Meeting Highlights and Background Briefing Report

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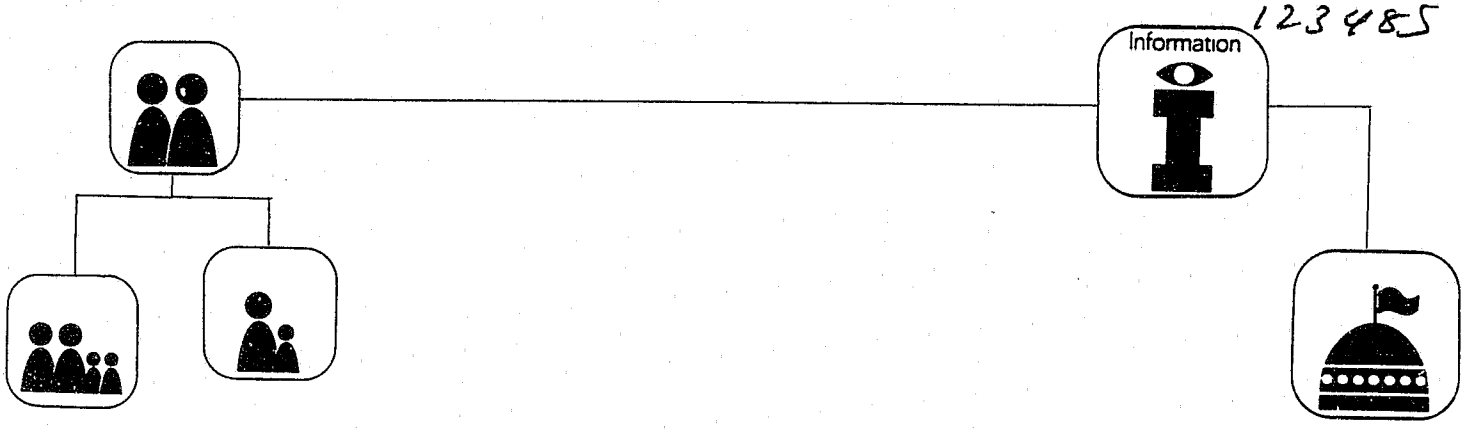

Adolescent Substance Abuse Treatment: Evolving Policy At Federal, State and City Levels

November 17, 1989, Mansfield Room (S. 207), the U.S. Capitol

Panelists: **Elizabeth Rahdert,** Ph.D. Division of Clinical Research, National Institute on Drug Abuse
Thomas Kirk, Ph.D., Acting Clinical Director, Alcohol and Drug Abuse Services Administration, Commission on Public Health, District of Columbia
Diane Canova, J.D., Director of Public Policy, National Association of State Alcohol and Drug Abuse Directors
Glenn Kamber, Deputy Associate Administrator, Office for Treatment Improvement in the Alcohol, Drug Abuse and Mental Health Administration

Moderator: **Theodora Ooms,** Director, Family Impact Seminar

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Adolescent Substance Abuse Treatment: Evolving at Federal, State and City Levels

Background Briefing Report
and
Meeting Highlights

Theodora Ooms and Lisa Herendeen

This policy seminar is one in a series of monthly seminars for policy staff titled, *Family Centered Social Policy: The Emerging Agenda*, conducted by the **Family Impact Seminar**, American Association for Marriage and Family Therapy, Research and Education Foundation, 1717 K. Street, N.W. Suite 407, Washington, D.C. 20006, 202/429-1825

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The American Association for Marriage and Family Therapy (AAMFT)
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Family Service America (FSA)
The National Council on Family Relations (NCFR)

Adolescent Substance Abuse Treatment: Evolving Policy At Federal, State and City Levels

Highlights of the seminar meeting held on November 17, 1989, Mansfield Room (S.207), the U.S. Capitol (a supplement to the Background Briefing Report)

Theodora Ooms, moderator, opened the meeting by noting that there is growing public concern about the continued widespread prevalence of substance abuse among adolescents and its tragic and costly consequences. In the past decade federal policy funded a variety of activities aimed at preventing teenage drug use and abuse (such as the "Just Say No To Drugs" campaign), but policymakers paid much less attention to the needs of teens who are already abusing drugs and caught up in the violent drug trade. Treatment services to help these adolescents get off and stay off drugs are scarce, underfunded and often not tailored to their special needs. At the November 17 seminar four panelists discussed the needs of adolescent substance abusers and the new interest at the federal, state and local levels in improving adolescent treatment services.

Elizabeth Rahdert, of the Division of Clinical Research, at the National Institute on Drug Abuse talked about what is known about the problem of adolescent substance abuse and the key components of an effective system of treatment.

She began by discussing the trends in teen substance abuse most relevant to the treatment issue. The field is changing very rapidly and a number of factors are impinging on it. There are two sources of periodic national data on adolescent drug use and abuse-- a high school seniors survey and a household survey. Some of the recent findings from these surveys are encouraging. Nationally although teens are smoking, drinking and using less drugs than a decade ago (see report pages 2-3), there are many right now that are clearly in need of treatment. Moreover these data sources definitely under-report the extent of adolescent drug abuse since they do not include teenagers who have dropped out of school, are not living at home etc. And it is these sub-groups who are often very troubled and are more likely to abuse drugs than other teens. In addition, a number of trends are quite disturbing. For example:

- There are significant numbers of teenagers needing treatment due to their daily usage of drugs and the kind of drugs they are using are much more potent and toxic. The availability of these more potent drugs is increasing, particularly in the inner city.

- Teenagers who abuse drugs daily are often more involved with other high risk behaviors which can lead to sexually transmitted diseases, (including AIDS), suicide, homicide.

- Another disturbing trend is that, unlike before, whole families are often now involved with illicit drugs leaving few drug free "guardians" available for therapists to work with or teenagers to get support from.

Rahdert said that the critical questions are how do we get these deeply involved teenagers into treatment and do the treatment services currently offered meet their needs? At present the referral process is often quite arbitrary and haphazard. Once a teenager is identified as having a problem with abuse, he/she is usually referred to whatever treatment service is readily available with little attempt to systematically assess the nature and severity of the problem or its relationship to other problems or to match the problem to the appropriate type of treatment.

Rahdert next outlined the components of an ideal system for treatment that takes into account assessment and referral prior to treatment. She noted that early identification is the crucial first step in helping adolescents. This is one area where there has been some progress and the decade's emphasis on education/ prevention has made a great difference. There is clearly a lot more public awareness of the importance of early identification and referral.

Screening and Assessment. Many teens experiment with drugs and alcohol. The challenge is how to identify those teens whose substance use has become, or is fast becoming, abuse. NIDA is developing a screening instrument for alcohol and drug abuse and related problems called the Problem Oriented Screening Instrument for Teenagers (POSIT). This tool, constructed as an easy to answer checklist, will screen in or out one or more of the following problem areas: substance use and abuse (including alcohol and drugs), physical and mental health, family relations, peer relations, educational status, vocational status, social skills, leisure and recreation and aggressive behavior /delinquency. This screen can be used by school staff, primary health care personnel, juvenile court personnel, youth recreation workers and other professionals from community agencies to identify those young people whose drug use requires further evaluation and referral for treatment and other services.

Urine testing, she said, has limited use for initial screening when you are trying to identify the patterns of adolescent drug use. The test is limited because the results only tell you that at one point in time there might be drugs in that person's system. And the test can result in both false positives and false negatives. Urine testing is essential as an adjunct in treatment and follow up.

When problems are flagged by the POSIT the teenager then needs to be referred for more comprehensive diagnostic assessment. Until recently there were no standardized diagnostic tools for assessing adolescent as there are for adults. To fill this gap, NIDA supported Ken Winters of the University of Minnesota in developing and standardizing the Personal Experience Inventory (PEI). This instrument, designed as a self-report inventory, documents the onset, nature, degree and duration of chemical involvement in 12-18 year olds. The P.E.I. also identifies other psychological, social and familial problems that may precipitate or sustain the substance abuse.

The information gleaned from the PEI is best put to use in a case management system, where the teenager and family can be guided to the best available services and be provided with the encouragement and support needed to use these services. Tom Babor in Connecticut is studying the cost effectiveness of such a case management system in Bridgeport, Connecticut which incorporates the POSIT and PEI.

Treatment. The next step is treatment. Therapeutic programs vary greatly in terms of the setting, length of stay, intensity (inpatient, residential, outpatient) and strategies usedwithin the program. However most treatment programs are based on one or other of two theoretical models about addiction. The first is the psychiatric model, which sees drug abuse as a *symptom* of problems residing in the individual 's psyche and interpersonal relationships. The other model is the addiction model which is adhered to by the self-help groups such as Alcoholics Anonymous and the Therapeutic Community approach. This model focusses directly on changing drug-seekingbehaviors and stopping the drug use itself. Family-based treatment can be integrated into either model.

