The Need To Invest In Adolescent Treatment

Policy Recommendations For Adolescent Substance Abuse Treatment In California

A REPORT FOR CALIFORNIA POLICY MAKERS APRIL 2004
The Need To Invest In Adolescent Treatment
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The Charles and Helen Schwab Foundation is a private charitable organization that stewards a philanthropic vision of building partnerships to improve lives. Through direct service and partnership in grant making initiatives, the foundation seeks to impact individual lives in a meaningful, lasting way and work collaboratively to inform philanthropic practices.

The foundation focuses its work in four program areas that reflect critical social issues with clear points of intersection — Homelessness, Poverty Prevention, Substance Abuse and Learning Disabilities. The foundation's goal in each of these areas is to promote the self-sufficiency of both individuals and organizations, as well as a positive interdependence with personal and community support systems that individuals require in order to achieve stability and fulfillment in their lives.

Partnership and collaboration are hallmarks of the foundation's work, which enables its programs and initiatives to capitalize on a synergy of resources, a confluence of expertise and a broad familiarity with diverse populations and environments across the country. Working collaboratively in multiple arenas and at many levels enables the foundation and its partners to forge holistic solutions to overlapping problems.

The foundation, based in San Mateo, California, was established by financier Charles R. Schwab and his wife Helen O. Schwab in 2001 from the merger of the Schwab Family Foundation and the Schwab Foundation for Learning.
California’s substance abuse treatment system for adolescents is in a state of crisis. Less than 10% of adolescents who need treatment actually receive services. The vast majority of those who do obtain treatment receive it as a consequence of entering the criminal justice system.

When we formed our foundation, we made a conscious decision to concentrate our resources on the most fundamental roadblocks to self-sufficiency and attainment in the lives of individuals and families. Alcohol and other drugs are a serious roadblock for many youth during the critical developmental years of adolescence. Effective substance abuse treatment must be made available to all youth who need it, whether it is a child conditioned by parental substance abuse, an adolescent in the juvenile justice system or a student failing in school as a result of drug use.

This report is the result of over two years of planning, research and partnership with individuals and agencies working in the field of adolescent substance abuse. Our foundation has worked closely with the County Alcohol and Drug Program Administrators Association of California and provided funding to develop the Alcohol and Drug Policy Institute, whose mission is to conduct and use research to support change in the field. Our first major project is this report on the state of the adolescent treatment system in California. It presents a series of policy recommendations that outline a course of action for California, immediately and over the long term, to establish a responsive system of adolescent care that implements best practices based on sound research.

Such a comprehensive approach will not be achieved without significant collaboration and partnership among public agencies and other providers of adolescent care, and between local, county and state levels of government. The policy recommendations outlined in this report model the value of collaborative work, demonstrating that partnerships have much more profound impact than funding alone because they result in broader expertise and more lasting changes within organizations and systems.

These policy recommendations challenge us with a clear choice: we can partner to use philanthropic and public resources constructively to detect and treat substance abuse before it derails lives, or we can continue to spend our limited resources on the human and societal costs of addiction. These recommendations are a first step — a critical first step we must take because our youth and California’s future hang in the balance.

Our goal is to create treatment capacity for 200,000 adolescents throughout the state and ensure that youth suffering from substance abuse have immediate support and treatment in their community. Our hope is that you will join us in our efforts to address this public health challenge and assist us as we work to find solutions. Together, we will make a difference that would be impossible to accomplish acting individually.

Helen O. Schwab
President, Charles and Helen Schwab Foundation

Charles R. Schwab
Chairman, Charles and Helen Schwab Foundation
When I joined the Charles and Helen Schwab Foundation to head the newly formed Substance Abuse Program, I was directed by the board to focus on treatment expansion and system change for adolescent substance abuse. In researching these issues, I found that the need for treatment services for adolescents was truly at a crisis state in California. Serving as an advisor to the Little Hoover Commission on its 2003 report, For Our Health and Safety: Joining Forces to Defeat Addiction, reinforced this assessment. Despite nearly two decades of experience in the treatment field, the scarcity of adolescent-specific services in California came as a shock.

To address this situation, the foundation collaborated with the Alcohol and Drug Policy Institute (ADPI) to develop a report on adolescent substance abuse treatment in California. Our objective was to provide information that would help policy makers understand the nature of substance abuse and the value of treatment, and take action to expand the availability of treatment for adolescents. We commissioned the Public Health Institute to compile California-specific research that would define the problem, analyze the current treatment system for adolescents, outline the characteristics of high-quality treatment design and assess the realistic financing options for such a system.

In December 2003, key people in the substance treatment field — treatment providers, county alcohol and drug administrators, researchers and educators — gathered to review the findings. Two days were spent in detailed discussions about the current state of adolescent treatment, an optimal system for adolescent treatment and what needs to be done to create such a system in California. The outcome was more than 30 possible policy recommendations that provided the basis for the eight recommendations in this report. It is a tribute to the passion of everyone who contributed to this report that differences of opinion and organizational self-interests were set aside to be able to develop recommendations that do not favor any one organization, service provider or government agency, but rather present non-biased, feasible approaches to help adolescents in need of substance abuse treatment.

A special thanks is owed to all the participants in this project for their input, disagreement, support and discussion. I also want to acknowledge and thank the foundation’s board for supporting this initiative, as well as the foundation staff and consultants who helped to make this report a reality. And, to the reader, thank you for your attention to this report. It is only a beginning. There are many dedicated and knowledgeable people who are willing and prepared to help legislators and other state leaders, through future reports and other means, make informed decisions about what they can do to help adolescents who suffer from substance abuse.

Ed Carlson
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Charles and Helen Schwab Foundation
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INTRODUCTION

1. GOVERNOR’S COUNCIL
2. COUNTY COALITIONS
3. YOUTH TREATMENT GUIDELINES
4. SCREENING AND ASSESSMENT
5. DEDICATED FUNDING
6. HEALTH INSURANCE PARITY
7. ADOLESCENT-SPECIFIC DATA
8. PUBLIC AWARENESS
Alcohol and drug treatment for youth is at a turning point, both in California and in the nation as a whole. New treatment methodologies have been designed to address the unique needs of adolescents, giving states the opportunity to create systems of care that address the comprehensive needs of adolescent substance abusers and their families. But in California, two key hurdles prevent adolescents with substance abuse problems from receiving the help they need: the absence of funding for adolescent treatment and the lack of coordination among the agencies and organizations that serve youth.

The little funding that does exist in a complex web of federal and state programs is threatened by California’s severe budget crisis, and no clear resolution is in sight. The majority of youth with substance abuse problems are referred to treatment through the juvenile justice system, which, though better funded than many other youth programs, still cannot meet the need for substance abuse treatment for its wards. The remaining publicly funded treatment programs in the state — some 1,700, of which 400 offer services to youth — struggle with inadequate funding, high employee turnover and rudimentary data collection systems that prevent them from adequately tracking clients’ progress and program effectiveness.

Many different state departments, agencies and organizations have a role in serving adolescents with substance abuse problems. Developing collaborative relationships among these groups would significantly improve treatment access, delivery and quality. Yet bureaucratic hurdles and “turf” tensions make such collaborations virtually nonexistent. The state Department of Alcohol and Drug Programs (ADP) has worked to implement reforms, but has not been empowered by the state or policy makers to affect meaningful change.

In exploring these troubling issues, the Charles and Helen Schwab Foundation joined with the Alcohol and Drug Policy Institute (ADPI) — a group comprised of treatment providers, county alcohol and drug administrators, researchers and educators — to define the state of adolescent substance abuse treatment in California. The foundation then held discussions with ADPI members and other interested parties to create a framework for a better system of adolescent substance abuse treatment.
Eight policy recommendations emerged from these activities, each addressing a different component of an integrated continuum of care for adolescents. We recognize that California’s current budget crisis stresses the need to optimize existing resources. However, we feel strongly that now is the time to bring these recommendations to the table for discussion. Our desire is not to divert funds from existing programs to support these recommendations. Rather, we encourage the state to make these recommendations — and the overarching problem of adolescent substance abuse — high priorities as the budget crisis abates. Nor do we advocate for the creation of more bureaucracy. Instead, we propose collaboration among the agencies and entities that serve youth to ensure that no child in need goes unnoticed.

The first policy recommendation calls for the establishment of a Governor’s Council on Adolescent Substance Abuse, comprised of heads of state departments that work with youth. The challenges of dealing with adolescent substance abuse require high-level intervention, and the Governor’s Council is designed to provide a forum for bringing this critical issue to the highest level of state government. The Governor’s Council will be responsible for the strategic planning, coordination and allocation of state resources for adolescent substance abuse treatment services. It will provide counties with technical and administrative support to implement county-based adolescent drug and alcohol treatment programs. The head of the California Department of Alcohol and Drug Programs is the likely choice to lead this council.

The second policy recommendation proposes that every county develop an integrated treatment system for youth with substance abuse problems. Most treatment services are delivered at the county level, and the greatest opportunities for collaboration and resource sharing exist here. This recommendation calls for counties to assemble a coalition of representatives from publicly funded youth programs to inventory existing county resources and collectively define the components needed to create a streamlined continuum of care for adolescent substance abusers. The coalition will draft an annual plan for adolescent drug and alcohol services in the county, approved by the county board of supervisors. Through the planning process, the county will develop a thorough understanding of its strengths and shortfalls in the area of adolescent substance abuse care, enabling it to develop an annual action plan to maximize funding and meet the needs of its youth more effectively.

The third policy recommendation calls for the adoption and mandated adherence to a set of treatment guidelines developed by the Department of Alcohol and Drug Programs. The ADP’s Youth Treatment Guidelines present specific standards of care for adolescent substance abuse treatment programs, and provide a blueprint for building treatment systems that address the comprehensive needs of adolescents. But despite their clear value, the guidelines have languished for lack of mandate and funding.

Screening and assessment are two critical precursors to appropriate treatment for youth, yet the state and counties have not adopted standardized, proven screening and assessment instruments. The fourth policy recommendation calls on the state to establish specific protocols for the screening and assessment of adolescents with potential drug and alcohol problems. It recommends that adolescents receive periodic screenings in a variety of settings where youth interact — for example, schools, community health organizations and physicians’ offices. Screenings are conducted to identify youth who exhibit signs of a potential drug or alcohol problem. Assessments, performed by health professionals, would provide a diagnosis and a treatment plan to address problems that are identified. It is critically important that counties develop standardized
protocols for the administration of scientifically-based screenings and assessments. Without a proper diagnosis, treatment is compromised.

Inadequate funding presents an array of problems for state and county governments — problems that are likely to persist until economic conditions improve. This situation, however, presents an opportunity to ask government to reassess priorities and create a new and sustainable funding source specifically directed to adolescent substance abuse treatment. The fifth policy recommendation does just that. Currently the state does not have a single funding stream dedicated to adolescent care, yet many opportunities exist to create one. Other states have allocated funds from vanity license plates, marriage licenses, alcohol taxes and lottery winnings to fund adolescent programs. The future well-being of California rests on the shoulders of today’s adolescents. A sustained funding source to help prevent and treat adolescent substance abuse disorders would be money well spent.

The private sector can play an important role in improving access to treatment for California’s youth, primarily through achieving parity for adolescent substance abuse treatment in health insurance coverage. The sixth policy recommendation calls upon the state to mandate that private insurance plans offer substance abuse and mental health coverage equal to coverage that is provided for medical disorders and diseases. Such coverage would cost consumers only $5 per year, while the benefits would be enormous. Parity would reduce pressure on the state budget, and the burden to citizens and businesses. With parity, many more adolescents have access to the treatment they need at a minimal cost while saving lives and dollars.

