CHILDREN AND FAMILY FUTURES
STRATEGIC PLANNING AND EVALUATION

SIDNEY L. GARDNER, M.P.A.
PRESIDENT

NANCY K. YOUNG, Ph.D.
DIRECTOR

MICHELLE BERELOWITZ, M.S.W.
JORGE B. LOPEZ, M.P.A.
KIM DENNIS, M.P.A.
ASSOCIATES

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ADDITIONAL CONSIDERATIONS IN REVIEWING THE MRMIB REPORT TO THE LEGISLATURE "THE VIABILITY OF PROVIDING ADDITIONAL ALCOHOL AND DRUG TREATMENT SERVICES TO HEALTHY FAMILIES CHILDREN"

At the request of the members of the California Alcohol and Other Drug Policy Forum, Children and Family Futures is pleased to offer the following report in response to the March 17, 1998 draft "The Viability of Providing Additional Alcohol and Drug Treatment Services to Healthy Families Children." Children and Family Futures is a California non-profit organization dedicated to improving outcomes for children and families, particularly those affected by alcohol and other drugs, by providing technical assistance and training to government, community-based organizations, and schools on strategic planning, evaluation, and measures of effectiveness. The following report is offered to the California Policy Forum, State agencies, and the Legislature as information and educational material to assist in deliberations on developing effective responses for California's children affected by alcohol and other drug problems.

BACKGROUND

Title XXI of the Social Security Act provides federal funding through a block grant to the states to provide medical insurance to uninsured children. California's Title XXI plan is among the first six State plans to be approved by the Health Care Financing Administration and uses the Public Employees Retirement System (PERS) health benefit package as its benchmark. The California plan is administered by the California Managed Risk Medical Insurance Board (MRMIB) and is being implemented through the Healthy Families Program (HFP). HFP will provide low-cost health insurance to uninsured children (age 1 to 19) from families with an annual income less than 200% of the federal poverty level and who are not eligible for no cost Medi-Cal (annual family income would be between $13,300 and $25,550 for a family of three).

Assembly Bill (AB) 1126 established the HFP and directed MRMIB, in consultation with the Department of Alcohol and Drug Programs (DADP), to provide to the Legislature a report *assessing the viability of using Title XXI funds to provide additional AOD services to children enrolled in HFP*. The HFP benefit for substance abuse services includes inpatient care for detoxification with no co-payment and limits outpatient services to 20 visits per benefit year with a $5 co-payment. The federal funds for the HFP will be matched with State funds at a 65:35 ratio.

4940 IRVINE BOULEVARD, SUITE 202 IRVINE, CA 92620 714.505.3525 FAX: 714.505.3626 EMAIL: NKYOUNG@CFFUTURES.COM

The report prepared by MRMIB in consultation with the DADP addressed three issues: 1) an overview of the AOD system of care; 2) a description of the benchmark plan services; and 3) an analysis of the viability of using federal funds to provide additional services. Factors included in determining viability were capacity, need for services, and appropriate match funds. This report offers additional information in each of the areas addressed by MRMIB.

I. OVERVIEW OF THE ALCOHOL AND OTHER DRUG SYSTEM OF CARE

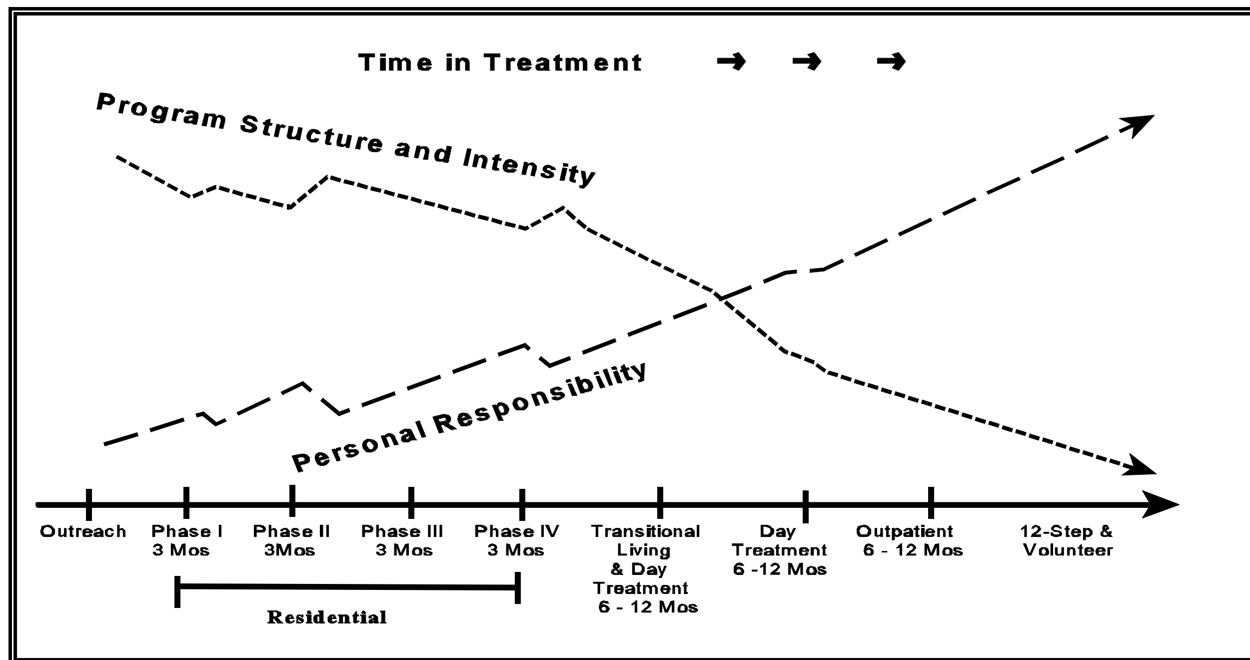
There is widespread agreement among all factions concerned with AOD problems that the publicly funded treatment and recovery system for California's children is inadequate. Solving the larger problem of the gap in adolescent treatment services in California should not be undertaken using only the new Title XXI resources. At the same time, the larger treatment gap must be a part of the discussion of HFP benefits because the benefit issue exists in that larger context of the full range of adolescent AOD needs. More importantly, the children and youth covered through the HFP need a benefit package that fills this gap in AOD services for the 16,500 adolescents estimated to need AOD services who will be covered by HFP. It is sound public policy for California to take advantage of federal matching funds to meet the needs of these 16,500 children rather than provide an inadequate plan and force HFP children and their families into the broader pool of 259,000 youth competing for scarce AOD services.

The MRMIB report points out that less than 4% of the treatment services provided to Californians through the publicly funded system were provided to youth (ages 12 to 18). Yet, almost 11,300 youth treatment services were provided in Fiscal Year 1996/97. These admissions represent more admissions to treatment than in the entire AOD system in 18 states. Although California's youth treatment system is woefully inadequate to meet the need of the estimated 259,000 teenagers who need services, the youth treatment system in California is larger than 18 states' entire AOD systems.