Rahdert concluded by recommending three directions that are needed in order to improve the treatment of adolescent alcohol and other drug use. Although some new studies are underway, basically there has been very little evaluation to date of the effectiveness of adolescent treatment programs. Thus, the first need is to provide dollars to support more research demonstration projects because we can at one and the same time provide increased treatment to serve those presently in desperate need **and** learn more specifically about what combination of services, specific therapeutic models/strategies, provided in which type of setting and for how long will be most effective for which adolescents (differentiated by " problem patterns'). Second, we need to provide more funds to support and encourage collaboration among treatment research projects to promote standard termonology, a core set of variables, measures and data collection procedures to beused by different sites. Alternatively, or in addition, planned multi-site demonstration studies could be funded. And third, demonstration programs need be more specifically targetted and designed for special sub-groups within the teen substance abusing population, such as pregnant teens, and inner city minorities.

The second panelist was **Thomas Kirk,** acting clinical director, Alcohol and Drug Abuse Services Administration, D.C. Commission on Public Health. He discussed some of the complex issues involved in helping adolescent substance abusers in an urban area such as D.C. In his remarks he said he would attempt to address the demand for treatment in the District, the services currently available, the linkage between substance abuse and other teen health problems such as pregnancy and AIDS, and present recommendations about how to improve the public treatment system.

The fact that an adolescent is using drugs is not by itself an indication of a need for treatment Kirk noted, since the majority of teenagers today experiment with drugs and/or alcohol as part of the exploration associated with adolescence. The critical question is: "Are there sufficient slots/or beds available to meet the treatment needs of adolescents whose drug use has progressed to abuse or dependence?"

- It is difficult to get an accurate picture of the " demand" for adolescent drug treatment in the District. A survey of drug use was conducted in the high schools in 1986, (any results available?) but the only regular source of statistics available comes from the juvenile justice system. These data provide some indication of " demand". In 1987 and in 88 about 1900-2000 juveniles were arrested for drug related offenses in D.C. This was a 55% increase over 1986, and a 330% increase over 1983. However the large majority (85%) of these arrests in 1987 were for sales not possession or drug use. Data from these arrests, probation records and positive urine tests suggest that only about 30% of youth arrested for drug offenses are users. (This is compared with 75% of adults arrested for drug offenses testing positive.)

- Cocaine is the primary substance abused, most specifically crack-cocaine which is highly addictive. In September 1989 80% of the 87 juveniles arrested who tested positive (on a urine test) used cocaine either alone or in combination. In the last few

months there is some indication from urine test data that cocaine use is levelling off. In fact, the percentage testing positive for any drug use among juvenile arrestees/probationers was lower in October 1989 than it has been for three years. PCP use, which was climbing to alarming levels, in the District, has appeared to be declining in the last two years. Drug related arrests are much more common for males, but those females arrested are more likely to be users. A disturbing trend is that there is a rise in the numbers of 13 year olds arrested who test positive for drugs.

- Waiting lists are another indication of demand. Staff in the department report that youth can usually be accomodated at the inpatient and residential units, although there is an acute shortage of residential slots for females who typically have to wait 60 days for an open slot. There are no significant waiting lists in the areas outpatient programs for youth.

- The typical route into treatment for adolescents in D.C. is through the court system. It is very rare for an adolescent to request drug treatment on a voluntary basis. Kirk quoted the comments of a program staff member as saying that " one of four things has to happen before a teenager will come into treatment: he/she gets arrested, is thrown out of school, has a drug overdose or acts crazy at home."

- There is not as wide a spectrum of types of treatment services for adolescent abusers in the District as there is for adults and certain components are lacking. Teens are served in the adult detoxification programs at D.C. General and St Elizabeths, where they are usually admitted on an emergency basis for a few days. There are no publicly funded 28 day programs for adolescents, but Kirk said these may not be appropriate for teenagers whose needs are much more complex than adults. There are two residential programs providing 30 beds for males but only 5 for females. There are several four outpatient programs offering 215 slots, but in Kirk's view the once or twice a week service they typically offer simply does not meet the needs. Plans are underway to establish an intensive, outpatient program at the Center for Youth Services in the South East where the teen would attend on a daily basis for several hours and there would be a variety of services offered.

- Kirk briefly described the components of one of the residential programs where a teenager would typically stay for 6-9 months. The program includes individual and group therapy and an academic school program. Families are also involved in the program, most effectively when buses are provided to pick them up in their communities to come to the program. The experience of one of these programs however was that the adolescent made much more progress in the first 45-90 days when they were deliberately isolated from any contact with their families. Once they started meeting with their families and going on visits home, the old destructive patterns returned. This highlights the need for transitional or halfway home settings for some of the adolescents prior to a full integration into their family setting.

Kirk did not have time to discuss the related issues of teen pregnancy and AIDS, nor the list he had compiled, in consultation with program staff, of twenty five system " needs", namely new program initiatives or emphases needed to improve the system of treatment offered to adolescent substance abusers in the District (see list attached on page x).

Diane Canova, the public policy director for the National Association of State Alcohol and Drug Abuse Directors (NASADAD) began by describing the organization. Its members are the states and territories administrators of publicly funded alcohol and other drug abuse prevention and treatment services. The publicly funded service system is only twenty years old. It was originally designed to meet the needs of indigent, adult alcoholics.

and it still has a long way to go to meet the needs of adolescents. Currently it serves primarily those who have no health insurance, or whose insurance does not cover or only partially covers needed substance abuse treatment.

Canova stated that we not only need to expand our knowledge of what works in adolescent drug treatment, but we also need to concentrate on expanding their access to services.

Adolescents are a state priority. Improving adolescent treatment services is top of the list of member priorities according to Canova. The number one need, from a list of 60, cited by state alcohol and drug abuse treatment administrators in a needs assessment survey NASADAD conducted in 1988 said Canova, was to expand slots for adolescents. Of the 1.7 million people admitted for treatment in 1988, only 215,000 were adolescents and children. Of the 1.7 treatment admissions, 1.2 million were for primarily alcohol, 518 thousand were for other drugs. "It is interesting," observed Canova, "that at the Federal level right now our focus is on illegal drugs when throughout the country alcohol continues to be the number one drug of abuse."

Strategies to expand access. To illustrate the access problems states are struggling with, Canova gave two examples. In Washington State, she said, they identified 80,000 children and adolescents that need substance abuse services but only 10% were able to be served in that year. As a result, the state passed legislation in 1988 earmarking $12 million in new monies for increased services for youth. They also successfully linked that money with other health and social and educational services. As another example, last year, in Utah a quarter of the state's total drug treatment money is spent on youth, but still they estimated that only 4.5 % of the youth in need were served.

The services a person receives reflects the services that are available, Canova pointed out. In most states these may or may not be what the patients need. In many states and communities services are stretched to their limits. In the face of rising demand, states are attempting to access other sources of public dollars to help expand adolescent substance abuse services. For example, States are attempting to expand the type of services Medicaid will cover. As it is now, Medicaid will often only cover expensive inpatient care which is often not what adolescents need. Coverage for substance abuse treatment by private health insurance is another area states are hoping to expand. Currently there is proposed Federal legislation, the Basic Health Benefits for All Act which would mandate employers to provide limited coverage of substance abuse treatment under the mental health benefit-namely for 45 days inpatient care and 20 outpatient visits. But this bill would preempt current state mandates which is regrettable because some states, such as Texas, have laws mandating much broader coverage.

New Federal dollars. Another source states are turning to for more assistance is increase in appropriations from the Federal government. Under pressure from the public, both the U.S. House of Representatives and the Senate have recently enacted substantial increases in funding through the transportation appropriations bill, HR 3015 (see p. 12-13).

"Up until now state and local governments have provided 60% of the total funds to public drug and alcohol programs," said Canova. "Only twenty percent comes from the Federal government and 20 percent from client fees and insurance reimbursement." The impending boost in federal dollars will be a welcome addition, she added.

The new omnibus drug Act HR 3015 would increase the dollars in the state's primary source of federal funding for substance abuse treatment namely, the Alcohol and Drug

Abuse and Mental Health Services Block Grant. Last year that grant was funded at $805 million (2/3rds went for drug and alcohol treatment, and 1/3 for mental health services), but this has now been increased for FY'90 by an additional $415 million dollars earmarked for substance abuse services. HR 3015 also creates some additional categorical programs which will provide grant funds directly on a competitive basis to community based programs.

Federal/State relations. Canova concluded by saying that despite this much-needed increase the states are still hoping to modify certain Federal requirements and regulations which make carrying out their programs difficult. One problem is that too much weight is given in the funding formulas to urban areas rather than rural areas. Another serious problem is that new federal mandates can create havoc with the state planning process and are often are not in concert with the needs identified by the indvidual states and communities. For instance, last fall due largely to the pressures of the AIDS epidemic, the federal government passed a bill that mandated half of a state's drug money should be spent on intravenous drug users. This has caused problems for states like Iowa and Utah which are not having the same kinds of problems with AIDS as New York, New Jersey, and Florida are. Although a waiver is available, at this time no state has been granted one.

The Congress proposed a mandate that would require states to increase their spending for pregnant drug abusers and their infants from 10% to 25% for FY '90. This is fine in principle, said Canova, and the states themselves have been urging more emphasis on services for women. However states have already put plans in place for the coming year and this new mandate may cause them take money out of another area in order to meet this new mandate. Since there is no set-aside for adolescents, services for children and adolescents are likely to be cut even though states have identified their expansion as a priority. (December 1989 update: this requirement was **not** enacted.)