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The Effects Of Drug Treatment

*Drug abuse can successfully be treated, and the benefits of treatment continue to be seen one year and five years after treatment, as this survey of adults demonstrates. Similar studies confirm these findings in adolescents.*

### One Year After Treatment

<table>
<thead>
<tr>
<th>Illlicit Drug Use Decreased by 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illegal Activity Decreased by 60%</td>
</tr>
<tr>
<td>Drug Selling Fell by Nearly 80%</td>
</tr>
<tr>
<td>Arrests Down by More Than 60%</td>
</tr>
<tr>
<td>Trading Sex for Money or Drugs Down by Nearly 60%</td>
</tr>
<tr>
<td>Homelessness Dropped by 43% and Receipt of Welfare by 11%</td>
</tr>
<tr>
<td>Employment Increased by 20%</td>
</tr>
</tbody>
</table>


### Five Years After Treatment

<table>
<thead>
<tr>
<th>Users Any of Illicit Drugs Reduced by 21%</th>
<th>Numbers Engaging in Illegal Activity Significantly Reduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine Users by 45%</td>
<td>56% Fewer Stealing Cars</td>
</tr>
<tr>
<td>Marijuana Users by 28%</td>
<td>38% Fewer Breaking and Entering</td>
</tr>
<tr>
<td>Crack Users by 17%</td>
<td>30% Fewer Selling Drugs</td>
</tr>
<tr>
<td>Heroin Users by 14%</td>
<td>23% Fewer Victimizing Others</td>
</tr>
<tr>
<td>38% Fewer Injecting Drugs</td>
<td>34% Fewer Homeless</td>
</tr>
</tbody>
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In order to ensure that funding is well-spent, the state needs an accurate measurement and evaluation system to track and monitor the effectiveness of treatment programs. To date, the treatment community has not agreed upon a standardized set of outcome measures, and it is severely limited in its ability to collect and share data on the clients it serves. In response to a federal mandate, California is in the process of developing a database to measure client outcomes. Known as Cal-OMS, this database will collect information on all adults in federally funded drug and alcohol programs in the state to facilitate program evaluation and treatment effectiveness. Although it does not contain fields of specific relevance to adolescents, it provides the only current opportunity for the state to measure the outcomes of adolescents in treatment. The seventh policy recommendation calls for adding adolescent data to Cal-OMS. This would be an important first step in ensuring that the programs to which youth are referred are effective.

One of the primary obstacles to gaining more support for adolescent treatment funding is the underlying issue of stigma. Unfortunately, the stigma attached to substance abuse inhibits many from taking action. Substance abuse is often viewed as an act of moral weakness rather than a disease that progresses from voluntary user to involuntary addict. It is critical that policy makers and the public understand the nature of substance abuse as a public health issue. The eighth and final policy recommendation proposes a public awareness campaign to draw attention to adolescent substance abuse as a serious public health problem with wide-ranging social consequences. Everyone who interacts with youth should be aware of the risk factors that tend to predispose a youth to substance abuse, while recognizing and encouraging the protective factors that prevent youth from abusing drugs and alcohol. Rather than stigmatize the youth who comes forward for treatment, we must address his or her problems with compassion and understanding, knowing where in the community to refer the youth for help.

Research shows that treating an adolescent costs considerably less than incarcerating a youth. Drug use and criminal activity decrease for virtually all who enter treatment — with increasingly better results the longer their stay in treatment. Those who receive treatment show an increase in employment, improved physical health, and improved social and interpersonal skills. It is critical for California to adopt a more cost-effective and medically effective approach to adolescent substance abuse. It is time now for the state and counties to bring their resources to the table — foremost among them, funding and collaboration — to develop an integrated continuum of care for youth through the most intelligent and effective means possible.

Although research on the effectiveness of adolescent substance abuse treatment is a relatively new field, there is significant evidence that treatment is both medically effective and cost-effective. Studies indicate that treatment reduces both drug use and crime by 40% to 60%. According to several conservative estimates, every $1 invested in treatment yields a return of between $4-7 in reduced crime, criminal justice costs and theft. When health care savings are included, total savings can exceed costs by a ratio of 12:1.
Adolescence is a critical juncture on the journey to adulthood, a time when young people test the rules and limits with which they were raised. Many experiment with alcohol and other drugs. For some, this initial experimentation advances to regular use and ultimately escalates into abuse and dependence, with serious consequences not only for the adolescent, but for families and communities as well.

Too often we allow young people to “fail” in this manner and then punish them for their failure. The number one source of referrals to adolescent drug treatment programs in the United States is the juvenile justice system.2 The vast majority of adolescents who receive substance abuse treatment have already been involved with the criminal justice system before it has been determined that they need substance abuse treatment.3 For the good of society and the health of our communities, it is critical to respond to the silent cries for help from youth before their actions escalate into criminal behavior and their future is forever marked by their involvement with drugs and the juvenile justice system.

The most recent findings of Monitoring the Future, an ongoing study of the behaviors, attitudes and values of 8th, 10th and 12th graders in America, show a slowing of declines in alcohol and illicit drug use (which peaked in 1996) among 10th and 12th graders, and a halt of declines in 8th graders’ use of illicit substances other than marijuana.4

Lloyd Johnston, principal investigator of the Monitoring the Future study, observes: "Eighth-graders have been the harbingers of change observed later in the upper grades. The fact that they are no longer showing declines in their use of a number of drugs could mean that the declines … observed in the upper grades also will come to an end soon. One concept … to the understanding of drug epidemics is that of ‘generational forgetting’. Even though one generation … may come to appreciate the hazards of a drug, those young people who follow after them may not possess that knowledge. It is possible that what we are observing with today’s eighth-graders is an early signal that generational forgetting is about to take place again, as it did in the early 1990s.” 5

Substance abuse affects youth across all social, economic and ethnic groups. The National Institute on Drug Abuse has highlighted data demonstrating that,
contrary to stereotypes, overall rates of drug abuse among racial and ethnic minorities are similar to the general population.6

The process of developing a problem with substance abuse or addiction is influenced by many factors, including: genetics; society, family and peer influences; pre-existing mental health disorders; and the addictive properties of the substance being used. Research has shown that, for most children, the vulnerable periods for drug experimentation and use are periods of transition from one developmental stage to another. For example, when children advance from elementary school to middle school or junior high, they face new social challenges, such as learning to get along with a wider group of peers. It is at this stage of early adolescence, generally between the ages of 12 and 13, that children are likely to encounter drug use for the first time.7 Research shows that young people who begin drinking before age 15 are four times more likely to develop alcohol dependence than those who begin drinking at age 21.8 And studies suggest that the younger an individual is at the onset of substance use, the greater the likelihood that a substance abuse disorder will develop and continue into adulthood.

Upon entering high school, many young people face additional social, psychological and educational challenges. These challenges can lead to increased use and abuse of alcohol, tobacco and other drugs. In fact, between the ages of 12 to 20, the rates of past-month use more than double for alcohol and tobacco, and more than triple for marijuana.9 More than 50% of 12th graders have tried an illicit drug, and one in four is a current user.10 When adults go on to college, marry or enter the workforce, they again face risks from alcohol and other drug abuse in their new adult environments. Young adults (ages 18 – 25) are the group most likely to engage in heavy drinking, smoke cigarettes and use illicit drugs.

The risks posed by alcohol and drug use are significant at every transition from late childhood through young adulthood, but they can be mitigated through prevention and early intervention efforts at each stage of a youth’s development.11

Substance abuse wreaks a terrible toll on adolescents. Research shows that 70% of all deaths among youth ages 15-24 can be attributed to three causes: unintended injuries, homicide and suicide.12 The single common denominator among all three causes is the use of alcohol and other drugs. Adolescent substance abuse is associated with motor vehicle crashes, sexual behavior resulting in unwanted or unplanned pregnancies or high-risk HIV infection, and involvement in violence and crime, according to the American Academy of Pediatrics. In addition, there is a strong correlation between adolescent alcohol use and many emotional and
behavioral problems including depression, intentional self-harm, aggressive behaviors, and delinquent behaviors such as fighting, stealing and truancy. As a result, many adolescents with substance abuse problems become involved with the juvenile justice system. Recent studies show that as many as four out of five teens in the juvenile justice system have drug or alcohol problems, yet fewer than 20% have access to substance abuse treatment programs. Another report suggests that each year more than 670,000 young people who are involved with the juvenile justice system meet the diagnostic criteria for one or more alcohol, drug or mental disorders requiring treatment. While the research on adolescent treatment in juvenile justice populations is limited, there is evidence that substance abuse among juvenile offenders can be effectively treated. One study reported a 74% rate of abstinence from substance use among juvenile offenders who completed treatment. Compared to the cost of incarceration, treatment is clearly a more economical alternative.

Alcohol and drug treatment for youth is at a turning point, both in California and in the nation as a whole. Treatment approaches are evolving but more and better services, particularly for adolescents, are needed. Initiatives to improve treatment effectiveness and build collaboration between researchers, providers and government agencies are being developed, but much more remains to be done. The treatment system remains in its infancy. Many existing pro-
Costs Of Substance Abuse

Substance abuse exacts a staggering cost on our national economy. Alcohol and drug abuse cost the nation more than $275 billion a year in health care costs, crime and related expenses.

Economic Costs Of Substance Abuse Are High, 1995

**ALCOHOL ABUSE $166.5 BILLION**

- Illness (46%)
- Deaths (21%)
- Medical (12%)
- Other related Costs (11%)
- Crime (9%)
- Special Conditions (1%)

**DRUG ABUSE $109.9 BILLION**

- Crime (58%)
- Illness (16%)
- Deaths (15%)
- Medical (7%)
- Special Conditions (4%)

Healthcare Costs Of Substance Abuse Top $114 Billion, 1995

**ALCOHOL ABUSE $22.5 BILLION**

- Hospitals (31%)
- Specialty Services and Support (30%)
- Treatment for Fetal Alcohol Syndrome (10%)
- Physician Services (9%)
- Pharmaceuticals (8%)
- Other Health Professionals (5%)
- Nursing Homes (3%)
- Health Insurance Administration (3%)

**DRUG ABUSE $11.9 BILLION**

- Specialty Services and Support (44%)
- Treatment for HIV/AIDS (37%)
- Other Drug-Related Disease Groups (10%)
- Hospitals (6%)
- Health Insurance Administration (3%)

SOURCE: ADAPTED FROM ROBERT WOOD JOHNSON FOUNDATION. SUBSTANCE ABUSE: THE NATION’S NUMBER ONE HEALTH PROBLEM. KEY INDICATORS FOR POLICY UPDATE. FEBRUARY 2001. AVAILABLE WWW.RWJF.ORG
grams fail to effectively address the specific needs of youth and are unable to provide an appropriate level of treatment that supports relapse prevention and aftercare, which are critical to the long-term success of both treatment and the individual.

Policy makers, researchers, state agencies and providers must work together to address the needs of all adolescents, helping them make healthy choices on the road to adulthood. Research shows that every dollar invested in treatment yields $7 in savings related to crime alone. When health care costs are factored into the equation, the savings relating to crime alone approach $12 for every $1 invested in treatment. In today’s budget climate, these statistics are more relevant than ever. We cannot afford not to invest in youth.


