telephone interview by a member of the project team in summer 2003. The questions were developed to address issues of concern identified by the national literature, the Alcohol and Drug Policy Institute, and prior work in the field by the senior authors of this report.

The 20 counties selected for the sample from the universe of California's 58 counties, which include small, medium-sized, and large counties, were those that had received youth AOD treatment funds from the state since the mid-1990s: Alameda, Alpine, Contra Costa, Fresno, Glenn, Humboldt, Imperial, Los Angeles, Mendocino, Orange, San Bernardino, San Diego, San Francisco, San Luis Obispo, Santa Barbara, Santa Clara, Santa Cruz, Sierra, Sonoma and Tehama.

The survey respondents were selected to include both county administrators and providers of adolescent alcohol and other drug treatment programsin each county. The names of participants are listed in Appendix II.

General Questions

Which services for adolescents do you currently have available, with how many program types and numbers of slots for each type? (structured list)

What is the current direction of your youth AOD treatment service capacity? (structured options)

Are you currently engaged in any collaborative/ inter-agency planning around youth AOD treatment? (open-ended)

What (complementary) services are your county's youth currently accessing, and what services would you like to see offered? (structured list)

Which agencies refer adolescent clients to treatment? (structured list)

What percentage of the referrals come from each agency? (structured ranges)

How satisfied are you with the referral process? (structured options)

Are there any sub-populations of your youth that you would like to prioritize for treatment? (open-ended)

What do you think have been the top barriers you have encountered in the delivery of treatment services to youth? (open-ended)

What do you see as the most important outcomes, benchmarks, or measurable successes for youth in treatment? (open-ended)

What types of data would you need to collect in order to measure these outcomes? (open-ended)

Additional County Administrator Questions

What percentage of your county AOD treatment dollars is expended on adolescent treatment? (structured ranges)

What amount of your county AOD treatment dollars is spent on adolescent treatment annually? (structured ranges)

What is the core model for most of the county's youth AOD treatment? (open-ended)

How satisfied are you with this model? (structured options)

Additional Provider Questions

Is your program county-operated, a private nonprofit, or a for-profit? (structured options)

How much money did your program receive this year for AOD youth treatment? (structured ranges)

What were the sources of these monies? (structured list)

What percentage of your adolescent clients had their services paid for by each funding source? (structured ranges)

If additional funding were available for your youth treatment program, to what would you specifically allocate the monies? (open-ended)

Are you currently engaged in screening or assessment activities? (open-ended)

What is the core model for your program? (open-ended)

How satisfied are you with this model? (structured options)

Some youth treatment providers work with family members and others do not. Can you tell me whether you do or not? (open-ended)

Appendix III
Glossary of Acronyms

Appendix III
Glossary of Acronyms

ADAM – Arrestee Drug Abuse Monitoring Program
ADP – California Department of Alcohol and Drug Programs
ADPI – Alcohol and Drug Policy Institute
AFDC – Aid to Families with Dependent Children
AOD – Alcohol and other drugs
ASAM – American Society of Addiction Medicine
ATP – Baca/Adolescent Treatment Program
CADDS – California Alcohol and Drug Data System
CADPAAC – County Alcohol and Drug Program Administrators Association of California
Cal-OMS – California Outcome Measuring System
CalPERS – California Public Employees' Retirement System
CBO – community-based organization
CDC- Centers for Disease Control
CDE – California Department of Education
CSAT – Center for Substance Abuse Treatment
CSS – California Student Survey
CSSA – California Safe Schools Assessment
CWLA – Child Welfare League of America
CYA – California Youth Authority
DATOS – Drug Abuse Treatment Outcome Studies
DAWN – Drug Abuse Warning Network
DHS – California Department of Health Services
D/MC – Drug Medi-Cal
DMH -– California Department of Mental Health
DSM-IV – Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSS – California Department of Social Services
ED – emergency department
EPSDT – Early and Periodic Screening, Diagnosis, and Treatment
FY – fiscal year
IDEA – Individuals with Disabilities Education Act
LAO – California Legislative Analyst's Office
MCAH – Maternal, Child and Adolescent Health
MTF – Monitoring the Future
NHSDA – National Household Survey on Drug Abuse
NIDA – National Institute on Drug Abuse
NSDUH – National Survey on Drug Use and Health
N-SSATS – National Survey of Substance Abuse Treatment Services
OJJDP – Office of Juvenile Justice and Delinquency Prevention
PHI – Public Health Institute
SAMHSA – Substance Abuse and Mental Health Services Administration

