



communiqué

A Memo to the Field from CSAT's Treatment Improvement Exchange

Substance Abuse Treatment and the State Children's Health Insurance Program (CHIP)

There's still a chance to make sure children and adolescents get substance abuse prevention and treatment and mental health services under CHIP.

special issue

SAMHSA Urges Constituents to Get Involved in State Children's Health Insurance Program Planning

— *Nelba R. Chavez, Ph.D., Administrator, Substance Abuse and Mental Health Services Administration (SAMHSA)*

On August 5, 1997, President Clinton signed the Balanced Budget Act of 1997, which created a new Title XXI of the Social Security Act called the State Children's Health Insurance Program (CHIP). CHIP, a block grant administered by the Department of Health and Human Services (DHHS), provides \$24 billion over the next 5 years to fund health insurance for uninsured children of low-income families. CHIP represents a valuable opportunity for States to access additional resources for comprehensive, quality mental health and substance abuse prevention and treatment services for children and adolescents. States determine eligibility and benefits. For this reason, it is critically important to SAMHSA and its customers that mental health and substance abuse services be integrated into every State's CHIP plan.

Unlike the basic medical services that are mandated by CHIP, such as age-appropriate immunizations and well-child and well-baby care, substance abuse prevention and treatment and mental health services are allowable but not required for plan approval. The legislation identifies mental health services as an "additional" benefit, while substance abuse treatment services are "optional." SAMHSA believes it is the responsibility of the field—all of us at the Federal, State, and local levels involved in providing mental health and substance abuse prevention and treatment services—to ensure that a full range of these services for children are covered in CHIP plans and to define what those services are.

Those who develop CHIP plans may not be fully aware of the significant mental health and substance abuse problems facing our Nation's children or of the science-based prevention and treatment services available to help them. This special issue of the *TIE Communiqué* aims to provide the information treatment advocates need to make the case for covering substance abuse services under CHIP. The benefits of CHIP to children and families are enormous. But they will not be fully realized unless mental health and substance abuse prevention and treatment services are part of each State's benefit package. The need is great.

- Children of women who abuse alcohol during pregnancy are at risk for alcohol-related birth defects, such as prenatal and postnatal growth retardation, facial anomalies, and nervous system defects, a pattern of outcomes known as fetal alcohol syndrome (FAS).

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- In 1996, approximately 9 million current drinkers were between the ages of 12 and 20, and the rate of past-month illicit drug use among youth ages 12 to 17 was 9 percent (NHSDA, 1996).
- One in 5 children 17 years old and younger—13.7 million children—may have a diagnosable mental disorder. One in 10 children between 9 and 17 years old—3.5 to 4 million children—may have a serious emotional disturbance. These youth have severe emotional or behavioral problems that significantly interfere with their ability to function socially, academically, and emotionally (DHHS, 1996).

States whose approved CHIP plans included substance abuse and mental health services are to be commended. These plans adopted creative approaches such as school- and community-based service settings, mobile treatment services, and respite care for treating addictive and mental health disorders. Substance abuse and mental health needs can best be addressed through health insurance packages that include access to high-quality and comprehensive systems of care, which encompass a wide range of community-based services and respond to cultural, individual, and family needs.

There's still a chance to make sure children and adolescents get substance abuse prevention and treatment and mental health services under CHIP. States can amend their CHIP plans at any time once they have been approved. States that did not include substance abuse prevention and treatment and mental health services in their first approved plan or that did not adequately or appropriately provide such services for children still have the opportunity to do so. SAMHSA strongly encourages stakeholders to participate in the development of CHIP plans and to advocate for amendments that include needed substance abuse and mental health services.

In order for CHIP to be successful, however, all uninsured eligible children must be enrolled. The number of uninsured children rose from 8.2 million in 1987 to 10.6 million in 1996. Because outreach to connect low-income children to comprehensive services is crucial, President Clinton directed eight Federal agencies with programs serving children and families to reach out and enroll uninsured children. In response, these Federal agencies developed plans to educate their workers, to help their workers educate families, to coordinate cross-agency and public-private efforts, and to identify and enroll uninsured children in Medicaid or CHIP (DHHS, 1998). Current CHIP provisions permit States to use up to 10 percent of administrative funds for outreach, the flexibility to find and enroll hard-to-reach children. (Please see the DHHS letter on outreach at <http://www.hcfa.gov/init/choutrch.htm>.)

We want to work with you to improve the health of all children, especially those with mental illness and/or addictive disorders. We encourage you to become involved in your State's CHIP planning process. Please call your State or Health Care Financing Administration regional contact person.

For a listing of contact people in your State, general information, and answers to frequently asked questions, visit www.hcfa.gov/init/children.htm. Or contact SAMHSA's Children's Health Representative, Duiona R. Baker, M.P.H., at (301) 443-5184 or dbaker@samhsa.gov. ■

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The Children's Health Insurance Program: Are Substance Abuse Treatment Services for Youth Really Optional?

— H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Director, Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA)

Children and adolescents suffering with substance abuse or mental health problems deserve the same care for these illnesses that children with other health problems receive. Yet the law establishing the State Children's Health Insurance Program (CHIP) defined substance abuse prevention and treatment services as "optional" and mental health services as "additional." This means that States may but are not required to cover substance abuse treatment and mental health care for children living in or near poverty.

We in the substance abuse treatment community know that alcohol and other drug treatment services must be considered part of a comprehensive system of care for our young people. Unless we become advocates for the inclusion of chemical dependency and mental health treatment in each State's CHIP benefits package, our young clients and their families will go without the medical care and support services they need for rehabilitation and healing. We must seize the opportunity to use the CHIP planning process to educate the public and policymakers about the causes, consequences, and costs of youthful substance abuse.

Too often, society regards substance abuse by young people as delinquent or deviant behavior. We must convey to CHIP decisionmakers that abuse of alcohol and other drugs by vulnerable youth is not an independent phenomenon that can be compartmentalized. Rather, substance abuse by children is inextricably bound to other difficulties these at-risk young people face. In the context of physical and sexual abuse, emotional abuse and neglect, developmental disorders, learning disabilities, attention deficit hyperactivity disorder, mental illness, or low intelligence, afflicted young people may turn to drugs

or alcohol as a form of self-medication to dull the pain and shame they feel.

Once a child or adolescent starts using drugs, substance abuse takes on a life of its own and has to be treated.

We must seize the opportunity to use the CHIP planning process to educate the public and policymakers about the causes, consequences, and costs of youthful substance abuse.

But to treat the addiction in isolation is almost certain to invite relapse. For treatment to be successful, the underlying conditions—the structural and emotional damage to the child—must also be recognized. The child who struggles with learning disabilities, mental illness, or chemical dependency does not wish for these conditions any more than does the child with chicken pox or juvenile diabetes. Providing treatment and family support services for youth with behavioral health problems is as important as immunization or any other basic medical service. CHIP benefits packages must reflect this reality.

The purpose of health insurance is to guard against undesired outcomes—to cover the cost of unexpected illnesses or chronic diseases and limit their recurrence. We expect our insurance policies to cover broken bones or cancer because we realize that though these unwanted conditions may not affect us or a member of our family today, they could strike at any time. We need to adopt the same attitude toward provision of treatment services for chemical dependency and mental illness.

We have a choice. We can treat vulnerable young people for substance abuse and its underlying causes. Or we can wait until the affected youth have lost their dreams, diminished their potential, and broken the law—and then imprison them. The questions society needs to answer are these: Can we really afford to divert even more of our young people into the criminal justice system? What costs more in terms of human potential and dollars—rehabilitation or incarceration?

By including the substance abuse and mental health services young people need in CHIP benefits packages, States can help the Nation focus on substance abuse and mental illness as matters of public health before they become matters of law enforcement. Treating drug abuse and its causes is far more economical than adjudication and incarceration. The positive outcomes of treatment far outweigh its costs.

It is this broad public health perspective that we want to encourage as States implement and amend their CHIP plans. ■



Find CHIP Information online at CSAT's Treatment Improvement Exchange (TIE) web site: www.treatment.org.

Building Teams Among Agencies Serving Children

— H. Rick Sampson, Director, Division of State and Community Assistance (DSCA), Center for Substance Abuse Treatment (CSAT), SAMHSA

During the winter and spring of 1998-1999, the Division of State and Community Assistance (DSCA) conducted four regional State team-building workshops on CHIP. These meetings were jointly sponsored by the three Centers of the Substance Abuse and Mental Health Services Administration (SAMHSA).

Attendees included State substance abuse agency directors and staff; representatives from the U.S. Department of Health and Human Services' Health Care Financing Administration (HCFA) and Health Resources Services Administration (HRSA); staff from diverse State agencies, such as public health, mental health, human services, children and family services,

rehabilitation services, and managed care agencies; and consumers of these services.

Together, State officials and service providers learned about CHIP and ways that this program could expand mental health and substance abuse treatment coverage for eligible youth. Workshop participants heard from Federal administrators and from colleagues in other States about "best practices" for CHIP outreach activities and benefit package design. Bringing these committed individuals together began the process of building State teams. States described their achievements, challenges, concerns, and future directions. Service providers and program administrators learned

about service definition from a financial perspective. CHIP administrators gained an understanding of the terminology used to describe substance abuse and mental illness treatment services, what constitutes appropriate length of stay in treatment, and what qualifications are required by practitioners to deliver specific services.

This issue of the *TIE Communiqué* supports, complements, and extends to a larger audience the work initiated at these regional meetings. We hope you will share it with people outside our field to educate them about what services our young clients need and what resources are necessary to deliver them. ■

Facts About Uninsured Children

- The percentage of people with health coverage provided by employers is decreasing: 41.7 million American workers are uninsured. Up to 12.5 million additional working people and their family members will lose employer health coverage between 1997 and 2002. Dependent children have been hardest hit by declining coverage.¹
- In 1996, 70 percent of all Americans added to the ranks of the uninsured were children. The employer-based health insurance system is collapsing for children, as businesses cut their support for dependent coverage.²
- The vast majority of uninsured children have parents who cannot afford the cost of health coverage for the entire family: 7 in 10 uninsured children have family incomes below \$26,660 for a family of 3.³
- In 1996, about 11 million children—15.4 percent of all children in America—were uninsured: 90 percent of these children lived in households with at least one working adult.⁴
- At least 3.3 million children under age 13 and more than 1 million children 13 and older are eligible for Medicaid, but not enrolled.⁴
- Of families that did not receive needed health care, 60 percent said they did not get care because they could not afford it.⁴
- Children aged 13 to 17 are nearly three times less likely to have a usual source of health care than children aged 5 and under.⁴
- Hispanic children are more likely than black or white children to be uninsured: 27.7 percent of Hispanic children are uninsured, compared with 17.6 percent of black children and 12.3 percent of white children.⁴
- Hispanic children are more likely than black or white children to be in fair or poor health: 7.8 percent of Hispanic children are so classified, compared with 4.2 percent of black children and 2.9 percent of white children.⁴

¹American Federation of Labor and Congress of Industrial Organizations. Statement by John Sweeney, President of AFL-CIO, Study Analyzing Decline in Employer-based Health Coverage. February 19, 1998; The Lewin Group. *Paying More and Losing Ground: How Employer Cost-Shifting Is Eroding Health Coverage of Working Families*. Washington, DC: AFL-CIO, 1998.

²Dorn, S., Teitelbaum, M., and Cortez, C. *An Advocate's Tool Kit for the State Children's Health Insurance Program*. Key Facts About Uninsured Children. Washington, DC: Children's Defense Fund, 1998.

³*An Advocate's Tool Kit*.

