CONSIDERATIONS FOR A CHILD/ADOLESCENT ORIENTED SYSTEM OF SUBSTANCE USE CARE IN PHILADELPHIA

OFFICE OF ADDICTION SERVICES ADVISORY BOARD
CHILD/ADOLESCENT SERVICES COMMITTEE
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Public Health models applied to behavioral health services result in a vision of service best articulated by SAMHSA as system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support, social integration and optimal health and productivity. Strategies put forth by NIDA, the ONDCP and the IOM corroborate this comprehensive national vision in other specific and dynamic ways.

In Philadelphia, the Child/Adolescent Substance Use Service System continues its quest to actualize this vision through a ***continuum*** of effective treatment and support services that are child/family/ provider-friendly; developmentally informed and appropriate; fiscally efficient, practical, accessible and resiliency/recovery informed. As the transformation moves forward, the Child/Adolescent Subcommittee of the Office of Addiction Services Advisory Board (and ad hoc members) was charged to review substances use services for children, adolescents and their families and then to provide recommendations for continued development. Viewed within a public health model and adopting principles of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Patient Protection and Affordable Care Act of 2010, the Health Care and Education Reconciliation Act of 2010, and Philadelphia's the *Blue Ribbon Commission Report*, this document will delineate the necessity of:

- system and service coordination;
- health promotion;
- prevention, screening and early intervention; and
- treatment, resilience and recovery support

to promote social integration and optimal health and productivity for individuals with substance use problems. Other national and local agencies and research and collaborative efforts were also used as guiding principles in this document. Sources include:

NATIONAL

- Comprehensive Community Mental Health Services Program for Children and Families and the Community Support Program (CSP)
- Health Care and Education Reconciliation Act of 2010
- Institute of Medicine (IOM) report "Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities", 2009
- IOM report Improving the Quality of Health Care for Mental and Substance Use Conditions
- "Mental Health: A Report of the Surgeon General"
- National Institute on Drug Abuse (NIDA)
- National Quality Forum's Standards of Care for Treatment of Substance Use Disorders.
- Office of National Drug Control Policy (ONDCP)
- Patient Protection and Affordable Care Act of 2010
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- U.S. Preventive Services Task Force (USPSTF)

LOCAL

- DBH Blue Ribbon Commission on Children's Behavioral Health (2007);
- *The Recovery Revolution: Will it include children, adolescents, and transition age youth?* **(**William L. White, M.A., Arthur C. Evans, Jr., Ph.D., Sadé Ali, M.A., Ijeoma Achara-Abrahams, Ph.D., & Joan King, APRN, BC);
- Principles from the Philadelphia Transformation to ROSC;
- OAS Strategic Plan/Goals; and
- DBH Practice Guidelines focus group discussion notes.

Two overarching themes emerged from these sources and were corroborated by the shared experience of the committee First, the system should include activities and services that go beyond traditional acute care residential or outpatient services to move beyond the isolation of problems that can occur in traditional treatment. Health Promotion and Prevention as well as Screening and Early Intervention, are critical in the promotion of healthy behaviors, in the prevention of risk and Behavioral Health problems, and in the reduction of the impact of behavioral health problems should they arise (BRC). BRC recommendations (which have not yet been realized) remain pertinent to these transformation efforts:

- Improve and expand broad-based prevention and health promotion activities to keep all children on the right track.
- ***Identify and intervene early with children who are vulnerable to behavioral health problems***.
- Identify and promptly refer youth experiencing behavioral health problems including those in early care and education, school settings, and the child welfare and juvenile justice systems.

Second, there is an absolute necessity of addressing and building protective factors in children, adolescents and families (e.g., competence, confidence, opportunity, attachment) when attempting design of <u>any</u> program services within any service system involving this age group (White, 2007; Theokas & Lerner, 2005; and Mershke and Patterson, 2003. Building protective factors fosters resiliency and increases options for long term success and is essential when working with adolescents and their families. Protective factors:

- are not static; they advance, are maintained, or recede as each layer of the ecosystem evolves;
- are most important during windows of vulnerability, e.g., transition from childhood to adolescence;
- are to resilience what recovery capital is to the long-term resolution of AOD problems; and
- increase in potency and duration of effects when combined and strategically sequenced.

The IOM (2009) points repeatedly in its research to the growing evidence that well designed prevention interventions reduce a range of problems and that these efforts are sustained over time to help individuals, families, groups build strengths that support well-being. IOM stated proven approaches, which if incorporated into Philadelphia's transformation, could change the scope of services for youth and families include:

- strengthening families by targeting and intervening in problems such as substance use or aggressive behavior, teaching effective parenting and communication skills, and helping families deal with disruptions , e.g., separation/absence of parent/spouse, or adversities, e.g., economic, illness, etc.;

- strengthening individuals by building resilience and improving cognitive processes and behaviors;

- preventing a host of specific disorders by screening individuals at risk and offering skills training and other preventive interventions; and
- promoting behavioral health by modifying school and community environments to target and support promotion prosocial behavior, coping skills and skills for healthy daily living.

This paper first focuses on the less defined and understood levels of wellness promotion/prevention and intervention services with an emphasis on those ***wellness promotion*** services that work to prevent risk behaviors and associated behavioral health problems, and ***intervention*** **services that work to address early signs of behavioral health risks and problems before youth meet criteria for a DSM diagnosis** (i.e., preclinical levels of service). This latter category of services is perhaps most critical as these tend to frequently be overlooked and non-reimbursable by current financing systems and finding streams despite the fact that these have the potential of significant impact and cost effectiveness before the need for formal treatment presents. Levels of Care discussions directed to substance use disorders on the adolescent scale are limited to Outpatient, Drug-Free treatment for purposes of this paper.

To reduce redundancy, the committee also stipulated to the single statement of the pertinent child/ adolescent goals in the OAS Strategic Plan addressing principles of care regardless of age, gender, sexual orientation, culture or special needs in a manner that is recovery/resiliency focused and trauma informed.

IMPLEMENTATION:

The challenge for the City and its providers and clients is to make real the vision and wisdom of all who collaborated on the above-named works. The Implementation Plan to do so depends on political will of those who influence major systemic improvements, addition of research and training supports, securing appropriate and flexible funding, and regulatory review/revision. All of these are necessary to make a service system that is: free of age barriers, clinically appropriate to client/family need, community and user friendly and easily accessed, and funded at appropriate levels with generous flexibility to meet the emerging service and recovery needs of clients/families entering, staying in and leaving formal services.

Local recovery resources for youth lags behind national trends and further compels the resource plan/ systems transformation to continue to focus on and include equitable services for children and youth and their defined families and easy age/developmentally appropriate access for everyone at every stage of service. Empowerment and resiliency are integral parts of development at any age and people with good resiliency traits recover better and longer and exponentially increase the return on the system's investment in their recovery. Implementation necessarily involves review of practice guidelines, service regulations and funding mechanisms with adjustments in each to create a substantive system of care that is clinically and fiscally accountable and responsive to need in 2011 and beyond.

Salient Features of an appropriately designed substance use service system for children and adolescents with appropriate practice guidelines are many and varied. Primary among them are the following:

Services should be *Accessible*: Removing barriers to service necessarily involves assertive outreach and engagement, providing services at times when they can be conveniently accessed; offered in places beyond agency sites that are natural and familiar to the intended population and provided by

people who are believable and worthy of their trust. This is most easily accomplished at the earlier levels of service, i.e., prevention and intervention, whose design puts them in places comfortable to most children. Co-locating treatment services in other than licensed sites is highly desirable, yet creates licensing and reimbursement difficulties because of existing mandates governing service delivery. ***However, creative regulatory revision would ease these barriers to access.***

The BRC specifically recommends that the substance use service array should be delivered by qualified providers and offered in additional sites such as schools and Department of Recreation facilities, i.e., settings that are natural and comfortable to children and youth and that screening to identify substance use problems should occur in all settings where youth are at high risk including mental health treatment settings, juvenile justice, and child welfare settings (e.g., foster care, group homes), etc. The Report also includes recommendations to identify/expand/create recovery/ resiliency-based support services for adults, children, and their families within the communities in which they live, including peer support services and pro-social socializing activities. In a timely manner, the BRC also recommended that services should be better integrated with other behavioral health services, particularly for youth with co-occurring disorders.

Perhaps most important is the need to "add by subtracting", i.e., to improve access by eliminating as many artificial eligibility requirements as is possible and ensuring access regardless of insurance status. Purchasing health-related services can be daunting to many families often relegating behavioral health services to the lower priorities. This is particularly critical to those youth with "pre-emergent treatment" needs best served at the intervention level as their substance use or exposure would not meet Medical Necessity or DSM diagnostic criteria for treatment. Insurance status barriers would also include those youth and families who do meet fiscal or other eligibility requirements for publicly supported insurances, but who remain functionally uninsured as they cannot meet the copay requirements of commercial insurance. Insurance/fiscal status never determined who will need services, but far too often determines who will get them.