SCHIP – State Children's Health Insurance Program
SED – severely emotionally disturbed
SoC – system of care
SSA – Social Security Act
STD – sexually transmitted disease
SUD – substance use disorder
TANF – Temporary Assistance for Needy Families
TEDS – Treatment Episode Data Set
YRBS – Youth Risk Behavior Survey

Bibliography

Aarons, G.A., Brown, S.A., Hough, R.L, et al. (2001). Prevalence of adolescent substance use disorders across five sectors of care. Journal of the American Academy of Child & Adolescent Psychiatry, 40: 419-426.

Alcohol and Drug Policy Institute. (2003). A planning approach for assessing county-level need, demand, and capacity in drug and alcohol treatment services in California. Irvine, CA: Alcohol and Drug Policy Institute.

Alcohol and Drug Policy Institute. (2002). Adolescent substance abuse treatment system of care: Concept paper. Irvine, CA: Alcohol and Drug Policy Institute.

Alcohol, Drug Abuse and Mental Health Services Administration. (1991). Medicaid financing for mental health and substance abuse services for children and adolescents. Technical Assistance Publication Series Number 2, Financing Subseries Volume 1. Rockville, MD: Alcohol, Drug Abuse and Mental Health Services Administration.

American Academy of Pediatrics. (2000). Insurance coverage of mental health and substance abuse services for children and adolescents: A consensus statement. October, 2000. Elk Grove, IL: American Academy of Pediatrics.

Austin, G. and Abe, Y. (2002). Continuation schools report: Findings on the use of alcohol, tobacco, and other drugs, from 8th Biennial Survey of California school students in grades 7, 9, and 11. Sacramento, CA: California Department of Justice, Attorney General's Office.

Barth, R.P. (2002). Institutions vs. foster homes: The empirical base for a century of action. Chapel Hill, NC: University of North Carolina, School of Social Work, Jordan Institute for Families.

Bever, J.E., Brannigan, R., & Nissen, L.B. (2003). Reclaiming Futures - Treatment improvement self-study workbook: A current capacity and needs assessment tool. Portland, OR: Robert Wood Johnson Foundation.

Bilchik, S. (1998). Mental health disorders and substance abuse problems among juveniles. OJJDP Fact Sheet. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, Department of Justice.

Brindis, C., Morreale, M., & English, A. (2003). The unique health care needs of adolescents. The Future of Children, 13(1): 117-135.

Burrell, S. and Bussiere, A. (2003). The "Inmate Exception" and its impact on health care services for children in out-of-home care in California. Prepared for The California Endowment. San Francisco, CA: Youth Law Center.

California Department of Alcohol and Drug Programs. (2000). Youth treatment guidelines. ADP Publication 8566. Sacramento, CA: California Department of Alcohol and Drug Programs.

California Department of Alcohol and Drug Programs. (2002). Youth treatment guidelines. Revised August 2002. Sacramento, CA: California Alcohol and Drug Programs.

California Department of Education. (2002). California Safe Schools Assessment 2000-2001 results: Promoting safe schools. Sacramento, CA: California Department of Education.

California Department of Education. Expulsion information for 2001-2002. Retrieved November 11, 2003, from http://data.cde.ca.gov/dataquest/expulsion/EdCodeSt.asp?cYear=2000-01&cChoice=EdC

California Department of Mental Health. (2003). California community mental health performance outcome report: Fiscal year 2001-2002 – A report to the Legislature. Sacramento, CA: California Department of Mental Health.

California Department of Social Services. (2002). Reexamination of the role of group care in a family-based system of care: A Status Report. Report to the Legislature, August 16, 2002. Sacramento, CA: California Department of Social Services.

California Health Interview Survey. (2002). California Health Interview Study (CHIS) Findings. University of California, Los Angeles, Center for Health Policy Research. Retrieved December 30, 2003, from www.chis.ucla.edu.

California Legislative Analyst's Office. (2001). Review of health insurance coverage pursuant to Chapter 305, Statutes of 2000 (SB 1764, Chesbro). Sacramento, CA: California Legislative Analyst's Office.

