



"The Voice for Treatment"

PUBLIC POLICY STATEMENT

Standards of Care for Adolescent Substance Use

Adopted by the CSAM Board of Directors, Oct 15, 2017

Passage of the Adult Use of Marijuana Act (Prop 64) provides California the opportunity and obligation to demonstrate that legal regulation of marijuana can be achieved not only without jeopardizing youth safety but can also improve drug education, prevention, early intervention and treatment of adolescent substance use. An estimated¹ 164,000 secondary students used marijuana 10 or more days each month (114,000 of whom used marijuana 20+ days per month) and an estimated 72,000 acknowledge binge drinking more than 10 days a month². Multiple careful studies have established that adolescents are more vulnerable to alcohol, marijuana, tobacco (including e-cigarettes) and other drug-related problems than adults, and documented levels of use prior to implementation of legalized recreational marijuana are cause for concern.

"Addressing adolescent substance use is a cost-effective, common-sense approach to preventing future challenges in other social services and other public health related areas..." — California Department of Health Care "Youth Services Policy Manual" (Draft)³

Adolescence presents complexities that require a different approach to drug education, prevention, early intervention and treatment of substance use disorders from that used for adults. School performance needs

to be supported, often involving assessment for learning disabilities, in order to encourage future vocational achievement. Healthy psychological development needs to be encouraged. Attachments to family, school, healthy adult role models and community need to be strengthened. Resiliency factors need to be identified and enhanced. Families need stabilization, and recovery-sensitive environments need to be promoted in schools and local communities.

Prop 64 dedicates 60% of net revenue, estimated initially at over \$500 million annually, to drug education, prevention, early intervention and treatment for youth. To assure that delivery of quality services for youth are met through this revenue, the California Society of Addiction Medicine, a professional society representing over 400 physicians dedicated to increasing access and improving the quality of addiction treatment, presents this overview of Standards of Care for Adolescent Substance Use.

AN INTEGRATED CONTINUUM OF SERVICES FOR ADOLESCENTS:

The duration of adolescence is relatively short but contains all the physical and psychological changes necessary to transition from childhood to young adulthood. The pace of adolescent development is fast, and the

pitfalls presented by alcohol, marijuana, tobacco and other drugs can be quickly consequential. The majority of adults suffering from alcohol and other drug dependence developed a pattern of substance use disorder as youths (18 or under) or young adults (19-25).

California has very few public-sector treatment resources for adolescent substance use disorders. **Prop 64 tax revenues should fund a new public-sector continuum of care for adolescent drug use prevention and treatment that is independent of pre-existing treatment facilities for adults.** Middle and secondary schools are the “workplace” for most adolescents. Any statewide system of prevention, early intervention and treatment for adolescents needs to develop close collaborations between the treatment and educational systems. School retention and performance should be key metrics in evaluations of overall effectiveness of substance use programs.

The primary goal of Prop 64 revenue disbursements from the Youth Education, Prevention, Early Intervention and Treatment Account should be to develop a continuum of care for adolescent substance use that rests on public health principles and a foundation of Student Assistance Programs (SAPs) at all middle and secondary school levels in California. SAP foci should be on supporting student psychological health, preventing substance use problems, assessing learning difficulties, and promoting school performance and retention. SAPs provide a necessary alternative to suspensions and expulsions for at-risk students. The goal should be to provide non-stigmatizing support that neither criminalizes nor pathologizes adolescent drug use.

The state of California has a unique opportunity to develop an entirely new, state of the art county-based outpatient and regional residential treatment system for adolescent drug users to work hand-in-hand with SAPs and other community resources. In order to accomplish these critical goals, Youth Account funds from Prop 64 revenue must remain sequestered and directed toward creation and maintenance of the adolescent continuum of care system outlined below. Prop 64 funds should not be used to fund the AB 3632 mandate on counties to provide mental health services for special education students or any other programs not specifically integral to the continuum of care model outlined below. At the base of the continuum of care, serving all adolescents, is a statewide system of school-based Student Assistance

Programs (SAPs) that provide the full range of preventive services outlined by the Institute of Medicine. When a diagnosis of substance use disorder is suspected, SAPs refer individuals up the pyramid to a county-based Core Outpatient Center for comprehensive evaluation and treatment, if needed. Adolescents requiring separation from their environment or intensification of treatment are referred to a Regional Residential Center. Liaison between levels assures continuity of care and protection of as much academic progress as possible.

I. PRETREATMENT SERVICES: EDUCATION, PREVENTION AND EARLY INTERVENTION

- a. Services need to be brought to adolescents, predominantly in middle and high schools
- b. Student Assistance Programs (SAPs) are the foundation for a continuum of services
 - i. 3-tiered prevention services (Institute of Medicine model)
 1. *Universal* prevention strategies provide drug education for every student, including parent education.
 2. *Selected* prevention strategies target subgroups known to be at elevated risk (e.g., those just entering high school or with a positive family history of addiction).
 3. *Indicated* prevention strategies focus on individuals known to have initiated risky behaviors (e.g., marijuana use or binge drinking).
 - ii. Promotion of a recovery-positive school environment, de-stigmatization of SUD
 - iii. Collaboration with community Alcohol, Tobacco and Other Drugs (ATOD) coalitions
 - iv. Confidential student support
 1. Individualized drug and mental health education
 2. Motivational interviewing
 3. Preliminary evaluation
 4. Family involvement when indicated
 5. Emphasis on school performance and school retention
 - v. Training teachers and administrators in identification of potential ATOD problems and referral to SAPs
 - vi. Early intervention and referral to Core Adolescent Outpatient Centers for professional evaluation
 1. When SUD is suspected