⁴Weigers, M.E., Weinick, R., and Cohen, J.W. *Children's Health 1996*. Rockville, MD: Agency for Health Care Policy and Research, 1998. MEPS Chartbook No. 1. AHCPR Pub. No. 98-0008.

Co-occurring Psychiatric Problems Among Adolescents: Variations by Treatment, Level of Care, and Gender

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Co-occurring psychiatric problems are common among adolescents who regularly use substances, particularly among those entering substance abuse treatment. Increased severity and co-occurring problems are also major criteria in level-of-care placement decisions (ASAM, 1996; CSAT 1993) and should be considered by States and other organizations as they define benefit plans for the Children's Health Insurance Program (CHIP).

The term "co-occurring" is used because, even for experienced diagnosticians, it is difficult to ascertain which comes first—the substance use or the psychiatric problem. Clinicians and researchers have suggested that adolescents may be trying to self-medicate underlying psychiatric problems or may be using substances to cope (inappropriately) with high levels of environmental, personal, and traumatic stress. It is also common for psychiatric symptoms (e.g., hallucinations, depression, anxiety) to follow substance use or to emerge once it subsides.

The term "co-occurring" is used because, even for experienced diagnosticians, it is difficult to ascertain which comes first—the substance use or the psychiatric problem.

Data from recent studies show that there is considerable variation in the rates of these other problems by pattern of substance use, setting (community, treatment), level of care (outpatient, inpatient), and gender. These patterns suggest the need for a more comprehensive approach to treatment

that includes the assessment and integrated treatment of psychiatric issues, including victimization, anger, and poor coping skills.

Over the past two decades, Federal, State, local, and professional groups have pushed for the development of specialized treatment programs targeted at adolescents. The Center for Substance Abuse Treatment (CSAT) has supported this movement through Treatment Improvement Protocols (TIPs), block grants, and capacity expansion and demonstration grants (CSAT, 1992; 1993; 1999b). As part of the Secretary of Health and Human Services' Youth Initiative, CSAT is also funding one of the largest randomized experiments ever conducted with adolescents to evaluate five different approaches to adolescent outpatient treatment (Dennis, Babor, Diamond, Donaldson, Godley, Tims, et al., 1998). A pervasive theme throughout this work is that adolescent substance use is correlated with a wide range of co-occurring problems and that these problems are more common among those presenting for treatment. A second theme is that these co-occurring problems differ from those of adults and vary by level of care and by gender.

Adolescent Substance Users in the Community

Many people assume that adolescent substance use is relatively harmless and that young people will eventually grow out of it. However, our analyses of a representative sample of 5,143 adolescents aged 12 to 18 from the National Household Survey on Drug Abuse (NHSDA)(McGeary, Dennis, et al., under review) show that more frequent use and use of multiple sub-

stances are directly related to increasing rates of both substance "use" disorders (e.g., dependence and abuse) and substance "induced" disorders (e.g., depression, anxiety, health problems).

The rates of reporting one or more symptoms of an alcohol-related disorder go from 0 percent among non-users to 51 percent among weekly alcohol users and to 67 percent among weekly marijuana and alcohol users. Rates of reporting one or more symptoms of a marijuana-related disorder go from 0 percent among non-users to 31 percent among marijuana-only users and to 77 percent among weekly marijuana and alcohol users. Rates of reporting one or more symptoms of substance use disorders related to other drugs (e.g., cocaine, inhalants, amphetamines, heroin) also follow this pattern, ranging from 0 percent among non-users to 1 percent among weekly alcohol users and 12 percent among weekly marijuana and alcohol users. We have also found that over 85 percent of the people who have one or more symptoms of dependence as adults started using under the age of 18; 40 percent or more started under the age of 15 (Dennis, McGeary, et al., 1999).

More frequent use and use of more types of substances were also associated with a wide range of other problems. Again using the NHSDA data from adolescents in the community, weekly marijuana and alcohol users were more likely than non-users to report symptoms related to:

- Delinquent behaviors (27 vs. 1 percent)
- Being arrested (23 vs. 1 percent)

- Externalized behaviors, such as conduct or attention deficit disorders (57 vs. 13 percent)
- Being in a fight (47 vs. 11 percent)
- Other aggressive behaviors (36 vs. 11 percent)
- Being engaged in illegal activity (69 vs. 17 percent) and/or being admitted to the emergency room (33 vs. 17 percent)

Demographically, substance use patterns were *not* significantly correlated with income or geography. However, weekly adolescent users of marijuana and alcohol were more likely than non-users to be male (59 vs. 51 percent), white (84 vs. 77 percent), over 15 (84 vs. 42 percent), and in high school (75 vs. 34 percent). Weekly users were also significantly more likely to have been in substance abuse treatment (12 vs. .01 percent), though, overall, less than 10 percent of adolescents with past-year symptoms of dependence have ever received any formal treatment (McGeary et al., under review).

Adolescents Entering Treatment

Marijuana is now the most common substance used among adolescents entering treatment, followed by alcohol.

All other drugs together represented less than 10 percent of admissions to the public treatment system. While the treatment literature has been dominated by residential studies, over two-thirds of adolescents in the public treatment system are seen in outpatient settings (OAS, 1997). Several large studies of adolescents entering treatment have consistently shown that increasing use and polysubstance use are again associated with higher rates of substance use disorders, substance-induced disorders, and a wide variety of co-occurring problems.

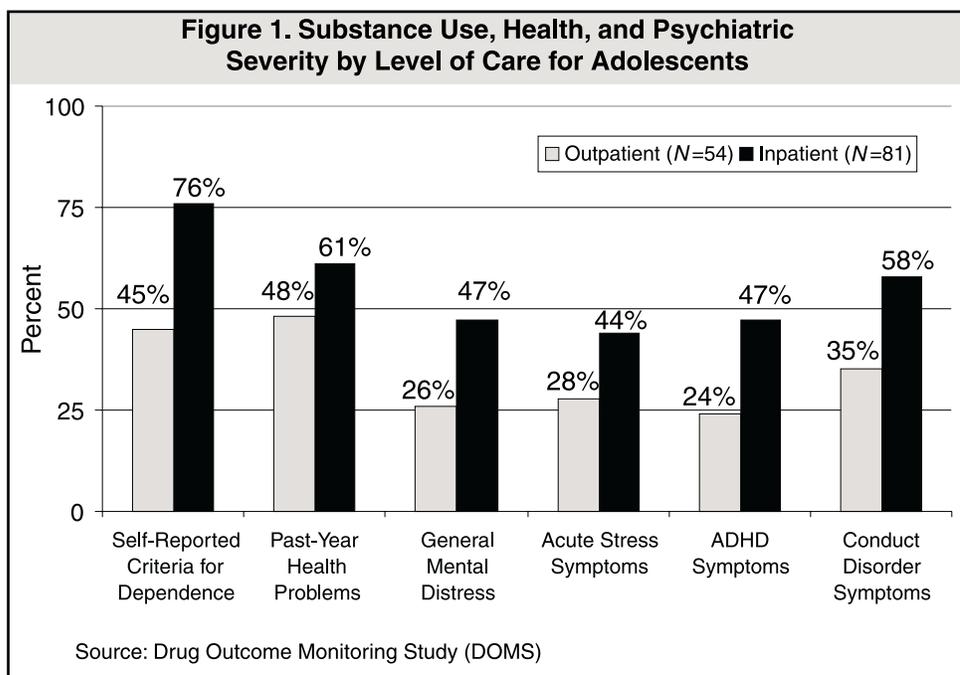
Moreover, studies repeatedly show that adolescents in treatment are even more likely to have multiple problems (Gerstein et al., 1997; Jainchill, Bhattacharya, and Yagelka, 1995; OAS, 1998; Rounds-Bryant et al., 1998). Findings are somewhat more mixed on variations by level of care. The greatest differences occur where formal placement criteria (e.g., ASAM, 1996; CSAT, 1993) are required and where inpatient treatment is reserved for adolescents with more severe or less manageable problems.

To illustrate some of the key differences between outpatient and inpatient treatment, we used data from 271 pa-

tients entering 11 adolescent treatment programs in Illinois, where ASAM's (1996) patient placement criteria are mandated by the State (Dennis, Scott, et al., 1998; 1999). Adolescents entering inpatient treatment were more likely than those entering outpatient treatment to be female (35 vs. 26 percent), to come from a controlled environment (73 vs. 46 percent), to have been in treatment before (76 vs. 41 percent), to have been using marijuana weekly (64 vs. 41 percent), and to have been using alcohol weekly (32 vs. 4 percent). Figure 1 illustrates that adolescents entering inpatient treatment were more likely than those entering outpatient treatment to self-report meeting criteria for dependence (76 vs. 45 percent), past-year health problems (61 vs. 48 percent), general mental distress (47 vs. 26 percent), acute stress symptoms (44 vs. 28 percent), ADHD symptoms (47 vs. 24 percent), and/or conduct disorder symptoms (58 vs. 35 percent). Thus, adolescents entering treatment had higher rates of problems than those in the community, with those entering inpatient treatment having the most severe substance use and other problems.

Variations by Gender

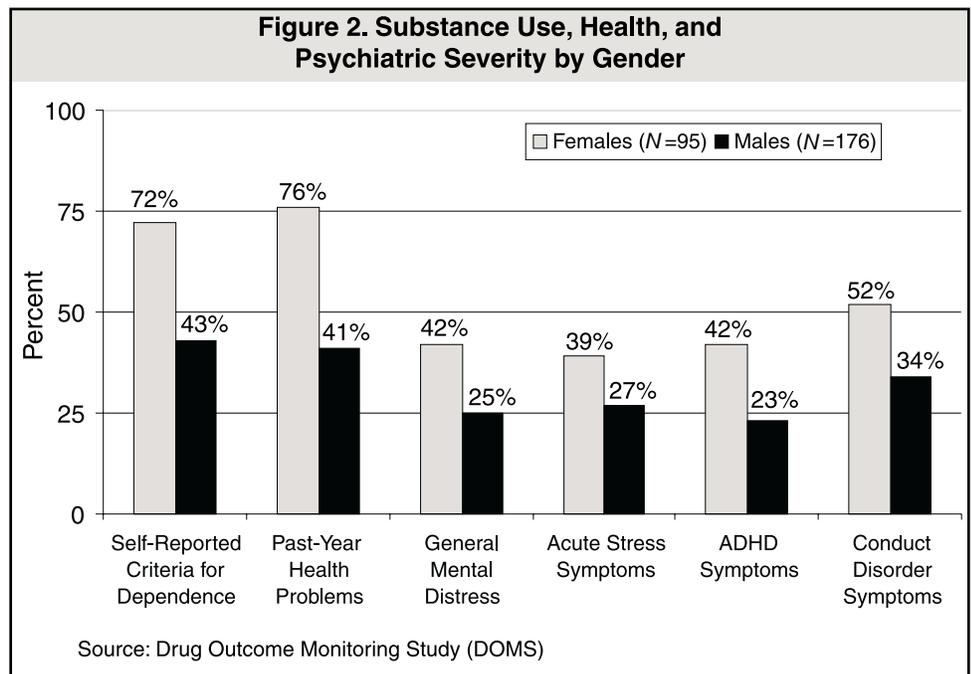
Recent literature also demonstrates that adolescent females often have higher severity than adolescent males in terms of their substance use and other problems, such as victimization and psychiatric co-morbidity (Bahr et al., 1998; Blechman and Kelly, 1997; Clark et al., 1997; Giancola et al., 1998; Grilo et al., 1998; Kandel et al., 1997; Rounds-Bryant et al., 1998). In the Illinois study discussed above, females were more likely than males to have been in treatment before, to have come out of a controlled environment, to have had multiple sexual partners, to have been victimized, to have used drugs weekly in their homes, and to have run away or been homeless. Females reported lower rates of marijuana use themselves and of weekly



alcohol use by others in the home. Figure 2 illustrates how females have greater severity than males in terms of their reported criteria for dependence (72 vs. 43 percent), past-year health problems (76 vs. 41 percent), general mental distress like depression or anxiety (42 vs. 25 percent), acute stress from victimization or guilt (39 vs. 27 percent), attention deficit/hyperactivity disorders (42 vs. 23 percent), and/or conduct disorder (53 vs. 34 percent). To simplify this figure, we collapsed the data across levels of care. The data were weighted based on the distribution of adolescents in outpatient (7,326) and inpatient (1,626) admissions in Illinois during 1997. However, within each level, females had higher severity than males on every single measure. Thus, while there is no definitive study demonstrating the superiority of gender-based programming, there is clear evidence that female adolescents have more severe and diverse clinical needs to be addressed than do males.