1. GOVERNOR’S COUNCIL

2. COUNTY COALITIONS

3. YOUTH TREATMENT GUIDELINES

4. SCREENING AND ASSESSMENT

5. DEDICATED FUNDING

6. HEALTH INSURANCE PARITY

7. ADOLESCENT-SPECIFIC DATA

8. PUBLIC AWARENESS
“While the state has put some resources into drug and alcohol treatment for adults, the treatment needs of adolescents have long been ignored. The state needs to address the needs of these children now, before our failure leads to their long-term addiction and all of the societal problems associated with addiction.”

Wilma Chan, Assemblymember, 16th District, California State Assembly
POLICY RECOMMENDATION 1:
GOVERNOR’S COUNCIL

An adolescent substance abuse council should be appointed by the Governor, and should be comprised of state department heads including but not limited to substance abuse, mental health, education, public health, treatment providers, social services, law enforcement, juvenile justice and probation. The council will be responsible for the strategic planning, coordination and allocation of state resources for adolescent substance abuse treatment services. The council will ensure that a statewide agency is defined and resources allocated to provide counties with technical and administrative support in the development, implementation and evaluation of evidence-based county adolescent alcohol and other drug treatment services.

The state needs to bring together the well-intended but disparate programs and agencies at the state and local level, in prevention, treatment and law enforcement, in the executive, legislative and judicial branches ... This statewide strategy must be focused on reducing alcohol and drug abuse and must employ the most effective prevention, treatment and enforcement tools, with resources directed to where the evidence shows they will do the most good.1

Adolescent substance abuse is a national public health problem with repercussions that are felt in every neighborhood throughout the country. In California alone, it is estimated that over 200,000 young people between the ages of 12 and 17 need help with a substance abuse problem. Yet in 2001, only 10% of these youth received treatment.2 Clearly, more must be done for California’s youth, and the impetus to improve the situation must begin with the highest levels of state government reaching out to form multidisciplinary collaborations among the agencies and organizations that work with youth.

Research on substance abuse has traditionally focused on the problems of adults. In recent years, however, researchers have explored how drug and alcohol use and abuse affects growing minds and bodies. What has emerged from these studies is a clearer understanding of the primary components needed for an effective continuum of care for adolescents with substance abuse problems, from prevention and early intervention through treatment, relapse prevention and aftercare.
We have learned that the most successful programs for adolescents must involve the youth’s family and community, and focus on the whole child — across medical, educational and psychosocial disciplines, and often simultaneously encompassing multiple agencies and environments where youth interact. Research has emphasized the importance of early intervention as a key to preventing a youth’s experimental use of alcohol and drugs from escalating into dependence and addiction.

Currently, the juvenile justice system is the primary conduit to treatment for youth — the point at which most adolescents are referred to treatment programs. We cannot afford to wait until children have committed a crime to provide them help. From a human and economic perspective, it is both more compassionate and cost-effective to employ scientifically proven prevention, early intervention and treatment programs in multiple settings throughout the community, with the goal of giving youth the knowledge and opportunities they need to make healthy choices that will prepare them well for their adult years.

While many embrace this vision for youth, its implementation poses significant challenges because current systems are often fragmented and diverse in their missions. For example, organizations that provide treatment services receive referrals from many different sources, each of which may have different criteria for treatment type and length, and outcome reporting.

While a number of state departments and agencies have a role in the prevention and treatment of adolescent substance abuse, institutional and bureaucratic hurdles often prevent them from working collaboratively. On the county level, many agencies operate in “silos,” preferring to control all aspects of a youth’s care rather than coordinating care with other agencies or organizations that may be better qualified to address a specific need. Characteristics of current funding streams contribute to isolation of expertise and resources. Inadequate and categorical funding prevents agencies and organizations from providing needed services and making the most effective use of the limited resources that are available.

Within the current system, many agencies work with the same youth, but often fail to coordinate their efforts. As a result, youth in their care are subject to inconsistent or incomplete assessments, inappropriate or inadequate treatment, and very little attention paid to aftercare and relapse management. By addressing the issue of adolescent substance abuse collaboratively, with special attention paid to the needs of the whole child, the state can ensure that youth receive intervention and care from the appropriate sources.
SHIELDS for Families, Inc., which provides broad-based services to 700 families affected by substance abuse and child abuse in south central Los Angeles, is an example of overcoming institutional obstacles to effectively blend funding and integrate services. SHIELDS for Families operates 15 programs providing substance abuse treatment, transitional housing, on-site child care, parenting classes, mental health counseling, family counseling, prevention and early intervention for children, physical health assessments, vocational training and job placement assistance, transportation and aftercare services. SHIELDS taps into more than 30 funding sources in order to provide its clients with a full complement of services under one roof. An independent evaluation of the program showed that 65% of clients successfully completed core treatment services. After six months, clients remained drug-free, with improved family relationships and no further involvement with Child Protective Services or the criminal justice system.\(^4\)

It is clear that systemic and institutional obstacles can be overcome, and there are many examples of productive collaboration between California’s state departments on a variety of social concerns. But interagency cooperation does not exist on the issue of adolescent substance abuse treatment. This lack of integration is a chronic concern among county administrators and service providers.\(^5\)

There is precedent for state-mandated collaboration among state departments and agencies to provide services to children in need. Assembly Bill 1741, passed in 1993 and sponsored by Bates, Alpert, Connolly, Moore and Napolitano, established an interagency coordinating council to synchronize various aspects of children’s services. The bill required the coordinating council to develop and implement a five-year pilot program for the integration of various children’s services and funding allocated to designated participating counties.

Similarly, it is imperative that collaboration and coordination of resources around substance abuse treatment services be a priority at the highest level. Every state agency should have a vested interest in the creation of an integrated system of adolescent

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**The Governor’s Council on Adolescent Substance Abuse**

*The Governor’s Council will be comprised of heads of all state departments and programs that deal with youth, including but not limited to:*

- Department of Alcohol and Drug Programs
- Department of Mental Health
- Department of Social Services
- Department of Corrections and California Youth Authority
- Department of Education
- Department of Health Services
- Attorney General’s Office
- County Alcohol and Drug Program Administrators Association of California (CAOPAAC)
- California Association of Alcohol and Drug Program Executives (CAADPE)
- County Probation Departments

The State Department of Alcohol and Drug Programs should assume the lead in recruiting and coordinating council members, as well as advising and advancing the council’s work.
treatment because the ripple effect of additional financial and resource burdens resulting from substance abuse and its consequences have an enormous impact, directly and indirectly, on every other aspect of the social services system.

The state must create the means for youth to find the help they need, and that effort must begin at the highest level of government. The Governor’s Council is designed to provide the leadership needed to enhance the availability and quality of services for youth across the state while working to increase communication across departments and break down barriers to collaboration and treatment. The council’s primary goal will be to provide the infrastructure needed to help counties define, develop and implement a continuum of care that meets the comprehensive needs of every adolescent. The state Department of Alcohol and Drug Programs (ADP) should assume the lead in recruiting and coordinating council members, as well as advising and advancing the council’s work. As the Little Hoover Commission, a bipartisan and independent state agency charged with increasing the efficiency and effectiveness of state programs, stated in its 2003 report, For Our Health and Safety: Joining Forces to Defeat Addiction, “the director of ADP should be given clear authority to assess prevention and treatment efforts and advocate for high quality treatment wherever it occurs.”

Research-Based Best Practices
The state can help counties benefit from the latest research on adolescents by mandating the use of research-based, adolescent-specific guidelines for screening, assessment and provider training to ensure that all adolescents receive the level and intensity of treatment required to address their needs. (The process of assessing substance abuse disorders in adolescents and tailoring age-appropriate intervention is discussed in Policy Recommendation 4: Screening and Assessment.)

Training, Education and Credentialing
There are more than 1,700 publicly funded substance abuse treatment programs in California, 400 of which serve adolescents. Every year, thousands of California youth receive publicly funded services from these programs, the majority of them in outpatient programs. Yet the state does not require outpatient programs for adolescents to adhere to uniform treatment or staff credentialing standards, and it has only limited requirements for residential programs. In fact, the state does not even require criminal background checks on the staff of outpatient treatment facilities, which provide the majority of adolescent treatment in the state.

It is imperative that treatment providers and all staff who interface with youth have the requisite qualifications to deliver effective care. The Governor’s Council, whose members represent a broad spectrum of agencies that interface with adolescents, must develop standardized treatment and outcome protocols, as well as credentialing and criteria for all personnel, to ensure that youth consistently receive quality care from competent staff in a safe environment.

Coordinated Management Information Systems
Agencies and organizations often collect a significant amount of information about the youth they serve, but in the absence of standardized protocols for data collection, it is difficult, if not impossible, to share that information among the agencies and organizations participating in the youth’s care.

The Governor’s Council will work to define standards for data collection and sharing across agencies and disciplines. By making the adolescent the primary focus of data collection efforts, the state — and the agencies and organizations who provide care — will be better able to monitor progress, measure treatment effectiveness and
coordinate aftercare, all of which are critical components of an integrated treatment system.

**Resource Sharing**

In today’s fiscal climate, it is crucial that the state work to maximize the use of existing resources while eliminating duplication of services. The Governor’s Council will work to identify the full range of funding sources available for adolescent substance abuse, encourage agencies and organizations to make effective use of the funds they are allocated, and direct funds to the programs delivering the most effective care.

**Supporting County Efforts**

Because the majority of adolescent substance abuse programs and services are county-based, the Governor’s Council will designate and fund a state agency to assist counties in developing, implementing and evaluating local adolescent substance abuse programs. The council will conduct a yearly review of county plans for adolescent drug and alcohol services, and will produce an annual progress report on its initiatives for the Governor. (Policy Recommendation 2: County Coalitions calls for the creation of county-based coalitions that will develop an annual plan for adolescent substance abuse services in each county.)

In *For Our Health and Safety: Joining Forces to Defeat Addiction*, the Little Hoover Commission recommended the formation of an entity such as the Governor’s Council, saying: “Reducing abuse and addiction needs to be a government-wide fight. While individual drug control programs may be excellent, the overall effort is unfocused and undisciplined. Treatment — clearly one of the best responses — is undervalued and under-used. And the stakes are too high not to honestly measure how well policies are working and then expand, modify or abandon policies based on the evidence. Through a state-wide council, California will have a mechanism to direct resources to the most effective responses.”

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1. GOVERNOR’S COUNCIL

2. COUNTY COALITIONS

3. YOUTH TREATMENT GUIDELINES

4. SCREENING AND ASSESSMENT

5. DEDICATED FUNDING

6. HEALTH INSURANCE PARITY

7. ADOLESCENT-SPECIFIC DATA

8. PUBLIC AWARENESS
“Youth are affected by multiple service systems. Treatment services for youth with co-occurring disorders are fragmented into multiple isolated treatment silos, with no incentive or strategy to work together. Unfortunately, the present state of treatment is to provide unintegrated services, despite the obvious need for integration and collaboration. We need to develop integrated assessments, collaboratives and shared treatment plans for youth so that they can access needed services through multiple entryways.”

Henry Van Oudheusden, MA, MSW
Corporate Director of Pacific Clinics,
Substance Abuse and Mental Health Services
POLICY RECOMMENDATION 2:  
COUNTY COALITIONS  

The state should require every county to develop an evidence-based continuum of care for adolescent alcohol and other drug services, to be approved annually by the county board of supervisors. Each county will establish a coalition with representation from all entities that receive public funds for youth services. Coalition members will collectively define the primary components needed for an integrated system that supports an effective continuum of care. Each county’s board of supervisors will appoint an adolescent substance abuse expert to direct and manage the activities of the coalition.