Glenn Kamber, the deputy associate administrator for the Office for Treatment Improvement (OTI) at ADAMHA, began his talk by saying that he would be discussing the issue of drug abuse wearing two different hats: a professional hat and a personal hat. Wearing his professional hat he said, he would discuss a number of activities through which this new Federal office, the OTI, plans to work to improve drug treatment around the country. The personal hat, he noted, draws on his training as a family therapist. He went on to say that these two areas of his life are naturally linked as, from his clinical practice he strongly believes that so many adolescent drug abuse problems begin early and can be prevented by working with the whole family---parents, siblings and even grandparents---to change their patterns of interaction.

The new Office of Treatment Improvement has as its mission to draw on the work of its four sister institutes (NIDA, NIAAA, OSAP & NIMH) to help the states improve their treatment services. In his remarks Kamber said he would share the preliminary ideas of Dr Beny Primm, newly appointed director of OTI, about some of the activities ADAMHA will sponsor to carry out this broad goal.

- Last year, when the Omnibus Drug Bill of 1989 passed it allowed ADAMHA to use 5% of state block grant monies to fund three vital federal activities: data collection, clinical research and technical assistance to states. Until recently there had been very little research emphasis on outcome research, that is finding out what treatment approaches work for whom. With this new monies, all three institutes began to conduct new treatment oriented outcome studies.

When ADAMHA , through NASDAD, conducted its needs assessment survey of state administrators, as Canova mentioned, their overwhelming cry for help was for increased treatment services for adolescents and children.

- In response, in order to help states better address the needs of adolescents, Kamber said ADAMHA organized and funded a national conference for adolescent substance abuse and mental health treatment in October, 1989. Thirteen hundred people from across the country came to hear state of the art presentations about research and treatment models and exchange ideas. Reflecting the importance ADAMHA places on family-oriented treatment, twelve of the panels focused on family issues and family involvement. The conference proceedings will be available from ADAMHA late in 1990.

- Another program that is in the planning stages at ADAMHA is the creation of a "bank" of specialized experts to serve in a consultant exchange program to be available to help state and local programs get new treatment programs started, or improve the effectiveness of existing programs. "Printed reports can only do so much, and are quickly outdated. The goal is to keep fluid, up to date, state of the art information in a field where so many people are struggling with a very difficult problems," said Kamber. This consultant exchange program will be built up from different topical " modules", and the first to be established will probably be on adolescents. Experts could then be available, for example, to help programs learn how to involve the teenagers' families more successfully in treatment to prevent the recidivism that Dr Kirk referred to.

- ADAMHA will be funding $30 million for demonstration crisis intervention programs within several urban areas specifically targetted by the federal drug csar's office. The money will be used to establish comprehensive drug treatment services in the area of diagnosis, aftercare and coordination with other services. Kamber noted that drug treatment programs are in desperate need of assistance in many urban areas due especially to severe staffing problems. In some programs counselor positions are advertised at a salary of $14,000 a year with no experience necessary. Furthermore, in some cities caseloads are so high that the ratio is 85 clients to one counselor. Such staffing conditions make it quite impossible to deliver treatment services that will effectively combat powerful addictive processes. The ADAMHA money, he said, will be used to try to improve program staffing by providing funds for inservice training and increasing salaries.

- Also, a large discretionary pot of money of $42 million will be used to look at the connection between criminal justice and treatment services in the local community for both juveniles and adults. "We hope to do more work with parole officers and corrections officers to help keep recently paroled prisoners stay off drugs," said Kamber.

Kamber concluded by saying that ADAMHA has a long history of working cooperatively and well with the states, and they hope to continue this record in efforts to improve accountability and assure that federal funds are well spent. The bill proposed in 1989, The Emergency Drug Abuse Treatment Expansion Act HR. 3630/S. 1735, which did not pass the Senate, would have the states for the first time provide the Office with copies of their state plans for review. This was not instituted to increase federal intrusion but rather to facilitate coordinated planning.

Kamber stressed that a lot of public monies are being spent on drug treatment and efforts must be made to ensure that the quality of treatment is high in order to decrease the number

of people who are readmitted for treatment. Further, he said, ADAMHA, hopes over the next several years, to fund research and documentation studies which will document which treatment approaches can make a difference in the onset and relapse of addiction.

Points raised during discussion

- A participant mentioned efforts in some high schools to work cooperatively with health personnel in order to provide drug treatment services on site to the students as a way of combatting the increasing problems of absenteeism, drop out and violence.

  Rahdert replied that such programs could be very useful. However they sometimes included or led to proposals for involuntary drug screening in schools which she believed presented many problems. How would the results be used, she asked? There is a fear that the information could be used for many purposes other than getting the adolescents into the right treatment program, and could violate privacy of the student and the family, be used very punitively etc. She recommended backing off involutary drug screening and putting energies into other types of early identification instead.

- Another participant asked whether there was a relationship between sexual activity, drug use and drop out rates among teens? The answer was, Yes. Also whether the screening instrument, POSIT was sensitive enough to pick up co-dependency? And whether a " student assistance program" similar to employee assistance programs would be a good idea for school systems to invest in. These would provide a voluntary testing program for students, accompanied by assessment and referral services.

  Rahdert said there were several items on the POSIT screen which could indirectly pick up signs of co-dependency and other related family problems. She added that voluntary screening in schools is a good idea but the mechanism for helping the adolescent and his/her family with a drug problem must be in place first. She said there must be adequate funding for treatment before screening is undertaken.

  Kamber added that the idea of voluntary urine testing in schools will run into trouble because denial is an enormous component of all addicts behavior, especially adolescent behavior. Most adolescents only come into treatment when they are faced with seriously negative consequences if they don't such as the diversion programs which offer treatment as an alternative to jail. He added that in his experience urine testing can be an enormously powerful tool in relapse prevention because it documents the progress an adolescent is making during rehabilitation.

- Is there a way for parents to know if their teenagers are using drugs asked a participant?

  Rahdert says there are many signs of an adolescent's drugs apart from urine testing. While some parents miss indicators of their adolescent's drug use, there are a lot of parent organizations and others sponsoring education and information programs to help parents become more aware of the early signs of drug use.

- When should adolescents go for treatment? At what level of use do they require treatment, asked a participant?

Rahdert said there was a continuum from "use" to "abuse" and as yet there is no agreement among specialists on a definite point at which " treatment" was indicated. The important point was that the type of treatment provided should match the level and intensity of substance use/ abuse. There could be some real dangers from sending a casual user to an intensive treatment program. That was why a thorough assessment at the beginning was so important, to determine just how serious the problem is.

- A participant from the Children's Bureau brought up two additional points related to treatment. One problem is that the drug of choice keeps changing. As soon as treatments were developed for heroin, she pointed out, crack, a derivative of cocaine, became the new problem drug. And a specially virulent form of methamphetamine, called " ice" had appeared on the West Coast. A second problem, she said, is that many of the adolescent drug users are mothers and there is a scarcity of treatment programs for young women, especially for pregnant ones.

- Is anybody tracking those individuals who are denied services or for whom services are not available? Canova said that NASADAD conducts periodic surveys of waiting lists. Two months ago the states reported that there were over 66,000 individuals who had signed up for treatment and been on a waiting list for at least a month. Waiting lists however are very " soft" data. In terms of total needs, states reported that last year they served 2 million individuals, out of an estimated 10 million who had severe substance abuse problems. Among these only $124,000 adolescents were served out of an estimated 1.6 million adolescents in need.

  Kamber pointed out that since the publicly funded services were available to all, and not means tested, the problem in access to services was not the eligibility requirements but the lack of resources or " slots".

Legislative Update: As of December 1989, the total appropriations for the ADMS Block Grant program increased by 48.1% to $1.2 billion. However state by state increases vary widely, and seven small states received no additional funds from the Emergency Drug Funding add on to the Transportation appropriations and most rural states experience slower than average growth. (See Federal Funds Information for States, Issue Brief 89-18) Also the Senate companion bill (S 1735) to HR 3630 providing funds for a demonstration program in the D.C. metropolitan area did not pass the Senate. When the Congress returns, the House and Senate conferees may reconvene in an attempt to work out a compromise between S. 1735 and H.R. 3630.