There are three critical issues that were not addressed in the MRMIB report in its overview of the AOD system that must be considered: (1) providing the appropriate level of structure and intensity of treatment programs for clients; (2) innovations in AOD treatment related to enhancing motivation; and, (3) the unique needs of children requiring AOD related services.

1. Providing Appropriate Levels of AOD Services

State-of-the- art AOD treatment adjusts the intensity and structure provided to a client based on the client's progress and improved ability to exercise personal responsibility. These adjustments to program intensity are depicted in the following graphic, adapted from a model developed by Dr. Vivian Brown, CEO of PROTOTYPES and Dr. George Huber of The Measurement Group from evaluation documents of PROTOTYPES Women's Center in Pomona.[1] PROTOTYPES, Centers for Innovation in Health, Mental Health and Social Service programs include each of the levels of care so that they can respond to differing needs of women and their children. The PROTOTYPES model depicts time lines for the women in their program; however, the critical issue in modern AOD treatment is the *flexibility* that is needed to respond to clients' needs as they progress (and sometime regress) in their treatment and recovery program.



While the PROTOTYPES program serves women and their children, the concept of varying the degree of structure that is required by a client is not unique to women.

In fact, the American Society of Addiction Medicine (ASAM) has developed criteria to assess which treatment options and levels of intensity are appropriate for clients.[2] Complete details, explanation, and training on implementing the criteria are available through ASAM and Dr. David MeeLee (a resident of Davis and Chair of the national ASAM criteria committee) has assisted DADP in adapting the ASAM criteria for California implementation and has provided training on ASAM criteria to many California AOD providers.

Using the continuum of care approach allows some clients to participate in treatment services while they are also attending school and/or working. However, it is clear that *clients who are more impaired require more intensive levels of care*. In addition, clients who are not successful in a specific level of care generally require more intensive services and structure in their treatment plan. While many persons unfamiliar with AOD treatment may observe a drop-out of treatment or positive drug test to be a treatment failure, the American Society of Addiction Medicine views the inability to remain abstinent as a clear marker that the intensity of treatment milieu must be increased. The AOD field has reached some consensus in attempting to standardize treatment according to the levels-of-care distinction. In California, a workgroup has adapted the ASAM criteria for California implementation, several counties are exploring the ASAM criteria as a tool to assess appropriate levels of care, and several providers have already implemented the criteria.

Determination of the appropriate level of care is made by assessing a client's level of functioning in six life areas. The lower the level of functioning in these critical life areas, the more intense and structure the treatment response needs to be. The six life areas are:

- Acute Intoxication and/or Withdrawal Potential
- Biomedical Conditions
- Emotional/Behavioral Conditions and Complications
- Treatment Acceptance/Resistance
- Relapse/Continued Use Potential
- Recovery Environment (Family and Social Situations)

In addition to detoxification services which can be delivered within each of the levels of care, there are three levels of outpatient care and four levels of residential care. This gamut of AOD services comprises the *continuum of AOD services* that should be available to clients and treatment providers in a flexible system of matching treatment intensity to client needs. These levels of care are listed below:

- Prevention

- Level 0.5 Early Intervention

- Level I Outpatient Services
  I-D Ambulatory Detoxification without Extended On-site Monitoring
  I - Outpatient Treatment

- Level II Intensive Outpatient/Partial Hospitalization Services
  II-D Ambulatory Detoxification with Extended On-site Monitoring
  II.1 Intensive Outpatient Treatment
  II.5 Partial Hospitalization Treatment

- Level III Residential/Inpatient Services
  III.1 Clinically Managed, Low-Intensity Residential Treatment
  (Halfway house; Supportive Living Environment)
  III.2-D Clinically Managed Inpatient Detoxification Services
  (Social Detoxification)
  III.3 Clinically Managed, Medium-Intensity Residential Treatment
  (Extended Residential Program)
  III.5 Clinically Managed, Medium/High-Intensity Residential Treatment
  (Therapeutic Community)
  III.7-D Medically Monitored Inpatient Detoxification Services
  III.7 Medically Monitored Intensive Inpatient Treatment

- Level IV Medically Managed Intensive Inpatient Services
  IV-D Medically Managed Inpatient Detoxification Services
  IV Medically Managed Intensive Inpatient Treatment

Again, the important concept is flexibility in treatment structure and intensity to respond appropriately to varying degrees of clients' personal responsibility during treatment. Responding appropriately to the amount of structure needed by a client requires a funding system that can support the various levels of care needed by a client.

Once in treatment, there are several approaches that are used. The specific therapeutic approaches are generally divided into three categories, with some adding a fourth: (1) physical methods, (2) psychological methods, (3) social methods, and (4) spiritual methods.[3, 4] The categories are described in the following table:

Physical Methods	Psychological Methods	Social Methods	Spiritual Methods
Detoxification Medications Acupuncture	Group, family, and individual psychotherapy Aversion therapy Behavior modification	Legal strategies Rehabilitation social skills training Self-help groups and mutual aid	Religiously oriented self-help groups

2. Innovations in AOD Treatment Related to Enhancing Compliance, Motivation, and Long-term success

Despite 25 years of research documenting treatment effectiveness[5] and cost offsets derived from AOD treatment,[6] the perception persists among the public and many policymakers that treatment "doesn't work." Thus, it is necessary to deal with that skepticism in any discussion about expanding treatment services.

Although multiple failed attempts to stop smoking (and resultant relapses) are readily accepted as common, the public is less willing to tolerate multiple attempts to stop the use of illicit drugs or the abuse of alcohol. Several recent national- and state-level studies have documented outcomes derived from AOD treatment and have found rates of AOD recovery similar to those of other diseases which require a behavioral change component as part of the treatment regimen. In addition, research conducted by McLellan and his colleagues documented that *AOD treatment compliance is comparable to compliance rates among patients treated for diabetes and hypertension*, two other chronic diseases requiring major behavioral changes. Less than one-half of diabetics comply with their medication protocols and fewer than 30% of persons with high blood pressure comply with the medication and prescribed diets.[7] Other research has documented increased long-term success based on increasing early motivation to change and focusing initial problem solving on the problem that the client perceives as most critical.

Motivational Interviewing. Recent advances in AOD treatment research have repeatedly shown that persons who are coerced to participate in AOD treatment have similar outcomes as those who voluntarily participate in treatment. In fact, some treatment providers have specialized in conducting "interventions" with persons who are not yet able or willing to admit that their AOD use is the cause of substantial family, work, and health-related problems. Intervening with a person who has not yet admitted that they are "powerless" over alcohol and other drugs is a primary component of early treatment protocols and allows the individual to move past denial to a willingness to change.