Services should be *Instituted As Early As Possible* and be *Comprehensive/Appropriate to Need*: It is crucial that a youth-focused ROSC reflect the *full integration* of primary prevention, screening and assessment, early intervention, clinical treatment, and non-clinical recovery support services - a continuum that includes outreach, wellness promotion, and extended recovery/resiliency supports for the individual and family/community.

Among many others, the Blue Ribbon Commission Report clearly articulates that "children should be engaged at whatever point they enter the system and the most appropriate type and level of care should be determined at that time. As providers stated, '***children should not have to fail a level of care before they are connected to the right services."*** Children and families must have choice in seeking and accepting services at care levels in which they are ready, willing and able to be involved. "Children should have access to an array of services that addresses their physical, emotional, social, and educational needs. Children should have access to services and supports that ensure a smooth transition from child to adult services." (BRC, DBH PG) A full array includes timely response to interest/motivation at a level of service that is minimally intrusive, engaging, practical and meaningful to the family and allows movement up and down the scale in a fashion coordinated with other service systems as needs present or are resolved. A comprehensive array that includes what families will view as practical treatment/intervention services and extensive and user-friendly, accessible recovery/resiliency resources will afford a more successful path to positive outcomes in treatment and reduce recidivism and cost in the long run.

Services should be *Coordinated/Systemically Integrated*: Children and youth with substance or exposure related concerns and who are "known to" any child-serving system should have access to substance use professional and paraprofessional services. "Children and families should receive integrated, coordinated care, regardless of the system or systems through which they receive it" BRC, DBH PG). This includes those identified by contact with the mental health system, law enforcement and Court system, DHS and provider social workers, foster care and child welfare staff, school SAP teams and after-school program staff. It also includes those who work with children/ families who experience homelessness in all its definitions, and those at primary risk of delinquency/ dependency actions, etc. This would necessary involve significant training of key child/family serving personal as promulgated again by the BRC so that these staff may "more readily recognize potential behavioral health problems, including substance abuse, among children and build on children's and families' strengths and resiliency to address potential problems."

Further coordination is also needed with programs serving adults with addiction concerns as their children generally live with fewer protective factors around them and are highly vulnerable to their own use. All formal and informal adult and child services providers should be trained to elicit information about children and children's needs. Services that strengthen the adolescent/young adult's prosocial living skills, resiliency factors, emotional regulation and critical thinking and decision making skills are essential to address the particular risk conditions they face regardless of the system that serves them.

Substance use is so directly and indirectly prevalent in the stories of children facing negative outcomes in every child-serving system that addressing this issue alone can resolve a multitude of conditions. The BRC reported that:

> *Children experiencing problems in school, at home, or with peers may be showing signs of mental, emotional, and behavioral problems.* These problems often come to the attention of parents in reports of repeated fighting, rule-breaking, school failure, or substance use. Children may also report feeling sad, depressed, or anxious.
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> *Some life events make children vulnerable to mental, emotional, and behavioral problems.* When children experience divorce (particularly those which are protracted) death, or incarceration of a parent, they may develop mental, emotional, or behavioral problems. These children are more likely to have physical health problems, use alcohol or drugs, and drop out of school. Physical and sexual child abuse is a serious factor in the development of depression, anxiety, and alcohol and drug abuse. When children are bullied or victimized, experience academic failure, spend time with deviant friends, or use alcohol and drugs, they may develop mental, emotional, and behavioral problems. Witnessing violence increases the likelihood of developing posttraumatic stress disorder, anxiety, depression, antisocial behavior, and the use of alcohol and drugs. *The importance of delivering services that are appropriate for the age and developmental level of children and youth should be recognized* ***across systems that serve children***. The extent to which practices are developmentally informed should serve as a key criterion in evaluating and designing services.

Any of the above conditions/behaviors should raise an alert for child-serving professionals in a cross-trained system with adequate service resources and coordinated care. There is no more time for due consideration for this practice, the virtues of which have again been extolled for years. This is an opportunity for coordinated care for which the Department can take the lead as it is prominent among

the BRC recommendations. By doing so, the Department could ensure through assessments of child-serving systems, that the BRC recommended services and supports are available during key transition points in children's lives (e.g., children going from pre-school to kindergarten, children changing homes, neighborhoods or schools, youth returning from juvenile placement and youth aging out of foster care). It would also ensure that those services and supports are appropriate for the ages and development levels of the children they serve. Education and training programs for professionals in all systems should include this developmental perspective.

The rate of child abuse cases alone that involve parental substance use has been set as high as 75% (DHS); truancy/dropout/delinquency/teen pregnancy rates have been highly correlated with alcohol or other drug use for decades. It really is time for child-serving realms of physical and behavioral health, welfare, education, recreation, juvenile justice and domestic relations to make a serious commitment to collaborative approaches to practice in real time. Children cannot wait any longer as their natural supports continue to erode along with public ones.

Services should be *Effective/Practical*: All levels of service to children/adolescents beyond the Universal Prevention level which begins with evaluation/review of larger group needs/strengths, should begin with and incorporate ongoing needs and strengths assessment that is developmentally appropriate and includes all persons with interests in the child in the input and decision making as developmentally appropriate or necessary. Standardized tools can be used as appropriate, but more importantly, assessments should include common dimensions across the field. Providers should incorporate sections unique to their populations or geography to add meaning and direction. Assessment and planning done in this manner should incorporate Motivational Interviewing into the process. These are the first steps in helping the child and family see the value of service engagement while at the same time addressing reluctance to commit to a process which removes drug use and replaces it with a more fleeting promise of something better to.

Service revision should incorporate the benefits of decades of research on child/adolescent services and evidence-based practices as well as emerging studies on effectiveness of other interventions to advise the development and implementation of services.

> **NIDA Principles of Drug Addiction Treatment** acknowledge that "adolescent drug abusers have unique needs stemming from their immature neurocognitive and psychosocial stage of development" particularly with regard to the phenomenon of brain development most closely associated with aspects of behavior such as decision making, judgment, planning, and self-control undergo a period of rapid development during adolescence. Adolescent drug abuse is also often associated with other co-occurring mental health problems. These include attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder, and conduct problems, as well as depressive and anxiety disorders. This developmental period has also been associated with physical and/or sexual abuse and academic difficulties."
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> "Adolescents are also especially sensitive to social cues, with peer groups and families being highly influential during this time. Therefore, services that facilitate positive parental involvement, integrate other systems in which the adolescent participates (such as school and athletics), and recognize the importance of prosocial peer relationships are among the most effective." Timely access to a comprehensive range of services that includes a family focus is essential. NIDA asserts that such services be "developmentally, culturally, and gender-appropriate" as integral when addressing adolescent addiction.

As defined by the **SAMHSA's National Registry of Evidence-Based Programs and Practices,** Evidence-Based Programs (EBPs) "...generally refer to approaches to prevention or treatment that are validated by some form of documented scientific evidence," i.e., several clinical research studies showed the service to be effective". Use of such practices as nationally vetted Prevention and Intervention curricula/programs and Treatment tools such as Cognitive Behavioral Therapies, all the Motivational models, various forms of family therapies and recovery-enhanced treatment programs is mandated by most child-serving systems. These methods are especially validated by SAMHSA and the **Office of Juvenile Justice and Delinquency Prevention (**OJJDP) in their efforts to assist practitioners and communities, and to a broader degree, public service systems, to implement evidence-based prevention, intervention and treatment programs that can make a difference in the lives of children and communities, and should be continued.

While Evidence-Based Practices are a given in service delivery in 2011 and very effective in treatment of many adolescents, those who are "treatment-resistant" (resilient?) or who just are not invested in service may have more success with alternatives such as Practice-Based Evidence (PBE). "Communities, agencies and families create PBE when they attempt to adapt treatment practices (particularly components of evidence-based practices) to their unique needs. Practitioners of PBE merge culturally and traditionally defined methods of treating substance abuse to insure a comprehensive, or wellness, approach to treatment. PBE informs selected interventions with the history and culture of the community in which it is practiced. PBE accepts that treatment should be grounded by scientific evidence, but also recognizes that treatment is most successful when informed by community experience. The involvement of an adolescent and his/her family is a strong component of PBE, with the adolescent and his/her caregivers collaborating with the provider on goals, success measures, and the best ways to achieve success." *(The North Carolina Adolescent Substances Abuse Project at the University of North Carolina at Greensboro; a SAMHSA and CSAT Grantee).*

From a developmental perspective, services must make sense to the adolescent and clearly must be matched to strengths, needs and "ready, willing and able" factors for any chance of success. This is especially true of youth not mandated into service but whose use or exposure causes disruptions in development or achievement that they do not see or that are not significant enough to them to warrant attention. There are far more of these than mandated youth and their loss of potential is staggering on a personal and community level. Alternative ways of engaging and retaining youth in services not yet evidence-based should be examined as means of serving these youth as providers increasingly involve them in service planning.