Variations by Age

Until the 1980s, adolescents were largely treated as part of adult systems (White, 1998). CSAT, several States, and providers have increasingly advocated for a specialized system targeting adolescents. In addition to the obvious developmental differences, adolescents have different patterns of use and co-occurring problems. To illustrate, we expanded our example with additional data on 465 adults from 11 treatment units in Illinois (Dennis, Scott et al., 1998; 1999). Adolescents were more likely than adults to report episodic and binge use (i.e., all day long) of both alcohol (60 vs. 47 percent) and drugs (51 vs. 42 percent), externalizing problems related to attention deficit/hyperactivity (74 vs. 56 percent) and/or conduct disorder (64 vs. 39 percent), being involved in the criminal justice system (73 vs. 37 percent), and being in a home environment where others were getting drunk weekly (24 vs. 19 percent). Though substance abuse was



still a major problem, adolescents were less likely than adults to meet criteria for substance dependence (48 vs. 67 percent), to have been in treatment before (69 vs. 80 percent), to have internalized problems from general distress like depression/anxiety (45 vs. 51 percent) or a stress disorder (65 vs. 51 percent), to have a history of being physically, sexually, or emotionally victimized (72 vs. 78 percent), to report weekly drug use in their home (13 vs. 19 percent), and/or to be homeless or a runaway (18 vs. 38 percent).

Even when they self-reported symptoms of dependence and/or getting in trouble from their substance use, adolescents were less likely than adults to perceive their substance use as a problem (38 vs. 70 percent). These clinical differences also suggest very different management strategies because of the higher rates of impulsivity/behavior problems and low motivation to change, again suggesting the need for programs specifically for adolescents.

Recommendations

In both clinical and community-based samples, we have found that the increasing frequency of substance or

polysubstance use by adolescents is associated with the presence of a substance use disorder and a host of health, psychiatric, and behavioral problems. Adolescents in treatment met more clinical criteria (typically 3 to 6 symptoms) than substance users in the community (who typically reported 1 or more symptoms). We also illustrated that:

- Placement criteria can be used successfully, triaging only the most severe adolescents into inpatient treatment
- Adolescent females have a different and higher severity profile than adolescent males
- Adolescents overall have a different profile from adults

These findings have important implications for program and benefit planning. First, less than 10 percent of adolescents reporting one or more symptoms of dependence in the community had ever been seen in treatment. Given the damage substance use disorders can do to the individual and his/her family, as well as the associated co-occurring problems, we need to increase our penetration. Two issues are likely to confound these efforts: moti-

vation and gender. Adolescents are much less likely to perceive their substance use as a problem, and we may have to rely more on external motivation (e.g., parents, schools, criminal justice system) to get them started in treatment. It also appears that fewer adolescent girls present for treatment than would be expected from community-based studies like the NHSDA. There are several potential reasons for this (e.g., perception that programs are male dominated, higher societal tolerance before referring adolescent females). But more work is needed to ascertain why.

Second, despite the high rates of co-occurring problems reported here and in the literature, many co-occurring problems go unrecognized. In the State of Illinois, for instance, the official rate of dual diagnosis (substance/other psychiatric) is still only 6 percent. Here we need an integrated approach to both assessment and treatment to ensure that these other problems are detected and addressed.

Third, much of what we know about comparing inpatient and outpatient treatment is based only on adults and predates modern efforts to reserve inpatient treatment for the most severe or unmanageable cases. Moreover, preliminary data from adolescent treatment does not replicate adult work (Dennis, Scott, et al., 1999; Pentz et al., 1990; OAS, 1998; Winters et al., 1999). Instead, it suggests that untreated adolescents largely get worse, adolescents treated as outpatients stay about the same, and those treated as inpatients improve more than outpatients (though they end up in about the same place). Thus, we recommend that comprehensive treatment plans should involve more early intervention (i.e., outreach, screening, and brief interventions for substance use), a full continuum of care for higher severity adolescents (starting with inpatient treatment and stepping down to outpatient care), and integrating the assessment and treatment of other co-occurring health, psychiatric, and environmental problems. ■

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Children of Alcohol and Substance Abusers Need Services

— Sharon Amatetti, M.P.H., Office of Policy Coordination and Planning, Center for Substance Abuse Treatment. Ms. Amatetti has focused on the special needs of addicted women and their children since 1992.

Substance use and abuse have a wide range of consequences for children. Young children may suffer from in-utero exposure to alcohol and other drugs through maternal use and from environmental exposure to parental substance abuse after birth and throughout childhood. Later, these children may suffer from their own use of alcohol and other drugs, most often during adolescence. Primary care and mental health services will be needed for these children, including developmental assessments and interventions throughout childhood, as well as during infancy and adolescence.

In-utero Exposure to Alcohol

Maternal alcohol abuse during pregnancy is associated with alcohol-related birth defects (ARBD). According to the *National Pregnancy and Health Survey* conducted by the National Institute on Drug Abuse (NIDA), 757,000 or 18.8 percent of the 4 million women who gave birth in 1992 reported having drunk alcohol some time during pregnancy (NIDA, 1997). Depending on the dose, timing, and conditions of exposure, as well as on the individual characteristics of the mother and fetus, prenatal alcohol exposure can cause a range of disabling conditions. A pattern of birth outcomes consisting of prenatal or postnatal growth retardation or both, facial anomalies, and nervous system defects is called fetal alcohol syndrome (FAS). The incidence of FAS in the United States is about 2 cases per 1,000 population (Church and Abel, 1998). Some children are diagnosable with full FAS; others have only partial manifestations (Streissguth, 1997).

While FAS and ARBD are not curable, early diagnosis and intervention are the strongest factors associated with fewer secondary disabilities

(Streissguth, 1997). These secondary problems become apparent as the child approaches and enters adolescence, and include mental illness; alcohol and other drug use and related problems; and antisocial behavior, including trouble in school and with the law. Diagnostic services for FAS and ARBD evaluations are needed to help families and the school systems they depend on to recognize and address alcohol and illicit drug problems, and to develop appropriate interventions and services for affected children.

In-utero Exposure to Other Drugs

NIDA's *National Pregnancy and Health Survey* also found that 220,000

The most common effects of drug use during pregnancy include higher rates of fetal distress and death, lower Apgar scores, premature birth, and growth retardation. Maternal drug use during pregnancy can also result in poor neurodevelopmental outcomes. Because maternal drug use is also associated with increased risk for sexually transmitted diseases, these children are at higher risk for congenitally acquired infections (Wagner et al., 1998).

Children exposed to drugs prenatally require monitoring and assessment for possible long-term problems. Particular attention should be given to growth during and after birth because of the

The services most often required by children living with a parent or parents who abuse alcohol and other drugs are those that support the entire family.

women, or more than 5 percent of women who gave birth in the U.S. in 1992, reported having used an illicit drug while pregnant (NIDA, 1997). Marijuana was the most frequently used illicit drug, followed by cocaine. These estimates may be low, however, because many women deny use out of guilt and fear of legal consequences.

Consequences of various drugs on the fetus are wide ranging. This is a result of differences in the properties of the drugs used; in the timing, intensity, and chronicity of exposure; and in the possible interactional effects of polydrug use during gestation (Wagner et al., 1998). Because the impact of maternal drug use on the fetus and newborn is complex, it is difficult to distinguish acute, temporary effects from long-term or irreversible effects on the child.

frequent association of intrauterine growth retardation and maternal drug use during pregnancy.

Environmental Exposure

Since women who are identified as drug users are more often from lower socioeconomic backgrounds (Van Baar, 1990), their children are likely to qualify for Medicaid or CHIP coverage. Women who abuse alcohol or other drugs during pregnancy are likely to continue doing so after giving birth unless they obtain substance abuse treatment and continuing support, with additional consequences to the child. There is a higher incidence of neglect and abuse in drug-abusing families. Among young children receiving foster care in 1991, an estimated 78 percent were from families where at least one parent was a drug abuser (GAO, 1994). More recent studies have found similar

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Adolescent Alcohol and Marijuana Treatment: Kids Need It Now

— Michael L. Dennis, Ph.D., Senior Research Psychologist, Lighthouse Institute of Chestnut Health Systems, and Principal Investigator of SAMHSA/CSAT's Cannabis Youth Treatment Cooperative Agreement Study; and Kerry Anne McGeary, Ph.D., Research Assistant Professor, Department of Economics and the Health Services Research Center, University of Miami, and Project Director, Cannabis Youth Treatment Cooperative Agreement Cost and Cost-Effectiveness Study.

As each State decides what and whom to cover under the Children's Health Insurance Program (CHIP), one of the questions that needs to be asked is, "Should we cover adolescent substance abuse treatment?" The answer is yes.

After declining in the 1980s, tobacco, alcohol, and marijuana use among adolescents has been rising again in the 1990s. The rate of adolescents aged 15 to 17 initiating marijuana use is rapidly approaching what it was in the 1970s and is more than 50 percent higher than it has ever been among those under age 15 (Dennis et al., 1998). In 1996, marijuana use reached a 12-year high among adolescents in 8th to 12th grade in terms of lifetime use (23 to 45 percent), past-year use (16 to 36 percent), and past month use (11 to 22 percent) (Graham et al., 1997).

Marijuana and alcohol use are highly intertwined, according to data from the National Household Survey on Drug Abuse (NHSDA) (OAS, 1995a). While 60 percent of adolescents aged 12 to 17 were not actively using in the past year, 24 percent were using alcohol, 15 percent were using both alcohol and marijuana, and 1 percent were using marijuana only; moreover, 2 out of 3 weekly adolescent users were using both alcohol and marijuana (McGeary et al., 1998). As one might expect, the frequency of substance use increased with age and grade in school, and was slightly higher among males. Contrary to stereotypes, frequent use was less likely among minorities and more likely among those who were employed. Further, there are no significant differences in the patterns of alcohol or marijuana use among adolescents in terms of their welfare status, income, or the metropolitan status of their community.

More frequent substance use and use of multiple substances are directly related to increasing rates of substance use disorders (e.g., dependence and abuse) and substance-induced disorders (e.g., depression, anxiety, health problems). Again, using data from the NHSDA, we have found that rates of reporting one or more symptoms of an alcohol-related disorder go from 0 percent among non-users to 51 percent among weekly alcohol users and 67 percent among weekly marijuana and alcohol users.