This early work by treatment professionals is sometimes referred to as "raising the bottom," (i.e., not waiting until the client "hits bottom") so that the individual and society do not have to incur the higher costs of continued AOD abuse. Ultimately, individual motivation is an important

ingredient in recovery, but motivation can be greatly enhanced by AOD professionals providing cognitive, supportive, and behavioral interventions during early stages of recovery. Much of the understanding of these early phases of treatment is based on work by Prochaska and DiClemente[8] who proposed that change is a process rather than a discrete event. The change process has been described in phases with distinct goals for working with a client at each phase:[9]

Phase	Aim of Intervention
■ Precontemplation	To increase the perception of risks associated with substance use by providing information and feedback
■ Contemplation	Explore the positive and negative consequences of use and tip the balance toward change
■ Determination	Preparation for change by strengthening the commitment to change by helping the client to determine the best course of action to take
■ Action	Acknowledge that the client may experience a sense of ambivalence and need a sense of reward for any success achieved
■ Maintenance	Requires continued vigilance toward the change process and achievement of personal goals
■ Relapse	Although not desirable, is a normal part of the change process and interventions are geared to minimizing problems associated with lapse or relapse by renewing the commitment to change

The critical component in early treatment is assessing the phase that a client is in and helping the client to move to the next phase until he/she is ready to take action. This explains the oft cited frustration of a friend or family member that doesn't stop drinking or using drugs despite repeated requests from loved ones. The tactic used must correspond to the individual's stage of change; telling someone to stop using AOD before they are in the action phase simply does not work. It is this early work by AOD treatment professionals that is key to engaging a client and sustaining the change process.

Matching Services to Immediate Needs. The mechanism that is used to help a client move into the action phase is making the connections between their AOD use and the consequences that they are experiencing as a result of their use. This seems almost comical to the outside observer, of course an individual can see the connections between their AOD use and the terrible devastation that is occurring in their life. In fact, we now know from neuroscience studies of addiction how to better understand the chemical mechanisms of denial. The over-saturation of dopamine in the brain leads the individual to continuing AOD use despite the negative consequences in their life.

Therefore, moving into the action phase requires enough structure in the treatment setting to allow for breaks in dopamine saturation so that the individual can understand the connection between their AOD use and the areas of life functioning that are being affected by their use. The domains included in a biopsychosocial assessment are explored in relationship to the individual's AOD use and then linked to specific services in the treatment plan which address that domain. There is recent evidence that addressing the need that the client perceives as *most urgent* results in more effective client engagement in the treatment process and leads to better outcomes.

The innovation in AOD services is that regardless of the level of care that the client is in (residential or outpatient), a comprehensive assessment enables the AOD worker to focus on the area of life that the client perceives as most urgent. Substance-abusing clients come to treatment with a host of interpersonal, legal, medical, financial, and other concerns. Making the connection between the immediate crisis that the client is experiencing and his/her substance use helps to ensure that treatment addresses the reality of the client's related problems, rather than providing treatment in a vacuum that ignores those other issues. This improves client's ability to engage in the treatment process and improve treatment compliance. However, it is a delicate balancing act; overwhelming a client with too much devastation in their life leads to relapse. This is why intensive levels of care are generally needed in the early phases of recovery.

Client Characteristics Requiring More Intensive Services. Client characteristics associated with better outcomes have been identified which leads to those characteristics which require more intensive services by some individuals. Of particular importance are employment, social/family support, and having a mental health diagnosis in addition to the substance abuse. In a recent review of treatment outcomes, 11 factors were identified as critical variables and are listed in the following table.[10]

Two things are clear: (1) adolescents who have suffered early trauma of child abuse and neglect and are involved in criminal behavior in many cases will fall into the harder- to-serve group; and (2) these clients will therefore need more intensive services.

Domain	Client Barriers to Success	Client Strengths and Assets
Age	Under age 30	Over age 30
Employment	Unemployed with little work history	Stable employment history
Motivation	Little acceptance of AOD problems	Desire to recover
Consequences and sanctions	Little fear of AOD-related consequences (e.g., loss of job or custody of children)	Fear of consequences reinforced by sanctions
Physical and social environment	Return to a neighborhood where drugs are readily available and with a drug-using peer group	Little contact with a "drug culture" and fewer life stressors (e.g., poverty)
Legal status and peer criminality	Numerous pre-treatment arrests and a peer group involved with criminal acts	Few pre-treatment arrests and a non-criminally involved peer group
Social Support	Family members or peers who cause interpersonal conflicts or fail to support goals of recovery	Family members and peer who exert pressure to stop substance use and provide emotional support for recovery
History of Drug Use	Using a variety of drugs, frequent drug use, younger age at onset of addiction, a longer course of addiction, and few days of sobriety prior to entering treatment	Use of a primary substance, older onset of addiction, a period of abstinence prior to treatment admissions
History of treatment	Numerous treatment attempts	Longer length of time in treatment
Dual diagnosis and Psychological problems	Significant psychiatric problems, high levels of anger, depression, childhood sexual abuse	No concurrent psychiatric disorders
Chronic Illness	Significant chronic illnesses (e.g., arthritis, back pain, asthma, emphysema, ulcers)	Good Physical Health

3. The Unique Needs of Children Requiring AOD Related Services

This discussion of client characteristics leads to the unique needs of children. Although attention to prenatally exposed infants is critical and renewed efforts have focused prevention efforts on services for adolescents, interventions for younger children (ages 5 to 12) of substance-abusing parents are still scarce, and these "middle children" are at high risk of developing their own AOD problems. We are continuing to miss the large group of children between early childhood and adolescence who need AOD interventions. These children neither adolescents nor in the 2 to 5 percent of CWS children who were identified as prenatally exposed should be a critical subset served by any expansion of AOD services for children. The needs of children of alcoholics (COAs) and children of substance abusers (COSAs) can be viewed in a developmental approach and the following section reviews the needs of all three of these age groups of children.

Birth Through Kindergarten. It is well established that infants and young children have specific needs for adequate bonding and attachment with their caregivers. In recent years we have gained new insights into the critical early years for brain development in young children. These early years for children with substance-abusing parents become critical years for intervention to assure that children receive appropriate stimulation, opportunities for brain development, and

emotional well-being through bonding and attachment for infants and younger children. Young children from substance abusing families need developmental assessments and interventions. A wealth of research on the developmental progress made by children who were prenatally-exposed to AOD confirms that targeted early intervention in language, motor, play, and social skills result in children ready to learn in kindergarten.

However, most of the children who were prenatally-exposed and/or living in substance abusing families do not qualify for these targeted early intervention services because they are "not bad enough" to receive developmental services through the Regional Centers programs. Therefore, AOD treatment providers who serve mothers and their children are forced to piece together developmental assessments and interventions from any flexible funding that may be available to them through their county contracts. Ensuring that young children of substance abusers receive developmental assessments and interventions could be a priority and will be discussed further in the HFP benefit section which follows.