ADOLESCENT SUBSTANCE ABUSE TREATMENT IN THE DISTRICT OF COLUMBIA

NEEDS

1. INTENSIVE OUTPATIENT PROGRAM, E. G. 15 HOURS/WEEK FOR NINE MONTHS. SLOTS ____
2. DAY TREATMENT PROGRAM, E. G. 8 - 10 HOURS PER DAY. SLOTS _____.
3. AFTERCARE SLOTS: ADJUNCT TO PROGRAM OR COMMUNITY BASED.
4. DUAL DIAGNOSIS RESIDENTIAL PROGRAM
5. ADOLESCENT PREGNANT FEMALE SPECIALTY PROGRAM (S)
6. ADOLESCENT FEMALE RESIDENTIAL SLOTS INCREASED, WITH SEPARATE SETTING FROM MALES.
7. INCREASED TYPES AND/OR VARIED STAFF COMPOSITIONS
8. HALFWAY HOUSES/SUPPORTIVE LIVING UNITS
9. MOBILE TEAMS FOR INTENSIVE OUTPATIENT SERVICES IN SPECIALIZED SETTINGS
10. SPECIALIZED FAMILY PRESERVATION INITIATIVES, SURROGATE PARENT
11. ADOLESCENT AA/NA EMPHASIS AND RETHINKING
12. CHILDREN OF SUBSTANCE ABUSER INITIATIVES, "ADDICTION RECOVERY CENTER FOR WOMEN," ATTENTION TO STIMULATION/DEVELOPMENTAL DELAYS/CULTURAL NEEDS, BROKEN CHEMICAL FILTER CONCEPTS
13. PREADMISSION TREATMENT HELP TO PARENTS WHO NEED TO MOVE YOUTH INTO TREATMENT
14. PROGRAM SEPARATION RELATIVE TO YOUNGER VERSUS OLDER ADOLESCENTS
15. "PAUSE" ALTERNATIVE SCHOOL
16. ABUSE/DEPENDENCE FOR ADOLESCENTS VERSUS FOR ADULTS - DEFINITION REVISIONS
17. PROGRAM LEVELING AND PATIENT CHARACTERISTICS, CLEVELAND CRITERIA FOR ADMISSION/ TRANSFER/DISCHARGE - ACUTE INTOXICATION/WITHDRAWAL, PHYSICAL COMPLICATIONS, PSYCHIATRIC COMPLICATIONS, LIFE AREAS IMPAIRMENT, TREATMENT ACCEPTANCE/RESISTANCE, LOSS OF CONTROL/RELAPSE CRISIS, RECOVERY ENVIRONMENT.
18. TRIAGE AND CASE MANAGEMENT SYSTEM/SETTING TIED TO # 17.
19. SLOT/BED PLANNING BASED ON # 17.
20. NEIGHBORHOOD BASED; LESS CENTRALIZED THAN ADULT SETTINGS
21. ACCESS POINTS; TIE TO TRIAGE SYSTEM AND TO # 20.
22. PATIENT CHARACTERISTIC EVALUATION APPROACH
23. ASSISTANCE WITH INDICATOR DRIVEN MONITORING AND EVALUATION SYSTEM; THRESHOLDS FOR EVALUATION AND POOLED DATA BASE.
24. "RESEARCH" WITH BIOPSYCHOSOCIAL PROTOCOLS/VARIATIONS
25. BRIDGING MENTAL HEALTH AND SUBSTANCE ABUSE "BOUNDARIES."

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ADOLESCENT SUBSTANCE ABUSE TREATMENT: EVOLVING POLICY AT FEDERAL, STATE AND CITY LEVELS

Background Briefing Report

INTRODUCTION

Teenagers are smoking, drinking and using drugs less than they were a decade ago, but the costs of teen substance abuse remain tragically high. Too many deaths, injuries and illnesses, and lost education and job opportunities are a direct result of adolescent substance abuse. After several years of "just say no" campaigns and wars against drug barons, the President and the Congress have shifted gears and are passing laws to put increased monies into drug treatment.

State administrators report that adolescents are at the top of their list of concerns about substance abuse. But in drafting their new treatment initiatives, federal legislators to date have shown little awareness of the special problems and needs of young people. This seminar reviews research and program experience to help answer the following questions. What is the extent of the problem of adolescent substance abuse? Who is most at risk? Do we know what kinds of treatment are effective with adolescents? What policies are needed? And what are the respective roles and responsibilities of the federal, state and local governments in combatting adolescent substance abuse?

DEFINITIONS AND TRENDS

(Sources: Bailey, 1989; Brown & Mills, 1987; Hein, 1988; Newcomb and Bentler, 1989; U.S. House, 1989; Wetzel, 1987.)

Recent data on the prevalence of adolescent substance use and abuse provide grounds for both optimism and continued serious concern. The optimistic view focuses on the steady and substantial decline in most types of substance use among youth since the peak in 1979 -1980. The pessimistic view notes that the rates remain very high, the highest among the industrialized nations, resulting in unacceptably high personal and social costs; that abuse remains especially high among certain disadvantaged subgroups of the teenage population and is linked with other destructive behaviors; and the recent sharp rise in the use of a particularly dangerous and toxic form of drug, crack-cocaine provides real cause for alarm.

Public discussions about adolescent substance abuse are rife with ambiguity and confusion about the nature of the problem. Before reviewing these trends in more detail we need to define some of the terms being used. (Note: we use the term adolescents to include minors ages 12-17 and young adults 18-19.)

Substances of concern. Any psychoactive, mood and thought-altering, substance that can be ingested into the body in any manner can be abused. The substances are subject to some forms of governmental control. In general, controlled substances are placed into two broad categories: those which it is **legal** to use, within certain parameters, and those that are **illegal**. For adults, legal substances are tobacco, alcohol, over-the-counter and prescription medications and inhalants (e.g. glue, paint thinners). Illegal substances include marijuana, cocaine/crack, phencylidine (PCP),

hallucinogens (e.g. LSD), heroin and other opiates. In addition, there is a new category of psychoactive drugs, the so-called " designer" drugs that are manufactured synthetically. Any regular use by a child or minor, and increasingly by a young adult age 18 - 21, of a psychoactive substance that is not medically prescribed is considered abuse. Adolescents are typically poly-drug users, most commonly mixing marijuana and alcohol.

Substance Use and Abuse. A distinction is generally made between one-time, experimental or occasional **use** of a substance and **abuse,** which is defined as use that is regular, frequent and heavy and that has harmful consequences to self and/ or others. Abuse of drugs may be temporary and acute or chronic and long term. Chronic abusers usually become chemically dependent, that is addicted to the substance; their use is compulsive. Whether certain behavior is considered to be abuse depends in part on the context, for example, an adult's moderate amount of use of alcohol at a social event or religious ceremony is not generally considered abuse, but if it is then followed by driving it would be.

Trends

There are two principal sources of national trend data on teenage substance use and abuse. The periodic *National Household Survey of Drug Abuse,* conducted by the National Institute on Drug Abuse (NIDA) permits estimates to be made of the prevalence of drug use for 12 - 17 year olds and for youth aged 18 - 25. And the annual *Monitoring the Future Survey* conducted by the Institute for Survey Research at the University of Michigan, provides estimates of the prevalence of substance use for high school seniors. This survey includes a report of daily as well as monthly and one time use and hence provides a clearer picture of the extent of abuse. However the data from this survey is clearly an underestimate of the prevalence of substance use among the teenage population as a whole since it does not include the 15 - 20% of 17 - 18 year olds who drop out of school and are generally thought to be at higher risk of abusing drugs.

Summary results from these two surveys are presented on Tables I and II (pages 19 & 20). The tables show the substantial decline in alcohol, cigarettes, and marijuana use among school-age adolescents since 1979/80, but an increase in cocaine use through 1985. Table II shows the decline in cocaine use in the last three years among high school seniors, however the survey data does not reflect the reported recent sharp increase in the use of coke, and especially crack/ cocaine among those teenagers most at risk of serious abuse, namely school drop-outs living in low-income, inner city areas.

- Urban usage rates are typically higher than rural rates. In general the rates of substance use increase with age and are higher for teenage males than females but these sex differences are small and almost insignificant for cigarettes and marijuana. Most published reports of this survey data do not provide breakdowns by socioeconomic status, or degree of urbanization, although that data is available. Racial breakdowns, while available, are seldom discussed in the secondary sources.

- Use of alcohol begins at an early age: In 1985, more than one in ten of 12 - 13 yr olds and over one third of 14 - 15 year olds, reported alcohol use in the past month. "By the time they are 16 -17 years old, half of U.S. teenagers use alcohol, one quarter are smokers, one fifth are marijuana users, and one in 30 use cocaine" (U.S. House, 1989).

- While the rates of alcohol and drug use are substantially higher in the high school seniors survey, (since they are older, 17-19), they also experienced a similar decline over this period. In 1988, 63.9% of seniors reported using alcohol in the preceding month as compared with 72% in 1980 (see Table II). Since 1985 there has been a sharp decrease in

cocaine use among seniors (from 6.8% to 4.6% in 1988), but there is some evidence that there has been an increase in their use of " crack".

- The use and abuse of alcohol increases sharply for older teens and young adults. Among college students, more than seven out of ten had used alcohol in the past month, and bouts of heavy drinking (five or more drinks on one social occasion) are very common: more than 55% of college men and 34% of college women reported such behavior. Use of marijuana dropped sharply among the older teens, but as coke became more available and to some extent more " fashionable" cocaine use rose substantially in the eighties and was higher for the high school class of 1985 then for the class of 1984. In 1985, a quarter of 18-25 year olds had tried cocaine at least once and nearly 8% of this age group had used coke in the past month.

- It is estimated that about 5% of high school seniors are serious drug abusers, in that they report that they use one or more illicit drugs on a daily basis. This is a very conservative estimate of the prevalence of serious drug use among this age group as a whole since it does not include the school drop-outs.

- There is a growing awareness of the issue of " co-morbidity " in adolescents. Adolescents experiencing mental health problems are at much higher risk for subsequent drug abuse. And the use and abuse of drugs and alcohol obscure the diagnosis and confound plans for treatment. The co-existence of several different kinds of problems poses a difficult, sometimes insuperable challenge for treatment services which, typically are designed to serve only one type of problem.