California Legislative Analyst's Office. (1999). An LAO Report- Services are cost-effective to society: Substance abuse treatment in California. Sacramento, CA: California Legislative Analyst's Office.

Cavanaugh, D. (2002). Financing a system of care for adolescents with substance use disorders: Opportunities and challenges. Prepared for the Robert Wood Johnson Foundation. Washington, DC: Georgetown University.

Center for Substance Abuse Treatment. (2000) Improving substance abuse treatment: The national treatment plan initiative. Changing the conversation. DHHS Publication No. (SMA) 00-3480. NCADI Publication No. BKD 383, U.S. DHHS, SAMHSA, CSAT.

Child Welfare League of America. (1998). Alcohol and other drug survey of state child welfare agencies. Washington, DC: Child Welfare League of America.

Child Welfare Services Stakeholders Group. (2003). CWS Redesign: The future of California's child welfare services. Sacramento, CA: California Department of Social Services.

Dennis, M. (2002). Treatment research on adolescent drug and alcohol abuse: Despite progress, many challenges remain. Invited commentary in Connection newsletter. Academy for Health Services Research and Health Policy. Washington, DC: Academy for Health Services Research and Health Policy.

Drug Strategies. (2002). Treating teens: A guide to adolescent drug programs. Washington, DC: Drug Strategies.

Edelman, S. (1998). Developing blended funding programs for children's mental health care system. A manual of financial strategies. Sacramento, CA: California Institute for Mental Health.

Etheridge, R. M., Smith, J. C., Rounds-Bryant, J. L., & Hubbard, R. L. (2001). Drug abuse treatment and comprehensive services for adolescents. Journal of Adolescent Research, 16(6): 563-589.

Gardner, P. (2001). Unmet mental health needs cause failure across youth-serving institutions. Youth Law News. 22(1).

Gehshan, S. (2001). Substance abuse treatment in State Children's Health Insurance Programs. Report to the Forum for State Health Policy Leadership. Washington, DC: National Conference of State Legislatures.

George Washington University Medical Center, The. (2003). Alcohol treatment coverage offered by health insurers in 5 states falls short of legal mandates – press release. Washington, DC: The George Washington University.

General Accounting Office. (2003). Child welfare and juvenile justice - Federal agencies could play a stronger role in helping states reduce the number of children placed solely to obtain mental health services. Washington, DC: United States General Accounting Office.

Gerstel, T. and Shane, P. (2001). Building community solutions to substance abuse and delinquency: Financing collaborative approaches and challenges for building integrated systems. Prepared for the Robert Wood Johnson Foundation Reclaiming Futures Initiative. Oakland, CA: Authors.

Grunbaum, J.A., Kann, L., Kinchen, S., et al. Youth Risk Behavior Surveillance – United States, 2001, June 28, 2002 MMWR 2002:51(No. SS-4).

Harwood, H., Fountain, D., & Livermore, G. (1998). The economic costs of alcohol and drug abuse in the United States. Fairfax, VA: The Lewin Group.

Holden, E.W. (July, 2002). The national evaluation of the Comprehensive Community Mental Health Services for Children and their Families Program. Presentation given at the Center for Substance Abuse Treatment conference, Baltimore, MD.

Hser, Y.I., Grella, C.E., Hubbard, R.L., et al. (2001). An evaluation of drug treatments for adolescents in 4 U.S. cities. Archives of General Psychiatry, 58(7): 689-695.

Johnson, K.A. and McBrayer, S.L. (2003). San Diego children's budget: financial data to improve future returns. San Diego, CA: The San Diego Children's Initiative.

Johnson, P. (1999). Substance abuse treatment coverage in state Medicaid programs. Report to the Forum for State Health Policy Leadership. Washington, DC: National Conference of State Legislatures.

Johnston, L. D., O'Malley, P. M., & Bachman, J. G. (2003)(a). Monitoring the Future national results on adolescent drug use: Overview of key findings, 2002. (NIH Publication No. 03-5374). Bethesda, MD: National Institute on Drug Abuse.

Johnston, L. D., O'Malley, P. M., & Bachman, J. G. (2003)(b). Monitoring the Future national survey results on drug use, 1975-2002. Volume I: Secondary school students. (NIH Publication No. 03-5375). Bethesda, MD: National Institute on Drug Abuse.