Elementary School-age Children. The childhood years require opportunities to develop self-concept and self-esteem which are cultivated through curiosity, initiative, and independence. For COAs and COSAs these opportunities are 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. The Children of Alcoholics Foundation states that support groups for school-age children help to build resiliency and protective factors including:[11]

- Bolstering Self-Esteem
- Providing Support
- Providing Consistency
- Teaching Coping Skills
- Encouraging Adaptive Distancing
- Providing a Positive Adult Role Model
- Encouraging Mutual Aid

The National Association for Children of Alcoholics has developed an excellent set of core competencies needed by health care providers in caring for children and adolescents in families affected by substance abuse.[12] They suggest three levels of competencies based on the levels of responsibility that the health care provider takes for the care of children. Needed competencies range from awareness and communication skills in Level I, to assessment and care management in Level II, to medical and behavioral treatment in Level III. (See endnotes for details.) While mentoring can be a very important force in these children's lives, the power of sharing with other children their life experiences cannot be emphasized enough. Again, the HFP's role in meeting the needs of this age group of children will be discussed in the following section.

Adolescents. For youth who become chemically dependent, a developmental perspective and approach to treatment is imperative. Most AOD treatment programs were originally developed for adult males. Just as the AOD field has adapted to a growing need for treatment services that are responsive to the unique needs of women, the AOD field must also be responsive to the unique needs of adolescents.[13]

Recent advances in AOD treatment have shown that programs for youth must include the characteristics, maturational effects, and developmental processes of adolescents into their program design and delivery. 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 to develop a chemical use disorder.

- *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 at the stage in which they began using alcohol, tobacco, and other drugs. For this reason, treatment of adolescent chemical dependence requires habilitation focus and requires more comprehensive treatment intervention than adult rehabilitation models.

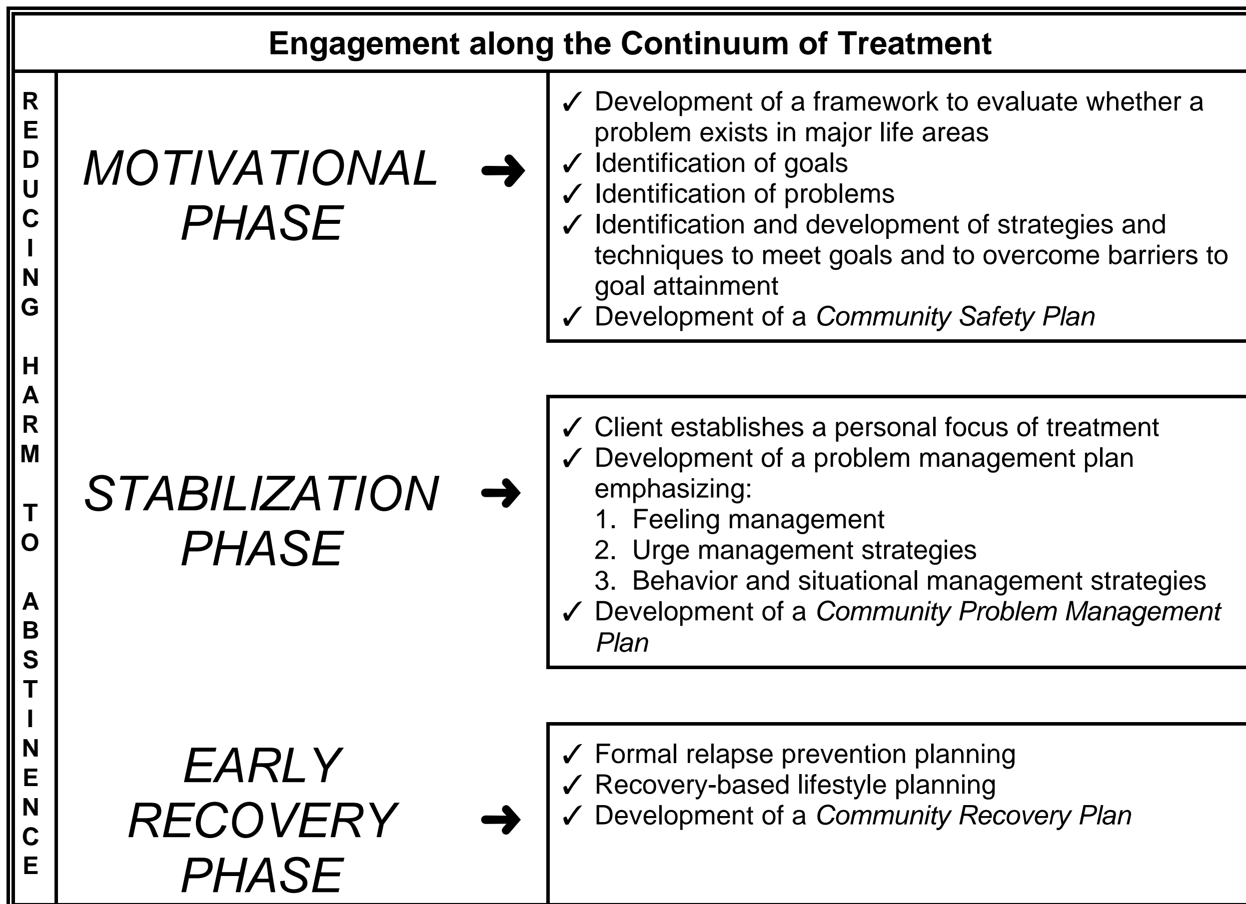
- *Stronger denial system.* Adolescents experience a stronger system of denial because, unlike adult addicts/alcoholics, they typically have not experienced the years of negative consequences related to their AOD use that adults have. As a result, they tend to have more difficulty connecting their problems to their drug use.

- *Stronger enabling system.* There is a wider acceptance of drug use by the adolescent peer group and this greater acceptance supports and normalizes drug taking and drug-related behavior.

- *Maturational delays.* Adolescents experience cognitive, affective, and behavioral/maturational delays directly caused by drug use. The younger that drug use is initiated, the greater the delays experienced 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.

Given these characteristics and developmental processes, adolescents tend to be less willing and able to adapt to abstinence in comparison to adults. Key to a motivational approach with teens is to assess the amount of structure that is needed to ensure treatment acceptance and readiness to change their behavior. The program model of stages for adolescents has been adapted from work at Berkshire Services for Children and is depicted in the following graphic.



It is clear that some adolescents can transition through these phases without requiring intensive structure in their treatment setting. However, for youth who are impaired in multiple areas of life functioning, it is clear that they require more intensive levels of structure in the early phases of treatment and recovery.