Consequences. Alcohol and drug abuse have many short, and long term, adverse health and legal consequences for young people, and, especially when associated with other behaviors, may bring additional risks such as becoming infected with the AIDS virus. As discussed in earlier seminars, the bulk of teenage high mortality and morbidity rates are a consequence of accidents, homicides and suicides related to substance use (see background briefing report for the seminar on Feb. 24, 1989). And a high proportion of juvenile arrests and sentences to jail or juvenile detention facilities are for drug related offenses. Since teenage substance abuse is so often linked with school failure, drop-out and early childbearing it often has negative effects on youths' job opportunities, and later employment and economic status.

While public alarm has focussed most on the immediate consequences of use of illegal, so-called "hard" drugs, as several public health advocates have pointed out, including former Surgeon General C. Everett Koop, the highest costs in the long run are incurred by the abuse of legal substances, namely tobacco and alcohol. Cigarettes alone will eventually cost the lives of more young people than all the other drugs combined.

It is difficult to estimate the numbers of teens at risk of developing AIDS through engaging in substance abuse. Studies of the prevalence of HIV infection in young adult populations, such as military recruits, suggest that a substantial number of teenagers may be infected, but, with the long latency period, they may not become ill until they are young adults. While only a small proportion are cocaine users, they and many other teenagers, who are not themselves drug users, place themselves at risk of HIV infection through sexual intercourse with young adults, IV drug users and others, who may already be infected. Thus sexually active teenagers, especially those who are sexually promiscuous, constitute a "bridge" for the transmission of the AIDS virus from the adult to the teenage population.

The high rates of teenage childbearing, especially in "underclass" communities with high rates of drug use, would suggest that there are numbers of addicted pregnant teenage mothers who place their babies at serious risk, although the majority of addicted pregnant women are older.

Youth at High Risk for Substance Abuse. Data reported in these national surveys show that the majority of teenagers at one time or another use illegal substances. However it is clear that of these, some teenagers are at higher risk than others of becoming serious abusers of alcohol and drugs. Research literature has identified several categories of youth presumed to be most at risk for serious substance abuse. These categories may overlap. They are: children of alcoholics and drug users; victims of physical, sexual or psychological abuse; school drop-outs; pregnant teenagers; economically disadvantaged youth; delinquent youth; youth with psychiatric disorders including depressed and suicidal youth; and disabled youth. Other categories include runaway and homeless youth and youth in foster and other types of out-of-home care.

Typically, services established to help adolescents with these kinds of problems have not been designed to either recognize the accompanying substance abuse problem or provide any help to deal with it. Thus the importance of identifying these categories of youth at risk is to help alert the professionals, parents and community members that substance abuse, while it may not be the most evident, presenting symptom, is frequently involved either as cause or effect of the other problems.

FACTORS AND STAGES IN THE DEVELOPMENT OF ADOLESCENT SUBSTANCE ABUSE

(Sources: Bailey, 1989; Du Pont, 1987; Coombs, 1988; Dishion & Patterson, 1988; Friedman, 1988; Glynn, 1984; Newcomb & Bentler, 1989;)

The causes of substance *use* appear to be somewhat different from the causes of substance *abuse*. Social influences, especially emanating from peers and the neighborhood, are the strongest and most consistent factors influencing drug use. But abuse of drugs is generally more strongly linked with individual and family factors leading to the need to self-medicate against internal distress or seek drug-induced highs. The distress is commonly a result of dysfunctional family patterns and dynamics and psychological and emotional factors such as poor self-esteem, school failure and learning disability, and poor social controls (e.g. nonconformity and disrespect for the law). Among adults there is growing evidence that alcohol abuse, and perhaps drug abuse, has a genetic component and there are a few studies that show a similar finding for children and adolescents.

Additional family factors associated with the development and maintenance of adolescent substance abuse include the parents' own drug and alcohol use and abuse, parenting styles, patterns of communication and conflict and other aspects of family dysfunction. In addition, teen substance abuse, and other behavior problems, may emerge due to, or are exacerbated by, the difficulties some families have in renegotiating relationships necessitated by their teenager's transition to adulthood. And adolescents are especially vulnerable to stressful family events such as death, illness, divorce, job loss and relocation .

Research attempting to understanding the etiology of substance abuse among teenagers has identified the various stages through which a given teenager may move from use to abuse. Typically a teenager may begin with a so-called " gateway drug" such as cigarettes and beer or wine, will then move on to hard liquor, and subsequently to other illicit drugs such as amphetamines, cocaine or PCP. Often more than one substance is used at a time: teenagers are poly-drug users. Involvement at one stage does not automatically lead to progression on to the

next. The factors that push a youngster on to the next stage are not well understood. Initiation at early ages into use of a gateway drug appears to increase the probability that the youngster will become a serious abuser.

The data suggest a " maturing out" of substance abuse in the sense that while most young people experiment with drugs and alcohol, and may use them fairly regularly for a while, they do not progress to the stage in which they become chemically addicted or suffer serious consequences from such use (unless of course, they become involved in a vehicle accident). The critical questions are why a small proportion of teenagers move through the stages and do become serious abusers and what, if anything can be done to intervene to prevent or reverse this progression? The answer to these questions are not yet known but studies are underway to investigate them.

POLICY AND PROGRAM GOALS

The central dilemma of public policy aimed at reducing adolescent substance abuse is to determine at what stage of this continuum of progression towards abuse the major portion of resources should be directed. There are three basic policy strategies: demand control, prevention and treatment.

1. **Demand Control.** Legislation aimed at controlling teenage drug and alcohol use and abuse through raising the legal age for drinking, imposing increased penalties for selling to minors, and for driving while intoxicated or under the influence.

2. **Prevention.** Education and prevention programs and strategies target the general population of teenagers, or, specifically those at risk, with the goal of abstention, or at least delay of initial use, for example " just say no" campaigns, and drug free schools.

3. **Treatment.** Education, prevention, early intervention and treatment programs aimed at those teenage users who are in danger of becoming addicted and those who are already substance abusers.

The distinction between prevention and treatment strategies is sometimes blurred. Many prevention efforts include early identification and referral services. And treatment programs usually include elements of education, especially when family members are involved, to prevent substance abuse in younger siblings or later generations. Most public resources and efforts have, until quite recently, focussed on the first two strategies. This seminar, and background briefing report, focuses on the third, treatment strategy which is gaining increased attention and resources.

TREATMENT OF ADOLESCENT SUBSTANCE ABUSE

(Sources: Bailey, 1989; Fishman, 1988; Friedman and Beschner, 1985; Newcomb and Bentler, 1989; Rahdert & Grabowski, 1988; Todd and Selekman, in press)

There is a lot of uncertainty and debate about the field of adolescent treatment. While more attention is now being paid to the need to treat adolescent substance abuse, many questions remain. Who needs treatment? What kinds of treatment services are available? What kinds of treatment are being used? How effective is the treatment that is available? Which types of treatment best meet the needs of different kinds of problems? These are all complex questions

which are only now being addressed and will take some time to answer. Some of the issues involved are briefly sketched below.

Assessment, screening, diagnosis and referral.

(Sources: Rahdert & Grabowski, 1988; Winters and Henley, 1988; Winters, in press)

The development and utilization of standardized assessment and diagnostic tools is an essential prerequisite of early detection and effective referral and treatment. Such tools can be simple self-report questionnaires, structured or semi-structured interview forms for the professional to use to guide diagnosis and rate behavior on a scale and so forth. Standardized assessment procedures are especially useful in overcoming the denial and resistance that is a primary characteristic of substance abusers and their families. Gatekeepers, that is adults who interact with teenagers in the course of their daily lives (parents, school personnel, and community recreation leaders etc.), need to know how to distinguish between casual use and the signs of abuse and when and how to help a teenager and family seek professional help.

Health care professionals need to be able to assess the nature and severity of the adolescent's drug use/abuse, and its relationship to other problems, in order to be able to make decisions about whether referral to treatment is indicated and what type of treatment is needed. Without effective assessment procedures too often teenagers do not obtain the treatment they need, or, on the other hand, they may be given more intensive, and expensive services than they need.

One of the important issues in adolescent assessment is the extent to which the procedure includes an assessment of the levels of family and community support available to the adolescent, as well as family factors that may be involved in the patterns of abuse (such as the parent's own problems of abuse). Thus many believe the self report instruments or guided interviews need to be administered to family members directly, and not solely to the adolescent.

In the developing field of adolescent substance abuse treatment, assessment is still in its infancy. Current assessment practices depend primarily on clinical judgement, are often based on inappropriate adult models of alcoholism or drug dependency and appear to vary greatly from facility to facility. Many assessment tools rely primarily on child and adolescent psychiatric classifications that provide little guidance for substance abuse diagnosis. However several efforts to develop reliable and valid assessment tools for use in adolescent substance abuse are underway including a) the development of the Personal Experience Inventory, an adolescent diagnostic instrument and b) the development of the Adolescent Assessment Referral System, of which the PEI is an integral part . Both projects are funded by NIDA.

Types of Adolescent Substance Abuse Treatment Programs.