Further exploration of alternative approaches such as PBE, Alternative Peer Group Programs which provide unique intensive peer-led but counselor-guided programming and Recovery High Schools with their exceptional sobriety effectiveness rates is indicated. Combining these with opportunities for sober housing for youth exiting various levels of treatment or residential placements and electronic or "wired" recovery and support options, the Department could advance its cutting edge systems transformations to attract, support and maintain youth in recovery environments as they mature to adulthood and beyond.

Services should be *Flexible*: "Create services and resources/opportunities for community intervention and prosocial activities that are accessible in community based settings through coalitions of existing treatment providers and, schools, recreation centers, grass roots community/

recovery based support organizations for children, adults and families and for those of any age in recovery processes" (BRC).

To implement this recommendation, the Child/Adolescent service system will need to include all services previously defined on the service spectrum, particularly at the outreach/prevention/ intervention levels. Service transitions at more intense levels of care already exist to a greater degree and they are often dictated by insurance or regulatory mechanisms. Needs and strengths of children and adolescents emerge and wane along predictable developmental patterns – until they are interrupted by substance use. For youth and families to remain engaged in during this flexible process, providers and supports must be equally flexible to adjust services across levels of care in response. Service array and all LOC service transitions must be structured in ways that prevent obstacles to fluid movement among needed services, all of which will require considerable collaboration with funding and reimbursement systems.

Services should be *Age/Developmentally Appropriate* along the continuum: Assuming a developmental perspective is at the heart of being person-centered in service, particularly so with adolescents given their unique psychology and physiology. Adolescent services are necessarily offered by adult professionals trained to meet the psychological needs of kids and attend to the developmental tasks that were interrupted by substance use and/or substantial exposure to substance use and other behavioral risk factors. These same adults must be equally adept at responding to families and other child allies throughout and beyond a service episode. Using a developmental approach also includes serving children and youth before and during the time that treatment needs present and providing resiliency/recovery supports to them and their families. This target group also includes transition aged youth and young adults often discounted by being caught between systems due to age-eligibility variables.

Child/Adolescent service staff by nature are oriented and trained to work with young people who are developmentally less mature than their chronological ages in behavior and attitude, lifeskills, world view, knowledge base, ability to navigate the wider world and who are still reliant on adult caregivers in most realms. Immature kids have no situational finesse skills; they live from self-reference and have difficulties seeing alternatives and solutions as problem solving skills generally are undeveloped. Kids with "developmental breaks" basically "go from 0 to catastrophe in 13 seconds" with no alternatives generated for dealing with normal emotional/psychological stress/ discomfort, making them peculiarly vulnerable to the lure and trap of addiction. Developmentally appropriate services intervene with deficit behavior and enhance the youth's resilience and resistance related to current and future substance-related problems.

Addressing age-appropriateness, the Blue Ribbon Commission notes that "Children's developmental needs change over time and supports and services should reflect the child's stage and push for mastery. Developmental stages are accompanied by expectations for mastery of the youth in multiple domains at home, at school, and with peers, and each stage is accompanied by expectations that certain milestones or developmental challenges will be met. During transitions such as pre-school to school age, middle school to high school, and transition to adulthood there are many opportunities for social and emotional growth that can be fostered by family and community. For children and youth who are at risk for developing behavioral health problems or for those who have already experienced the onset of a behavioral health problem, these transitions can be more challenging. Developmentally appropriate services and supports must be available for those in need during transition points."

Traditional adult-focused peer-led fellowship or recovery services and client-only focused treatment are woefully inadequate for the younger service population with its complicated subgroup system and developmental challenges. As stated in the DBH Practice Guidelines Draft, this "does not diminish the importance of focusing on developmental issues as applied to adults (both historical and current), but only that the trajectory of adult and child/adolescent development are different in nature, scope, and consequence". The BRC succinctly notes "service delivery across this array must embrace a developmental framework, recognizing that adolescent service needs are significantly different from those of adults."

Services should be *Family Focused/Involved*: Substance use and all its derivatives constitute a recipe for wreaking havoc on family life and individual development. In this case, age actually matters given the developmental considerations already discussed. For adolescent services of any level to be meaningful and successful, consideration and support to and involvement of family members must be an utmost priority in the planning and delivery of services regardless of who the affected family member is. However, this is not to say that youth without an involved family should not be accepted into care. Quite the contrary as their need for services is great. Consequently, finding a significant other (e.g., other adult family member, coach) will be needed so as to optimize the potential for behavioral improvement.

Along with the BRC, NIDA, SAMHSA, DBH PG, IOM, White et al, emphasize the need to respect and involve family members at every step possible with due consideration of their circumstances. "This is particularly critical for parents of children who may be juggling limited finances, other young children, transportation issues, etc., so flexibility is key to inclusion. Additionally, it is incumbent on systems and providers alike to offer family treatment and resource management, coordinate and not replicate multiple services and to provide ongoing support to the primary client, and to the family system through consultation, telephone recovery check-ups; peer-run support groups facilitated by family members; family education on early addiction recovery; and strategies to promote sustained wellness. Continuing care planning is a collaborative effort between providers, peer-based supports, the individual receiving services, and family members when possible." To this end, providing advocates to help families navigate increasingly complex service systems is indicated.

Special needs groups also need special considerations in the areas of direct service and family involvement. Children who have primary caregivers with behavioral health problems are vulnerable to behavioral health problems themselves. This is also true of children exposed to long-term illness in their families, those who meet homeless definitions, those is out-of-home placements or experiencing the loss of parents/caregivers for any reason. It also applies to those who have been abused, neglected and/or exposed to violence as well as those with significant academic difficulties and those with challenges relating to their racial, ethnic or cultural background, sexual orientation, or gender identity or problems due to chronic health issues or physical disabilities (BRC).

Services should be ***Recovery Focused:*** White and Godley in their commentary on adolescent recovery, note perhaps the most important and realistic condition for R/ROSC for adolescents, that "solutions to AOD problems already exist in the lives of individuals, families, neighborhoods, and communities and that our focus of study should be extended to learn from these successes." Much collaboration is necessary to bring about an equitable distribution of community and faith-based resources that can provide developmentally appropriate and practical recovery capital to City neighborhoods. The added benefit of doing so is that the same emerging network also serves the resiliency needs of families in recovery while benefitting primary and relapse prevention as well.

Stipulating to the volumes of resiliency/recovery research and evidence based practices as the basis for systemic transformation, it is clear that applying these principals is one thing, devising a methodology to measure outcome and therefore validity is clearly another. The latter is an important concurrent move to the former in the redesign of Philadelphia's service system for children and adolescents and is an urgent recommendation and challenge to DBH and providers alike. This paper has incorporated Resiliency and Recovery concepts throughout in an effort to demonstrate the desire of many that Philadelphia's be a system that can easily be recognized as "recovery-oriented, family-driven, developmentally appropriate, culturally nuanced, highly individualized, and focused on youth resilience, strengths, and empowerment" (SAMHSA)

To this end, the following recommendations address options to sustain recovery support at levels that leave them more connected to concrete assistance as they leave the structure of formal treatment:

- Ensure that there is a seamless transition between intervention/treatment and recovery services, i.e., no "break" between discharge from IOP or inpatient treatment and placement in a recovery program (sober high school, after-school programs, peer support groups) since it is often during this transition that the success of an adolescent in early recovery is most threatened. (Ginsburg, Brendler)

- Create at least one district high school for students working a sober program that follows the recommendations for best practices of the Office of National Drug Control Policy and the Association of Recovery Schools. The continued attendance or return to a school where there are no (or limited) recovery supports in place and where there are other students actively using seriously threatens the chances that an adolescent can sustain sobriety. In fact, 8 of 10 students will relapse within the first 6 months, and 50% will be using at similar or higher levels than before intervention/treatment (NIH and Winters).

- Create and maintain a database of peer-driven support meetings and pro-social activities available in city neighborhoods that are directed by, attended by and focused on the particular needs of adolescents including NA, AA, CA, non-12 step peer groups, "Friday Night Live" (White) and alternative peer group supports.