Summary

The key issues presented above that should be considered by the State agencies, MRMIB, and the Legislature in assessing the viability of providing additional AOD treatment services to HFP children are:

- The infrastructure currently available to meet the AOD treatment and recovery needs of youth is larger than the entire treatment systems of 18 states and providing funding to serve special populations increases their admissions rates to the overall system
- Based on a individual's level of functioning in biopsychosocial domains, the level of structure and intensity of the treatment/recovery milieu must be flexibly adjusted to meet the needs of the client
- Clients who are more impaired in multiple domains of life functioning require more intensive levels of structure in early recovery phases

- Helping a client move into the determination and action phases of recovery requires a balance between enough treatment structure to break the dopamine saturation syndrome and understanding the connection between his/her AOD use and the consequences of their use
- Understanding the connection between AOD use and consequences is more effective when the treatment professional is addressing the need that the client perceives as most urgent
- Barriers to AOD treatment success are found among adolescents who are involved with criminal activity, are victims of child abuse/neglect, have a drug-using peer group, are depressed, and have little acceptance of AOD problems or consequences
- Children of alcoholics and substance abusers between the ages of birth and kindergarten require developmental assessments and interventions
- Children of alcoholics and substance abusers who have reached school-age require group and individual interventions to address their unique needs to appropriately develop their self-concept and self-esteem
- Adolescents who require substance abuse treatment and recovery services have treatment service needs that must be met within the unique developmental processes that are underway during the teen years

II. DESCRIPTION OF THE BENCHMARK PLAN SERVICES

While the benchmark plan services are modeled on the current commercial market, the initial reaction to this benefit package from ***every*** *AOD professional and member of the AOD Policy Forum* was that detoxification and 20 outpatient visits was woefully inadequate to meet the needs of the vast majority of children who need AOD services who are living below 200% of poverty. This reaction was based on their professional judgment regarding the levels of functioning among youth that are treated in the AOD system. However, the current state-wide information system maintained by DADP does not include information on the biopsychosocial levels of functioning and unique treatment needs of clients entering publicly-funded AOD services. Therefore, the MRMIB report does not include a discussion of these issues.

Two primary concerns were expressed by the AOD treatment and recovery professionals in discussing the benefit package:

1. The benefit is not responsive to the need for flexibility in the intensity and structure required during AOD treatment by adolescents based on their level of functioning in the biopsychosocial domains; and

2. The benefit does not address the unique needs of children in a developmental perspective; rather it assumes the same benefit for each developmental stage of children.

This problem in health benefits is evident among the commercial plans that are available to California's middle-income youth. For youth who will be covered by the HFP and based on the previous discussion of barriers to successful AOD treatment outcome, the adequacy of the health

benefits becomes more extreme. Youth who have more severe problems in multiple domains of life functioning are more likely to be living in families with very low-income households. Since services have not been readily available to them, they are more likely to present for treatment with more severe problems in multiple domains.

III. AN ANALYSIS OF THE VIABILITY OF USING FEDERAL FUNDS TO PROVIDE ADDITIONAL SERVICES

Although the current benefit package for HFP is in state law and meets the federal minimum requirement for services, that benchmark requirement by the federal government does not mean that the benefit is adequate to effectively intervene in the lives of children affected by AOD problems. Nor does the required benchmark mean that California should adopt the minimum benefit for these vulnerable children. In fact the Florida legislature is currently debating a much different approach to its Title XXI program. The Florida legislature recognizes that using federal match funds (at a 65 to 35 ratio) to meet the needs of this vulnerable group of children makes good budget sense. Their proposal includes an annual benefit of 7 days of detoxification services, up to 30 days of residential care, and up to 40 outpatient visits per year. Therefore a state does not need to adopt the minimum and in our State with escalating youth violence and unacceptable school drop-out rates, every effort to use federal funds to intervene with children affected by AOD should be maximized.

The MRMIB report on viability of using federal funds specifically excluded an analysis of “the need for services within the benchmark plan.” Their analysis focused on three issues which we will also address.

Capacity

As previously mentioned, the 1996-97 admissions to AOD treatment for youth are a larger number of admissions to the entire AOD system in 18 other States. These approximately 11,300 admissions are a very small percentage of the 259,000 youth who need services. There are 820 adolescents placed on a waiting list during any given month in the State. Yet, there is a California-specific system to build upon. However, the discussions about HFP during the AOD Policy Forum seemed to adopt a chicken and egg approach. Some representatives of the Legislature and State agencies stated that since there is no infrastructure to meet the adolescent treatment needs, there should not be an expanded treatment benefit. On the other hand, AOD professionals stated that the infrastructure to meet the needs can’t happen unless there is a benefit package that will pay for the treatment services. The evidence from meeting the AOD treatment needs for women is informative on this issue.

The national gender gap for AOD treatment admissions has been at a 75/25 split for several years. That is, women have represent roughly 25% of treatment admissions in the nation. The following table shows California’s recent experience in increasing admissions to treatment for women.[14]

	Women		Men		Total
Fiscal Year	N	%	N	%	
1991	66,181	30%	156,516	70%	222,697
1992	45,206	34%	89,227	66%	134,433
1993	49,330	35%	93,551	65%	142,881
1994	55,878	37%	96,697	63%	152,575

We did not have access to the exact numbers for the more recent treatment admissions, yet we have been told that women represent almost 40% of the 1996-97 treatment admissions. This change in treatment admissions did not happen because infrastructure was built before funding was provided. This improvement in the ratio of women's treatment admissions in California is a result of deliberate action taken by the State legislature by making funding available through State general funds in the early 1990s. In addition, the federal government has required that pregnant and parenting women receive priority treatment admissions since 1992. These actions have improved the women's treatment admission rates.

We believe the State's experience in expanding treatment admissions for women will be replicated for youth. If insurance benefits are available to pay for treatment, the AOD treatment system will adjust to provide the services for which funding is provided.

The other very important issue related to HFP is the exclusion of the AOD treatment provider system from the designation of the community provider plan in the MRMIB regulations. The AOD treatment and recovery system includes providers who are licensed and certified to be Medi-Cal providers. However, the AOD system also includes providers who are not Medi-Cal providers and would therefore not be eligible to serve this population. This exclusion of a significant resources for AOD services is an issue that must be addressed—the professionals with the experience to treat AOD problems have essentially been excluded from the provider network for HFP by excluding them from the designation of safety net providers.

Need for Services

The MRMIB report cites the current experience in the commercial health insurance market and current DADP system as evidence that the need for AOD treatment is not greater than the 20 outpatient visits in the benchmark plan. Analysis of current utilization of benefits in relationship to this benefit package is circular. In the commercial market, if adolescents have a benefit package for 20 outpatient visits, of course they are not exceeding that benefit in their utilization. *Utilization analysis does not reveal the benefits that were needed by the youth*; rather, utilization analysis reveals what service package their health coverage allowed them to receive. Utilization of services does not include analyses of the services that were needed based on client assessments. In addition, it is well documented in the scientific literature that primary care physicians and nurses do not screen for and have not been adequately trained in AOD assessment skills. Penetration rates for accessing AOD services via the primary health care system are notoriously low. Clearly the utilization data fail to justify a need for comprehensive and flexible AOD services.

To address the question of need for services, Children and Family Futures has analyzed data from three sources: (a) California AOD providers; (b) the youth data from the national treatment study DATOS (Drug and Alcohol Treatment Outcome Study); and, (c) the California State Demand and Treatment Needs Assessment Study: Dependence and Abuse of Alcohol and Other Drugs Among California Arrestees.