Until the past decade there were very few alcohol or drug treatment services specifically designed for adolescents and in many communities that is still the situation. However in the past few years a range of hospitals, clinics, and community based programs have sprung up designed to treat the drug-abusing adolescent. In 1982, out of over 3,000 substance abuse treatment facilities surveyed by NIDA, only 155 had adolescents as their main clientele, and even fewer had program practices designed specifically for adolescents. In 1984, one survey revealed 400 adolescent drug treatment programs nation-wide. In a survey sponsored by the National Association of State Alcohol and Drug Abuse Directors (NASADAD), states reported that in 1988, 3.8% of admissions for alcohol treatment and 14.5% of drug abuse admissions were for individuals under age 18.

The different types of adolescent treatment services available range along a continuum, though few communities offer the entire range. These include:

-Hot lines

-Community outreach and referral programs

-Hospital emergency room detoxification and referral services

-Outpatient clinics

-Day treatment, as an alternative school program or after school

-Inpatient intermediate care programs (typically 28 day stays, but may, if publically funded, last up to six months)

-Therapeutic Community (TC) residential programs, which typically last for 6-18 months

-Half-Way House programs, which provide a supportive, drug free residence while the teen attends school and prepares for eventual rehabilitation with his family or independent living

- Community based, volunteer, self-help groups, such as AA, Al Anon, Ala/Family, Families Anonymous, Tough Love etc. (see * below)

In these various settings, adolescents and their families may receive individual counseling, psychological testing, drug education, remedial schooling, family therapy, group therapy,peer support, and multiple family therapy.

Outpatient programs are the most common form of treatment used, accounting for perhaps 80% of admissions for drug treatment. The growth in the numbers of adolescents served by specialized treatment programs has been largely confined to high and middle income families who have insurance to pay for the services. In recent years the steep rise in the number of inpatient admissions for adolescent drug treatment has caused considerable alarm, especially as much of this rise has occurred in the rapidly growing for-profit sector.

However it is important to note that large numbers of teenage substance abusers receive services and treatment from other types of agencies, since their drug use is only one aspect of a range of other problems. These agencies include mental health clinics and hospitals, juvenile detention facilities, child welfare agencies and community based programs such as runaway youth shelters. However, these institutions are seldom equipped to provide specialized treatment for the alcohol or drug abuse.

Several new publications identify and describe different types of treatment models for adolescents (for example, see Friedman and Beschner, 1985). An important addition will be the proceedings of the conference on *Treatment of Adolescents with Alcohol, Drug Abuse and Mental Health Problems*, sponsored by ADAMHA. ADAMHA has also commissioned a special survey of model state programs which will be made available in 1990 (see below, page 14).

Much of the literature to date suggests that the dominant treatment models in the field have been developed to serve white, middle class teenagers. Since the problem of substance abuse cuts across all economic racial and cultural lines a major challenge for this emerging literature is to identify program models that have been specifically designed, and tested, to work with adolescents from different socioeconomic, racial, cultural and ethnic groups and types of communities (that is urban, suburban and rural).

* The adult substance abuse treatment literature strongly emphasizes the importance of attendance at Alcoholics/Narcotics Anonymous and similar groups as an adjunct to treatment and, in after care, as essential to sustain their recovery. This is another example of how treatment models designed for adults do not work effectively for adolescents. AA has not generally proved to be a successful program for teenagers, in part because it is a highly authoritarian model and has not been adapted for their age group. However many teen substance abusers' families do get a great deal of help and support from the various self-help groups designed for family members. And young people are becoming very involved in the fast growing self-help movement, Children of Alcoholics.

Family Involvement in Adolescent Treatment.

(Sources: Bry, 1988; Coombs, 1988; Dishion & Patterson, 1988; Fishman, 1988; Friedman & Beschner, 1988; Todd & Selekman, in press.)

Family issues are high on the list of reasons for entering drug treatment. One study reported that 48.5% of teenagers identified family-related problems as the most important of the reasons why they entered drug treatment. There is a growing conviction among mental health professionals and administrators that the family context exerts a powerful influence upon adolescents. The involvement of family members- parents, siblings, step-parents, grandparents or others - is essential to help understand the factors underlying the teenager's abuse and related problems, to make the changes necessary in family relationships that will enable the teenager to change and to sustain and reinforce recovery. In addition, the presence of a seriously troubled adolescent in the family creates enormous pressures on the family system which require clinical attention and support from health care professionals and other parents.

The large majority of adolescent treatment programs involve family members as an integral part of the treatment. In many adolescent treatment programs family involvement of some type is **required**, the adolescent will not be admitted unless the parents agree to be involved. They are involved in various ways, with varying levels of intensity, including education, family therapy, and parent peer groups. In addition to the treatment modalities mentioned, families may serve as host homes, providing temporary " foster care" to addicted youth enrolled in the treatment program in which their own youngster has been enrolled.

Effectiveness of Treatment

Very little is known about the differential effectiveness of these treatment programs for adolescents. Few programs have conducted any self-evaluation, do follow up, or include control groups in their studies. Some programs that have conducted evaluations report high rates of success among those who complete the program but large numbers drop out of the program. Little is known about which types of programs are more successful than others and which are the most cost effective. While there is evidence that long term, institutional treatment for adult alcohol abuse is more successful than short term, we do not know if the finding holds true for adolescent substance abuse treatment. A general consensus of the studies to date is that " those programs that involve the family in treatment and are tailored to appreciate and incorporate the unique aspects of the adolescent's life period are more successful " (Newcomb and Bentler, 1989, p.247). Given that increasing amounts of public and private health dollars are being spent on adolescent substance abuse treatment, there is clearly an urgent need for increased funding for well designed program evaluations.

alcoholism and mental health services result in offsetting cost savings through reducing expenditures for medical illnesses.

Medicaid is a primary source of financing health care for poor adolescents although it only covers about 40% of low income adolescents. Most teenagers who are not eligible for Medicaid have no other insurance coverage. In fact, half of all adolescents 10-18 years old with family incomes below 50% of poverty are not covered by Medicaid (see Newachek, in press).

The Medicaid program does not specifically itemize substance abuse services as separate from other mental health related services. Those states that choose the option to cover psychiatric inpatient and some outpatient services do fund some substance abuse services in this way. Others may use the rehabilitation or case management options. However since in the Medicaid reporting system they are subsumed under mental health services there is no way at present of identifying Medicaid expenditures on substance abuse treatment. A recent survey of the states conducted by NASADAD did ask for the first time whether states covered substance abuse services with Medicaid funds and 30 reported that they did. A study is planned to collect more detailed information from the states about their patterns of Medicaid expenditure for substance abuse treatment.

In summary, teenagers seeking treatment for substance abuse who are ineligible for Medicaid and whose parents have no medical insurance, or their insurance does not have coverage, have very little access to treatment. In many communities this is a very serious problem, especially in low income, urban and minority communities -- such as the District of Columbia --in which, apart from a few free standing, non-profit community based programs, the most common access to treatment comes after a drug related offense, via the juvenile justice system . There are serious questions about whether there are sufficient publically funded, outreach, early intervention and treatment services in these communities and whether the services available are of the type that adolescents can use and need.

There are some counties where a carefully developed county-wide system provides a continuum of services including community outreach, referral and assessment services, and day and residential treatment available at low or no cost for low income adolescents and their families who have problems with substance abuse. For example, Montcomery County, in Maryland has established such a comprehensive, family-centered, system which is 75% financed with local tax revenue. (It is operated through the Division of Addiction and Youth Treatment Services of the Department of Addiction, Victim and Mental Health Services.) There are no states that have established a comprehensive state-wide treatment system providing the full range of services for adolescent substance abusers, although states such as North Carolina, Wisconsin, Washington and others have forged some innovative state wide programs within certain areas of treatment.

EVOLVING STATE POLICY

(Sources: King & Craig, 1989; Meltzer/ CSSP 1989; Olson, 1989; NCSL/Craig, 1989;)

A central issue in the current policy debates is whether the federal government should assume a more active role in providing resources for substance abuse treatment, and whether, along with increased resources, it should assume more direction over how these monies are to be spent.

Since the enactment of the block grant legislation in 1981, states have assumed increasing responsibility for deciding on how to use the declining federal dollars allocated for substance abuse services. The alcohol and drug abuse portion of the ADAMHA block grant suffered a 25 % cut from 1980-81, and suffered further reductions in succeeding years. It was not until the passage of

the 1986 Anti- Drug Abuse Act (P.L. 99-570), and the creation of a new alcohol and drug abuse treatment block grant that federal funds for alcohol and drug abuse services were increased.

Meanwhile, however, in response to the rising need for services, states and local governments have increased their financial support of these services significantly and are finding many creative ways of financing them. Currently, state and local funding comprises about 50% of the total expended for public alcohol and other drug abuse treatment and prevention services; the federal share is about 20% and the remainder of support comes from third-party reimbursement, client fees and other sources. In 1988, over 100 pieces of legislation were passed by over 35 states dealing with the growing problem of substance abuse.

States are clearly recognizing the rising demand for specialized substance abuse services for adolescents. In 1987, NASADAD conducted a survey of all state Alcohol and Drug Abuse agencies to establish national priorities. The survey results identified as the number one priority to *"develop and /or expand programs for teenagers with alcohol and drug abuse problems"*. Each state organizes and administers substance abuse services for adolescents differently and funds these services from different sources.