Recent studies show effective drug and alcohol treatment requires a 'network' of community support for the young person’s success in the community … Most of the successful programs are comprehensive — or what some would call 'ecological': they address the multiple problems of children, youth or families wherever they arise — in the family, the community, the health care and school systems … They tend, insofar as possible, to deal with the roots of those problems, rather than just the symptoms. ¹

Every year, the nation spends $414 billion dealing with the consequences and effects of drug and alcohol abuse. ² In California, the figure approaches $33 billion annually.³ The limited funds available for substance abuse prevention and treatment are delivered to counties, schools and prisons through a fragmented system of more than 15 separate funding streams lacking a central focal point.⁴ Studies show that when agencies collaborate in developing a research-based, integrated system of care, they can maximize their effectiveness while making optimal use of limited resources. Youth are served best when they are provided a streamlined continuum of care, from the first prevention and early intervention efforts through screening, assessment, treatment, relapse prevention and aftercare.

The leadership for building this integrated system of care in each county must come first from the state through the proposed Governor’s Council on Adolescent Substance Abuse (see Policy Recommen-
Policy Recommendation 2: County Coalitions

This council will provide counties with the necessary components to define, develop and implement a comprehensive and integrated treatment system for youth in their communities. Counties, in turn, will create a coalition comprised of publicly funded community agencies and organizations that interface with youth, as well as other interested community organizations such as youth advocacy groups, faith-based organizations and community organizations.

The coalition will develop a comprehensive plan for adolescent substance abuse services in the county, building an integrated system of care that addresses the community’s needs using research-based practices. The coalition also will advocate for a realignment of resources based on priorities, best practices and ways the community can fill the gaps as youth transition from one setting to another (e.g., from treatment back into the community).

Through the process of developing a strategic plan detailing local requirements, counties will be better equipped to advocate for additional resources for funding, treatment, training and education. Smaller counties, which often lack access to the level of resources that are available to larger cities for the effective care of youth, can benefit from this increased collaboration and sharing of resources.

County Coalition

The county coalition will create opportunities for agencies to share information and increase awareness of the strengths and resources of other agencies. It will provide a vehicle through which agencies and organizations can coordinate and streamline services and eliminate duplication of resources, thereby maximizing the use of funding available to the community while enhancing the effectiveness of programs serving youth. The county Alcohol and Other Drugs (AOD) Administrator should assume the lead in recruiting and coordinating coalition members, as well as advising and advancing the coalition’s work. Further, the AOD Administrator should integrate the work of the coalition with that of existing groups in the county if appropriate.
Developing a County Plan for Adolescent Alcohol and Drug Services

Each county in the state will develop an annual plan for the provision of adolescent alcohol and drug services. The plan, approved by the board of supervisors, will define the key components needed to provide an evidence-based continuum of care for adolescents through an assessment of county goals, capabilities, requirements and funding. Through the planning process, the county will develop a thorough understanding of its strengths and shortfalls in the area of adolescent substance abuse care, enabling it to develop an annual action plan to more effectively meet the needs of its youth.

Inventory Existing Capabilities

The coalition will look beyond the traditional substance abuse treatment model to achieve the goal of making adolescent substance abuse treatment a community-wide endeavor, and will take an inventory of the county’s existing capabilities for protecting and caring for youth throughout the continuum of care.

With the collaboration of coalition members, the county will explore existing programs and services available in a broad array of settings, from schools and after-school programs to social service agencies, the juvenile justice system, community activities and treatment programs. The coalition will then be able to identify gaps in the current system, allowing them to develop a more integrated system of care that meets the needs of youth, their families and the community.

Explore Existing Funding Resources

Currently, there is a wide and fragmented array of funding sources available to counties for substance abuse treatment, with limited funds earmarked for adolescent care. Through the broad and diversified experience of its members, the coalition will be able to define funding resources available in the county, whether the funds are designated specifically for adolescent substance abuse services or simply for general programs serving youth. As a unified voice for adolescents, the coalition will be in a position to influence the way in which all funds are disbursed, and work together to use existing funds to maximize their effectiveness from both a medical and an economic perspective.

Standardized and Research-Based Care

By developing an annual plan for the provision of adolescent substance abuse services, counties will have the opportunity to ensure that the needs of adolescents and young adults are matched to appropriate care using standardized and research-based screening and assessment tools, and placement principles such as those developed by the American Society of Addiction Medicine. It will provide treatment in the least restrictive environment appropriate, and will include a periodic evaluation of the youth’s response to treatment, with care or services adjusted as needed.

Creating An Integrated System of Care

Programs that are part of an integrated continuum of care for adolescents must be relevant, developmentally appropriate and meaningful for the youth they serve, as well as for the youth’s family and the community. They must also address each stage of an adolescent’s involvement with alcohol and other drugs.

This requires focusing on prevention and early intervention, to educate youth about making healthy choices as they progress through adolescence. Programs in the next stage in the continuum address the needs of adolescents who are actively using alcohol or other drugs. Age- and setting-appropriate screening and assessment tools must be used to accurately identify these youth. Programs further along the continuum of care serve adolescents who are dependent on drugs or alcohol, and who may have co-occurring mental and substance abuse problems, requiring a more intensive level of treatment. Every
component of the continuum of care must be geared to the specific needs of the adolescent, employing research-based practices to produce measurable outcomes across all agencies involved in the youth’s care.

Barriers to Collaboration
Practitioners and policy makers agree that collaboration and case management are key components in building an integrated system for youth alcohol and other drug treatment. However, achieving the level of interagency collaboration required to create a comprehensive continuum of care historically has proven difficult. For example:

- Partnerships with juvenile justice agencies — the primary source of treatment referrals in California — offer significant benefits to clients in the legal system. However, they reveal conflicts over public safety versus rehabilitative missions. For youth in the juvenile justice system with substance abuse problems, effective rehabilitation and the prevention of recidivism will depend on the extent to which their treatment needs are identified and comprehensively addressed.

- Partnerships with schools, which have 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 reluctance of schools to identify with the problem of adolescent substance abuse pose additional challenges. Yet schools provide the ideal setting for delivering prevention and early intervention programs.

Continuum Of Substance Use, Abuse And Dependence
Most adolescents who experiment with alcohol, tobacco and illicit drugs will not develop a physical dependency. But if experimentation and casual use escalate into frequent and heavier use, they are more likely to develop a chemical dependency.
Partnerships with youth mental health organizations reveal disagreement over different diagnostic criteria and treatment goals for the youth served, and the different paradigms and techniques of care. There is a strong correlation between mental health and substance abuse problems — particularly among youth. Research shows the most effective treatment for co-occurring substance abuse and mental health problems addresses both issues simultaneously. Therefore, it is crucial for substance abuse and mental health to work collaboratively to effectively treat co-occurring disorders.

While these barriers to collaboration are seemingly inevitable in public systems, they are far from insurmountable. And because the majority of substance abuse services for adolescents are administered at the county level, it is essential that each county in the state develop an annual plan to manage the needs of their communities, working across agencies and organizations to create an integrated, comprehensive continuum of care.

Studies show that every dollar invested in treatment yields a return between $4 and $7 in reduced drug-related crime, criminal justice costs and theft. In the context of unrelenting budget crunches and dwindling revenues, it is in the counties’ best interests — now and for the future — to develop an effective system to care for their youth.


3. YOUTH TREATMENT GUIDELINES
POLICY RECOMMENDATION 3:
YOUTH TREATMENT GUIDELINES

The state should adopt and mandate adherence to the California Department of Alcohol and Drug Programs (ADP) Youth Treatment Guidelines for all programs that provide adolescent alcohol and other drug services, regardless of whether or not they receive funding directly from ADP.

California has a pressing need for a coordinated system of treatment services designed specifically for youth with alcohol and other drug problems. The model system will provide multiple and diverse services and treatment approaches to holistically address a youth’s alcohol and other drug-related problems, surround youth with opportunities to succeed, and prevent more severe problems in adulthood. These guidelines are an important part of a long-term effort targeting the youth population with comprehensive and integrated services.¹

As our knowledge of adolescent substance abuse and treatment continues to broaden and deepen, our shortcomings in this field become more pronounced and clear. Currently, only one in 10 adolescents suffering from substance use disorders receives treatment, and of those who do receive treatment, only 25% receive enough.² While it is imperative that we address the lack of treatment availability, we must also analyze the appropriateness of treatment methods.

Until recently, there were few alcohol and drug treatment programs designed specifically for youth in California, and there are few standards of practice or safeguards in place to assure adolescents’ safety while in programs. Existing standards and regulations offer little assistance because they have no specifics related to youth and their unique needs.
At the same time, funding for adolescent treatment exists in small pockets in various agencies but standards do not. An example is group homes that are funded through the Department of Social Services. Nearly all residential treatment services funded for adolescents exist in group homes, over which the state Department of Alcohol and Drug Programs (ADP) has no oversight. This exemplifies a situation in which technically any group could call itself a substance abuse treatment provider and not be held to any level of standards or competency.

As counties and communities have begun to develop new youth programs, the lack of agreed-upon standards and adolescent-focused resources has complicated the issue of coordinating state funds. The Adolescent Alcohol and Drug Treatment and Recovery Program Act, popularly known as “the Baca Bill” after its sponsor, Democratic Assemblyman Joe Baca, was enacted in 1998 to address this problem. The Baca Bill authorized ADP to develop standards and procedures for adolescent treatment.

ADP assembled a Standards Development Workgroup comprised of county alcohol and drug administrators, youth treatment providers and other treatment experts, and representatives from other agencies such as probation, social services and public health. The workgroup, which met between early 2000 and late 2002, has been an important focus of statewide synergy in the development of youth treatment, and the creation of a collaborative network of practitioners and policy makers around the state.

The immediate goal of the workgroup was to identify and document the treatment models and interventions that research has found to be effective with youth. These best practices were included in the guidelines to ensure that youth intervention and treatment services are safe, appropriate and cost-effective.

In 2000, ADP published an initial set of guidelines, which were revised and expanded in 2002. To date, the state has not mandated the use of these guidelines. Informal discussions with a sample of county administrators reveal that few have adopted the guidelines due to the lack of a state mandate and the additional funding required for implementation.

The Youth Treatment Guidelines highlight ways to tailor treatment specifically for youth, and provide guidance to counties and providers in the development and operation of youth treatment services. These guidelines were designed to serve as:

* an educational resource for policy makers and professionals working in youth services systems;
* a guide for the juvenile justice system in choosing and placing youth in effective programs; and,
* a benchmark for counties and treatment programs to establish their own plans for youth alcohol and drug treatment services based on local need.

The guidelines contain detailed recommendations — many of which are echoed in this report — to help treatment providers create an integrated and comprehensive continuum of care that addresses the unique needs of the adolescent substance abuser. The complete text of the Youth Treatment Guidelines can be found at www.adp.ahwnet.gov/RC/pdf/8566.pdf.