California AOD providers. In consultation with several representatives of the Policy Forum, the County Alcohol and Drug Program Administrators Association of California (CADPAAC) distributed three separate survey instruments to the County AOD administrators for their distribution to treatment providers. The three surveys were distributed as follows:

Target Providers	Purpose of Data Collection	Number of Responses
Adult treatment providers who also serve the young children of their clients	To determine the availability of developmental assessments and interventions for young children of substance abusers	35
Adult treatment providers	To identify how many AOD providers identify children of substance abuse for services	131
Adolescent treatment providers	To identify the unique treatment/recovery needs of youth seeking AOD services based on the consequences they have suffered in major life functioning domains	64

Young Children

Of the 35 agencies who responded to the survey and provide services to children of the adults in their treatment programs, 20 provide child care; less than half (15) provide developmental assessments while only 13 provide developmental services. Group services for the child's problems associated with a parent's AOD abuse are provided by 25 providers and individual counseling is provided by 24.

Adult treatment providers who responded to the survey represent approximately 10% of California providers. Of the 131 providers, only 33 reported that they collect data on their clients' children. Although this survey is not representative of all California providers, this low rate of providers that collect data on the children of their clients was also found in previous analyses of provider and county data systems reported by Polinsky and Young. In fact data about children of substance abusers in treatment is not included in the federal minimum data set and is not reported by the vast majority of states' information systems. (Florida and Massachusetts are exceptions and have collected data on children for many years.)

Adolescents

While only 64 providers of adolescent treatment services responded to the survey, they reported over 10,000 treatment admissions. These providers are clearly representative of the 11,300

treatment admissions reported by DADP. The following table shows the number of teens and providers in the five levels of care.

Level of Care	Number of Youth Served	Number of Providers
In-patient detoxification	16	1
Residential	808	6
Outpatient with medication	155	4
Intensive Outpatient Drug-Free	471	10
Outpatient Drug-Free*	8,805	57

* Less than 9 hours of service per week

In relationship to the HFP benefit package, it is important to note that only 1 provider stated that they currently provide detoxification services for adolescents but 57 providers provide out-patient counseling services.

The providers were asked to report the percentage of teens who experience various biopsycho-social problems at the time they are admitted to their treatment programs. The following table shows the average percentage of teens reported by 60 of the respondents.

	ADOLESCENTS in Tx (average %, n=60)
GENERAL SAFETY	
Physical or sexual abuse	**37**
Parental AOD abuse	**49**
Involved in a gang	30
On probation	**57**
Involved in delinquent/criminal behavior	**66**
Are homeless/living on streets	4
PHYSICAL HEALTH	
Dental hygiene problems	20
Poor physical health	19
Involved in HIV high-risk behavior	**52**
Are pregnant	6
Have STDs	10
MENTAL HEALTH	
Depression	**39**
Bipolar disorders	8
Are suicidal	14
FAMILY SOCIAL SYSTEMS	
Good family support system	**24**
Good community support system	**18**
Good peer support system	**15**

	ADOLESCENTS in Tx (average %, n=60)
GENERAL SAFETY	
BEHAVIORAL	
Attention Deficit Disorder Hyperactivity	27 19
SCHOOL/WORK	
Learning-related problems **Poor academic performance** **Poor academic attendance** Poor work performance/loss of job	44 **69** **62** 27
OTHER (open-ended question)	
Conduct disorder/oppositional defiant Anger/violence/fighting Post traumatic stress disorder	55% (n=12) 52% (n=6) 37% (n=4)

The ASAM Patient Placement Criteria rates the six areas of life functioning as low, moderate, or high functioning. The following rates the average adolescent portrayed by treatment providers in relation to the ASAM criteria.

Life Domain	Evidence from Providers	Functional Rating
■ Acute Intoxication and/or Withdrawal Potential	Not addressed	
■ Biomedical Conditions	Less than 20% have poor physical health	High
■ Emotional/Behavioral Conditions and Complications	37% with history of physical or sexual abuse 39% depressed 27% with ADD	Moderate
■ Treatment Acceptance/Resistance	55% with conduct disorder/oppositional	Low
■ Relapse/Continued Use Potential	49% have parents with AOD abuse	Low
■ Recovery Environment (Family and Social Situations)	Less than 25% have family, peer, or community support system	Low

Based on the chart of client characteristics that are barriers to successful treatment outcomes, this population of youth clearly fall in the category of higher barriers to success. Based on the California Implementation of the ASAM Patient Placement Criteria, a client coming to treatment who is low functioning in three of the six domains, would meet the criteria for initial treatment placement in Level III services (residential care). If the teen was in the 25% with a supportive environment for recovery, he/she may be appropriate for Level II - Intensive Outpatient (more than 9 hours per week of structure).

Drug and Alcohol Treatment Outcome Study (DATOS). The UCLA Drug Abuse Research Center (DARC) is analyzing the adolescent sub-population of the National Institute on Drug Abuse study of client outcomes. DATOS represents over 10,000 treatment admissions during 1993 through 1995. The adolescent sub-population includes 3,400 treatment admissions. DARC researcher Dr. Christine Grella and her staff conducted special runs of the data set during the week of April 6th to respond to the needs of State policymakers. Client characteristics were analyzed to ascertain if there were significant differences among the youth based on their insurance status. Insurance status was defined as None (n = 514), Private (n = 1,240), Public (1,057), and Unknown (n = 314). Further details of the DATOS study can be obtained from Dr. Grella at DARC. Summarized below are the pertinent findings:

	Insurance Status		
	None	**Private**	**Public**
Male*	Almost 80% of group	68% of group	Almost 77% of group
Current age	15.9	15.8	15.8
Ethnicity* Uninsured significantly more Minority youth	38% Caucasian 30% African American 30% Hispanic 3% Other	71% Caucasian 12% African American 13% Hispanic 4% Other	33% Caucasian 38% African American 27% Hispanic 3% Other
Drugs Ever Used	98% have used marijuana; 92% have used alcohol; Less likely to have used Narcotics, Amphetamines, Hallucinogens, Inhalants	98% have used marijuana; 96% have used alcohol; More likely to have used Narcotics, Amphetamines, Hallucinogens, Inhalants	98% have used marijuana; 87% have used alcohol; Less likely to have used alcohol, Cocaine, Heroin, Narcotics, Sedatives, Amphetamines, Hallucinogens or Inhalants
Mean age first use	Alcohol is 1st used drug @ 11.9 years Marijuana is 2nd used drug @ 12.8 years	Alcohol is 1st used drug @ 11.8 years Marijuana is 2nd used drug @ 13.0 years	Alcohol is 1st used drug @ 11.9 years Marijuana is 2nd used drug @ 12.8 years
Years between 1st regular use and 1st treatment (SD)***	2.1 (1.6) Waits longest before treatment	1.8 (1.5) Waits shortest before treatment	2.0 (1.6)
Currently in School*	60.8%	72.6% Most likely to be in school	59.7% Least likely to be in school
Not attended above Middle School	53%	39%	55%
Modality in Treatment	More likely to be in long-term residential (74%)	More likely to be in short-term inpatient (43%)	Likely to be in long term residential (58%)
Criminal Justice Case	More likely to have CJ case (62%)	Least likely to have CJ case (44%)	More likely to have CJ case (62%)
Referral Source	Most likely referred by legal system (46%)	Least likely referred by legal system (26%) Most likely referred by family/friends (53%)	Likely to be referred by legal system (41%)

	Insurance Status		
	None	**Private**	**Public**
Moderate to Severe alcohol dependence	Less likely alcohol dependent (30%)	Most likely alcohol dependent (44%)	Less likely alcohol dependent (30%)
Moderate to Severe marijuana dependence	Less likely marijuana dependent (55%)	Most likely marijuana dependent (67%)	Less likely marijuana dependent (56%)

*** $p \leq .001$

This analysis reveals a very interesting picture of youth entering AOD treatment. Uninsured youth are much more likely to be referred to treatment by the legal system and much less likely to be referred by their family or friends. Uninsured and publicly-insured teens are more likely to have dropped out of school at the middle school age. Looking at the client barriers to better treatment outcomes, this group of children clearly falls into the "more difficult" category. However specific to their drug use, insured teens in this national sample (who were predominately Caucasian) were more likely to be dependent on alcohol and marijuana than were the uninsured or publicly-insured youth.