Similarly, rates of reporting one or more symptoms of a tobacco-related disorder increase from 3 percent among non-users to 32 percent among weekly alcohol users and 67 percent among weekly marijuana and alcohol users. Rates of reporting one or more symptoms of a marijuana-related disorder go from 0 percent among non-users to 31 percent among marijuana-only users and 77 percent among weekly marijuana and alcohol users. Rates of reporting symptoms of disorders related to other drugs (e.g., cocaine, inhalants, amphetamines, heroin) also follow this path, ranging from 0 percent among non-users to 1 percent among weekly alcohol users and 12 percent among weekly marijuana and alcohol users.

Over time, generations have been defined by peaks in the use of alcohol, opioids, cocaine, and then crack. Among adolescents in the 1990s, the defining drug has clearly become and continues to be marijuana. In fact, among 12- to-17-year-olds, marijuana is now the primary substance of abuse among adolescents entering treatment (OAS, 1997). High rates of marijuana and alcohol use among adolescents are related to many other problems. Relative to non-users, adolescents

who reported weekly marijuana and alcohol use are about four times more likely to report past-year behavior problems related to attention deficit hyperactivity disorders, conduct disorder, or delinquency (57 percent vs. 4 percent), dropping out of school (25 percent vs. 6 percent), being involved in a major fight (47 percent vs. 11 percent), and being involved in one or more illegal activities during the past year (69 percent vs. 17 percent) (McGeary et al., 1998). Moreover, they were 8 to 23 times more likely during the past year to have:

- Committed a theft (33 percent vs. 4 percent)
- Damaged property (31 percent vs. 3 percent)
- Shoplifted (41 percent vs. 4 percent)
- Been on probation (16 percent vs. 1 percent)
- Been arrested (23 percent vs. 1 percent)
- Sold drugs (31 percent vs. 0 percent).

In terms of health care, adolescents who used marijuana and alcohol weekly were also twice as likely to have been to the emergency room during the past year (33 percent vs. 17 percent). In fact, marijuana is now the primary substance mentioned in both adolescent emergency room admissions and autopsies (OAS, 1995b).

Adolescent substance use is likely to have a long-term impact on both the individual and on society. Table 1 uses data on adults from the NHSDA to look at their probability of having one or more symptoms (Sx) of tobacco, alcohol, and/or marijuana disorders based on their age of first use. Relative to

people who started using after the age of 18, those adolescents who started using before the age of 15 are more likely to report major problems related to their use *as adults*: about twice as often for tobacco (26 percent vs. 13 percent), four times as often for alcohol (27 percent vs. 7 percent), and about six times as often for marijuana (24 percent vs. 4 percent) (Dennis et al., 1998). Conversely, among adults reporting one or more substance disorder symptoms in the NHSDA, more than 85 percent started using before the age of 18—with about 40 percent starting before the age of 15.

Despite the rise in substance use, the range of related problems, and the potential for long-term consequences, few adolescents have ever been in treatment. Even though 14 percent of adolescents reported one or more past-year alcohol disorder symptoms, 8 percent reported one or more cannabis disorder symptoms, and 4 percent reported other substance disorder symptoms, only 1 percent reported ever having been to a substance abuse treatment program (McGeary et al., 1998).

While substance use is often a chronic condition, treatment does help. Long-term studies of adult substance abuse treatment show that 25 to 35 percent of adults recover after a given treatment episode and tend to stay better, that those who relapse tend to deterio-

rate without further re-intervention; and that each time there is a re-intervention, another proportion tends to be moved into the recovery column (Simpson and Savage, 1980).

While information is still emerging about adolescent treatment effectiveness, there is considerable tension between efforts to develop short-term, cost-effective treatments and findings that 50 percent or more of treated adolescents relapse to marijuana or alcohol use within the first 3 months after discharge (Brown and Vik, 1994; Brown, Vik, and Creamer, 1989; Catalano et al., 1991; Kennedy and Minami, 1993). There are, however, several promising options for improving treatment effectiveness by focusing on motivational enhancement, relapse prevention, problem solving, coping strategies, case management, family support, family therapy, and by working with the adolescent's concerned others to change their environments (Azrin et al., 1994; Brown et al., 1994; Graham et al., 1996; Kadden et al., 1989; Liddle et al., 1995).

Substance use among adolescents is at a new high and is related to a multitude of problems in the public health system, government, society, and America's families. While the Federal and State governments are continuing their efforts to reduce use among future generations, substantial numbers of adolescents are already using and

need more formal treatment. Unfortunately, they are not likely to get it under the current system. Government leadership is needed to head off the likely long-term consequences of this problem, both for the health of these individuals and that of the Nation.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized the need for further study of adolescent treatment. As part of the Department of Health and Human Services Secretary's Youth Initiative, the Center for Substance Abuse Treatment has embarked on a major randomized field experiment to directly evaluate five of the most promising models of adolescent outpatient treatment and hopes to have the main findings by the fall of 2000 (Dennis et al., 1998, or see www.chestnut.org/cyt).

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Table 1. Probability and Relative Risk of Having 1 or More Substance Disorder Symptoms as an Adult, Based on Age of First Use

Substance Used	Age of First Use of Substance*					
	Under 15		15-17		18+	
	1+ Sx	Odds	1+ Sx	Odds	1+	
Lifetime Tobacco Users (N=10,887)	26%	2.00	20%	1.54	13%	1.00
Lifetime Alcohol Users (N=12,795)	27%	3.92	15%	2.12	7%	1.00
Lifetime Marijuana Users (N=5,847)	24%	5.71	9%	2.16	4%	1.00

*All are significant at P<.05.

Source: Dennis, McGeary, French, and Hamilton (1998)

Reaching CHIP Parents: Some Anecdotes From Head Start

— Michael Keane, Dr.P.H., The CDM Group, Inc., Senior Analyst, Head Start Family and Child Experiences Survey

Since Head Start already does income determination to identify eligible families and then helps enrolled families overcome financial and other barriers to obtain health and dental care, Head Start has been seen as a natural venue for outreach to children who might qualify for coverage under CHIP. Indeed, ACF, which administers

Head Start, has already developed outreach and enrollment strategies to serve children eligible for either Medicaid or CHIP. Some families do not apply because:

- They don't want to be associated with the stigma of a "poor people's" program.

- Parents may have had bad experiences with Medicaid and prefer to avoid it.
- In some States, a family must first be denied coverage by Medicaid in order to apply for CHIP. Some families don't want to go through that denial process. ■

Facts: Children Begin Using Alcohol and Drugs at Younger and Younger Ages

- Alcohol, cigarette, and other drug use starts early: More than 12 percent of adolescents reported that they first tried alcohol in 4th grade, and 10 percent indicated that they smoked their first cigarette during the same time period. Incidence of drug use increases throughout elementary and junior high school, particularly 6th and 7th grade.¹
- A national survey conducted in May and June of 1995 found that 23 percent of preteens (grades 4 to 6) polled had been offered drugs. Between 1 and 2 percent tried marijuana and cocaine as a result.²
- The rate of overall drug use among 8th graders increased 126 percent from 1991 to 1997. Every day, an average of 6,488 American children and teens try marijuana for the first time, 1,786 try cocaine, and 386 try heroin.³
- Methamphetamine is used by increasingly younger children. In Arizona, 6th graders are more likely to try methamphetamine than are high school seniors nationwide (17 percent of 6th graders compared to 4 percent of high school seniors.)⁴

¹National Adolescent Health Information Center. Fact Sheet on Adolescent Substance Use. Division of Adolescent Medicine and Institute for Health Policy Studies, University of California, San Francisco: November 1995, p. 3.

²Partnership for a Drug-Free America, 1995 Partnership Attitude Tracking Study, February 1996. From CESAR FAX, April 29, 1996, Vol. 5, Issue 16.

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Developmentally Appropriate Alcohol and Illicit Drug Services for “Middle” and Teenaged Children*

— Nancy K. Young, Ph.D., Sidney Gardner, M.P.A., and Kimberly Dennis, M.P.A., *Children and Family Futures*, Irvine, California

Although attention to prenatally exposed infants is critical and renewed efforts have focused attention on services for adolescents, interventions for the 5-to-12-year-old children of substance-abusing parents are still scarce. These “middle children” are at high risk of developing their own alcohol and other drug (AOD) problems.

The needs of children of alcoholics (COAs) and children of substance abusers (COSAs) can be viewed developmentally. It is well established that infants and young children have specific needs for adequate bonding with and attachment to their care givers. For infants and children with substance-abusing parents, intervention during these early years becomes critical to assure that they receive appropriate stimulation, opportunities for brain development, and emotional well-being through bonding and attachment.

We are continuing to miss the large group of children between early childhood and adolescence who need AOD interventions. These children—neither adolescents nor prenatally exposed—should be a critical subset served by AOD treatment services for children.

During childhood, individuals develop self-concept and self-esteem through cultivation of curiosity, initiative, and independence. For COAs and COSAs, such nurturing is often disrupted, which interferes with normal development. These children need services that specifically address their families’ AOD problems, including group interventions with their peers and formal treatment. They also need supportive adults to reinforce the message that their parents’ AOD abuse is not their fault and is not the path their own life needs to take.

For adolescents who become chemically dependent, a developmental perspective and approach to treatment is also imperative. Just as the AOD field has adapted treatment services so that they are responsive to the unique needs of women, the AOD field must also recognize the unique needs of

For infants and children with substance-abusing parents, intervention during these early years becomes critical to assure that they receive appropriate stimulation, opportunities for brain development, and emotional well-being through bonding and attachment.

adolescents. Recent advances in AOD treatment have shown that programs for youth must incorporate in their design and delivery the characteristics, maturational effects, and developmental processes of adolescents. As specified by Kirkman and Hall (1998), the critical differences between youths’ and adults’ AOD-related problems and treatment include:

- **Rapid progression.** Adolescents often make the progression from first use to full chemical dependence within a period of 6 to 18 months; among adults, a 2- to 7-year period is common.
- **Narrow repertoire of coping skills.** Unlike adults, who often arrive at the chemically dependent stage with an array of coping strategies developed by life experiences, adolescent chemical dependence is such that the development of these strategies is curtailed and arrested at the stage in which youths began using alcohol, tobacco, and other drugs. For this reason, treatment of

adolescent chemical dependence requires a habilitation focus and more comprehensive treatment intervention than adult models.

- **Stronger denial system.** Adolescents have a stronger system of denial because, unlike adults, they have not experienced years of negative consequences related to their AOD use. As a result, youth tend to have more difficulty connecting their problems to their drug use.
- **Stronger enabling system.** There is a wider acceptance of drug use by the adolescent peer group, which supports and normalizes drug taking and drug-related behavior.
- **Maturational delays.** Adolescents experience cognitive, affective, behavioral, and maturational delays directly caused by drug use. The younger the age at which drug use is initiated, the greater the delays in the maturation process.
- **Developmental issues.** Chemical dependence impacts negatively on the adolescent developmental tasks of individuation, separation, and autonomy. These are necessary developmental processes for transitions to young adulthood.

* Reprinted by special permission of the Child Welfare League of America, Washington, DC, from: N.K. Young, S. Gardner, and K. Dennis. *Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy*, 1998, pp. 99-102. For copies of the book, contact the Juvenile Justice Clearinghouse, (800) 638-8736.

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Alcohol and Illicit Drug Use Prevention, Treatment, and Maintenance: Three Components of a Quality System of Care for Youth

— Rochelle L. Rollins, Ph.D., Health Resources and Services Administration (HRSA), and Sheri Rucker, M.S.W., Center for Substance Abuse Prevention (CSAP), Office of Managed Care (OMC)

Progressive States have included substance abuse prevention and treatment in their Children's Health Insurance Program (CHIP) plans. These States are at the forefront of recognizing and acting upon the huge cost savings realized by substance abuse prevention and treatment. In an effort to incorporate substance abuse services in State plans, prevention proponents would be wise to emphasize the pervasiveness of substance abuse across the life cycle, the high co-occurrence of mental health and substance abuse problems, the demonstrated effectiveness of prevention strategies, and cost offsets. As a marketing strategy, documenting and disseminating information about science-based preventive interventions and their linkage to cost offsets are vital activities for providers and administrators.