- Develop affordable sober houses/other sober living facilities within the city for older adolescents/young adults who need placement outside of their homes or neighborhoods in order to maintain recovery.

- Partner with area colleges and universities to establish recovery programs for students in recovery continuing onto post-secondary institutions so to decrease the chances of relapse and interruption of school. Look to Rutgers, Augsburg, University of Texas at Austin and 15 other college programs around the country for best practices.

DEVELOPMENT AND FISCAL CONSIDERATIONS:

FUNDING AND PAYMENT STRATEGIES: SAMHSA reports that in the public sector, individuals/ families/youth with complex mental and substance use disorders receive services funded by federal, state, county and local funds. These multiple funding sources often create a maze of eligibility, program and reporting specifications that create funding silos featuring complicated administrative requirements. If services are to be integrated, then dollars must be also intertwined. In the same way

that Medicaid will be required to streamline eligibility and enrollment, the good and modern system must either blend or braid funds in support of comprehensive service provision for consumers, youth and families.

Similarly, the BRC notes that "typically, the mental health service system and the drug and alcohol treatment system have been segregated with separate physical locations for services, separate funding of services, separate training of providers and often too little combined expertise in addressing the needs of youth who have substance use problems as well as mental health problems". Thus, children and adolescents who have co-occurring mental illnesses and substance use disorders are inadequately served."

The virtues of FFS or Cost Reimbursement funding are clearer for adult services than for youth. If accounting for service delivery under funds allowed is the goal of FFS/CR conversion, it is a problem on the Child/Adolescent side - better outcomes are realized from a family and youth programmatic orientation rather than from a purely fiscal approach. Program funding is the more appropriate funding and reimbursement approach as it supports the flexibility to transition easily among LOC for affected youth and their families as treatment and recovery needs emerge. Flexible fiscal capital in service delivery is a prerequisite for developing recovery capital in children, adolescents and families.

RETURN ON INVESTMENT: According to the Institute of Medicine in a 2009 brief for policy makers, *mental health and substance use disorders among children, youth, and young adults are major threats to the health and well-being of younger populations which often carry over into adulthood. The costs of treatment for mental health and addictive disorders, which create an enormous burden on the affected individuals, their families, and society, have stimulated increasing interest in prevention practices that can impede the onset or reduce the severity of the disorders. Making use of some of the effective evidence-based interventions already at hand could potentially save billions of dollars by addressing behavioral problems before they reach the threshold for a diagnosis and require expensive treatment.*

The IOM further states that many comprehensive interventions for school-age children and adolescents also appear to be cost-effective in a range of service systems, including education, child welfare, primary health care and juvenile justice. Youth development programs that focus on improving parent-child relationships and reducing problem behaviors, such as substance use and violence, have been shown to have benefit-cost ratios ranging from 3:1 to 28:1.

To this end, leaders, funders, and researchers should collaborate to develop outcome measures and guidelines for economic analyses of prevention and mental health promotion activities, incorporate guidelines and measures related to economic analyses into program announcements, and include analysis of costs and cost-effectiveness of interventions to prevent MEB disorders in young people in evaluations of effectiveness studies whenever possible. It is important to note, however, that the significant societal benefits of preventing BH disorders among young people may warrant intervention when an effective approach is available, even if the cost-effectiveness of such interventions is not yet ready. Producing more widespread cost-effectiveness analyses may take years, placing many young people at unnecessary risk.

Coordinating efforts to address these overarching issues in ways that remove obstacles to the complete system transformation envisioned is of primary importance. DBH, in its iterations of Practice Guidelines that include operational and fiscal dimensions, and its examination of viable funding and payment alternatives has already assumed this mantle. Inclusion of providers and clients/families in

this process is commendable and unique and further assistance from these groups is recommended in the development of new services and the exploration of new grant sources and program supports.

WORKFORCE DEVELOPMENT: SAMHSA notes its own directive *"that in conjunction with the Health Resources and Services Administration and provider associations SAMSHA will need to develop strategies for creating learning models to ensure the workforce has the information, technical assistance and culturally relevant training to effectively implement improved practices. Recruitment and retention efforts will need to be enhanced, especially to increase the available pool of culturally, ethnically and racially diverse practitioners and advance the development and use of peer/family specialists and recovery organization staff to address the demand for mental health and addiction services.*

Three critical efforts loom large: (1) redeployment of the shrinking professional workforce to positions of consultation and oversight; (2) augmentation of the existing workforce to include trained family, youth and peer supports as part of the paid workforce; and (3) a more concerted pre-professional training effort to prepare new frontline and professional providers for the modern delivery system that is consumer- and family-driven, youth-guided, recovery/resiliency-oriented and evidence-based.

As per OAS Strategic Goals, "insure the full complement of skilled professionals needed to expand and sustain necessary youth and adult service options by addressing workforce development issues including identity, salary, qualitative supervision infrastructure and professional development. Address the real and critical need for workforce development by providing sufficient compensation and reimbursement for training that would grow enough competent treatment, intervention and prevention service professionals to meet the growing need especially in areas of assessment, trauma informed/specific care, dual diagnosis, child psychiatry and especially in the outpatient level of care."

DATA/OUTCOME MEASURES: For all of the recommendations for transforming the Child/ Adolescent Substance Use service system to be viable, reasonable outcome and data collection methods that are goal directed and user and cost friendly must be developed in a coordinated manner. Philadelphia is blessed with a research-rich environment already fluent in substance service system in the City and on state and national levels as well. Academics, providers and research professionals should collaborate with DBH to develop a set of measures and data standards that are meaningful to the Philadelphia locale and which can be used to inform service development/transformation.

Providers also need assistance from OAS to obtain SCA needs data, NOMS results, PAYS results, etc., and current and inclusive county data in regard drug and alcohol level of use and treatment not restricted only to MA service recipients as many children and youth are served outside that funding/ data stream.

CONCLUSION:

Perhaps the best summary of need and purpose illustrated in this paper is provided by the Board on Children, Youth, and Families (BCYF) within the Division of Behavioral and Social Sciences and Education of the National Research Council and the Institute of Medicine. In their 2009 study report, they state the following:

> *Clear windows of opportunity are available to prevent MEB (Mental, emotional, and behavioral disorders which include depression, conduct disorder, and substance abuse) and related problems before they occur. Risk factors are well established, preventive interventions are available, and the first symptoms typically precede a disorder by 2 to 4 years. And because mental health and physical health problems are*

interwoven, improvements in mental health will undoubtedly also improve physical health. Yet the nation's approach to MEB disorders has largely been to wait to act until a disorder is well-established and has already done considerable harm. Tools to equip young people who are at risk with the skills and habits they need to live healthy, happy, and productive lives are available. What is lacking are the will, social policies, and collaborative strategies to adequately support the healthy development of the nation's young people.

Much of the work required to coordinate an expanded array of cross-systems services to Philadelphia's children and families at variable exposures to risk conditions and behaviors is and can be championed further by the DBH. Establishing an Office of Prevention Services within the Department of Behavioral Health structure with sufficient supports to build and sustain these efforts and would strengthen addiction outreach, engagement, and prevention activities/services/planning for children/ youth and families (OAS Strategic Plan) and, in fact, bolster all Philadelphia systems that care for the City's children and families. DBH is to be commended for initiating and sustaining the inclusive and successful process thus far of systems transformation and for its determination to apply all possible resources to the enhancement of child and adolescent services in Philadelphia.

LEVEL OF SERVICE: PREVENTION

As an organizing framework for prevention services for children and adolescents, the system should consider utilizing a combination of the Public Health Model (PHM) of three "stages" of prevention, the Institute of Medicine's (IOM) three classifications as well as the National Institute of Drug Abuse 's (NIDA) sixteen Prevention Principles. These organizing concepts have valuable perspectives, and frame this perspective on Prevention services through the DBH system**. For purposes of this paper, the secondary and tertiary levels of prevention which focus more on targeted or indicated individuals for whom primary universal application of prevention messages is not sufficient to mitigate their risk factors, are addressed in the Intervention section.**

Primary Prevention shares with IOM's Universal Preventive Intervention classification, a focus on the universal population as the target with attention is drawn to activities as targeted to a whole population group that has not been identified on the basis of individual risk. The PHM **Primary Prevention** schema emphasizes the outcome of this focus, namely that interventions are seen as directed at averting potential health problems before they start. This is consistent with research which shows that early intervention with risk factors (e.g., aggressive behavior and poor self-control) often has great impact than later interventions, by diverting a child's "life path" away from problems and toward positive behaviors (Ialong et al., 2002).