Jordan, P. (2003). Integrated services for children and families. Sacramento, CA: California Institute for Mental Health.

Kamradt, B. (2002). Funding mental health services for youth in the juvenile justice system: Challenges and opportunities. Delmar, NY: National Center for Mental Health and Juvenile Justice.

Kaplan, S. (1999). Healthy Families program: Building a better alcohol and drug treatment system for California youth. Sacramento, CA: California Institute for Mental Health.

Kavale, K.A. and Farness, S.R. (2000). History, rhetoric, and reality – Analysis of the inclusion debate. Remedial and Special Education, 21(5): 279-296.

Klein, D., Shane, P., et al. (2001). Interim year one report of the Adolescent Treatment Project evaluation. Report to the California Department of Alcohol and Drug Programs. Oakland: Public Health Institute.

Klein, D., Shane, P., et al. (Unpublished) (2003). Final report of the Adolescent Treatment Project. Report to the California Department of Alcohol and Drug Programs. Oakland, CA: Public Health Institute.

Klein, D., Shane, P., et al. (Unpublished) (2002). Annotated youth treatment guidelines 2000 suggested revisions. Report to the California Department of Alcohol and Drug Programs. Oakland, CA: Public Health Institute.

Little Hoover Commission. (2003). Still in our hands: A review of efforts to reform foster care in California. Sacramento, CA: Little Hoover Commission.

Little Hoover Commission. (2001). Young hearts and minds: Making a commitment to children's mental health. Sacramento, CA: Little Hoover Commission.

Little Hoover Commission. (1999). Now in our hands: Caring for California's abused and neglected children. Sacramento, CA: Little Hoover Commission.

McKay, J.R. (2001). Effectiveness of continuing care interventions for substance abusers. Implications for the study of long-treatment effects. Evaluation Review, 25 (2): 211-232.

McLellan, A.T., Lewis, D.C., O'Brien, C.P., et al. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. Journal of the American Medical Association, 284(3): 1689-1695.

Marty, D.A. and Chapin, R. (2000). The legislative tenets of client's right to treatment in the least restrictive environment and freedom from harm: Implications for community providers. Community Mental Health Journal, 36(6): 545-556.

Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.F., & Friffith, J.H., eds. (2001). ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition-Revised (ASAM PPC-2R). Chevy Chase, MD: American Society of Addiction Medicine, Inc.

Meyers, K., Hagan, T.A., Zanis, D., et al. (1999). Critical issues in adolescent substance use assessment. Drug and Alcohol Dependence, 55(3): 235-246.

National Conference of State Legislatures. (2003). The state of SCHIP budgets and programs. 2003. Denver, CO: National Conference of State Legislatures.

National GAINS Center for People with Co-Occurring Disorders in the Justice System. (2001). Maintaining Medicaid benefits for jail detainees with co-occurring mental health and substance abuse disorders. Fact Sheet Series. Delmar, NY: The National GAINS Center.

National Institute of Justice. (2003). Preliminary data on drug use and related matters among adult and juvenile detainees: Arrestee Drug Abuse and Monitoring (ADAM) Program. NIJ Fact Sheet. Washington, DC: National Institute of Justice, Office of Justice Programs, Department of Justice.

National Institute on Drug Abuse. (1999). Principles of drug addiction treatment: A research-based guide. NIH Publication No. 99-4180. National Institute on Drug Abuse, National Institutes of Health.

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: 2003.

Office of Juvenile Justice and Delinquency Prevention. (2002). Detention in delinquency cases, 1989-1998. OJJDP Fact Sheet. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, Department of Justice.

Office of Juvenile Justice and Delinquency Prevention. (2002). Drug offense cases in juvenile courts. OJJDP Fact Sheet. Washington, DC: Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, Department of Justice.

Orland, M.E. and Foley, E. (1996). "Beyond decategorization: Defining barriers and potential solutions to creating effective comprehensive community-based support systems for children and families." Washington, DC: The Finance Project.

Physician Leadership on National Drug Policy. (2002). Adolescent substance abuse: A public health priority. Providence, RI: Brown University, Center for Alcohol and Addiction Studies.