Drawing on the extensive professional experience of the Standards Development Workgroup, ADP’s Youth Treatment Guidelines provide a blueprint for building a system that can change lives in communities across the state. The guidelines outline a comprehensive, integrated continuum of care to address the screening, intervention, treatment and aftercare needs of adolescent substance abusers in the state. They also offer the state a standardized tool for evaluating treatment programs. But the guidelines remain a severely
Youth Treatment Guidelines
The youth treatment guidelines developed by the California Department of Alcohol and Drug Programs address the following areas of service and care:

1. GUIDING PRINCIPLES FOR YOUTH TREATMENT
2. TARGET POPULATION
3. OUTCOMES

4. SERVICE COMPONENTS
   A. OUTREACH
   B. SCREENING
   C. INITIAL AND CONTINUING ASSESSMENT
   D. DIAGNOSIS
   E. PLACEMENT
   F. TREATMENT PLANNING
   G. COUNSELING
   H. YOUTH DEVELOPMENT APPROACHES TO TREATMENT
   I. FAMILY INTERVENTIONS AND SUPPORT SYSTEMS
   J. EDUCATIONAL AND VOCATIONAL ACTIVITIES
   K. STRUCTURED RECOVERY RELATED ACTIVITIES
   L. ALCOHOL AND DRUG TESTING
   M. DISCHARGE PLANNING
   N. CONTINUING CARE

5. SERVICE COORDINATION AND COLLABORATION
6. CULTURE AND LANGUAGE
7. HEALTH AND SAFETY ISSUES
8. LEGAL AND ETHICAL ISSUES
9. ADMINISTRATION

SOURCE: CALIFORNIA DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS

neglected resource untapped through lack of funding and the absence of mandates. Only by mandating every adolescent treatment program in the state to adopt and adhere to the guidelines — and providing the funding required to accomplish this — can the state give young people with substance abuse problems the help they need to live productive, fulfilled lives.

2 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. (Available at www.icpsr.umich.edu/SAMHDA/das.html)
1. GOVERNOR’S COUNCIL

2. COUNTY COALITIONS

3. YOUTH TREATMENT GUIDELINES

4. SCREENING AND ASSESSMENT

5. DEDICATED FUNDING

6. HEALTH INSURANCE PARITY

7. ADOLESCENT-SPECIFIC DATA

8. PUBLIC AWARENESS
“There are certain illnesses around which no wall can ever be built high enough to adequately shield our own children without working to shield all children. Adolescent substance abuse is clearly one of those illnesses, and commands this sort of community-wide effort.”

Lonnie R. Bristow, M.D., M.A.C.P.
Former President of the American Medical Association
Member, Physician Leadership on National Drug Policy
POLICY RECOMMENDATION 4: SCREENING AND ASSESSMENT

The state should establish evidence-based standardized screening and assessment protocols for adolescent alcohol and other drug abuse to ensure that periodic screening of at-risk adolescents will occur in a variety of settings where youth interact, including but not limited to schools, public and community health organizations, physicians’ offices, emergency rooms, juvenile justice, child protective services, substance abuse treatment programs and mental health facilities.

Screening and assessment are not neutral or passive procedures. Used intelligently, they can provide vital information, thus contributing to effective care.\(^1\)

Identifying substance abuse problems in adolescents and determining the appropriate level of intervention is a critical component of any effective system of care. It is essential to take a multidisciplinary approach to screening and assessment, working in collaboration with communities and families to ensure that each adolescent’s individual needs are met.

Although sometimes used interchangeably, screening and assessment are two separate processes with progressive degrees of scrutiny that require different levels of training and clinical expertise to administer. As defined here, screening is a type of triage in which the general adolescent population is screened for key indicators, such as those outlined in the CRAFFT screening tool on the following page. It does not require drug testing. Administration of screening tools can be done in a variety of settings and requires a modest level of training. When key indicators are found in a youth, he or she is referred for an assessment, which is administered by a clinician with expertise in substance abuse. The outcome of a clinical assessment is a tailored treatment plan for the individual, which provides a critical link between the identification of the problem and the course of action needed to be taken in response to findings.\(^2\)
While recognizing that budding individuality, risk taking and independence are all part of a young person’s normal development, it is important that adults and peers be aware of adverse behaviors adolescents exhibit that could lead to problems in school, with family and in the community. An adolescent who begins using drugs or alcohol is typically not dependent; the development of a serious clinical substance abuse disorder usually takes place no sooner than a year or two from the commencement of use. Many adolescents who drink, smoke or take illicit drugs will never develop a physical dependency or have negative experiences as a result of using substances. However, heavier, longer-term and more frequent use is likely to result in problems with health, school, work and/or the law. This points to the critical importance of early screening to detect potential problems before they escalate — while, at the same time, taking care not to label or pathologize a young person who has started to use drugs.

Substance abuse screening is critical to the health care of adolescents in light of findings that one-fourth of adolescent medical patients may need at least a brief intervention and one-sixth may need a referral to treatment. When an initial screening indicates that an adolescent may have a substance abuse problem, the youth should be referred to a licensed health care professional for a formal assessment.

In order to successfully identify adolescents who need help, and to provide the care they require, there must be a defined methodology for diagnosing their problems. It is essential to adopt and consistently use standardized, age-appropriate and research-based screening and assessment tools to accurately determine the needs of adolescents. Several well-researched instruments are available, ranging from brief screening tools which can be administered in a few minutes to comprehensive assessment instruments that can take up to three hours.

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**CRAFFT Screening Instrument**

An example of a screening tool that has been shown to be reliable and effective for health care professionals is the CRAFFT questionnaire, which is brief and practical for administration in a health care setting. CRAFFT is a mnemonic device of key words in each of the text’s six questions:

- C: Have you ever ridden in a car driven by someone (including yourself) who was “high” or had been using alcohol or drugs?
- R: Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?
- A: Do you ever use alcohol or drugs while you are by yourself, alone?
- F: Do you ever forget things you did while using alcohol or drugs?
- F: Do your family or friends ever tell you that you should cut down on your drinking or drug use?
- T: Have you ever gotten into trouble while you were using alcohol or drugs?

**Significance Of Age Of First Use**

The earlier a youth begins drinking or using drugs, the more likely he or she is to continue that use as an adult. 45% of adults surveyed who began drinking before the age of 15 continued to drink as adults — nearly twice the rate of those who waited until age 18 or older. Early intervention programs can play a critical role in helping adolescents develop healthy behaviors as adults.

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**Percent With 1+ Past Year Symptoms As An Adult**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Under Age 15</th>
<th>Aged 15-17</th>
<th>Aged 18 or older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Pop. = 176,188,915 OR = 1.9*</td>
<td>34%</td>
<td>23%</td>
<td>45%</td>
</tr>
<tr>
<td>Marijuana Pop. = 176,188,915 OR = 1.9*</td>
<td>51%</td>
<td>41%</td>
<td>63%</td>
</tr>
<tr>
<td>Other Drugs Pop. = 38,997,916 OR = 1.5*</td>
<td>62%</td>
<td>48%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Assessing youth for drug and alcohol involvement is a clinical process, requiring the careful implementation of procedures across a wide range of service systems and providers. Clear and consistent diagnostic criteria are a necessary first step. The state, together with counties and local communities, must develop standardized and evidence-based protocols for identifying at-risk youth and agree upon the use of criteria, such as the American Society of Addiction Medicine’s Patient Placement Criteria, to define the most appropriate level of treatment needed.

The clinical assessment should entail a complete evaluation of the youth’s environment and influences, and should result in a treatment plan that addresses all identified problems, whether they are physical, emotional or psycho-social in nature. In addition, an adolescent assessment instrument must be developmentally appropriate, statistically valid and suitable for use in the various settings in which it may be administered. An instrument’s practicality is also important: it must be easy to conduct, score and remember. Several validated screening and assessment tools are available and it is important to define which one is most effective for a particular setting (e.g., school, health care facility, juvenile justice).

Research indicates that adolescent substance abuse and dependence is often associated with the severity of emotional and behavioral health problems. Therefore, clinical assessments for substance abuse disorders in adolescents should include screening for co-occurring medical and mental health disorders. Disruptive behavior disorders co-exist with substance abuse more often than not. It is thought that this may explain the high prevalence of substance abuse problems in juvenile justice populations, the source of 44% of adolescent treatment referrals nationally. Periodic screening for substance abuse and mental health problems is also imperative throughout a youth’s involvement with the juvenile justice system.
Depression, anxiety disorders, mania, post-traumatic stress disorder and other mental health conditions also appear to be common among adolescents with substance use problems. They also tend to have poorer physical health than adolescents in the general population.

Health care professionals can play an important role in screening, intervening and referring their adolescent patients to substance abuse treatment. The American Medical Association’s Guidelines for Adolescent Preventive Services recommends that all health care professionals ask adolescent patients about their use of alcohol and other drugs on an annual basis. Unfortunately, adherence to this guideline is low. In fact, less than half of physicians report screening all adolescent patients for substance use, and only 5% of all adolescent referrals come from healthcare providers. Often, physicians are treating the acute medical conditions resulting from drug abuse and addiction, rather than recognizing and managing the underlying problem of chemical dependency.

Much of what research has demonstrated about the effectiveness of treatment remains largely underutilized in the medical field and community treatment settings. The Institute of Medicine and its Committee on Community-Based Drug Treatment points out that researchers and clinicians need to communicate more fully with one another. This sentiment is echoed by state and county administrators, who recognize that opportunities for intervention are being missed while youth, and communities in which they live, are paying the price. Clearly, standardized screening and assessments that identify adolescents with substance use and other disorders are needed; effective treatment plans cannot be developed without proper diagnosis.

Virtually all adolescent treatment providers agree that adolescent substance abuse programs must include:

- evidence-based, standardized, adolescent-focused assessment;
- outreach to families, youth, organizations and communities;
- support for the youth’s family through the assignment of a case manager to coordinate the delivery of other services in tandem with those delivered to the youth who is being served; and
- protocols that provide for ongoing re-assessment and “stepped-up” or “stepped down” care to address aftercare and relapse issues.

But despite general agreement with the principles outlined above, few counties to date have successfully implemented them. Countywide screening and referral plans are rare. Instead, counties typically have fragmented referral and placement relationships, often based on criteria of convenience rather than the client’s need. In many cases, the appropriate treatment for youth does not exist within reach. Many county alcohol and drug program administrators report having few if any early intervention programs for youth, sparse outpatient care sites, no intensive outpatient or day treatment, no publicly funded detoxification or crisis intervention, and no local residential treatment for those unable to remain at home.

In addition, few counties have community-based youth alcohol and drug services at any of these levels that are culturally appropriate to the diverse backgrounds of the youth they serve. By standardizing the criteria through which youth are admitted to treatment, it is hoped that counties — and the state as a whole — will collaborate to provide treatment options that meet the unique needs of every adolescent.

Identifying youth with possible substance abuse disorders is a community effort. Every adult who
interacts with youth in a familial or professional capacity should understand the warning signs that indicate a substance abuse problem, be aware of risk-identified behavior, and know where in the community to send a youth for a clinical assessment and referral to appropriate treatment. To miss the warning signs of a child in need is to dismiss his or her potential. It is the responsibility of every member of the community to ensure that its youth are safe, secure, healthy and free to seek whatever help they may need to build a successful future. And it is the responsibility of the state to ensure that treatment is available to them. Without a comprehensive, integrated treatment network in place, screening and assessment will result in youth identified with substance abuse problems but no where to turn for help.