IOM's **Universal Preventive Intervention** classification is particularly rich in its application of NIDA Prevention Principles in the areas of risk and protective factors and program delivery. Programming should take advantage of the approaches to risk and protective factors that are fundamentally embedded in the research and evidence-based curricula approved by the Substance Abuse and Mental Health Service Administration (SAMHSA), which include outcome-validating pre-and post-instructional survey testing. Programming provided to this population is referred to as a "universal dose." NIDA Principles, attached at the end of this document are the primary reference guiding specific recommendations that follow.

Broadly defined, individual strategies are short-term actions focused on changing individual behavior, while environmental strategies involve longer-term, potentially permanent changes that have a broader reach, with the best prevention plans using a dual approach. Therefore, providers should deliver primary prevention services through developmentally appropriate lesson plan series provided by nationally validated curricula and adhere to structure, content, and delivery faithful to the "core elements of the original research-based intervention" (Spoth et al., 2002b). Program services should:

- enhance protective factors and reverse or reduce risk factors, including those that variously exert their influences throughout the maturation process, i.e., family, peers, and age, gender, ethnicity, cultural and environmental factors;
- address all forms of drug abuse, including under-age onset of legal and illegal drugs, as well as inappropriate use of legally obtained substances (e.g. inhalants) and prescription or over-the-counter medications; and
- address all forms of risk conditions in youth and families as they are interrelated and multi-systemic; utilizing risk and protective factors for combating alcohol and drug issues will assist with other problem behaviors, including substance abuse, violence, delinquency, teenage pregnancy, and school dropout.

Providers should continue to raise awareness that developmentally appropriate perspectives be respected for those younger than 24 years across all other contexts, including system transformation strategies. For children (under 13 years of age), youth (ages 13-17), and the transition-aged (ages 18-24), developmental maturation is particularly significant because it is incomplete until approximately age 24. Volumes of brain development research have established that the adolescent brain (ages 13-24) is unlike that of either children or adults, because it is influenced by risk taking-enhancing hormonal influences not found in those older or younger. As a result, it is inappropriate to assume that strategies developed for adults will apply to youth and the transition-aged.

The Prevention system should emphasize the importance of utilizing prevention-focused curricula that is evidence-based and nationally validated and which must be implemented with fidelity as to content, prescribed number and duration of lessons due to proven effectiveness. Instructors should be trained behavioral health professionals such as Prevention Specialists, to ensure an adequate threshold of knowledge of material and practice guidelines and be able respond appropriately to student inquiries/ reactions. Research continues to support the decades old better outcomes of prevention services that are delivered by the qualified professional described above than those from discontinuous lessons by staff not specifically trained/experienced in the principles supported by science of prevention.

SCHOOL PROGRAM RECOMMENDATIONS:

Prevention services should address school-based programming by focusing on programs aimed at the general population at key transition points. Universal education should address natural and developmental transition points or identified vulnerable points, such as preschool to kindergarten, elementary school to middle school, and middle school to high school. Providers, for example, should conduct preparatory interventions for ninth-graders who will be entering high school.

Preschool programming focuses particular attention to the aggressive behavior, poor social skills, and academic difficulties that are indicators for drug abuse. Service to this age group is an area of improvement needed and providers will need training and curricula in these areas.

At the elementary school level, in addition to factors evident at the preschool level, Providers should address higher risk factors for drug abuse, including academic failure and school drop-out, through age-appropriate curricula. Risk factors should be addressed through instruction that equips student participants with the following skills: self-control, emotional awareness, communication, social problem-solving and academic support.

The middle school and high school curricula used by Providers should address the age-appropriate approach to risk factors, emphasizing academic and social competence. Research-based instruction should instill more sophisticated skills in the areas of: communication, peer relationships, self-efficacy and assertiveness, drug resistance skills, reinforcement of anti-drug attitudes, and strengthening personal commitments against drug abuse. In Philadelphia-specific research, Quill et alia (2006) confirmed development of drug refusal plans by students in Philadelphia, while Meyers et alia (2010) confirmed significant changes in attitudes toward substances and violence, as well as improvements in the characterization of peer groups and academic achievement.

Prevention programs should be long-term with repeated intervention via age-appropriate "booster" programs that reinforce prevention goals from one academic year to the next to prevent the “diminishing effect” on benefits gained without follow-up in the high school years (NIDA). Providers

should establish relationships of mutual trust with school personnel to foster "booster" programming, and raise the community's awareness that continuous reinforcement of messaging, ages K-12, is necessary if the desired effects of system transformation are to be achieved.

TRAINING RECOMMENDATIONS:
All prevention providers should be trained in Student Assistance Program (SAP). SAP is a mandated K-12 program in all Pennsylvania public schools. Knowledge of the SAP Process and a relationship with the school SAP team would assist the provider in making appropriate referrals to assessment service when concerned about children who may need intervention or treatment levels of service.

A comprehensive Substance Use service system should equip Prevention Specialists with skills through training in curricula, underlying content, and the classroom management practices that foster students' "positive behavior, achievement, academic motivation, and school bonding." With NIDA's emphasis on interactive techniques, Prevention programs should employ cooperative learning because such techniques enable "active involvement in learning about drug abuse and reinforcing skills" (Botvin et al., 1995).

COMMUNITY PROGRAMS:
There are multiple paths to Prevention and principles of Prevention Services should include a commitment to service access points in the community that are points of entry which are natural and non-stigmatizing. In addition to schools, these include out-of-school time program sites, recreation and community centers, social service agency sites, libraries, etc. Such practice will increase the likelihood that children and their families obtain services. Programs should be designed to intervene with children and families as early as pre-school age to identify and address risk factors for any number of difficulties and should extend through adolescence and young adulthood particularly at times of transition. Prevention Providers will need assistance in building capacity to establish and maintain such linkages.

Prevention services should address drug abuse programs in the local community, as well as targeting modifiable risk factors and strengthening identified protective factors (Hawkins, et al., 2002). Provider services could include resource management for linkage to real-time resources for families in their communities.

To support the development of healthy community environments, Prevention services should address the needs of children, youth and the transition-aged in the zip codes/Police Districts with the highest stress statistics, schools with dangerous incidents, and persistently dangerous schools and their feeder schools. Additionally, for therapeutic linkages emphasizing wellness and a holistic approach to the child, linkage should be explored with primary care providers and leisure/recreation sites or providers, such as Y's. Providers will need to develop capacity to establish and maintain such linkage.

To address programming reaching populations in multiple settings, Providers should also forge linkages to clubs, faith-based organizations, and the media. To enhance their capacity for these linkages, Prevention Providers will need to acquire curriculum, such as the social media curriculum of Temple University's Rene Hobbs.

Community prevention programs should be developed that combine two or more effective programs. Providers will need to build capacity or work through collaborations to achieve recommended

combinations, such as family-based and school-based programs, which are considered to be more effective than a single program acting alone (Battischtich et al., 1997). Providers could benefit from a pilot program that funds establishment of such linkages.

Providers could also establish student advisory groups to help develop appropriate social and other media strategies to reach students' peers. Youth should be explored as a resource, for example, peer buddy programs, peer mediation, cross-age tutoring and mentoring, and SADD.

FAMILY PROGRAMS:

In addressing family programming, Providers should provide training that enhances parent monitoring and supervision skills. Training can include rule-setting, techniques for monitoring activities, praise for appropriate behavior, as well as moderate, consistent discipline that enforce defined family rules (Kosterman et al., 2001). For those whose risk levels are beyond the Primary Prevention level of service, linkage to the Intervention or Treatment LOC is appropriate for more intensive intervention. Providers should also disseminate information for parents/caregivers that reinforces what children are learning about the harmful effects of drugs, and opens opportunities for family discussions about the abuse of legal and illegal substances. Providers need to acquire the curricula and training to augment service levels for this activity.

BENEFITS/RETURN ON INVESTMENT:

Recent research (Greenberg et al., "The Economic Return on PCCD's Investment in Research-based Programs: A Cost-Benefit Assessment of Delinquency Prevention in Pennsylvania," 2008, at www.prevention.psu.edu) shows that the cost-effectiveness goals of NIDA Prevention Principle 16 (a savings of up to $10 in treatment for alcohol or other substance abuse) has been exceeded. This Penn State Prevention Research Center report concludes that due to effectiveness and wide reach, life skills training (e.g., Botvin) results in a $25 return on investment (ROI) for every dollar invested, a result that far exceeds that of any other intervention evaluated in the report (including Big Brothers/Sisters; multidimensional treatment foster care; multisytemic therapy; functional family therapy; nurse-family partnerships; and the Strengthening Families Program 10-14).