Substance abuse is a serious health problem in the United States. Each year, more than 11 percent of preventable deaths and 6 percent of all deaths are attributed to alcohol, tobacco, and the use of illicit drugs (McGinnis, 1993). The toll is high in monetary as well as human costs. According to one analysis, health care costs in the United States would drop by \$14 billion if alcohol, tobacco, and drug problems could be prevented (CSAP, 1995). For example, a drug-affected baby incurs \$63,000 in health costs over 5 years and a child born with fetal alcohol syndrome (FAS) requires \$30,000 yearly in neonatal care (CSAP, 1995; Rice, 1995). Older children also suffer from the effects of parental substance abuse—and from their own. Teens and preteens are especially vulnerable. By the age of 11, 1 in 5 children has smoked cigarettes, and 1 in 11 children has had his/her first drink of alcohol (AMA, 1994).

There is often a fine line between prevention and treatment, a continuum that was not captured by early conceptual models of preventive interventions. Drug abuse preventive interventions had traditionally been classified within the public health model as either primary, secondary, or tertiary (CSAP, 1991). According to this model, primary preventive interventions protect people who have not begun to abuse substances. The goal is to decrease the incidence of new users. Primary preventive interventions promote health for the general population and focus on a specific protection related to an identified pathogen or subpopulation. Secondary preventive interventions, also called early intervention, are directed towards people in the early stages of substance abuse. The goal is to reduce and eliminate use. Tertiary preventive interventions seek to stop or lessen the negative effects of substance abuse through treatment and rehabilitation (NIDA, 1997). The following table depicts this classic public health model.

In 1994, the Institute of Medicine (IOM) proposed a new framework that incorporated Gordon's (1987) operational description of prevention. The IOM's Continuum of Care portrays how

prevention, treatment, and maintenance fit together to provide a continuous set of health care services. Prevention is divided into three categories: universal, selected, and indicated. Universal strategies target either the general population or a designated segment (e.g., local community, school). Examples include parenting classes, informational media campaigns, and newsletters. Selective strategies target subsets of the total population that are considered to be at risk for substance abuse. The subset receives the intervention to deter the onset of a diagnosable disorder. Examples include skills training for at-risk youth and alternative youth programs. Indicated strategies target specific individuals who show early signs of behavior linked to substance abuse. Typically, these individuals have low resiliency and few protective factors. Youth who are assessed to need preventive interventions are usually referred by schools, family members, or the judicial system. Examples of interventions include Student Assistance Programs (SAPs) and skills training (CSAP, 1998b; NIDA 1998b, 1997).

Widely accepted prevention research stresses the impact of the family on whether people will develop substance

Traditional Public Health Model			
	Primary Prevention	Secondary Prevention	Tertiary Prevention
Purpose	Prevent the occurrence	Reduce the duration	Limit impairment and prevent sequelae
Activities	Promote health	Detect and screen	Optimize coping skills and adjustment
	Specific protection	Diagnose and treat early	Rehabilitate

abuse problems, either as adolescents or adults. Whether a family will be a risk or protective factor for a child is heavily influenced by such issues as adequate parenting, family stability, and substance abuse dependency of the parents. Similarly, communities can also have a positive or negative effect on a child's health and wellness. High-quality health care is an important protective factor, as is a low crime rate, good schools, and access to adequate social services.

The Center for Substance Abuse Prevention promotes constructive lifestyles and norms that discourage drug use and create social and physical environments that facilitate drug-free lifestyles (CSAP, 1995). CSAP focuses on selected populations most at risk for developing substance abuse problems: children living with substance-abusing parents; youth whose parents are involved in the criminal justice system; youth without caring, consistent adults in their lives; youth who are doing poorly in school; teenagers involved in delinquent behaviors or gangs; and families living in high-risk neighborhoods and communities. CSAP-funded demonstration programs have yielded evidence that preventive interventions are effective in reducing the demand for alcohol, tobacco, and illicit drugs. CSAP's role is to bridge the gap between science and practice. CSAP fosters the development of comprehensive, culturally appropriate preventive interventions, policies, and systems that are based on scientifically defensible principles.

CSAP promotes family-based approaches to prevent substance abuse among children and adolescents. These approaches focus on three family-centered activities that have shown great potential for success (CSAP, 1998b):

- **Parent and family skill training** that can improve poor parent-child communication, child behavior, and parenting skills, while reducing family conflict.

- **In-home support services** that focus on decreasing domestic violence, child abuse and neglect, and child placements. In-home services must be aimed at reducing youth crime and arrest rates and helping youth to improve social skills, anger management, school attendance, and adherence to curfews. These services need to be intensive, comprehensive, and long term.

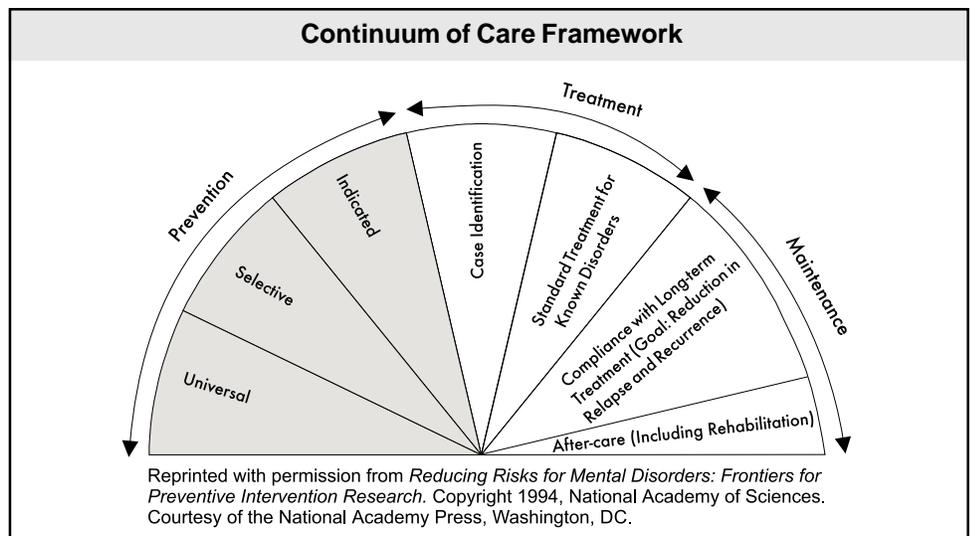
- **Family therapy** to improve family functioning and reduce such antisocial behaviors as juvenile delinquency, recidivism, and child abuse.

As with other health care services, prevention and treatment interventions will be provided in a managed care environment. In 1997, the American College of Mental Health Administrators convened a meeting for leaders in the mental health and substance abuse fields to discuss how to preserve quality care under managed care. This meeting, referred to as the Santa Fe Summit, resulted in the creation of a risk-and-evidence-based framework for maintaining and measuring preventive interventions in managed care (American College of Mental Health Administrators, 1998). The framework requires that prevention providers be thoroughly trained in relevant risk assessment tools, and further that only conditions for which there are known, science-based preventive interventions be targeted. A

final key component of the framework is the documentation of the cost of the preventive interventions at the population and individual levels. This framework will be useful as prevention providers and administrators plan and monitor their services under the Children's Health Insurance Program.

Preventive services are an essential element of a comprehensive health care delivery system. Prenatal, postnatal, infant, and early childhood substance abuse and mental health screening, identification, and appropriate referral are critical to a comprehensive continuum of care. To foster collaboration and coordination among consumers, providers, and community-based organizations in each State, CSAP's Office of Managed Care sponsored a constituency meeting to discuss next steps for the substance abuse prevention community. The following action steps were proposed:

- Become familiar with the provisions of CHIP and educate colleagues on the options.
- Develop an approach and position for the inclusion of substance abuse and mental health services, including preventive services, in State plan design.
- Draw upon State experience with Early Periodic Screening, Diagnosis,



and Treatment Program (EPSDT) outreach efforts related to substance abuse prevention, such as teen pregnancy/mother outreach, and school health strategies.

- Identify, attend, and participate in the public process of CHIP design, such as consumer panels for the Medicaid Advisory Committee and Title XXI Regulations and Special Needs Plan process for children.
- Network and participate in the State plan review process to help influence the scope of substance abuse prevention services outlined in the CHIP plan.
- Educate constituents on the impact of substance abuse in their State.
- Monitor the implementation of CHIP and all revisions to State plans.
- Maintain contact with Health Care Financing Administration (HCFA) and Health Resources Services Administration (HRSA) regional offices for technical assistance.
- Coordinate outreach to children and families eligible for services through Starting Early/Starting Smart, Head Start, WIC, Healthy Start, child care resource centers, and other community-based initiatives.
- Maintain communication with State legislators and officials responsible for CHIP.
- Collaborate with public health officials, Title V directors, State Medicaid directors, child care advocacy groups, schools, universities, and foundations to evaluate efforts.

Substance abuse and mental health constituencies have an important opportunity to influence the development of a comprehensive behavioral health benefit package tailored to children. Because substance abuse may be overlooked as a benefit during the design of State plans, proponents must ensure, through aggressive outreach, that their input is valued during the CHIP implementation and amendment process. Identification of lead agencies and public comment and

review processes are key in the development of strategies to include substance abuse and other supportive or enabling services. Clearly, an effective alcohol and illicit drug prevention program in CHIP plans will have a profound impact on the success of this children's health initiative.

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Additional Online Resources on CHIP

Agency for Health Care Policy and Research
<http://www.ahcpr.gov>

Health Care Financing Administration
<http://www.hcfa.gov>
<http://www.insurekidsnow.gov>

Health Resources and Services Administration
<http://www.hrsa.gov>

The Annie E. Casey Foundation
<http://www.aecf.org>

The Robert Wood Johnson Foundation
<http://www.rwjf.org>

Children's Defense Fund
<http://www.childrensdefense.org>

Families USA
<http://www.familiesusa.org>

National Conference of State Legislatures
<http://www.ncsl.org>

National Governor's Association
<http://www.nga.org>

National Mental Health Association
<http://www.nmha.org>

Quality Services for Adolescents With Substance Abuse Prevention and Treatment Needs: A Brief Review

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The State Children's Health Insurance Program (CHIP) will provide coverage for approximately 5 million previously uninsured children. Thus, States will have to meet the challenge of providing health care services for a much larger proportion of adolescents up to age 18 than ever before. With the high prevalence of substance abuse in the adolescent population, it is important that CHIP plans cover the full continuum of alcohol and illicit drug prevention and treatment services for youth.

The Scope of the Problem

Adolescent Substance Abuse

Studies have shown marked increases in adolescent substance abuse since 1990. Though use of some drugs has leveled off in the last 2 years, a recent study of drug use among American teens reveals that more than one-third of all high school seniors have been drunk in the last month, nearly a third report using marijuana, and more than 10 percent have used an illicit drug other than marijuana (Johnston, 1997).

A limited number of studies have measured the prevalence of adolescent substance use disorders. The available data estimate that between 3 and 4 percent of the adolescent population qualify for substance abuse treatment as measured by *DSM-III-R* criteria (Cohen et al., 1993; Warren et al., 1995). With adolescent substance use on the rise, it is likely that the demand for prevention and treatment services will increase in the coming years.