1. GOVERNOR’S COUNCIL
2. COUNTY COALITIONS
3. YOUTH TREATMENT GUIDELINES
4. SCREENING AND ASSESSMENT
5. DEDICATED FUNDING
6. HEALTH INSURANCE PARITY
7. ADOLESCENT-SPECIFIC DATA
8. PUBLIC AWARENESS
For many years the California State PTA has advocated for comprehensive school community drug abuse prevention programs and has encouraged the availability of good counseling and other support services in response to youth substance abuse and underage drinking. The California State PTA believes that it is time to advocate for compassionate responses to student substance abuse by promoting the many extracurricular, after-school and prevention programs that increase the connectedness of troubled and at-risk students to their schools and thereby strengthen their chances for success.

Carla Nino, President, California State PTA
The state should establish a new and sustainable funding source specifically dedicated to adolescent substance abuse treatment.

The choice for governors and state legislators is this: either continue to tax their constituents for funds to shovel up the wreckage of alcohol, drug and nicotine abuse and addiction or recast their priorities to focus on preventing and treating such abuse and addiction.1

Investing in adolescent drug and alcohol intervention and treatment programs is money well spent, as many studies have demonstrated. With an integrated continuum of care for substance abuse treatment, the state could save millions of dollars every year in substance abuse-related expenses such as crime and health care. However, in California’s current budget crisis, the money to fund such programs simply does not exist. In the meantime, young people continue to suffer the effects of substance abuse, and the state as a whole pays the price. When the budget crisis is resolved and funds are once again available, it is critically important that adolescent substance abuse be placed first in the funding queue. The potential cost-savings are too great for the state to ignore or neglect.

The current funding system is in need of reform, as well. Alcohol and drug treatment in the state is funded through a collection of disparate funding streams. The majority of funds are allocated for specific populations. These funds, called “set asides,” have the advantage of ensuring that money is available to address the needs of certain groups. However, there is no set aside for adolescent drug and alcohol treatment. As
a result, treatment programs that serve youth must cobble together funding from a variety of sources — a complex, inefficient and expensive process. One of the largest set asides funds the criminal justice system. Of the $414.7 million in state General Fund expenditures for treatment, 62% goes specifically toward treatment in the criminal justice system. Despite this, treatment within the prison system still is limited compared to the need for treatment that exists. However, treatment outside of the criminal justice system is even more limited, especially for youth, whose substance abuse problems present a much more expensive long-term public liability.

Of the $733.4 million available for substance abuse treatment in the state in 2001-02, only $159.3 million was available for the general population. This categorical funding creates a host of problems for treatment providers, including difficulty in treating clients with co-occurring disorders and/or those who need to access resources from more than one state agency at the same time. It also creates potential conflicts between federal and state categories and local needs. Perhaps the greatest drawback of categorical funding is that it does not necessarily address the needs of those whose drug dependence impose the highest human and economic costs.

The California Department of Alcohol and Drug Programs (ADP) administers public funds directly earmarked for alcohol and drug treatment, working in partnership with county governments, private and public agencies, organizations, groups and individuals. ADP draws funding from the federal Substance Abuse Prevention and Treatment block grant; the state general fund for designated programs; federal and state portions of Drug Medi-Cal costs; and other special programs.

With such a complex web of funding sources, it is critical that the state allocate resources strategically in order to make more funds available for treatment programs designed for adolescents with substance abuse

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**Comparative Costs And Outcomes: California Youth Authority (CYA) vs Treatment**

California could save millions of dollars annually by providing treatment to adolescents with substance abuse problems rather than incarcerating them. The cost of one year’s incarceration could fund treatment for 26 youth, and the benefits to the state would be dramatic: 9 out of 10 CYA wards resume a life of crime, while relapse rates for youth who receive treatment can be as low as 11%.

<table>
<thead>
<tr>
<th>Percent of CYA wards with substance abuse problem</th>
<th>Annual cost to incarcerate one child in CYA</th>
<th>Average cost of outpatient substance abuse treatment for one child</th>
<th>Recidivism rate of CYA wards</th>
<th>Average relapse rate after treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>65%</td>
<td>$80,000</td>
<td>$3,000</td>
<td>91%</td>
<td>11%</td>
</tr>
</tbody>
</table>

**Sources:**

1. Center on Juvenile & Criminal Justice. Aftercare as afterthought: Re-entry and the California Youth Authority
2. Assessment of the Mental Health System of the California Youth Authority. Report to Governor Gray Davis. December 2001
3. Center on Juvenile & Criminal Justice. Aftercare as afterthought: Re-entry and the California Youth Authority
4. Reclaiming Futures: The Problem. The Cost
5. Center on Juvenile and Criminal Justice. Reforming the Juvenile Justice System
problems. The Little Hoover Commission report, *For Our Health and Safety: Joining Forces to Defeat Addiction*, published in March 2003, outlines several strategies that would allow the state to make better use of public and private sector funds available for drug treatment, including those summarized below.\(^6\)

1. **Make the Most of Available Funds**
   The state and counties should ensure that they are using all available matching funds to leverage federal dollars, including Medi-Cal, Early Periodic Screening, Diagnosis and Treatment (EPSDT), Healthy Families, Social Security and Social Security Disability, and federal foster care funds. The state also should explore the possibility of a federal waiver on the use of Title IV-E foster care funds for alcohol and other drug treatment.

2. **Identify New Sources of Revenue**
   While maximizing current funding sources, it is imperative that the state explore ways to generate ongoing, sustained revenue for adolescent treatment from reliable sources. Such revenue must not “rob Peter to pay Paul” by diverting funding from other vital services. California can learn from the experience of other states that levy taxes on luxury items, marriage licenses, vanity license plates, lottery earnings and alcohol sales to fund youth substance abuse treatment.

3. **Increase Private Sector Involvement**
   Health insurance plans typically provide coverage for mental health and substance abuse at a significantly lower reimbursement rate than other health conditions. By mandating insurers to cover those conditions at the same rate as (in parity with) other health problems, much of the burden on state funds would be alleviated. The issue of parity is discussed in detail in Policy Recommendation 6: Health Insurance Parity.

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**Funding Sources in California**

Funding of youth substance abuse treatment programs in California is complex and, in many cases, predicated on other programs, conditions and prerequisites. The funding streams identified in the accompanying box are a handful of state and federal categorical funding mechanisms in which financial support for alcohol and other drug treatment theoretically might be available. However, in most cases these funds are fully allocated, and if they are used for treatment they must be diverted from another service.

While we can try to maximize other funding sources, that alone doesn’t address the basic problem that *there is no dedicated funding for adolescent substance abuse treatment*. Without funding, policy recommendations are pointless, proposed mandates are meaningless, additional responsibilities for state and county agencies are impossible, and the opportunity to help hundreds of thousands of California youth get back on track is lost.
Adolescent substance abuse wreaks havoc on families and communities across California every day, and costs our state a staggering $32.7 billion annually in lost productivity, crime, health care and treatment costs. Its greatest toll, however, is levied on our future and the youth who are robbed of the chance for a meaningful and fulfilling life. Ironically, the cost of treatment is a tiny percentage of the total annual expenditure, yet an investment in treatment produces remarkable returns: every $1 spent on treatment yields savings of $7 in crime-related costs.

It is imperative that California make a serious commitment to funding adolescent substance abuse prevention and treatment services, marshalling the resources to address this critical social and public health problem so that every child has the opportunity to live a life free of addiction and its consequences.

3 Ibid.
4 Ibid.
5 Ibid.
6 Ibid.
1. GOVERNOR’S COUNCIL

2. COUNTY COALITIONS

3. YOUTH TREATMENT GUIDELINES

4. SCREENING AND ASSESSMENT

5. DEDICATED FUNDING

6. HEALTH INSURANCE PARITY

7. ADOLESCENT-SPECIFIC DATA

8. PUBLIC AWARENESS
POLICY RECOMMENDATION 1:  
GOVERNOR'S COUNCIL

An adolescent substance abuse council should be appointed by the Governor, and should be comprised of state department heads including but not limited to substance abuse, mental health, education, public health, treatment providers, social services, law enforcement, juvenile justice and probation. The council will be responsible for the strategic planning, coordination and allocation of state resources for adolescent substance abuse treatment services. The council will ensure that a statewide agency is defined and resources allocated to provide counties with technical and administrative support in the development, implementation and evaluation of evidence-based county adolescent alcohol and other drug treatment services.

POLICY RECOMMENDATION 6:  
HEALTH INSURANCE PARITY

The state should mandate that health insurance plans provide coverage for adolescent substance abuse treatment equal to (in parity with) coverage provided for other physical disorders and diseases.

Parity creates a level playing field for all insurers and provides adequate risk-sharing over a large population to minimize any premium increase due to the claims experience of any one group.¹

Health insurance is a strong predictor of whether or not an adolescent will receive needed health care services. However, having health insurance does not necessarily ensure that an adolescent will receive the treatment he or she needs. Even adolescents who have access to health care — either through private or public insurance — are not receiving adequate treatment. The Center for Substance Abuse Treatment estimates that one in 10 adolescents who needs substance abuse treatment receives it, and of those who do receive treatment, only 25% receive enough.²

Over the past decade, inadequate insurance coverage for substance abuse services, low rates of reimbursement and managed care regulations have resulted in a decrease in access to substance abuse treatment.³ Sources of funding are fragmented and complicated, and vary greatly by the source of insurance coverage and geographic area. From 1987 to 1997, private funding for substance abuse treatment (from private insurance, out-of-pocket and charitable sources) was outpaced by inflation and grew much more slowly than for health care expenditures generally.⁴

In addition, the role of managed care in the U.S. health care system has expanded rapidly in the past decade and there is increasing concern about its effect on substance abuse treatment.⁵ It is certain that
failure to address the increasingly serious issue of financing substance abuse treatment for our nation’s youth will result in long-term physical health, mental health, economic and social consequences.

Health plans and third-party payers typically provide less extensive coverage for substance abuse treatment than for general medical services. Some insurance companies provide no benefits for treatment services. Requiring private insurers to provide coverage for substance abuse treatment equal to (in “parity” with) coverage for other physical disorders and diseases would improve access to treatment and reduce the cost burden on the public sector. Increasing private insurance coverage would also stimulate private sector development of treatment programs, medications and protocols, which are discouraged economically in the current system. Until 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 alcohol and drug treatment needs of youth.6

In recent years, legislative activity designed to introduce parity in insurance coverage for mental health and substance abuse treatment has experienced a resurgence.7 The 1996 Mental Health Parity Act requires health plans to provide the same annual and lifetime benefits for mental health as are already guaranteed for other aspects of health care. However, to date, no equivalent federal bill has been passed for substance abuse benefits even though the cost of providing parity for substance abuse treatment is one-eighth that of mental health costs.8

A landmark initiative to provide mental health benefits to federal employees did include substance abuse coverage. On June 7, 1999, President Clinton directed the Office of Personnel Management to achieve parity for mental health and substance abuse coverage in the Federal Employees Health Benefits Program (FEHBP) by 2001. Clinton noted that the FEHBP’s action could serve as a model for other employers and insurance providers.9

As of mid-2002, 33 states had enacted parity laws. Of these, 19 required full parity for mental health and substance abuse. Thirty-one states have identified substance abuse as a priority issue for the 2004 legislative session. In 1999, California enacted a partial parity law, Assembly Bill 88 sponsored by Thomson, which excludes substance abuse from the mandated offering of mental health benefits. The legislation requires alcohol (but not drug) abuse treatment, and applies only to group insurance policies.