Pires, S.A. (2002). Building systems of care, A primer. Prepared for the National Technical Assistance Center for Children's Mental Health, Center for Child Health and Mental Health Policy, Georgetown University Child Development Center. Washington, DC: The Georgetown University.

Prescott, L. (1998). Improving policy and practice for adolescent girls with co-Occurring disorders in the juvenile justice system. Delmar, NY: The National GAINS Center.

Reed, D. and Karpilow, K. (2002). Understanding the child welfare system in California: A primer for service providers and policymakers. Berkeley, CA: California Center for Research on Women and Families, Public Health Institute.

Riggs, P.D. (2003). Treating adolescents for substance abuse and comorbid psychiatric disorders. Science & Practice Perspectives, 2(1). Washington, DC: National Institute on Drug Abuse, National Institutes of Health.

Rosenbach, M., Lake, T., et al. (2003). Effects of the Vermont mental health and substance abuse parity law. DHHS Publication SMA 03-3822. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Scanlon, A. (2003). State spending on substance abuse treatment. Policy matters: Critical issues in health care access. Washington, DC: National Conference of State Legislatures.

Shane, P., Jasiukaitis, P., & Green, R.S. (2003). Treatment outcomes among adolescents with substance abuse problems: The relationship between comorbidities and post-treatment substance involvement. Evaluation and Program Planning, 26(2003): 393-402.

Shane, P., Dasinger, L.J., Jasiukaitis, P. (June, 2003). Using hierarchical linear modeling to assess multi-modal outcomes and compare treatment effectiveness among treatment programs for adolescents with substance abuse problems. Presentation given at the annual meeting of the society

Shane, P. and Jasiukaitis, P. (August, 2003). Pre- and post-treatment indicators of substance abuse treatment outcomes. Presentation given at the American Psychological Association 110th Convention, Chicago, IL.

Skager, R., and Austin, G. (2002). Ninth Biennial California Student Survey 2001-2002 major findings: Alcohol and other drug use grades 7, 9, and 11. Sacramento, CA: California Department of Justice, Attorney General's Office.

Stevens, S. and Morral, A., eds. (2002). Adolescent substance abuse treatment in the United States: Exemplary models from a national evaluation study. Drugs and Society. New York, NY: Hawthorn Press.

Sturm, R. (2001). The Costs of covering mental health and substance abuse care at the same level as medical care in private insurance plans. Presentation to the National Conference of Insurance Legislators. Santa Monica, CA: RAND Corporation.

Substance Abuse and Mental Health Services Administration. (2003). Overview of Findings from the 2002 National Survey on Drug Use and Health (Office of Applied Studies, NHSDA Series H-21, DHHS Publication No. SMA 03–3774). Rockville, MD.

Substance Abuse and Mental Health Services Administration. (2003). Strategies for developing treatment programs for people with co-occurring substance abuse and mental health disorders. SAMHSA Publication 3782. Rockville, MD: SAMHSA.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. National Survey of Substance Abuse Treatment Services (N-SSATS): 2002. Data on Substance Abuse Treatment Facilities, DASIS Series: S-19, DHHS Publication No. (SMA) 03-3777, Rockville, MD, 2003.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Treatment Episode Data Set (TEDS): 1992-2000. National Admissions to Substance Abuse Treatment Services, DASIS Series: S-17, DHHS Publication No. (SMA) 02-3727, Rockville, MD, 2002.

Substance Abuse and Mental Health Services Administration. (1998). The costs and effects of parity for substance abuse insurance benefits. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Teplin, L., Abram, K., McClelland, G., et al. (2002). Psychiatric Disorders in Youth in Juvenile Detention. Archives of General Psychiatry, 59: 1133-1143.

Turner, S., Davis, L.M., Steinberg, P.S., et al. (2003). Statewide evaluation of the CYSA/TANF Program: Final report. Prepared for Chief Probation Officers of California. Santa Monica, CA: RAND Corporation.

Watkins, K., Burnam, M.A., Kungt, F.Y., et al. (2001). A National survey of care for persons with co-occurring mental health and substance use disorders. Psychiatric Services, 52(8): 1062-1068.

Wu, P., Hoven, C.W., & Fuller, C.J. (2003). Factors associated with adolescents receiving drug treatment: Findings from the National Household Survey on Drug Abuse. Journal of Behavioral Health Services Research, 30(2): 190-201.