Co-occurring Disorders

Many adolescents present with both alcohol and other drug use and mental health disorders. A growing body of empirical evidence indicates that as many as half of adolescents with alco-

hol and other drug use disorders also have co-occurring mental health disorders (Petrila et al., 1996). A study conducted by Stowell and Estroff (1992) found that 83 percent of adolescents entering treatment for a primary substance use disorder also met *DSM-III-R* criteria for an Axis I psychiatric disorder.

Youth with co-occurring disorders have multiple and complex needs; providers should be aware of the implications for assessment, treatment, and follow-up care. Substance use may mask underlying psychiatric disorders, and the treatment of mental health disorders may be complicated by an adolescent's substance use. Substance abuse treatment programs for adolescents should be prepared to conduct thorough psychiatric assessments, and mental health treatment programs should screen adolescents for substance abuse.

A Quality System of Care

Substance abuse is a chronic, relapsing disorder with multiple pathways. A quality system of care incorporates the full range of prevention and treatment services. Research over the past decade has resulted in improved understanding of the risk factors and pathways of progression from experimental to problem use among adolescents. Prevention services to adolescents need to be integrated into community and health care delivery systems to treat young people throughout the developmental process. Early identification of alcohol and other drug use in adolescents, followed by appropriate assessment and early intervention, are essential components of a quality system of care.

A broad range of promising treatment options currently exists for adoles-

cents with substance abuse disorders. State CHIP planners should be aware that substance abuse disorders occur on a continuum of severity. Therefore, a mix of treatment options is needed to address adolescent treatment needs. Decisions regarding the intensity and setting of treatment need to be based on a thorough diagnostic assessment, including factors such as severity of substance use, co-occurring health and mental health disorders, family environment, and juvenile justice involvement.

In a quality system of care, treatment services are provided in the least restrictive environment and tailored to the cultural, developmental, and environmental needs of adolescents and their families. Research indicates that such factors as length of time in treatment, family involvement, and the range of services provided are associated with positive treatment outcomes (Catalano et al., 1991; Stanton, 1985; Wynne et al., in press; Liddle and Dakof, 1995). Substance abuse prevention and treatment services are coordinated with those services provided by other delivery systems, including mental health, child welfare, education, and juvenile justice. A coordinated system of community-based services must be maintained for an extended period of time in order to respond to the diverse needs that arise for adolescents at different stages of the development process.

In a quality system of care, both mental health and substance abuse treatment programs should be equipped to treat co-occurring disorders when they are identified. Studies by Petrila, Foster-Johnson, and Greenbaum (1996) indicate that youth with co-occurring disorders have special treatment needs, including:

- Attention to developmental and other characteristics of adolescents
- A treatment focus that examines and involves the adolescent's social and family networks
- The adaptation of clinical interventions for adolescent dual diagnoses
- The need for services to be coordinated and integrated across multiple systems and points of contact

Specific service options for adolescents coping with co-occurring disorders include crisis intervention, inpatient programs, residential treatment programs, day treatment programs, and outpatient counseling (Fleisch, 1991). Recent literature also underscores the importance of reassessing youth when treatment is completed to plan more effective aftercare and to ensure the availability of wraparound services for multiple conditions.

Substance Abuse Services in a Quality System of Care

A quality system of substance abuse care includes the following services tailored to adolescents:

- **Prevention services** for adolescents at risk for developing substance abuse problems, involving education, anticipatory guidance, screening, and brief counseling
- **Assessment and referral services**, such as diagnostic and evaluation services and crisis intervention
- **Psychosocial/psychotherapeutic services** for adolescents with substance use disorders administered by psychiatrists, psychologists, clinical social workers, and certified drug counselors
- **Pharmacological treatment** or prescription medications to assist in the withdrawal process, maintain abstinence, and prevent relapse
- **Case management and wrap-around services**, which coordinate substance abuse services with other community-based systems of care

Self-help or 12-Step programs, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Alanon constitute another key component of a quality system of community-based care for adolescents. These programs serve as an important adjunct to the treatment service system components identified above. They provide a supportive, member-facilitated environment for adolescents attempting to maintain abstinence from drugs and/or alcohol. Researchers have found a positive correlation between self-help group attendance and abstinence. Adolescents attending self-help group meetings at least twice a week were more likely to be drug and alcohol free 1 year after completing treatment (Hoffmann et al., 1993).

Prevention Services

Prevention services are an integral part of the continuum of care for substance abuse (Institute of Medicine, 1994). Family-based approaches to prevent substance abuse among children and adolescents have shown great potential for success (CSAP, 1998; Kumpfer, 1989; Kumpfer, 1987) and may include one or more of the following activities:

- **Parent and family skill training**, which can reduce conflict and improve poor parent-child communication, child behavior, and parenting skills
- **Family therapy**, which can improve family functioning and reduce such antisocial behaviors as juvenile delinquency, recidivism, and child abuse
- **In-home support services**, which focus on decreasing domestic violence, child abuse and neglect, and child placements. In-home services must be aimed at reducing youth crime and arrest rates and at helping youth to improve social skills and school attendance, to manage anger, and to adhere to curfews. These services should be intensive, comprehensive, and long term.

Community-Based Preventive Services

Adolescents who are recipients of early interventions are usually referred by schools, family members, or the judicial system. Student Assistance Programs (SAPs), for example, operate in junior and senior high schools and offer early identification of student problems, referrals to designated community service agencies, support groups, and individual counseling provided in school (James, 1994).

Outreach efforts to at-risk youth populations help prevent substance use within the targeted groups. Outreach services also facilitate entry into treatment for youth with serious substance abuse problems. As noted by Wyman (1997), outreach may be particularly important for certain groups, such as homeless youth, who have an especially high incidence of drug abuse.

Clinical Preventive Services

Clinical preventive services are provided in health care settings and target asymptomatic individuals based on their individual risk profiles. Guidelines for adolescent preventive services have been developed by a number of health organizations, including the Department of Health and Human Services (DHHS) and the American Medical Association (DHHS, 1998; Elster and Kuznets, 1994). These preventive services guidelines recommend that clinicians perform alcohol and drug screening and incorporate early intervention services as part of routine well-child care. Patient education, anticipatory guidance, and patient counseling are early intervention strategies that can reinforce positive health behavior and reduce the risk of alcohol and other drug abuse.

Screening, through use of pre-visit questionnaires and clinical interviews, is an effective means of detecting problem drinking and substance use in adolescents (DHHS, 1998). Substance abuse may be especially difficult to detect among adolescents be-

cause the effects of alcohol and other drugs can be obscured by the emotional and physical upheaval most teenagers experience. A number of screening instruments have been developed for use with adolescents in health care settings (CSAT TIP 31, 1999).

Patient Education/Counseling, also referred to as anticipatory guidance, should be provided to all children and adolescents and their families as part of routine well-child care. Preteens and adolescents should be alerted to the dangers of alcohol and drug use and be taught strategies to refrain from use. Patient education/counseling services involve different strategies related to risk identification and assessment of patient and peer use of alcohol or other drugs in the adolescent's environment, including home, school, or work. Parents should be questioned on whether there is a family history of alcohol or drug abuse. Confidentiality limits with respect to parent and teenager should be clearly explained (DHHS, 1998).

Screening and Brief Intervention (SBI) is an early intervention strategy used in primary care settings. SBI is targeted to patients identified as at risk for developing alcohol or other drug abuse problems, e.g., college students who show a pattern of hazardous alcohol consumption. Within one or several office visits, a clinician explains screening results, provides information about the risks of substance use, and negotiates goals and strategies for change. Some of the benefits of SBI are increased wellness, decreased substance abuse, and reduced use of health services. While the efficacy of this approach is well established in college-age and older adult populations, health care programs have been slow in implementing SBI because of the need for provider training, and program planning and implementation (Health Care and Community Services, 1997).

Assessment and Referral Services

Assessment and referral services diagnose and evaluate the adolescent to determine the nature and severity of substance abuse and related problems. A comprehensive assessment will address adolescent functioning in multiple domains:

- Strengths or resiliency factors, such as self-esteem, family, other community supports
- History of substance use, including frequency, length, and pattern of use
- Health history, including physical and mental health history and physical examination
- Developmental issues, including influence of traumatic events
- Sexual history
- Family history and home environment
- School and vocational history
- Peer relationships, including interpersonal skills and neighborhood environment
- Social services agency involvement

A number of standardized assessment tools have been developed for adolescents and have been tested for reliability and validity (CSAT TIP 31, 1999). Substance abuse assessment requires specialized skills and should be conducted by professionals who have specific training and experience with adolescent substance use disorders, e.g., a substance abuse specialist, psychologist, or other mental health professional. If diagnostic assessment for mental health problems is indicated, this should be done by a professional who is licensed to make mental health diagnoses.

Crisis Intervention

In many cases, adolescents who have substance abuse problems are not identified until a crisis arises. Crisis

intervention services assume a variety of forms, but all models aim to help the adolescent and his or her family manage an acute or emergency situation.

According to the American Society for Addiction Medicine (1994), crisis intervention should focus on de-escalating the situation by eliminating the potential for further injury to self or others, reducing pain, and decreasing the client's anxiety. Not infrequently, crisis intervention services also involve medical treatment, such as detoxification from an overdose or from drug interactions. Other interventions, such as those used by school crisis intervention teams or hotlines, may employ only psychotherapeutic techniques and referrals. Crisis intervention services provide immediate response to an acute medical or psychosocial episode. The goal of crisis intervention is the immediate referral of the adolescent to an appropriate substance abuse assessment service.

Psychosocial Treatment

Individual, group, and family-oriented counseling/psychotherapy, commonly referred to as psychosocial treatment, are the most frequently used types of treatment. Psychosocial treatment methods to treat substance abuse are based on a number of different theoretical models, e.g., cognitive behavioral, behavior modification, psychodynamic, insight-oriented, and motivational enhancement. A combination of therapy formats (individual vs. group) and theoretical models may be used in the course of a treatment episode.

Psychosocial methods have been demonstrated to be effective in treating substance abuse problems in the general population (McClellan et al., 1997; Simpson, 1997). A number of studies have demonstrated the effectiveness of diverse theoretical models, including peer group therapy (Fisher and Bentley, 1996); cognitive behavioral therapy (Azrin et al., 1994); problem-solving and coping skills training

(Hawkins et al., 1991); and relapse prevention techniques (Myers and Brown, 1993). Stanton and Shadish (1997) conducted a meta-analysis that supports the effectiveness of family therapy for adolescents as an adjunct to other treatment approaches.

Pharmacological Treatment

Routinely provided in conjunction with psychosocial treatments, pharmacological agents address symptoms of withdrawal, help maintain abstinence, and prevent relapse.

Detoxification ensures a safe process of physiological withdrawal from one or a combination of drugs. Detoxification services are provided on an inpatient or outpatient basis, depending on the severity of the medical problems associated with withdrawal. Many adolescents who abuse substances have not yet developed physiological symptoms of dependence. Martin and colleagues (1995) report that only 22.6 percent of the adolescents in a clinical sample with a DSM-IV diagnosis of alcohol dependence experienced some form of physiological withdrawal.

Currently, most detoxification services are provided on an outpatient basis and are viewed as a first step in a more comprehensive approach to treatment, involving counseling and other support services (Lowinson et al., 1992). Adolescents who experience medical complications from overdose or who have associated psychiatric and other medical problems receive detoxification services on an inpatient basis.

Opioid Addiction Treatment

Methadone and LAAM (levo-alpha-acetyl-methadol) are synthetic opiate agonist medications that treat heroin addiction. Used in conjunction with counseling, medical, vocational, mental health, and other appropriate services, these are the only medications the Food and Drug Administration (FDA) has approved for this purpose. Studies have consistently demonstrated their effectiveness when prop-

erly administered and offered in combination with comprehensive services (Senay, 1985; Sells, 1977).