One of the primary arguments against providing parity for the treatment of substance-related disorders is the fear that the cost to third-party payers will be too high.10 Few seem to question the benefits of providing treatment for drug addiction, especially given extensive scientific evidence in its favor. However, many people doubt the

“Although treatment of alcoholism and drug addiction compares favorably with that of other chronic recurring disorders, many insurers have not yet granted equal status to this health issue. Treating—and covering—substance use disorders, rather than only relieving the symptoms of related conditions like liver disease or injuries, is in the interests of insurers, employers, medical providers and patients.”

JOIN TOGETHER (WWW.JOINTOGETHER.ORG), FUNDED BY THE ROBERT WOOD JOHNSON FOUNDATION AND THE BOSTON UNIVERSITY SCHOOL OF PUBLIC HEALTH
practicality of requiring insurance providers to cover the costs of substance abuse treatment.

In fact, parity costs very little to implement, and its benefits to individuals, employers and society are significant. A study conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that offering full parity for substance abuse treatment would increase insurance premiums by only 0.2%. A study by the RAND Corporation concluded that adding substance abuse parity to a plan with no substance abuse benefits would increase costs by 0.3%, and providing unlimited benefits would increase costs by approximately $5 per member per year.

Mandating parity would not place an undue burden on businesses that offer health insurance to their employees because, generally, small businesses of fewer than 25 or 50 employees are exempt from state parity mandates, as are companies that self-insure health benefits.

Ensuring Solutions to Alcohol Problems, a national initiative sponsored by George Washington University and funded by the Pew Charitable Trust, provides research-based resources to help curb the avoidable health care and other costs associated with alcohol use. Recently, Ensuring Solutions examined 11 state studies on parity, including California. Their analysis shows that:

- Equitable coverage reduces pressures on financially distressed states’ budgets (and the tax burden to states’ citizens and businesses). Oregon, for example, found the state saves $5.62 in tax-supported health, corrections and welfare costs for every state dollar spent on people who complete treatment.

- Parity increases the number of people who receive treatment, thereby reducing their long-term cost to the state. In addition, more get treatment as outpatients rather than inpatients, while the length of more expensive hospital stays is sharply reduced.

- The benefits of mandatory employment-based insurance parity are substantial. A North Carolina legislative report concludes: “Studies from several states have consistently shown that appropriate treatment of chemical dependency results in a significant reduction in medical claims, absenteeism and disability; an increase in productivity; and a healthier and safer environment for all employees.”

- According to a PricewaterhouseCoopers actuarial analysis, the cost of parity to individual businesses goes down sharply when all or most businesses in a state are required to have equal coverage.

SAMSHA researchers have also analyzed a number of states with parity laws. They concluded:

- Most state parity laws are limited in scope or application and few address substance abuse treatment. Many exempt small employers from participation.

- State parity laws have had a small effect on premiums. Cost increases have been lowest in systems...
with tightly managed care and generous baseline benefits.

- Employers have not avoided parity laws by becoming self-insured, and they do not tend to pass on the costs of parity to employees. The low cost of adopting parity allows employers to keep employee health care contributions at the same pre-parity level.
- Costs have not shifted from the public to private sector. Most people who receive publicly funded services are not privately insured.18

Several major political and professional organizations have published statements of support for parity legislation. The Office of National Drug Control Policy cited four major reasons for its support of parity:

1. Parity will help to close the treatment gap.
2. Parity will correct discrimination.
3. Parity is affordable.
4. Parity will reduce the overall burden of substance abuse to society.19

Vermont implemented the nation’s most comprehensive parity law in 1998, extending equal coverage to both mental health and substance abuse services. An evaluation was conducted to determine the law’s effects on employers, health plans, providers and consumers. The evaluation found that in the first two years after the parity law took effect, mental health and addiction treatment spending dropped by 8% to 18%.20

“Parity did not result in changes in the availability of employer-sponsored insurance in Vermont, as some had predicted, largely because the costs attributed to parity were small,” according to a synopsis by Margo Rosenbach, co-author of the study.

The consequences of substance abuse cost the nation billions of dollars annually. Substance abusers are among the highest-cost users of medical care in the U.S., although only 5% to 10% of those costs are directly related to addiction treatment. In California alone, 96 cents of every dollar spent on substance abuse is used to pay for the havoc wreaked on public programs such as juvenile justice, public safety and family assistance.

California State Taxes And Substance Abuse
Substance abuse places an enormous financial burden on the state budget, and the majority of funds are used to deal with its negative consequences. Although treatment has been proven to be effective, California spends only 4¢ of every substance abuse dollar on treatment programs.

However, once the substance abuser receives treatment, his or her utilization of health care services drops dramatically, eventually reaching the same level of use as others in the general population.21 Mandating parity in insurance benefits will significantly improve access to treatment, save the state millions of dollars annually, and enhance the quality of life for our youth and the communities we live in — at a cost of pennies a day.
1 Curley, B. Parity is cheap, but must be mandated – and enforced. Join Together Online. November 2003. (Available at www.jointogether.org)


4 Ibid.


11 Substance Abuse and Mental Health Services Administration. The costs and effects of parity for substance abuse insurance benefits. 1998.

12 Ibid.


18 Substance Abuse and Mental Health Services Administration. The costs and effects of parity for substance abuse insurance benefits. 1998.


1. GOVERNOR’S COUNCIL

2. COUNTY COALITIONS

3. YOUTH TREATMENT GUIDELINES

4. SCREENING AND ASSESSMENT

5. DEDICATED FUNDING

6. HEALTH INSURANCE PARITY

7. ADOLESCENT-SPECIFIC DATA

8. PUBLIC AWARENESS
POLICY RECOMMENDATION 7: ADOLESCENT-SPECIFIC DATA

The state should mandate the inclusion of adolescent-specific data in the California Outcome Measuring System (Cal-OMS) database to ensure that comprehensive data are collected on every adolescent who enters substance abuse treatment in the state.

Community leaders should advocate for the development of comprehensive, results-oriented treatment systems by holding institutions accountable for improving treatment quality and assuring collection of local data to feed [into] results management systems.¹

The ability to collect, analyze and share data on clients and program performance is an important component of effective substance abuse treatment programs. Uniform, consistent, accurate and current information on clients in treatment is essential to providing appropriate care and case management across all agencies and organizations involved in the treatment delivery.

Data collection is also an important tool in assessing client outcomes — how well clients are faring in treatment — as well as a means to evaluate treatment program effectiveness. Recent studies have suggested that program funding should be tied to program effectiveness, yet it was noted that the infrastructure needed to support program evaluations is sorely lacking both nationally and in most states.²

Unfortunately, there is a lack of standardized protocols for measuring treatment program quality. Retention rates and length of stay in treatment are the two factors most commonly used to assess performance.³ Without comprehensive data, decisions are more likely to be guided by opinion and ideology than by knowledge and performance.⁴ As the primary purchaser of treatment services, the state has tremendous leverage to set quality standards and encourage providers to strive for continuous improvement by linking pay to performance.⁵
Currently, the only data on youth admitted to drug and alcohol treatment programs in the state is maintained in a database called the California Alcohol and Drug Data System (CADDS). CADDS was designed primarily for the collection of data on adults, rather than youth. In addition, it does not track individual clients, but instead tracks admissions to treatment programs — resulting in incomplete and often misleading data that lacks key indicators of a client’s progress in treatment.

CADDS is maintained by the Department of Alcohol and Drug Programs (ADP) and used by county alcohol and drug program administrators and county-contracted treatment providers. The programs most likely to report to CADDS are those that are regulated by and receive treatment program funding through ADP and county alcohol and drug program administrations. Historically this has been a network that serves adults, consisting of a majority of outpatient clinic programs and a smaller number of residential programs that are licensed to admit only adults (although a few have received waivers to admit a very small number of youth).

Other alcohol and drug treatment programs, with different primary funding sources and regulatory oversight — including many of those who provide services to youth — are currently less likely to report to CADDS. These include school-based programs, which historically have provided prevention programs and are now expanding to offer treatment; social service-funded foster care group homes that provide alcohol and drug services primarily to probation-referred youth; and programs in juvenile justice institutions, juvenile drug courts or community-based probation settings. Because of the limitations of the CADDS data, it cannot provide the state and counties the information needed to track youth throughout treatment and aftercare, and it is considered insufficient for use in evaluating the effectiveness of adolescent treatment programs.

In 2000, the federal government mandated agencies and organizations that receive federal funds through block grants from the Substance Abuse and Mental Health Services Administration to collect data in “core” indicator areas, and to assess their performance against negotiated objectives or targets. In response to this mandate, ADP is developing the California Outcome Measuring System (Cal-OMS) database. Eventually, Cal-OMS is expected to collect data on all adults in publicly funded alcohol and drug treatment programs in the state, including outpatient, residential, detoxification and early intervention programs. Cal-OMS is designed to facilitate program evaluation by collecting data on measures such as client alcohol and drug use, changes in a client’s employment status, and involvement with the criminal justice system.

While Cal-OMS shows promise in improving the quality and effectiveness of alcohol and drug treatment programs for adults in California, there is a critical need for a similar undertaking for the thousands of adolescents who suffer from substance abuse problems. At this time, there are no plans to include youth data in Cal-OMS, or to include assessment and outcome treatment measures that
are appropriate to youth at either the national or state levels. Yet research has shown that this data is a crucial element of an effective and integrated continuum of care for adolescents with substance abuse problems. In order to deliver effective intervention, treatment and aftercare, the state and counties need to be able to monitor a youth’s progress across agencies and organizations; over time; throughout different levels of treatment and care; and as they transition back into their school and family lives.

It is evident that the state and counties must have access to reliable, adolescent-specific data in order to ensure that the most effective treatment is being provided. This data will provide the critical information needed to develop and implement best practices for adolescent substance abuse treatment. Without this information, it is not possible to meet the needs of adolescent substance abusers or cost-effectively manage the limited resources available to care for them. Adding adolescent data to Cal-OMS is an important first step in addressing this critical need.


3 Ibid.

4 Ibid.

5 Ibid.
1. GOVERNOR’S COUNCIL

2. COUNTY COALITIONS

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5. DEDICATED FUNDING

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8. PUBLIC AWARENESS
Once an adolescent finds he or she is unable to stop using without help, then treatment should be provided on demand and in a safe environment. The stigma on seeking help must be erased so that teenagers can get the treatment they need. We need to identify children who are at risk for addiction at a much earlier age and provide the interventions they will need to avoid alcohol and other drugs.”

The Honorable Judge Peggy Hora
Alameda County Superior Court
POLICY RECOMMENDATION 8:
PUBLIC AWARENESS

The state should sponsor a public information campaign to increase awareness of adolescent substance abuse as a public health problem that affects every community throughout the state.

Because of the wealth of scientific research that we have amassed, we have a tremendous opportunity to try to change the way in which the public sees and talks about drug abuse and addiction. Overcoming misconceptions and replacing ideology with scientific knowledge is our best hope for bridging the great disconnect and bringing the full power of science to bear on the problem of drug abuse and addiction.¹

Many people view substance abuse as strictly a social problem. There is a tendency to characterize people who take drugs and drink excessively as morally weak, undisciplined or criminally inclined. Many believe that substance abusers and addicts should be able to stop drinking or taking drugs simply by changing their behavior or by “just saying no.” These myths have not only stereotyped those with substance abuse problems, but also their families, their communities and the health care community who works with them. Substance abuse and drug addiction are public health problems that have wide-ranging social consequences. It is time to replace these myths about substance abuse and drug addiction with the truth: chemical dependency is a disease that responds well to treatment.²

Addiction does not begin the first time a young person drinks alcohol or experiments with drugs. In fact, the majority of young people across the country experiment with alcohol and drugs at least once in their youth. Research has shown that 70% of all
12th graders have experimented with alcohol, and over half have used illicit drugs. Girls are just as likely as boys to experiment with drugs and alcohol, and students in suburbia drink and use illegal drugs just as often as their counterparts in urban schools. However, most will not develop an addiction to alcohol or illicit drugs. Understanding the dividing line between adolescents who experiment and those who develop substance use disorders is a critical part of dealing with the problem.