Many states in recent years have increased their funding for substance abuse and mental health services through a variety of financing mechanisms (see NCSL, 1989). It is not clear how much of this increased funding has been spent on adolescents. However these mechanisms are not without controversy . They include:

Earmarking revenues: The practice of designating specific taxes and fees for particular programs. Several states have earmarked special cigarette and alcohol taxes, fines for drunk driving offenses, and funds from the sale of seized controlled substances to fund specific new services.

Trust Funds and Lotteries. Other potential sources of funding include special funds or trusts established legislatively, that enable the state to tap into a variety of privately contributed funds (wills, gifts, bequests), funds from special sales and grants, to fund specific child oriented programs. Several states have enacted such legislation and others are pending. In addition state sponsored lotteries occasionally allot a portion of the revenues for human services.

Mandates. As discussed above, another strategy is to employ the state's regulatory power to increase covered benefits or require certain health benefits be made available as an optional benefit. Since 1972, 20 states have passed laws mandating that group insurance policies include alcoholism or alcoholism and drug dependency treatment benefits. The best known and most ambitious of these laws is the 1988 Massachusetts Health Security Act, which aims to extend health and mental health benefits to all state residents through funding a state health insurance program and requiring employers, who do not offer health coverage to pay into the state program.

Increasing or Reallocating State Appropriations. The NCSL report identifies eight states which have recently increased state funding for mental health and substance abuse programs as illustrative of recent state action. These are Arizona, California, Illinois, Massachusetts, Pennsylvania, Virginia, and Washington. Several of these mention a specific focus on services for youth. In addition other states have been attempting to reallocate funds from phasing down institutions, blending interagency budgets, reusing surplus property and so forth.

Expanding Medicaid Funding. States have many opportunities for expanding Medicaid services for adolescents substance abuse by adding new optional services, or raising limits on the amount, duration and scope of covered mandatory and optional services. However these actions need to be accompanied by finding sources of additional state revenues to pay the state matching share, which can range from 20-50% of total costs of these new services.

Integration and Coordination of Systems of Care and Treatment. In addition to these piecemeal efforts, some states, and private sector projects, are beginning to think of ways to finance a much more comprehensive, coordinated, community-based and family-centered systems of services for troubled children and their families. The goal is to develop flexible financing strategies that cut across traditional categorical programs, individual diagnostic labels and fragmented delivery systems. It is believed that such systems will not only help to fill the gaps but may often prove more cost effective, avoiding duplication, improving coordination and avoiding unnecessary costly, institutionalized services. Some states are finding creative ways of using Medicaid funds to finance these kinds of systems of care, primarily for seriously emotionally disturbed children and adolescents by, for example, use of the rehabilitation services and case management options.

The thrust of this new thinking is coming from the field of childrens mental health stimulated by the CASSP/ NIMH program and child welfare reform efforts (see Meltzer, 1989) but is only beginning to penetrate the field of adolescent substance abuse. However, as these efforts develop they will undoubtedly begin to develop more linkages with those who are delivering alcohol and drug abuse services to young people. The Robert Wood Johnson's new 26.4 million program initiative, *Fighting Back: Community Initiatives to Reduce Demand for Illegal Drugs and Alcohol*, is one such step. (See July 7, 1989 seminar background briefing report for more information on integration of services.)

EVOLVING FEDERAL POLICY

The 1989 Omnibus Drug Bill H.R. 3015

(Sources: CRS/Hogan, 1989; Democratic Study Group, 1989.)

President Bush's Proposal: In a televised news conference on September 5, 1989 President Bush unveiled a comprehensive national drug strategy for the reduction of drug abuse and drug trafficking. The report outlining the strategy was prepared in compliance with a provision of the Anti-Drug Abuse Act of 1988. The new strategy proposed substantial increases in funding for drug enforcement and treatment and prevention. It continued the previous commitment to attack both the supply of and demand for drugs. Overall, the proposed spending request amounted to $7.9 billion for FY 1990 which was a level 39% higher than the estimated enacted total for FY 1989, and 94% higher than that for FY 1988.

Because there were no major new increases for interdiction some consider the proposal to signal a stronger commitment to street level issues of enforcement and treatment. One new theme was the strong emphasis on reducing the demand for drugs by targeting the casual drug user with strict penalties. Roughly half (49%) of the funds would go for drug treatment programs and another 29% for prevention and education.

Two months after the request, Congress responded to the President's proposal with its own package of increased drug funding. In addition to anti-drug funds provided in the other twelve appropriations bills, the Congress enacted an omnibus bill which included several of the President's proposals. This bill, was attached to the fiscal 1990 transportation appropriations bill (H.R. 3015) which requested $3.2 billion for the anti-drug measure for FY 1990. The total combined funding for the drug war in FY 1990 amounts to $8.8 billion, $3.2 billion (56%) more than the previous year's level and $900 million more than the Bush Administration requested. Of

this amount, approximately $2.6 billion is allocated for drug abuse education, prevention and treatment.

H.R. 3015 has received approval from the House and the Senate and now goes to President Bush for approval which is expected to be forthcoming. Within the anti-drug funding in this transportation bill, $998.6 would be spent on prevention and treatment. The bulk of this funding is for the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) within the Department of Health and Human Services, which receives $727 million, half of which goes for block grants to states. About two thirds of the block grant funds is designated to be spent on substance abuse.

The ADAMHA block grants provide, under an allocation formula, financial assistance to states and territories for the development of prevention and treatment programs that would target intravenous drug users, the mentally ill, emotionally disturbed children and adolescents, women (especially pregnant women and women with dependent children). The remainder of the money goes to federally run programs which include: crisis area treatment grants, homeless substance abuse demonstrations, Quality of Treatment Grants, OSAP Prevention Grants, Community Youth Activities, New Community Prevention Grants, National Institute on Drug Abuse Research, Treatment Demonstration Grants, National Institute on Alcoholism Research, Treatment Outcome Evaluations, and ADAMHA Training and Direct Operations.

The block grant, originally established by the Omnibus Budget Reconciliation Act of 1981, allowed the states greater flexibility in controlling resources and addressing service needs within the state. States, in turn, contract with approved providers for the direct provision of services at the local level. States were required to develop a plan for spending the block grant monies which needed to be reviewed in a state public hearing. The Federal Government retains responsibility for assuring state compliance with block grant legislative requirements and for providing technical assistance. The new legislation moving through Congress shifts back to the federal government more control over how the state substance abuse monies is to be spent.

H.R. 3015 also provides increased funding for prevention and early intervention activities of the Office for Substance Abuse Prevention and the Department of Education's Drug Free Schools Program. In addition to the strong focus on education and prevention, OSAP provides grant programs focusing on early intervention and treatment for at-risk youth and funds demonstration programs for pregnant addicted women (see July 7, 1979, seminar background briefing report). Within other divisions of the Department of Health and Human Services, programs receiving additional funds include the Youth Gang Program (which provides federal support for projects to combat drug abuse among youth, discourage participation in gangs, and refer gang member for drug treatment and rehabilitation) and the Runaway and Homeless Youth Program (which provides funding for counseling to runaway youth and their families and to homeless youth in an effort to prevent or reduce illicit drug use).

ADAMHA'S New Treatment Initiative.

The Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), Public Health Service, has launched a major new initiative to enhance national leadership in efforts to improve the quality and expand the accessibility of treatment services for drug abuse. One of the first steps in this initiative was to hold an invitational conference to focus on the much neglected area of adolescent treatment.

Conference on Treatment of Adolescent with Alcohol, Drug Abuse, and Mental Health Problems sponsored by ADAMHA was held on October 2-4, 1989 in Alexandria, Virginia. Over 1100 invited administrators and clinical staff from public and private sector agencies

attended the successful three day conference. The purpose of the conference was to present and discuss the latest research on adolescent substance abuse and mental illness, identify promising models of treatment and review financing and organizational problems and solutions. There was an particular interest in focussing on the issue of " co-morbidity", namely the co-occurrence in many adolescents of psychiatric problems and substance abuse and its implications for programs and policy.

A number of publications will be available as a follow up to the conference . Among these are:

-Conference proceedings-- including summaries of all 99 conference sessions

-Resource Directory of State Model Treatment Programs

-Report on State Medicaid Financing of Adolescent Substance Abuse and Mental Health Treatment

-Resource Monograph on Family Involvement in Adolescent Treatment.

Office for Treatment Improvement, ADAMHA. ADAMHA's new Office for Treatment Improvement was established in October 1989, to lead and administer the new drug abuse treatment initiative. The Office will provide Federal financial assistance and program expertise to State and local alcohol, drug abuse and mental health administrators and clinicians to improve the quality and availability of alcohol, drug abuse and mental health services. The Office will focus especially on improving treatment for drug abuse, and has various responsibilities assigned to it under new anti-drug legislation. For example in HR 3630 (see below) the legislation requires that ADAMHA develops guidelines and standards for each area to be covered by the state alcohol, drug abuse and mental health plans, and will review the state plans in the light of these. In addition the Office for Treatment Improvement " shall establish a model State substance abuse treatment plan to guide the States." If these provisions are enacted, there will be an opportunity for ADAMHA to help the States expand and improve upon the treatment that they provide specifically for adolescents even though current law does not identify adolescents as a priority group for treatment services.