Characteristics of California Juvenile Arrestees. Between August 1995 and September 1996, the UCLA Drug Abuse Research Center collected data from 668 juvenile detainees in 14 California counties. Data include a face-to-face interview and a urine sample that is tested for the presence of drugs.

Under the direction of Dr. Douglas Anglin, Mr. Jeffrey Annon conducted special analyses of these data during the week of April 6th to respond to the State policymakers need for data regarding youth AOD treatment. Their analysis examined differences in the youth's characteristics and need for treatment based on health insurance status. In particular we asked if uninsured youth were significantly different from privately- or publicly-insured youth on key characteristics. There were 83 uninsured youth, 269 youth with private insurance, and 276 youth with public insurance.

	Insurance Status		
	None	**Private**	**Public**
Male	Almost 93% of group	87% of group	87% of group
Ethnicity* **	23% Caucasian 19% African American 48% Hispanic 10% Other	30% Caucasian 19% African American 36% Hispanic 16% Other	20% Caucasian 32% African American 31% Hispanic 17% Other
Ever in Treatment*	4.8	12.6	8.0
Feel need for treatment (percent) **Drug only** **Alcohol only** **Alcohol & Drug**	 10.8 3.6 4.8	 6.3 1.5 7.4	 6.9 2.9 4.7
Charge this arrest* **Felony** **Misdemeanor**	 63.9 36.1	 55.0 45.0	 66.7 33.3

	Insurance Status		
	None	**Private**	**Public**
Charge for this arrest*			
Violent	21.7	27.1	30.8
Drug	12.0	7.1	6.5
Property	19.3	25.3	30.8
Misc	47.0	40.5	31.9
Ever arrested before	85.5	79.6	85.1
Arrested in past 12 months	71.1	64.7	60.5

* $p \leq .05$; *** $p \leq .001$

These data show that uninsured youth were more likely to have been arrested for a felony crime, more likely to have ever been arrested before this arrest, and more likely to have been arrested in the previous 12 months. In addition, on the point of whether these youth will "voluntarily access treatment," 19.2% of these youth state that they need AOD treatment, a level 36% above that of insured youth. Again, these data point to a group of youth who are more likely to fit into the category of clients with significant barriers to successful outcomes who require more intensive treatment structure.

Appropriate Matching Funds

The issue of appropriate matching funds which the MRMIB analysis treats briefly as a prerequisite to pursuing federal Title XXI funds is affected by the unique recent history of California's approach to special populations and Medi-Cal matching.

In a state where more than $80 million in general funds were appropriated for a variety of populations needing AOD services during an era of greater budget stringency than now exists, the argument that there are no general funds available is really not at issue—it is rather an argument that no additional general funds are available at this time for this particular population. The argument that "the budget has already been made up," and the HFP has been approved by the Health Care Financing Administration, and that the timing of requests is late may have an impact on executive branch agencies, but it is not relevant to the responsibility of external organizations in assessing the needs as they experience them at the State, county, and local levels.

The greatest issue raised in addressing matching is part of the much larger issue that has characterized California's unusual approach to funding AOD services for the past years—the unwillingness to draw down available federal funds for the obvious needs of its citizens. The artificial capping of Medicaid funding for AOD services results in any increases in allocations for a particular sub-population within this group decreasing the funding available for other groups within the total capped appropriation. This is an allocation process that ignores needs entirely and treats the artificial cap as the only relevant feature of the policy discussion. As long as the artificial cap is in place, the argument that matching funds are not available also becomes partially circular—they are not available due to the capping, not due to any structural inability of the state to draw down federal funding for every dollar it allocates to matching purposes.

Of importance in this regard is the recent effort by the Department of Health to expand coverage for children through Medi-Cal. While this is a very necessary and important goal for the State, any increase in Medi-Cal enrollment without directly addressing its impact on the artificial cap set for Drug Medi-Cal benefits simply displaces other Californians who also need AOD services.

In this context, least convincing of all is the argument that 100% state funds should be allocated to adolescent treatment, when a greater amount of treatment for more youth could be provided with matching federal funding under Title XXI. If treatment is important enough to justify allocation of new state funding, it is hard to understand why it is not important enough to seek federal matching to increase the impact of state dollars on a problem that has been assessed to need $19 million (ADP's estimate of what would be needed to make up the gap in services between the group that would "voluntarily access services" and those already receiving services or covered by Healthy Families) in more resources for youth who would "voluntarily access treatment."

Once a gap in adolescent treatment has been agreed to exist, the priority should be to fill that gap with the optimum combination of federal and state funding. Any expansion of adolescent treatment should capture as many federal matching dollars as possible, and any expansion beyond that should fill the gap for children and youth who do not have access to federal matching funds.

It should be clarified that there are five separate budget items under review in this discussion: Medi-Cal funding from state and federal sources, Healthy Families funding from state and federal sources, and the portion of state general funds which are flexible since they do not match any federal sources. Taking the Title XXI funding and coverage decisions out of the context of this broader set of all of the funding allocations results in a narrowed focus on one of these five pots of funding—the state matching for Title XXI, rather than a more strategic plan for increasing adolescent treatment across the board, using all these fiscal tools. In the absence of a strategic plan for the needed expansion of adolescent treatment, funding for Title XXI is all that is being addressed.

IV. CONCLUSIONS AND RECOMMENDATIONS

The charge to the MRMIB group was to assess the viability of federal funding from HFP; the report that followed, as discussed above, addressed the data and system capacity issues rather than the type of services and benefits needed by the youth covered by the HFP. Saying that "data is not now available to identify the additional services that children may need," as the MRMIB report does, is accurate as far as it goes, but it does not address the additional evidence of need drawn from a survey of providers, DATOS, and California juvenile DUF data– all of which are currently available. The conclusions of these studies are clear: youth entering substance abuse treatment are affected by childhood sexual and physical abuse, depression, high-risk sexual behaviors, criminal behavior, poor academic performance, a weak family support structure–all of which argue for more intensive and structured treatment than can be provided by detoxification and 20 out-patient visits.