The FDA and the Drug Enforcement Administration regulate these medications through registration of practitioners. FDA regulations (21 CFR, part 291.505) pertinent to the CHIP population state that "a person under 18 is required to have had 2 documented attempts at short-term detoxification or drug-free treatment to be eligible for maintenance. A 1-week waiting period is required after such a detoxification attempt, however, before an attempt is repeated." The consent of a parent, guardian, or responsible adult is a precondition for admission to treatment.

Case Management

All models of case management serve a core set of common goals, including "helping the client implement personal reentry plans, monitoring the client's progress, intervening in client and family crises, and most importantly, helping the client to create links with prosocial support structures within the larger drug-free community" (Spear and Skala, 1995). Case management facilitates treatment by addressing individual needs and linking adolescents to services available in several different environments.

Descriptive studies highlight the increasing use of adolescent substance abuse case management models (Evans and Dollard, 1992; Godley et al., 1994). Studies of adult populations suggest that case management improves the quality of substance abuse treatment. A recent study found that the inclusion of case management services increased client retention in both residential and outpatient programs. Furthermore, residential clients receiving case management services were less likely to relapse during a 90-day follow-up period (Schwartz et al., 1997).

Wraparound Services

Substance abuse treatment is most effective when adolescents and their

families have access to a full range of community support services. The wraparound model allows adolescents and their families to work with an interdisciplinary treatment team to develop a service plan tailored to the client's unique circumstances.

A recent inquiry by the Committee on Quality Assurance and Accreditation Guidelines for Managed Behavioral Health Care found that an individual's larger social context must be considered if treatment is to achieve long-term, positive outcomes (Edmunds et al., 1997). In one instance, treatment providers assembled a consortium of social service agencies, schools, corrections personnel, churches, and community organizations to support a day treatment program for adolescents in rural areas (Bricker and Bricker, 1995). Edmunds and colleagues (1997) recommend that wraparound models be included as a part of the managed care accreditation process.

Substance Abuse Service Delivery Settings

Adolescent substance abuse services are provided either in nonresidential/outpatient or in residential settings. Nonresidential or outpatient service settings offer less restrictive care that varies in intensity but does not include overnight accommodation. Residential treatment settings provide 24-hour care and may include hospitals, residential facilities, therapeutic communities, and group homes. In general, adolescent treatment service systems provide appropriate services in the least restrictive setting. Eighty percent of adolescents in substance abuse treatment receive care in outpatient settings (Kaminer and Bukstein, 1989).

Nonresidential/Outpatient Settings

Nonresidential/outpatient service settings deliver prevention services and a broad range of treatment services of varying intensity. CSAT TIP 32, *Treatment of Adolescents With Substance Use Disorders* (1999), identified three levels of professionally

directed evaluation and treatment service: nonintensive (fewer than 9 hours per week), more intensive (9 to 20 hours per week), and day treatment (as many as 40 to 60 hours per week). Services provided to adolescents in outpatient settings are typically coordinated with the school schedule and may include after school and evening programs as well as structured programs during weekends and vacation periods.

School-Based Health Clinics

(SBHCs) provide substance abuse prevention services, counseling, and referrals. A study of one SBHC conducted by Anglin, Naylor, and Kaplan (1996) found that 8 percent of students sought substance abuse services in this setting. The Colorado School Connections Program, conducted through Kaiser Permanente, offers comprehensive health care (primary care clinical and preventive services, including substance abuse assessment and referral) at 20 school-based health centers to low-income, uninsured children.

Day Treatment, sometimes referred to as partial hospitalization, provides professionally directed evaluation and treatment in a structured program. Day treatment programs typically provide services for adolescents for more than 4 hours a day, usually between 5 to 7 days a week. These programs include individual counseling, on-site adolescent self-help groups, group and family counseling, educational services, and referral.

Structured outpatient treatment is a viable alternative to inpatient care for adolescents who have adequate family and community supports, who are motivated to accept treatment, and who are willing to cooperate in the treatment program (Lowinson et al., 1992). Individuals and family members with higher levels of interpersonal and intrapersonal functioning are more successful in this setting (Feigelman, 1987; Friedman et al., 1986). An early outcome study documenting the effec-

tiveness of adolescent day treatment found significantly reduced substance use levels compared to pretreatment.

Residential Settings

Residential treatment settings include a range of domiciliary facilities and may include professionally directed medical, psychiatric, and/or psychosocial treatment and 24-hour supervision and care. The residential care continuum includes psychosocial care at the most intensive end and group home living without professional supervision at the least intensive end (CSAT TIP 32, 1999).

Nonhospital-based residential treatment facilities include community-based programs, therapeutic communities (TCs), and halfway houses. Residential settings are designed to remove the adolescent from the home and school and provide a new, drug-free environment. Services may include individual and group counseling, self-help groups, educational activities, recreation, and drug education in addition to 24-hour supervision. Adolescent residential treatment programs may range from 1 to 12 months and may include outdoor or wilderness experiences to foster self-esteem and cooperative behavior (CSAT TIP 32, 1999).

Inpatient Hospital Programs

Inpatient hospital treatment settings provide both psychiatric and medical services and are used for adolescents with more severe substance abuse problems or with chronic psychiatric and substance abuse problems. Hospital inpatient treatment includes assessment; individual, group, and family counseling; and behavior modification. Hospital-based substance abuse treatment for adolescents typically does not extend beyond 2 months (Lowinson et al., 1992).

Therapeutic Communities offer a highly structured, intensive, and comprehensive treatment program that typically includes daily encounter

groups, group therapy, counseling, tutorial learning sessions, formal education, and residential job functions. Residential job functions and facility management roles are a vehicle for teaching self-development.

The therapeutic community provides an environment in which residents can develop social skills and productive lifestyles. TCs emphasize the role of mutual reinforcement and social pressure to maintain abstinence and eliminate antisocial behavior (DeLeon, 1994). As of 1994, 20 to 25 percent of TC clients nationwide were adolescents. Adolescents entering TCs are likely to have more acute substance abuse problems, as well as other mental health disorders, learning disabilities, and criminal justice involvement (Jainchill, 1994).

Group Homes/Therapeutic Foster Care

, also referred to as halfway houses or independent living, are community-based, nonmedical transitional living arrangements with varying levels of treatment planning and staff supervision. These settings provide food, shelter, and vocational, recreational, and social services to adolescents in a supportive atmosphere. Residents may work and/or receive educational training outside of the group home. In therapeutic foster care, a small group of adolescents is placed in a family situation with foster parents who have some experience working with youth who abuse substances (CSAT TIP 32, 1999).

Conclusion

Promising prevention and treatment interventions exist for adolescents who are at risk for or are currently evidencing substance abuse problems. States implementing CHIP should incorporate a full range of prevention and treatment services that can be sustained throughout the adolescent's developmental process. Under the Federal block grant program, a number of States have developed quality service delivery models for adolescents, addressing prevention and treatment

needs for substance abuse as well as for co-occurring mental health and substance abuse problems. State CHIP administrators should contact their State Substance Abuse Agency Director to obtain up-to-date information on how existing substance abuse and mental health delivery systems can be integrated into the CHIP planning and implementation process. A list of State Agency Directors is available at www.treatment.org. ■

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Outreach Strategies in the State Children's Health Insurance Program: What is Outreach and Why is it Important?

— Vicky Pulos, Associate Director of Health Policy, Families USA, and Lisa Gallin Lynch

Participation rates in expanded Medicaid and separate State-funded insurance programs for children suggest that States need to do a better job getting the word out to working families. Expanding eligibility is not enough to ensure coverage. Aggressive outreach efforts are also needed. Both the existing Medicaid programs and the new Children's Health Insurance Program (CHIP) must be made more family friendly.

CHIP defines outreach as activities to inform families of available coverage and to assist them in enrolling in these

Expanding eligibility is not enough to ensure coverage. Aggressive outreach efforts are also needed.

programs (2102[c] of the Social Security Act). Each State submitting a CHIP plan must describe how it will find and enroll eligible families. The biggest barrier to enrollment is that families simply do not know that public insurance programs for their children exist or how to apply for them. A poll taken several months after passage of CHIP found that only 29 percent of all parents and only 26 percent of parents of children without health insurance had heard anything about the program (Harvard, 1997). A 1995 survey in Minnesota found that one-third of uninsured residents were not aware of MinnesotaCare, the State-funded insurance program, and of those who had heard of it, one-third did not know how to find out whether they were eligible or how to enroll. Researchers estimated that about four-fifths of uninsured children were probably eligible for MinnesotaCare (Call et al., 1997).

In addition to lack of knowledge about public insurance programs, misinfor-

mation, especially about Medicaid, is another barrier to enrollment. Many people still incorrectly assume that Medicaid eligibility is limited to single-parent families receiving cash assistance from Temporary Assistance to Needy Families (TANF, formerly Aid to Families with Dependent Children or AFDC). As part of a regional outreach initiative, the Southern Institute on Children and Families interviewed AFDC and transitional Medicaid recipients, community workers, and others about their knowledge of the Medicaid program. The institute found that a majority of recipients did not know that a child could get Medicaid even if the parents live together. Nor were recipients aware that transitional Medicaid was available after a parent moved from welfare to work. Even among community workers and providers, few knew about the higher Medicaid income limits for children under age 6 (Shuptrine et al., 1998).

The current Medicaid program covers younger children at higher income levels than older children. This is confusing for families, and many States using CHIP to expand Medicaid eligibility are doing so in order to enable all children in the same family to be in the same health coverage program. States creating separate programs face greater challenges in coordinating coverage between Medicaid and the new program. No one wants to see families bounced back and forth between programs, or denied as over-income by the Medicaid agency and denied again as Medicaid-eligible by a separate CHIP agency. It is also important for continuity of care that children do not have to change coverage programs or doctors as family income fluctuates.

States are exploring different ways of coordinating coverage, including the use of joint application forms and the

use of the same agency to make eligibility determinations for both Medicaid and a separate CHIP. Other continuity-of-care strategies include the 12-month continuous eligibility option and the use of the same delivery system for Medicaid and a separate CHIP.

Strategies for Spreading the Word

The Clinton Administration sponsored a national children's health outreach initiative to enroll uninsured children in Medicaid or CHIP, whichever program matches their eligibility. Callers to a national toll-free number (1-877-KIDSNOW) will be connected automatically to a toll-free number in their State. In addition, several national chain stores and trade organizations have agreed to help publicize CHIP by printing the toll-free number on grocery bags and enclosing information with prescriptions, for example. The President has also directed eight Federal agencies with jurisdiction over children's programs—the Social Security Administration, and the Departments of Agriculture, Interior, Education, Health and Human Services, Housing and Urban Development, Labor, and the Treasury—to develop plans to help enroll children, including distributing information and coordinating the application process through the School Lunch Program, Head Start, and other programs serving the target population.

Media campaigns get the word out to the public using radio, television, newspapers, billboards, and posters. The messages should describe the program and give information about how and where to apply. Some States also supply a web site address. Every State is including some kind of media campaign in its outreach plan. Arkansas has run television spots about its children's Medicaid program, ARKids

First, and reports that almost half of all applicants identified television as their source of information.

Targeting locations and agencies serving children reaches parents where they are likely to be found: child health care providers, schools, child care centers, and other businesses and agencies that serve children. Such organizations may publicize the CHIP program by displaying posters and brochures or including information about CHIP in newsletters or other materials sent to parents. In addition, the staff may be trained to make referrals or to assist parents in obtaining and completing application forms.