A recent study by the University of Illinois's Collaborative for Academic, Social and Emotional Learning (2008) evaluated "social-emotional learning" instructional programs provided to over 300,000 students in universal populations, and showed outstanding results that reinforce the efficacy of NIDA's Prevention Principles. Participants "significantly improved," compared to nonparticipants, in: Achievement test scores and school grades, social and classroom behavior; and how they feel about themselves and interact with others ("The Positive Impact of Social and Emotional Learning for Kindergarten to Eighth-Grade Students," at www.casel.org). Therefore, DBH and Providers should emphasize universal populations and doses in their program delivery planning and outreach.

LEVEL OF SERVICE: INTERVENTION

Inclusion of intervention services in the established array of multisystem supports for Philadelphia's children and youth is no longer a luxury. With the depletion of traditional and specialized funding streams and supports and the emphasis on building resiliency in families and communities, incorporating these services is imperative to achieve this goal and preclude the need for more expensive and extensive treatment and multiple system involvement. Expanding service options on the continuum of care in the direction of intervention/prevention/outreach and engagement would identify and serve earlier, those children at varying degrees of risk, regardless of insurance/eligibility status.

Research documents the effectiveness of evidence-based pre-diagnostic*, early intervention and psycho-social intervention as credible interventions thereby reducing the need for referrals to higher, more costly levels of care. It also supports the value of these services in earlier identification and linkage to proper levels of treatment or social services for those youth and families needing more intensive behavioral health or child welfare assistance. These engagement and pre-diagnostic, early intervention services represent a critical component of an effective continuum of care for youth and families, given the unique challenges that they face accessing the behavioral health system.

Resiliency-empowerment programs for vulnerable children and youth living in chronic risk situation along with parent/family/skill-building and psychoscial support activities would also be part of this pre-clinical level of care. In addition to self/parent referrals, portals for service access typically include the full range of systems with which youth and their families come into contact (e.g., Student Assistance Program and other school personnel, judicial/probation/Youth Aid Panel staff, treatment and recovery home clients and staff, other child service systems such as DHS, DOH and their contracted providers, and formal and informal community resources such as libraries, community/ recreation centers, faith communities, civic/advisory/beneficent groups). Most recently health care providers have joined this group. In fact, *with the national emphasis on screening, brief intervention and referral to treatment (SBIRT) within the health care system, having intervention programs to which health care providers can refer is critical to realizing the research outcomes these programs have demonstrated (see Madras, et al. 2009, NIDA RFAs, SAMHSA, the Patient Protection and Affordable Care Act of 2010, and the Health Care and Education Reconciliation Act of 2010).*

*** NOTE:** "Focusing on symptom multiplicity and severity rather than diagnosis has been suggested (Angold, Costello, Farmer, Burns & Erkanli, 1999; NASADAD, 1998; NASADAD, 1999; Pollock & Martin, 1999; Winters, Latimer & Stinchfield, 1997). ***Research indicates that not all adolescents who have experienced serious consequences as a result of substance use will meet DSM-IV criteria for a substance use disorder (Pollock & Martin, 1999).*** Called ***diagnostic orphans***, these youth present with serious use patterns and problems that require treatment (Pollock & Martin, 1999; Winters, Latimer & Stinchfield, 1997) but symptom constellations do not meet a specific diagnosis. Similar findings appear in the mental health literature where symptoms may be at a sub threshold diagnostic level but serious functional impairment exists nonetheless (Angold, Costello, Farmer, Burns & Erkanli, 1999). **These issues call the applicability of the DSM system into question, can impact eligibility decisions and reimbursement mechanisms, and will require policy changes."** From, Meyers K. & McLellan A.T. (2005). The American Treatment System for Adolescent Substance Abuse: Formidable Challenges, Fundamental Revisions and Mechanisms for Improvements. In M.E.P. Seligman and D. Evans (Editors) *Treating and Preventing Adolescent Mental Health Disorders: What We Know and What We Don't Know.* Oxford University Press. New York.

Applying the Public Health Model of Prevention in terms of a continuum of service that addresses not only prevention of problems but intervention on the pre-diagnostic problems of youth:

- **Secondary** prevention is directed at early detection and intervention (needs assessment and referral to appropriate community-based services or intervention or higher level treatment services).

- **Tertiary** prevention is directed at minimizing disability and avoiding relapse (focused individual and/or family interventions at the pre-clinical level of service to address risk issues prior to their escalating to more harmful levels.

Secondary and Tertiary Prevention are also known as **Intervention** as there is indication of problems/need. At this level, use of environmental strategies, very much favored by the Prevention field, is a natural intervention which incorporates prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems and policies. However, as Sis Wenger, President/CEO of the National Association for Children of Alcoholics (NACoA) notes in her recent article for DrugFree.Com, *"the primary environment that influences, for good or ill, the alcohol and drug use choices of today's and tomorrow's youth is the family, and most specifically the parents. This is the environment that nurtures both society's contributing adults and society's most costly problems in education, health care, mental health, the work place, the justice system and the prison system"*. (Wenger, The Partnership at DrugFree.Org, 2011)

In Intervention service, focus should be on using family-identified strengths and needs in service design and which provide skill-building in protective factors that increase pro-social attitudes and behaviors, increase parents' and caregivers' capacities to provide safe, nurturing, pro-social environments and relationships for and with their children, and effective family management. Intervention services should include:

- outreach, engagement, education activities to identify/build interest/motivation to engage in intervention services
- needs and strengths assessments through SAP/other qualified provider personnel;
- family-focused counseling and skill-building and psycho-social support interventions at the pre-clinical level, including parent empowerment groups with a protective factor focus;
- service consultations with professionals in other service systems to effect service coordination/ access to additional services;
- case management for linkage to real-time resources for families in their communities; and
- topic related, skill-building and psycho-social resiliency strengthening/empowerment programs for vulnerable children and youth living in chronic risk conditions and for those sending distress signals through their behavior or isolation, etc.

SERVICE CONSTRUCTS: At all levels of intervention/prevention activity, services and strategies should:

- address all forms of risk conditions in youth and families as they are interrelated and multi-systemic as well as their relationship to developmentally appropriate protective factors;
- increase children's and families' pro-social attitudes and skills and adherence to positive norms such as academic success, strong family bonds, and personal responsibility;
- be available for children and families as soon as it is felt they could benefit especially at developmental/educational/social transition times (e.g., middle to high school);

- expand eligibility to pre-diagnostic levels so that services are available to families regardless of "DSM-related eligibility particularly given the diagnostic orphan literature", socioeconomic or insurance status if adverse conditions increasing risk are present;
- be pegged to their developmental levels and families' abilities to commit to service; and
- match families' and schools stated needs and desires in order to be effective for children and to achieve prevention goals.

RATIONALE: Intervention targets services for children/youth described as at greater risk for behavioral health issues related to substance use and mental health, child welfare dependency/ delinquency and truancy/drop out behaviors. Risk is elevated for these children due to increased/ chronic family stressors, fewer natural child and family supports, and exposure to situations/conditions associated with increased potential for abuse/neglect and transient AOD problems.

Identified families include those experiencing disrupted family life/structure, exposure to violence and traumatic events, challenged or compromised parenting capacity/skills, significant unusual or chronic patterns of youth risk behaviors including disruptive, delinquent, educational distress, truanting actions, acting out, etc., and families with histories of substance use, incarceration and or economic distress. Higher levels of chronic acting out behaviors, chronic exposure to or experimentation with substances, initial brushes with law enforcement, family functioning/distress, and school behavior problems would be primary reasons for families to request this service though all are associated with higher risk for substance use.

Individuals/families can become at-risk when the ability of the parents/families to provide optimal nurturing and guidance to their children is compromised by any number of adverse conditions or circumstances, **and** when sufficient resources are not in place or easily accessible as supports to protect against, belay or counter those risk conditions. This would include children and families living with few or no known protective factors/supports to counter risk effects. Research indicates that children with some protective factors despite a greater number of risk factors actually can fare well or at least better than their peers with equal risk but no protective factors. Resiliency research also supports the need for children to interact with caring adults who serve as positive role models in their lives.

Family-focused counseling techniques and case management consultation when desired are used as tools for prevention/intervention. Although these services could be perceived as behavioral health treatment related, they are, in fact, also pre-diagnostic interventions, i.e., applied when the symptoms of distress expressed behaviorally do not reach the level and severity of diagnosis that would direct them to mental health or substance use treatment which is common among adolescents with substance use problems (see Angold, Costello, Farmer, Burns & Erkanli, 1999; Pollock & Martin, 1999; Winters, Latimer & Stinchfield, 1997). Generally at this stage of intervention, these clients greatly benefit from topic-related skill building groups, parenting supports and individual and family skill-building programs. Program services are designed to reduce the impact of risk factors associated with dependency, delinquency, truancy or behavioral health and to strengthen in individuals and families, those aspects which preclude the onset of risk behavior.