The Office plans to provide financial and technical assistance to localities (for example, to natural disaster areas and to a limited number of target cities) and to high risk populations such as pregnant drug-abusing women, adolescents and intravenous drug abusers (who are at high risk for AIDS). The Office will set standards and monitor and evaluate programs, so that effective treatment approaches may be established, documented and promulgated nationwide. With regard to adolescents the Office can be expected to build upon the ADAMHA sponsored conference on Adolescent Treatment held in October 1989.

The newly appointed Associate Administrator of the Office of Treatment Improvement is Beny Primm, M.D.

Drug Free Schools Program, Department of Education

A substantial amount of this new anti-drug money will go to the Drug Free School and Communities Program in the Department of Education which is responsible for administering Title V of Elementary and Secondary Education Act, as amended by the Anti-Drug Abuse Act of 1988 (P.L. 100-690). The main purpose of the legislation is to fund innovative prevention and early intervention programs. While the program's main focus is on prevention there are some monies

available for intervention. Grants will be made to state education agencies, school districts, colleges, universities and other public and private nonprofit entities (including parent groups, community action agencies, and other community-based organizations) to carry out services.

The legislation targets most of the prevention efforts at all youth, but half of the Governors' portion of the funds are targeted to high-risk youth defined as individuals under 21 who have started to use alcohol and other drugs, who are the children of substance abusers and/or are victims of sexual or physical abuse. The definition of high risk also includes high school drop-outs and those who have experienced school failure; pregnant teenagers, economically disadvantaged teens; those who have committed a violent or delinquent act, and those who have experienced mental health problems, or attempted suicide or are disabled by long-term injuries. The definition is nearly identical to the Office of Substance Abuse Prevention's (OSAP) High Risk Youth Program. The difference between this program and OSAP's is that it is more narrowly school-based, and will place most of its efforts on prevention. Grant monies could be used to fund support groups within high schools. However, it is not clear how these two programs administered by separate federal agencies will coordinate at the community level.

The Drug-Free Schools program is likely to receive $545 million in total funds for FY 1990. Most, but not all, of these funds are allotted to state and local grants. Each State's allocation is divided between 70% to the State Education Agency and 30% to the Office of the Governor. The SEA must allot at least 90 percent of the funds it receives to local education agencies to improve anti-drug abuse education, prevention, **early intervention, and rehabilitation referral programs.** The Governor provides financial support for anti-drug abuse efforts to community-based organizations. The Drug Free Schools program also supports programs for Native American Youth, and for Native Hawaiians and a range of other activities at the federal level.

To evaluate the implementation of the Drug Free School's state and local program, a study is being conducted by Research Triangle Institute. The study began on October 1, 1988 and findings will be available in the Fall of 1990.

LOCAL DRUG POLICY: the Emergency Drug Abuse Treatment Expansion Act of 1989, H.R. 3630.

Local authorities at city and county level have been struggling under enormous odds to fight the war against drugs. The situation is especially serious in inner city neighborhoods where both crime fighting and treatment resources are universally deemed to be inadequate. And, as noted above, poor teenagers, living in inner cities areas, are at high risk of involvement in drugs and related crime, and are the least likely to have access to treatment services. The drug related deaths of so many young people in cities such as the District of Columbia, are only the most visible and publicized of the many tragic consequences of adolescent substance abuse. It is hoped that the expanded federal treatment dollars resulting from recently enacted legislation will find their way into urban communities and help to fund a range of effective treatment services specifically designed for the inner city population.

New money is on its way to the District of Columbia and surrounding areas for its war on drugs. Passed by the House on November 13, the Emergency Drug Abuse Treatment and Expansion Act of 1989, H.R. 3630, is an anti-drug bill. Section 202 authorizes $35 million to $50 million of FY 1990 appropriations for ADAMHA to establish a "model" drug treatment program for the national capital area through a grant to a public or nonprofit private entity which may sub-contract with other agencies to deliver the services. "Despite the expenditure of billions during the 1980s to combat drug abuse, little has been done to develop a comprehensive regional approach to the provision of effective and accessible treatment services," according to Rep. Henry Waxman (D-

CA) the bill's primary sponsor. This bill will attempt to develop and implement a workable, comprehensive drug treatment approach to a local metropolitan community which has a serious drug problem. (The demonstration program portion of the bill incorporates some of the concepts contained in two earlier bills, HR 2456 and HR 3426 introduced by Congressman Pete Stark.(D-CA) earlier in the year.) The bill assigns NIDA to evaluate the effectiveness of the demonstration program.

The legislation targets all drug addicts, but gives priority to homeless persons, intravenous drug users, pregnant women and residents of publicly-assisted housing.

Besides giving a large infusion of treatment funds to the D.C. area this bill strengthens the legislative authority for several federal drug treatment programs which have been given expanded funding this year including rural communities, drug treatment centers dealing with addicted mothers and their infants, community health centers, migrant health care centers, homeless health care centers, and the waiting list program created in the 1988 drug bill.

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Prepared by Theodora Ooms and Lisa Herendeen, Family Impact Seminar
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100. **Alcohol, Cigarette, Marijuana, and Cocaine Use Among Teenagers.** As of 1985, alcohol use was quite prevalent among males and females of ages 12-17; even among the 14-15 age group, over one-third reported having used alcohol during the last month. After a peak of popularity at the end of the last decade, use of marijuana has decreased, especially among older teens. Not surprisingly, older youth are much more likely to use controlled substances than are younger teens. By the time they are 16-17 years old, half of U.S. teenagers use alcohol, one-quarter are smokers, one-fifth are marijuana users, and one in 30 uses cocaine. Male teens are more likely than females to use alcohol and cocaine, but sex differences are not large.

FROM: U.S. House of Representatives, Select Committee on Children, Youth and Families, U.S. Children and Their Families: Current Conditions and Recent Trends, Report prepared by Child Trends, Inc. Washington, D.C. U.S.Government Printing Office, 1989

TABLE I

Alcohol, Tobacco, Marijuana, and Cocaine Use
Among Teenagers, 12-17, by Age and Sex, 1974-1985

	Percent Reporting Use of Substance In Past Month		
	1974	1979	1985
Alcohol*			
All teens 12-17 years	34%	37%	31%
Age:			
12-13 year olds	19%	20%	12%
14-15 year olds	32%	36%	35%
16-17 year olds	51%	55%	48%
Sex:			
Males	39%	39%	34%
Females	29%	36%	29%
Cigarettes			
All teens 12-17 years	25%	nc	16%
Age:			
12-13 year olds	13%	nc	6%
14-15 year olds	25%	nc	15%
16-17 year olds	38%	nc	26%
Sex:			
Males	27%	nc	16%
Females	24%	nc	15%
Marijuana			
All teens 12-17 years	12%	17%	12%
Age:			
12-13 year olds	2%	4%	4%
14-15 year olds	12%	17%	12%
16-17 year olds	20%	28%	22%
Sex:			
Males	12%	19%	13%
Females	11%	14%	11%
Cocaine			
All teens 12-17 years	1%	1%	2%
Age:			
12-13 year olds	na	na	<1%
14-15 year olds	na	na	1%
16-17 year olds	na	na	3%
Sex:			
Males	na	na	2%
Females	na	na	1%

* In 1979 and 1985, private answer sheets were used for alcohol questions; in earlier years, respondents answered questions aloud.

nc = Data not comparable because definitions differ.

Note: Data are based on household interviews of a sample of the population 12 years of age and over in the coterminous U.S.

Source: National Center for Health Statistics, Health United States, 1987, Table 48; National Institute on Drug Abuse, National Household Survey on Drug Abuse: Main Findings, 1985, 1988.

99. **Alcohol and Drug Use Among High School Seniors**. After reaching a peak near the beginning of this decade, the use of most controlled substances has declined steadily among high school seniors. Cocaine continued to become more popular between 1980 and 1985, but new data show a dramatic decline in cocaine use during the last two years. (Use of a particularly powerful form of cocaine known as "crack" went up by one-tenth of 1 percent between 1987 and 1988, however.) Marijuana use among high school seniors showed the greatest decrease in prevalence during the 1980s, dropping by almost half. On the other hand, close to two-thirds of high school seniors still report using alcohol during the preceding 30 days.

FROM: U.S. House of Representatives, Select Committee on Children, Youth and Families, U.S. Children and Their Families: Current Conditions and Recent Trends, Report prepared by Child Trends, Inc. Washington D.C.: U.S. Government Printing Office, 1989

TABLE II

Percent of High School Seniors Reporting Use of Alcohol or Drugs in Previous 30 Days, 1975-1988

Substance	1975	1980	1985	1987	1988
Alcohol	68.3%	72.0%	65.9%	66.4%	63.9%
Marijuana	27.3%	33.7%	25.7%	21.0%	16.0%
Stimulants*	8.7%	12.1%	6.8%	5.2%	4.6%
Cocaine	2.1%	5.2%	6.7%	4.3%	3.4%
LSD	2.5%	2.3%	1.6%	1.8%	1.8%
PCP/Other Psychedelic	na	2.3%	1.3%	.6%	.3%
Heroin	.6%	.2%	.3%	.2%	.2%

* Stimulants prescribed by a doctor are not counted. Beginning with 1985, the data are based on a revised questionnaire item, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

Source: L. Johnston, J. Bachman, and P. O'Malley, Monitoring the Future, University of Michigan: Institute for Social Research, annual volumes, 1975-1986, and unpublished data provided May 1989.