Direct mail campaigns send CHIP information to parents likely to have eligible children. Coordination with other programs serving families with children enables the States to identify these families more effectively. For example, both Florida and Tennessee plan to send information to families receiving food stamps but not Medicaid. Illinois will be sending information to noncash assistance families using the State's child support enforcement services. Wisconsin has targeted families terminated from cash welfare assistance. Several States plan to include CHIP information in materials sent to parents of school children about the free and reduced-price school meal program. Child support enforcement programs might also be involved in CHIP outreach. "Not only does this agency have records about which children do not have coverage through private insurance or Medicaid, it also has financial information about parents that would be useful . . . to screen for CHIP eligibility. Moreover, the child support agency could assist the State in collecting from non-custodial parents any CHIP premiums the State decides to impose, and could move children to private insurance if and when it becomes available to them through their non-custodial parents" (Roberts, 1998).

Widespread distribution of application forms can be accomplished in

States that have shortened the form and that accept mail-in applications. Michigan has combined a short application with its informational brochure. Within a few months of implementation, South Carolina had mailed over 500,000 copies of its 1-page application with a cover letter from the Governor; South Carolina reported over 35,000 new enrollees in the first 9 months of the program. Rhode Island sends application forms to all children in school.

Targeting special populations is necessary. Hispanic children are disproportionately represented among the uninsured. To reach them, information should be translated into Spanish. California is proposing translation into 10 threshold languages, and Tennessee is preparing a video for deaf parents. Several States, including Colorado and Illinois, promise special efforts to reach homeless and migrant children, as well as those living in rural areas. Massachusetts is offering grants to community organizations to find hard-to-reach children, including teens, children of seasonal workers, and young parents. In addition, CHIP requires States to identify how they will enroll American Indian children. HCFA has urged States to consult with tribal governments. ■

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but somewhat lower incidence rates for children in foster care in California and Illinois (65 percent and 74 percent respectively) (GAO, 1998).

The services most often required by children living with a parent or parents who abuse alcohol and other drugs are those that support the entire family, including substance abuse treatment for the parent(s), services that enhance parenting skills to decrease the risk of child abuse and neglect, or alternative placement for the child if parental drug use poses a serious safety risk. Children living in households where one or more parents abuse alcohol or other drugs often benefit from services to meet their own mental health needs. ■

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Substance Abuse Benefits in State Children's Health Insurance Programs

— Shelly Gehshan, M.P.P., Program Manager, National Conference of State Legislatures (NCSL)

It has been over 2 years since Congress enacted the State Children's Health Insurance Program (CHIP), and the pace of policy and program development in States is still brisk. All 56 States and Territories have submitted plans and received approval from the Health Care Financing Administration (HCFA) to implement their programs. An approved plan does not mean the design phase is over, however, because the law gives States substantial flexibility to change their programs. Some States have already submitted plan amendments, and more can be expected to do so as gaps in their current strategy become clear, political leadership or fiscal considerations change, and program performance information becomes available.

It is likely to take quite a few years for CHIP programs to reach maturity. These new programs will take shape and grow slowly over time as States refine their approach and eligible families learn about their availability. Nevertheless, analysts and advocates inside and outside of government are examining the design and implementation phase of CHIP and asking critical questions. One of these is how the new programs will handle the need for alcohol and other drug abuse treatment for adolescents.

Under CHIP, States can choose to expand Medicaid, establish a new private program, or do some combination of the two. As of September 9, 1999, 27 States expanded Medicaid, 16 established a new private program, and 13 pursued a combination approach. While it now looks as though a majority of States have chosen to expand Medicaid, the numbers are deceiving. Most States with a combination program have made small expansions in Medicaid, often to add older children at the State's current

income eligibility level, and established a private plan for children in families with higher incomes. States continue to submit plan amendments to HCFA. About one-third of these amendments expand the original CHIP program, another one-third add a private program, and one-third make a technical change to conform to Federal or State law or to correct a problem.

The critical factors for States in choosing which approach to take have been predictability and cost: Medicaid is an entitlement, so all eligible children must be enrolled; private programs are capped so States can limit the number of children served. States have also chosen Medicaid because it is quicker to expand Medicaid than to develop and implement a new program, administrative costs are low, and the benefit package is well suited to the needs of children (even those with special health care needs). Plus, if there is only one program, there are no sticky equity issues to confront about different groups of children getting unequal benefits or service systems. Another reason, given recent trends, is that adding CHIP children to the existing pool of Medicaid recipients makes a larger group and gives States more bargaining power in negotiating rates with managed care companies.

Which approach a State takes does not immediately determine what substance abuse treatment benefits will be available. (For a complete description of benefits available in each State, consult the chart posted at NCSL's web site: www.stateserv.hpts.org.) Of the 56 States and Territories, and the District of Columbia, 28 are offering Medicaid benefits, 8 are offering full substance abuse treatment benefits, 14 are offering limited treatment benefits, and 1 does not cover substance abuse treatment. Five more states

cover treatment, but limits are not specified in their plans. The eight States with full benefits are offering packages that resemble coverage available under the private market to people with employer-sponsored insurance (detoxification services, 30 days of inpatient treatment, and some number of outpatient visits). The 14 States with limited benefits primarily offer outpatient treatment, or both inpatient and outpatient treatment with low annual or lifetime limits.

These benefit packages might not work well for adolescents, since young people and adults need different treatment options. They are less likely than adults to need inpatient detoxification services, since their substance abuse may not have lasted long enough to cause serious physical withdrawal. They may be more likely than adults to have co-occurring mental health problems, particularly depression and problems related to physical and sexual abuse. There is a much greater need for counseling of a youth's family members, parents, and care givers than there is for adults. In addition, the location and timing of care for adolescents is different from that for adults. Adolescents are more likely to need treatment that allows them to live at home with their families or care givers, and may respond well to programs that are scheduled after school or during the summer. Finally, adolescents are often impulse-driven, which means that treatment needs to be available when they are ready. Plans that require families to complete extensive paperwork and precertification processes in order for an adolescent to receive treatment may find that the opportunity for treatment has been lost.

A State's choice of whether or not to expand Medicaid has broad implica-

tions for what benefits children in need of substance abuse treatment will receive. States that have expanded Medicaid will have one system. All children, whether newly eligible or already in the program prior to the enactment of CHIP, will receive the same benefits from the same providers. States that have chosen a private or combination program will have two systems. Most of these will have two sets of benefits and different delivery systems, although some States have tried to design their programs to be “seamless.” States such as Kansas and North Carolina have tried to plan their programs as Medicaid “look-alikes” so that recipients who have changes in income will not notice changes in co-payments, benefits, or providers, even though they may actually change from Medicaid to the private program, or vice versa.

To make matters even more complicated, in some States with private or combination programs there will be two insurance sources in one family. This will occur in States that have “stair-step” Medicaid eligibility, which covers children of different ages at different percentages of the Federal poverty level (FPL). For example, children under age 6 might be covered to 133 percent of FPL and children 6 to 15 up to 100 percent of FPL, with a separate new private program for higher income children. In these States, coordination between Medicaid and a new private CHIP plan will be critical. (Under Federal law, States are required to provide Medicaid for children under age 6 up to 133 percent of FPL, and children under age 15 up to 100 percent of FPL. Older children are being phased in one year at a time. States are allowed to cover older children and those with higher incomes, and most do, although coverage varies significantly.) Of course, this replaces the current situation, in which some families have younger children enrolled in Medicaid while older children are ineligible and uninsured.

What States provide in the way of substance abuse treatment through

Medicaid has never been clear because inpatient care and physician services are required services that are not reported according to diagnosis. At a minimum, States must provide inpatient detoxification and outpatient services (that are billed as physician services). Also, States are barred from reimbursing for any services delivered by a State institution with more than 16 beds that treats “mental diseases,” such as mental retardation or chronic mental illness. For the most part, this has prevented States from providing residential substance abuse treatment for Medicaid patients.

Children and adults may receive very different substance abuse services, however. Under Early Periodic Screening, Diagnosis, and Treatment (EPSDT), which is a federally mandated benefit under Medicaid, States must provide any service children need, whether or not it is part of a State Medicaid plan. So even if a State provides only the minimum in substance abuse treatment for other eligibility groups, if a physician screening determines that a child needs additional treatment, Medicaid must provide it.

Equity is the most important issue that arises for children and adolescents in need of substance abuse services in States that have opted for private or combination plans. Although families may be very similar in terms of health problems, social supports, involvement in the workforce, and demographics, those below Medicaid income levels will receive Medicaid benefits, and those above will receive different and generally lesser benefits. Three examples will show the range of experiences children insured by private CHIP programs will face in different parts of the country.

■ In **Pennsylvania**, a child covered by the private program will receive no substance abuse treatment benefits at all. Children will have to access services available through the community-based system.

■ In both **Alabama** and **Florida**, which are among the States with limited benefits, children in private programs will have low limits on inpatient treatment (72 hours, or detoxification only) and a maximum of 20 outpatient visits per year.

■ In **Connecticut**, children in the private plan can receive 45 days of inpatient and detoxification services per year for drug abuse and 60 days per year for alcohol abuse, and 60 outpatient visits per year. In **Kentucky**, another State with full benefits, all medically necessary services are available and will be provided through agencies that subcontract with managed care plans.

In all States, by comparison, a child covered by traditional Medicaid is eligible for a full range of substance abuse treatment services, either through EPSDT or through State plan benefits delivered by a fee-for-service or a managed care mechanism. Some States have handled the equity issue by using the Medicaid benefit package for the new private program. New Jersey will be providing the same substance abuse benefits in its private program, KidCare, as in Medicaid.

Although substance abuse benefits for children may be greater under Medicaid than private or combination programs, Medicaid is no panacea. Medicaid programs vary considerably in their ease of enrollment, the extent of their conversion to managed care, the richness of their benefits, and the breadth and depth of their provider networks. There is also a great difference between the existence of benefits and whether needy patients receive them. For decades, there have been problems with Medicaid provider participation, distribution, and reimbursement rates. While the recent shift to managed care in Medicaid programs may have eased provider problems somewhat, it also means that recipients have complex new systems to navigate in order to get care. And the transition to managed care means that recipients in one part of a State may

receive different benefits from different providers than people in other parts of a State.

Another important issue arises with all the CHIP plans, be they Medicaid, private, or combination programs. Most States are contracting with managed care organizations (MCOs) to deliver both physical health and substance abuse and mental health services. The quality of these programs may rest on the details spelled out in the contracts between States and MCOs. These providers may have little or no experience with low-income, culturally diverse populations and may not be appropriately staffed to serve children and adolescents. Medically speaking, children are not just small adults, and an appropriate array of pediatric providers must be available to serve them. Also, States will need to require MCO contractors to provide linkages with traditional community-based treatment services so that families have somewhere to turn if their children need more treatment than their plan provides.

Finally, it is clear from watching the development of CHIP plans that the goal is not just to insure a new group of children, but to improve their health. In theory, it isn't difficult to offer an insurance program and make it work for people. In practice, even after 33 years, Medicaid is still a work in progress. Like Medicaid, CHIP will face challenges in outreach, enrollment, cost control, service delivery, and much more. It will take a sustained effort on the part of providers, advocates, parents, researchers, and policy makers to monitor the implementation of children's health programs in their States and share information about what works and what does not. Only feedback about substance abuse treatment provision for adolescents, as well as other aspects of CHIP plans, will enable States to improve these programs over time. ■

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TIE Communiqué

A Memo to the Field from the Center for Substance Abuse Treatment (CSAT)

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