There is significant evidence supporting the importance and efficacy of these intervention services which are also uniquely positioned to serve those youth and families who fall between systems for a wealth of reasons and who, if they remain un/underserved at this level, surely will increase the rolls in the behavioral health, dependency, delinquency, and truancy systems with all of the associated

collateral consequences and increased financial costs. This is especially significant for those "children who have experienced sustained exposure to severe parental addiction and/or mental illness for they can suffer profound developmental effects and are in greatest need of indicated prevention and early intervention services" (Werner, 2004 referenced in White, 2009).

SUPPORT RECOMMENDATIONS: To support continuity of funding and purpose for intervention services, providers generated practical and research-based recommendations that might govern intervention levels of care practices when intervention is recognized as a legitimate service on the substance use services continuum of care.

- Intervention/Prevention services initiated at the "pre-diagnostic' level should consider **social necessity** in determining eligibility for public insurance programs. Revisit policies that exclude prevention/intervention services as a consequence of payment procedures/policies. To expand eligibility for covered services, develop Social Necessity Criteria as necessary for identification/ eligibility determination for intervention/treatment services when application of Medical Necessity Criteria has the potential for excluding the child/youth from service. Motivation/ interest in any level of service for children and adolescents should be sufficient enough to meet any eligibility criteria.

- Establish and sustain non-insurance based funding for children and youth income-ineligible for publicly financed insurance; establish same funding structure for Prevention LOC services. Lift any prohibitions against using Treatment dollars for counseling pre-diagnostic and at risk kids at the Intervention level. Create appropriate service levels to address needs of pre-diagnostic substance users as well as non-substance using children and youth (COA) who are at greater risk of using due to family/life situations/circumstances.

  At best, restore program funding for child and adolescent services at the less intense elements of the spectrum, exclusive of residential LOC. At the very least, convert program funding to real-time cost reimbursement to provide the fiscal resources for providers to use all best practices in the care of children and adolescents, particularly those not on the FFS payment fee-schedule.

- Establish Prevention/Intervention as secured and viable services with sufficient funding support so that a meaningful service system may be expanded across City neighborhoods and communities to serve as both wellness promotion/prevention and resiliency/recovery supports for youth and families.

These issues have been historical roadblocks for access to services prior to eligible diagnosis for substance use disorders. As noted for consideration in the larger introduction are these additional barriers to easily identifying and obtaining services also include: stigma, lack of information, restrictive points of entry, inconvenient transportation, language barriers, time constraints on when and where services are offered, and the ability to purchase services.

Additional operational/systems recommendations include:

- Expansion of the SAP infrastructure to include elementary schools and other community sites to improve/create service access for younger children and their families and for youth not attending school and their families and reintroduction of substance use SAP service education to currently SAP eligible middle and high schools.

- Increased linkages between child and adult SUD services to assist with identification of children vulnerable for BH risk factors who would benefit from intervention services with the desired result of addressing SU issues affecting the entire family. This group of children is aptly tagged as "the most at-risk, the most ignored" by Sis Wenger, President/CEO of the National Association for Children of Alcoholics (NACoA) in a recent article referenced earlier.

- Inclusion of training on identification of children at risk of behavioral health problems and procedures for facilitating referrals for intervention services in regular staff training/development programs for DHS, Police and Fire, courts and criminal justice departments, and other City agency staff with access to family residences as part of their regular duties.

- Collaboration with other child-serving systems such as Child Welfare and Family Court. Judges, Court and DHS personnel could include identification of and service information for appropriate clients of their systems as part of their service protocols, especially with parents appearing in Family Court for any reason including domestic violence, custody or support issues and for those in dependent care. Expanding these protocols could include greater awareness/training in effects of parental substance use on children beyond the obvious neglect and abuse concerns.

- Mimic for intervention services, the development and implementation of SBIRT screenings for referrals to SU treatment. Develop/implement similar strategies for risk identification/assessment practices and training of healthcare professionals to enable earlier intervention with young people vulnerable to substance use and other risk influences such as family/peer exposure to violence, gambling, criminal/delinquent actions in family/peer/school settings, etc. The efficacy of such intervention can be easily tested in Philadelphia through a systemic effort to pilot SAMHSA's recently released underage alcohol use screening protocol for health professionals which authenticates alcohol use in adolescents as a marker for other risk behaviors *(Alcohol Screening and Brief Intervention for Youth, A Practitioners Guide, NIAAA, 2011).*

- Development of appropriate identification/information materials coupled with a distribution system to move these education materials to:

    1. **Community:** Faith Communities, fellowship groups (AA, NA, etc.) could include direct education or provide education materials regarding children affected by parent's SA.

    2. **Schools:** School personnel who intervene regularly with substance abusing parents or their spouses/partners can provide information and education as to the children's behavior and service options.

    3. **Behavioral Health:** Expand SA TX protocols to include greater awareness of effects of parental SA on children and the family as a whole.

    4. **Juvenile Justice/Law Enforcement:** The staff of the Juvenile Division of the Office of the District Attorney and its affiliates and law enforcement and related programs such as Police District Youth Aid Panels as well as their respective Advisory Boards and Town Watch groups are all in position to identify and refer appropriate youth/families for intervention with sufficient education and training.

    5. **Department of Recreation/Afterschool Programs/Child Care programs/District Health Centers** and information clearing house services and their partners could be primary sources of identification and referral given their unique and regular exposure to families over time.

LEVEL OF SERVICE: OUTPATIENT TREATMENT

Recent findings from the 2010 National Household Survey on Drug Use and Health (NSDUH) indicate that approximately 9% of adolescents in the US met DSM-IV criteria for an substance use disorder in the past year (SAMHSA, 2010), **representing over 1.8 million youth age 12-17** (United States Department of Health and Human Services, 2010). Of the 1.8 million youths who needed treatment in 2010, 138,000 received treatment at a specialty facility (about 7.6 percent of the youths who needed treatment), leaving 1.7 million who needed treatment for a substance use problem but did not receive it at a specialty facility.

These data are made that much more concerning by the fact that perceived harm and risk from drug use is declining with use beginning at earlier ages than in years past (Monitoring the Future, 2010). Not surprising, a myriad of public health problems such as injuries, behavioral and mental disorders, and sexually transmitted diseases are left in their wake.

Although it is widely accepted that adolescent are not adults and as such, adolescent–specific treatment is needed, few substance abuse treatment providers offer adolescent-specific programs. In fact, only 32% of all US treatment providers (or one in three providers) offered "programs or groups" for adolescents (SAMHSA, 2004). The lack of providers is further compromised by limited "quality": recent research shows that many adolescent service providers lack components considered essential to effective adolescent substance abuse treatment (Brannigan, SchackmanFalco& Millman, 2004; Knudsen, 2009; Mark, Song, Vandivort, Duffy, Butler, Coffey& Schabert, 2006; Schackman, Rojas, Gans, Falco, & Millman, 2007). This not only leaves significant room for improvement, but also places Philadelphia in a unique position to become a leader in the transformation of the continuum of care for adolescent substance use.

Acknowledging the current need for cutting-edge transformation of the child/adolescent system to meet emerging needs more effectively in every domain, the following are nine key quality dimensions and five evidence based practices within each of those dimensions that represent what is needed for effective adolescent substance abuse service delivery (see Brannigan, Schackman, Falco& Millman, 2004 for a description of their development). It should be noted that these key quality dimensions and evidence-based practices within each of those dimensions are in the process of being updated (Meyers, Cacciola, Arria, Bates, 2010).

KE1: Assessment & Matching
1. In its screening and assessment process, does the program use either a standardized substance abuse instrument or a structured clinical interview?
2. In its screening and assessment process, does the program use a standardized mental health instrument?
3. Beyond routinely updating the treatment plan, does the program reassess clients at some point during treatment?
4. Is the client's physical health addressed in the assessment?
5. Does the program specify that the treatment plan addresses mental health issues?

All programs should provide <u>comprehensive</u> bio-psychosocial assessment (include CBH requirements & family history, trauma screen, academic and educational screen, other involved systems, assets and

risk factors etc.). Assessment should incorporate standardized comprehensive assessment tools such as the Comprehensive Adolescent Severity Inventory (CASI) or the Global Assessment of Individual Needs (GAIN) and supplemented by other symptom-based measures as needed (e.g., Trauma Symptom Child Checklist). The Assessment process should be strengths based, person first, and resiliency oriented (see DBH's "Tools for Transformation Series: Person First Assessment & Person Directed Planning"), include relevant collateral information (e.g., from schools, family members, other involved systems), and include an assessment of the following categories:

Assessment Areas
Alcohol/Other Drugs
Tobacco
Other addictive behaviors
(e.g., gambling, sex/porn, gaming)
School/Vocational
Peer Relationships
Legal/Juvenile Justice
Family
Mental Health/Psychiatric
Trauma/Serious Stressors
(e.g., family/residential instability, victimization, crime, grief and loss)
Physical Health
Sexual Health
Motivation/Stage of Change/Treatment Readiness
Strengths/Assets

Additionally, assessment should not be static. Adolescent needs/strengths/service status should be re-assessed as needed/desired throughout treatment and should include but not be limited to treatment plan reviews and upon changes in clinical status to monitor progress, or lack thereof, and to guide treatment.