The issue of viability is part of the larger issue of overall strategy in meeting the full range of treatment needs for adolescents *using all available funding sources*. Given the lack of matching flexibility resulting from California's decisions about use of Medicaid funding and the artificial cap, it seems difficult to conclude that adequate attention has been given to creating that comprehensive strategy to meet treatment needs and maximize all funds available in doing so.

The recommendations that follow from this analysis include the following:

- Children covered by Healthy Families should be assessed for the full range of their developmental needs, including developmental psychologists' services to young children who need assessment and intervention based on their parents' AOD use.

- DADP should make information available to providers and other child- and family-serving organizations such as schools, clinics, and family resource centers, so that these agencies know that 20 outpatient visits can be billed through HFP for children of substance abusers; active outreach and culturally sensitive marketing as intended for the rest of Title XXI is necessary.

- MRMIB should designate AOD providers who are under sub-contract to the Counties as safety net providers and encourage all health plans to include these safety net providers in their provider networks.

- As recommended in the MRMIB report, DADP should be encouraged to work with other systems, especially juvenile justice, mental health, and child welfare to assess their capacity to identify, screen, assess, and secure treatment for adolescents in this target group. More in-depth review of the capacities and needs of these state agencies and their local counterparts is essential to understanding what is happening in these other systems, as these agencies have the potential to reinforce what any new benefit may provide under HFP.

- The AOD field in California should continue ongoing efforts to implement a standardized level of care instrument for adolescents so that there is a formal basis for collecting useful information about levels of care which are needed. A report back to the legislature by the end of 1998 should summarize progress made by funders and providers in clarifying the system of levels of care criteria to be used statewide.

- With respect to the recommendation that MRMIB should request that the HFP plans voluntarily collect data on the number of children needing services that exceed the substance abuse benefit in the benchmark plan and in year two, three stronger action steps are needed:

  - DADP should collect added and richer data on the adolescent population beyond CADDS current data sets, since the data system now in place will not tell us many of the most important things we need to know about this population; e.g., "successfully completed treatment" is not a useful referent for the adolescent population for whom longer-term follow-up is critical, co-occurrence of other disorders are not now captured by the current data systems. This data should include information on HFP youth who have exhausted their HFP benefits and are seeking treatment from other public sources.

- The private health plans should be required, not requested, to collect this data, with special reference to the 8.2% assumed rate of penetration, to report on whether that benchmark is being reached and whether needs have been assessed in enough depth to know if services beyond the 20 out-patient visits are needed by the youth seeking treatment.

- A more in-depth survey of the capacity of the treatment system that is already in place and its ability to provide services to a larger group of adolescents under a blend of HFP and other funding

■ DADP should add children of adults seeking treatment to its current data set so we know how many kids need intervention for their own issues related to parents' use.

Attachments:

List of Adolescent Treatment Providers who Responded to the CADPAAC Survey

Adolescent Treatment Providers who Responded to the CADPAAC Survey

Survey#	Program Name
ADOL1	PhoenixHouse
ADOL2	Sierra Recovy
ADOL3	Turning Point
ADOL4	Ventura Co Behavl AOD Pgm
ADOL5	NCADD East San Gabriel + Pomona
ADOL6	Casa de San Bernardino
ADOL7	Center for Cmmty Cnslg + Educ
ADOL8	Operation Breakthrough
ADOL9	Oasis Counseling Centers
ADOL10	San Benito Co. Subst Abuse Pgm
ADOL11	Fortuna Community Svcs Pattern Pgm
ADOL12	Didi Hirsch CMHC/Family Svc of LA
ADOL13	Tahoe Youth and Family Svc
ADOL14	ADTS-DDP
ADOL15	Tehama Co Health Agency D+ A Div
ADOL16	Inglewood Medical + Mental Health Svcs
ADOL17	Alcoholism Council of Antelope Valley
ADOL18	Matrix Institute
ADOL19	The Effort
ADOL20	CA Drug Consultants
ADOL21	Touchstones
ADOL22	Progress House Cnslg Center
ADOL23	Santa Clara Co Dept ADS
ADOL24	Redland-Yucapa Guidance Center
ADOL25	Merced Co Alc + Drug Svcs
ADOL26	Ettie Lee Homes for Youth
ADOL27	High Desert Center
ADOL28	Kings Co for Kingsview Corp
ADOL29	New Morning Youth and Family
ADOL30	Aliso Viejo/Health Care Agency....
ADOL31	EAP-Addiction Recovery
ADOL32	Merrill Community Services
ADOL33	Inland Valley D+ A Recovery Svcs
ADOL34	Fullerton ADAS
ADOL35	San Luis Obispo Co D+ A
ADOL36	Anaheim Drug Abuse
ADOL37	Drug Abuse Alternatives Center
ADOL38	Rim Family Services
ADOL39	San Diego Youth + Community Services
ADOL40	Center for Human Devel
ADOL41	Phoenix House

ADOL42	Phoenix Academy
ADOL43	ADAS - Santa Ana Clinic
ADOL44	Newport-Mesa ADAS
ADOL45	Tarzana Treatment Center
ADOL46	Philbrick's Place
ADOL47	Asian American Recovery Services
ADOL48	Henry Ohlhoff Outpatient Programs
ADOL49	So. Co. ADTS - outpatient
ADOL50	Sierra Family Services
ADOL51	Humboldt Co AOD programs
ADOL52	ELCA Lifeskills
ADOL53	Pride Health Services Inc
ADOL54	Glen Roberts Child Study Center
ADOL55	Kings View Madera Cnslg Center
ADOL56	Perinatal ADAS
ADOL57	MHS Inc - Venture Day Adol
ADOL58	Los Angeles Centers for ADA
ADOL59	NCADD - Van Nuys
ADOL60	Ch Hosp, div of Adol Medicine, S.A. Tx
ADOL61	Matrix Institute
ADOL62	Soledad Enrichment Action
ADOL63	La Clinica Del Pueblo
ADOL64	El Proyecto del Barrio

V. Notes and References

1. PROTOTYPES Women's Center. Dr. Vivian Brown Executive Director. 5601 West Slauson Avenue, Suite 200, Culver City, CA 90230 (310) 649-4347.

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5. Two national studies prior to DATOS (described in this report) were the Drug Abuse Reporting program (DARP), which included treatment admissions between 1969 and 1973, and the Treatment Outcome Prospective Study (TOPS), which studied admissions between 1979 and 1981. DATOS included treatment admissions between 1991 and 1993.

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12. National Association for children of Alcoholics (1997). Core competencies for involvement of health care providers in the care of children and adolescents in families affected by substance abuse. New York: National Association for Children of Alcoholics. Sis Wenger Executive Director. 11426 Rockville Pike, Suite 100, Rockville, MD: 20852 (301) 468-0985.

13. Berkshire Farm Center and Services for Youth. 13640 Route 33, Canaan, New York 12029. (518) 781-4567.

14. Admission data from the annual State Resources and Services Related to Alcohol and other Drug Problems reported by the National Association of State Alcohol and Drug Abuse Directors.