- 2. When cognitive/learning difficulties are suspected
- vii. SAPs provide liaison with Core Adolescent Outpatient Centers
- viii. Adjunct Peer Resource Referrals
 - 1. Community-based, faith-based and private peer support groups
 - 2. 12-Step and other programs developed for teens

- 1. Homeless
- 2. Juvenile Justice
- 3. Foster Care

- b. Six (6) Regional Residential Treatment Centers

These will serve the network of Core Adolescent Outpatient Centers and serve as intensification-of-treatment resources for adolescent outpatients who are unstable, refractory, or unusually complex. Each center must develop an accredited education program and resources for assessment and remediation of learning disorders.

- c. Inpatient psychiatric care is to remain within existing hospital based system.

II. TREATMENT SERVICES

Adolescents require treatment in separate facilities from adults at all levels of care. Age-appropriate treatment goals require a *developmental/maturation* focus and uniquely trained staff. The complexities of adolescent development produce unique issues that are quite different from the usual care offered in adult treatment settings. Moreover, adolescents require safety and must not be exposed to adult predatory behaviors. Family engagement is essential. And, since schools are the “workplace” for most teens, a close liaison between school-based programs such as SAPs and the community-based outpatient treatment system is essential.

California is lacking a public-sector treatment system for drug using adolescents, and Prop 64 funding should be used to develop this system. A county-based system of outpatient adolescent clinics needs to be supported by 6 regional residential treatment centers for unstable or refractory cases.

- a. Core Adolescent Outpatient Centers
 - i. One or more OP Center in each county, depending on its youth population base
 - ii. Hours need to accommodate school needs
 - iii. Comprehensive evaluation, including learning disorder evaluation when indicated
 - iv. ASAM Placement Criteria used to determine medical necessity and level of care
 - v. Intensive outpatient (4-12 weeks) and ongoing long term outpatient care
 - vi. Satellite support groups to increase accessibility to ongoing care
 - vii. Liaison with school-based SAPs, satellite groups, primary care physicians, outside therapists and higher treatment levels
 - viii. Assertive outreach for treatment dropouts, adolescents who are not in school and other high risk populations including

III. OUTPATIENT AND RESIDENTIAL TREATMENT ELEMENTS AND STAFF COMPETENCIES

- a. Comprehensive SUD, psychiatric and cognitive/learning evaluations
- b. Treatment of co-morbid psychiatric disorders, including trauma therapy
- c. Medical detoxification (when needed) and medication management provided by and supervised by a physician
- d. Treatment methods:
 - i. Individual therapy
 - ii. Drug and mental health education
 - iii. Group therapy (peer, multi-family, relapse reduction, life skills)
 - iv. Family engagement and treatment
- e. Oral Drug Testing, confidential, privacy-protected, and on-site. Oral drug testing technology is sufficiently advanced to be used preferentially over urine testing. Oral methods are more dignified, less intrusive, easily observed and less subject to tampering.
- f. Language, culture and gender sensitivity
- g. Individual case management
- h. Outreach specialist for school and treatment dropouts
- i. Tele-health capacity when transportation is problematic
- j. Statewide-standardized Electronic Medical Records (EMR) and Management Information Systems (MIS) facilitating outcome studies and outreach for dropouts from care

IV. CORE OUTPATIENT TREATMENT CENTER STAFFING

- a. Program or Clinical Director – PhD, MD or Masters level
- b. Addiction Medicine-certified Physician - part-time to full-time, depending on clinic caseload, to provide medically supervised detoxification and medication management
- c. Licensed Therapists – PhD, PsyD, MFT, and LCSW trained in
 - i. Substance Use Disorders
 - ii. Adolescent Psychological Development
 - iii. Motivational Enhancement and Cognitive Behavioral Therapy
 - iv. Dual Diagnosis Management
 - v. Family Systems Therapy
- d. CAADAC-certified counselors – supervised by licensed therapists
- e. Outreach specialist
- f. Administrative support for liaison with schools, satellite groups, residential treatment centers, residential psychiatric facilities and primary care physicians
- g. Educator to organize and supervise academics

REFERENCES

- ¹ Combining California Healthy Kids Survey 2015 data (http://surveydata.wested.org/resources/Biennial_State_1315.pdf) and California Department of Education secondary school enrollment data (<http://www.cde.ca.gov/ds/sd/cb/cfeenrollmentcomp.asp> and <http://www.cde.ca.gov/ds/sd/cb/ceffingertipfacts.asp>)
- ² Data include 1,941,000 9th through 12th grade and 118,000 nontraditional students.
- ³ Youth Services Policy Manual - DRAFT, page 58, DHCS
- ⁴ http://ca-sdfsc.org/docs/resources/SDFSC_IOM_Policy.pdf