In recent years, scientists have made great strides in understanding the physiology of addiction and dependence, and its destructive physiological effects on adolescents. Research has shown that while initial drug or alcohol use is clearly voluntary, addiction to or dependence on a substance is a chronic, relapsing disease in which brain chemistry becomes altered. Thus, the voluntary user may become the involuntary addict. As users progress through the severity continuum, the role of volition, or voluntary involvement with drugs, drastically declines. This means that society, which is relatively tolerant in its attitude toward teen experimentation, tends to condemn an individual’s drug involvement just at the stage when it is no longer a question of “knowing better.” The notion that motivation alone is all that is required to change substance-abusing behavior grossly underestimates the multiple determinants of abuse and addiction.

Scientists have also made important discoveries about the conditions that predispose youth to substance abuse and addiction (“risk factors”) — as well as the qualities that help young people make healthy choices that will serve them well for the future (“protective factors”). Researchers have identified the primary targets for preventive intervention: family and peer relationships, and school and community environments. It is our responsibility to put this knowledge to work in order to give every child a chance for a healthy, productive and fulfilling future.

Despite growing scientific consensus that drug and alcohol abuse cause chemical changes in the brain, with particularly serious consequences for young people, the public continues to stigmatize young people with drug and alcohol disorders. Instead, communities should embrace this problem and work together to eradicate the abuse and treat the abusers.

The evolving public response to the AIDS crisis in our country offers a relevant example of de-stigmatizing a serious public health threat and shifting public focus from negative judgment to altruistic assistance. In 

<table>
<thead>
<tr>
<th>RISK FACTORS</th>
<th>PROTECTIVE FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chaotic home environment</td>
<td>Strong bonds with the family, school, religious organizations</td>
</tr>
<tr>
<td>Ineffective parenting</td>
<td>Active parental monitoring with clear rules of conduct</td>
</tr>
<tr>
<td>Lack of mutual attachments and nurturing</td>
<td>Success in school</td>
</tr>
<tr>
<td>Inappropriate behavior in the classroom</td>
<td>Social skills and friends</td>
</tr>
<tr>
<td>Low commitment to school</td>
<td>Problem-solving skills and resilience</td>
</tr>
<tr>
<td>Peer rejection</td>
<td>Sense of purpose and future</td>
</tr>
<tr>
<td>Association with drug-using peers</td>
<td>High expectations (of self, by parents, in school)</td>
</tr>
<tr>
<td>Alienation and rebelliousness</td>
<td>Participation in family, school and community activities</td>
</tr>
</tbody>
</table>

the early years of the epidemic, AIDS was viewed as a moral issue: those who had the disease were largely shunned by the public and stigmatized for their sexuality or intravenous drug use. Yet through educational efforts like the one undertaken in New York City in the 1990s, AIDS has come to be recognized as a public health concern rather than a moral issue.

In 1990, no school system in the country had a comprehensive AIDS prevention education program in place, despite staggering rates of teen pregnancy and sexually transmitted diseases (STDs), as well as evidence that many of those who were infected with HIV had acquired the virus as teenagers. School districts and their leaders were unwilling to acknowledge the fact that students were engaging in behaviors that were putting them at risk of HIV infection.

The New York City public school system developed a comprehensive school-based AIDS prevention program that included condom availability at the high school level. Initially, opponents of the proposal framed adolescent sexuality as a moral issue and called upon the school district to emphasize abstinence over education or condom availability. The school district ultimately was able to make the case that the greatest moral imperative was to save the lives of children. The resulting prevention program, evaluated over a three-year period, was found to be effective at reducing rates of pregnancy and STD infection, and at reducing rates of sexual activity among adolescents. It has since been adopted by school districts across the country.

In order to solve the pervasive problem of adolescent substance abuse, we must approach it with the same vigor and candor that characterized early AIDS education. The California Department of Drug and Alcohol Programs (ADP) has an active educational outreach program. The ADP web site lists 225 downloadable publications. In 2003, ADP distributed 700,000 fact sheets and other materials, and the agency fielded 37,000 phone calls. Clearly the public is hungry for information. An educational public awareness campaign could complement the work of ADP and enhance its outreach exponentially. Until the public understands the prevalence and consequences of substance abuse, young people caught in its grip will continue to struggle alone, afraid to seek the help they need.


3 Ibid.


1. GOVERNOR’S COUNCIL

2. COUNTY COALITIONS

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ADDITIONAL RESOURCES
NATIONAL
American Academy of Pediatrics (AAP)
www.aap.org
The AAP’s Substance Abuse: A Guide for Health Professionals covers risk and protective factors; the role of primary care physicians; prevention, screening and intervention; and assessment, diagnosis, referral and treatment of substance problems.

Center on Addiction and Substance Abuse (CASA)
www.casacolumbia.org
CASA at Columbia University does extensive work on the social and economic costs of substance abuse, as well as effective prevention, treatment, and law enforcement strategies.

Center for Substance Abuse Prevention (CSAP)
www.samhsa.gov/centers/csap
CSAP, a division of the Substance Abuse and Mental Health Services Administration, is the sole federal agency responsible for improving the accessibility and quality of substance abuse prevention services.

Center for Substance Abuse Treatment (CSAT)
www.samhsa.gov/centers/csat2002/
CSAT, a division of the Substance Abuse and Mental Health Services Administration, works to expand the availability of effective treatment and recovery services for alcohol and drug problems.

Charles and Helen Schwab Foundation
www.schwabfoundation.org
The foundation’s Substance Abuse Program focuses on building treatment provider capacity and expanding access to adolescent substance abuse treatment. Its publications include the BEST Planning and Assessment Guide, a guide to building service providers’ capacity.

Criminal/Juvenile Justice Treatment Networks (CJJTN)
www.cjnetwork.org
CJJTN is funded by the Center for Substance Abuse Treatment to increase access to substance abuse treatment by focusing on systems integration and information-sharing across agencies.

Drug Strategies
www.drugstrategies.org
Drug Strategies is a nonprofit research institute that promotes more effective approaches to the nation’s drug problems.

Join Together
www.jointogether.org
Join Together is a national organization of community coalitions that provide educational resources and data on substance abuse and gun violence.

Monitoring the Future
www.monitoringthefuture.org
Monitoring the Future is an ongoing study of the behaviors, attitudes and values of America’s adolescents and young adults.

National Clearinghouse for Alcohol and Drug Information (NCADI)
www.health.org
As the information service of the Substance Abuse and Mental Health Services Administration, NCADI is the nation’s largest resource for current information and materials on substance abuse.

National Household Survey on Drug Abuse
www.samhsa.gov/oas/nhsda.htm
This survey, conducted by the Substance Abuse and Mental Health Services Administration, is the primary source of information on the prevalence, patterns and consequences of drug and alcohol use and abuse in the American public, ages 12 and older.
### National Institute on Drug Abuse (NIDA)
www.nida.nih.gov
NIDA is a division of the National Institutes of Health whose mission is to bring the power of science to bear on drug abuse and addiction.

### National Mental Health Association (NMHA)
www.nmha.org
NMHA is a national, state, and local advocate for policy and program development that provides comprehensive systems of care for all children and adolescents at risk for mental health, substance use and co-occurring disorders.

### Physician Leadership on National Drug Policy (PLNDP)
www.plndp.org
PLNDP is a group of nationally acclaimed physicians who promote a public health approach to addiction and substance abuse.

### Reclaiming Futures
www.reclaimingfutures.org
Reclaiming Futures is a five-year initiative of the Robert Wood Johnson Foundation, to promote new opportunities and standards of care in juvenile justice. The foundation will use findings from the initiative to create model solutions for communities across the country.

### Robert Wood Johnson Foundation
www.rwjf.org
The Robert Wood Johnson Foundation is the leading private funder of substance abuse treatment in the U.S. Its publications on the field include *Substance Abuse: The Nation’s Number One Health Problem.*

### Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov
SAMHSA is the federal agency charged with improving the quality and availability of prevention, treatment and rehabilitative services in order to reduce the cost to society resulting from substance abuse and mental illnesses.

### Vermont Association for Mental Health/Fighting for Parity
www.vamh.org/parity.html
*Fighting for Parity in an Age of Incremental Health Reform* provides strategies for achieving parity based on Vermont’s successful effort to change insurance coverage inequity.

### CALIFORNIA

#### Government Sites
Official sites operated by federal, state or local government agencies that offer information related to substance abuse problems. For links to all California state departments, go to www.california.gov

- **California Care Network**
  www.calcarennet.ca.gov

- **California Counties’ Web Sites**
  www.csac.counties.org

- **California Department of Alcohol and Drug Programs**
  www.adp.cahwnet.gov

- **California Rural Health Policy Council**
  www.ruralhealth.ca.gov

- **Little Hoover Commission**
  www.lhc.ca.gov

#### University/Academic Research Sites
Sites focusing on research, policy and new program development in the substance abuse field.

- **Alcohol Research Group (ARG)**
  www.arg.org

- **Public Health Institute (PHI)**
  www.phi.org

- **Pacific Southwest Addiction Technology Transfer Center (ATTC) Network**
  www.psattc.org
UC San Francisco Institute for Health Policy Studies  
www.ihps.ucsf.edu

UCLA Integrated Substance Abuse Programs (ISAP)  
www.uclaisap.org

UCLA Center for Healthier Children, Families and Communities  
http://healthychild.ucla.edu

UC San Diego School of Medicine, Addiction Technology Transfer Center  
www.attc.ucsd.edu

Western Center for the Application of Prevention Technologies  
http://casat.unr.edu/westcapt

**Alcohol and Other Drugs**

Sites providing general information on alcohol and other drugs, public advocacy services and support for community efforts.

California Association of Addiction Recovery Resources (CAARR)  
www.caarr.org

California Association for Alcohol and Drug Educators (CAADE)  
www.caade.org

California Association of Alcohol and Drug Program Executives, Inc. (CAADPE)  
www.caadpe.org

California Society of Addiction Medicine (CSAM)  
www.csam-asam.org

CalPartners Coalition  
www.calpartners.org

Center for Applied Local Research  
www.cal-research.org

County Alcohol and Drug Program Administrators Association of California (CADPAAC)  
www.cadpaac.org

Marin Institute  
www.marininstitute.org

Partnership for a Drug-Free California  
www.drugfreeca.com

**Children, Youth, Families and Communities**

Sites focusing on activities to strengthen youth, families and communities.

California Center for Health Improvement  
www.cchi.org

Children and Family Futures  
www.cff.org

Center for Civic Partnerships  
www.civicpartnerships.org

California Healthy Kids Resource Center  
www.hkresources.org

California Institute for Mental Health (CIMH)  
www.cimh.org

Fight Crime: Invest in Kids California  
www.fightcrime.org/ca

Lindesmith Center / Drug Policy Alliance  
www.lindesmith.org

PolicyLink  
www.policylink.org