KE 2: Comprehensive, Integrated Approach
6. Does the program either provide mental health services for clients onsite or coordinate their care with community mental health providers?
7. Does the program address physical health issues by providing medical services either onsite or by referral?
8. Does the program provide sexual health services, such as testing for STDs, either onsite or by referral?
9. Does the program maintain communication with the client's home school system regarding academic issues?
10. Does the program maintain contact with juvenile justice officials regarding clients who have been referred by the juvenile justice system?

Treatment should begin with a thorough orientation process that includes an overview of the program for both children/adolescents and their families and introduction to key staff, peers, and family representatives, since it is widely recognized that:

1. *treatment decisions for adolescents are better informed by pre-treatment psychosocial factors than by drug use severity* (Latimer, Newcomb, Winters & Stinchfield, 2000); and
2. *treatment effectiveness is contingent upon treatment for the array of co-morbid dysfunctions within clinical samples* (Kazdin & Weisz, 1998; Williams & Chang, 2000).

As such, treatment must be matched to the full range of concomitant problems brought to the program by the teen (e.g., comorbid mental health problems), include a range of adjunctive services (e.g., life skills, job readiness, opportunities for creative expression), and delivered in multiple formats (individual, group and family work). Evidence-based services such as Motivational Enhancement Therapy (MET) and Cognitive Behavioral Therapy (CBT) should be used (See CSAT manualized treatments). As you will see in KEX, a range of adjunctive, pro-social after school educational and recreational activities is also indicated. As with most child/ adolescent services already discussed, funding and regulatory concerns are major issues for service upgrades.

KE 3: Family Involvement
11. Does the program assess the client's family beyond simply reviewing family history or perceptions?
12. Does the program provide the client's family with individual and/or multifamily therapy sessions?
13. Does the program maintain contact with the family for the duration of the client's treatment?
14. Does the program specify that family or caregiver involvement is mandatory?
15. Does the program specify that it will refer parents who are abusing substances to treatment?

It is widely established that family involvement is critical to positive outcomes of treatment (Wagner and Waldron, 2001; Waldron and Turner, 2008). Referral to treatment of household members is critical so as to have a supportive recovery environment with clean and sober role models. Individual family therapy focused on addressing enabling behaviors, splitting, etc., multi-family parent training sessions (focused on positive communication skills, positive reinforcement, and limit setting and consistent discipline practices), and multi-family support and educational sessions (what can be expected during adolescence given its distinct developmental period) are critical. As noted earlier, finding a significant other, e.g., other adult family member, coach for youth without an involved family will be needed so as to optimize the potential for behavioral improvement. [**NOTE:** As seen below, family advisory councils can also help inform the continuing development of appropriate services within programs.]

KE 4: Developmental Appropriateness
16. Does the program vary activities and/or curricula based on the developmental level of the client?
17. Does the program utilize a curriculum designed specifically for adolescents?
18. Does the program incorporate experiential or hands-on activities into treatment?
19. Does the program specify that its protocol is tailored to the concrete thinking needs of adolescents, rather than abstract thinking?
20. Are adolescent clients typically treated only with other adolescents, as opposed to being integrated with adult clients?

Adolescents are a unique population requiring different assessment and therapeutic approaches (see Deas, Riggs, Langenbucher, Goldman, & Brown for a discussion, 2000). Both classic and contemporary adolescent theorists (e.g., Piaget, Steinberg) discuss the maturational and developmental considerations of this developmental period given that youth are in a continuous state of social, biological, cognitive and emotional development (Feldman & Elliott, 2003). As such, multiple *developmentally-focused* intervention approaches and a wide array of non-AOD services are needed to meet the needs of adolescents with SUD. Given that frontal lobes undergo important structural change during adolescence and are responsible for "executive cognitive functioning" otherwise known as advanced thinking processes, programs must varies the way in which information is presented, skills are taught, and therapy is conducted (e.g., concrete content, role-plays) given the ages, maturity and developmental levels of clients, and must provide opportunities for input into their plans given their need for independence. Also, when adolescents are part of the decision making process, they tend to have better outcomes (Friedman, Terras, Kreisher, 1995).

KE 5: Engage & Retain
21. Does the program emphasize building a therapeutic alliance between staff and clients to engage and retain the client?
22. Does the program utilize motivational enhancement techniques, such as Motivational Interviewing?
23. Does the program incorporate positive reinforcements, such as increasing responsibilities and/or privileges, in order to provide incentives for client participation?
24. Does the program utilize special recreational programming (such as wilderness programming or art therapy) and/or offer courses of particular interest to adolescents (such as sexual health or life skills training) to engage and retain clients?
25. Does the program make special efforts to incorporate the family in order to keep the client engaged?

It is widely accepted that client engagement in drug abuse treatment is associated with favorable treatment outcomes. Initially thought to be determined by the client's characteristics, it is now known that the perceived helpfulness of services, and a positive client-counselor relationship actively engages the client in treatment. Additionally, reducing barriers to attendance (convenient hours, providing transportation reimbursement) and providing useful (and fun) ancillary services can actually improve effectiveness (Fiorentine, Nakashima, and Anglin, 1999). Being creative in program design by attending to these factors are critical when trying to get an adolescent to remain and participate in the treatment program. As stated below, this should be supplemented by having a workforce who want to work with this age group and who are sufficiently skilled do so. Also as discussed by Meyers et al, 2010, outreach and re-engagement procedures for missed sessions can help to moderate poor attendance.

KE 6: Qualified Staff
26. Does at least one direct service staff member have training in adolescent development?
27. Does at least one direct service staff member have training in co-occurring disorders?
28. Is at least one member of the direct service staff a trained family therapist?
29. Does the program provide ongoing training for direct service staff?
30. Do all clinical supervisors possess at least a master's degree?

Since knowledge of adolescent development, and skill and interest in treating youth is of paramount importance (Deas, Riggs, Langenbucher, Goldman, & Brown, 2000; Winters, Stinchfield, Opland, Weller, & Latimer, 2000), training in adolescent development is key both in terms of hiring requirements as well as in ongoing in-service training. Further given the wide constellation of problems that co-occur with this disorder, youth need access to specialists (e.g., family therapists) either on-site or through referral and can benefit from exposure to adolescents and young adults in their own stable recovery working/volunteering in provider-managed roles.

KE 7: Gender & Cultural Competence
31. Is the program designed to meet the needs of minority youth?
32. Does the program provide clients with gender-specific group sessions?
33. Does the content of the program's individual and group sessions differ according to the distinct needs of males and females?
34. Is the program designed to meet the needs of gay and lesbian youth?
35. Does the program have safety measures in place to ensure boundaries between co-ed patients and staff?

In Philadelphia, the advent of ROSC principles in service partnerships affords providers an opportunity and a mandate to ensure that their services are competent in all ways significant to clients' success across diverse individuals and groups. This means that services then, are client-centered, designed with the client as an active partner and are appropriate to and respectful of culture, defined broadly, as well as to the individuality of each person. Providers who employ a "person-first" approach in all service interactions work to ensure that a person's race, ethnicity, language capability, religion, spirituality, gender, gender identity, sexual orientation, social role, age, physical ability, cognitive ability, and/or economic status is acknowledged and incorporated in the delivery of services thereby building trust in a successful therapeutic alliance. Infusing this approach into service also requires that a person's life experiences and relationships, positive and negative, be part of the context in which a service response is formed.

The inclusion of single-sex groups and groups for LGBTQ teenagers with applicable session content within traditional adolescent substance abuse treatment programs can serve to address differences known to exist within these groups of youth so that they benefit from care based upon an understanding of practices and worldviews of these groups. Additionally, exposing clients to other young people in recovery as described above who mirror their own identity-shaping characteristics is another option for thoughtful consideration in program/service planning.

KE 8: Continuing Care
36. Does the program create a continuing care plan for the client beyond simply referring clients to outside services?
37. Does the program specify that the client's continuing care plan lasts for at least 6 months?
38. Does the program link clients with relevant community services upon discharge?
39. Does the program address relapse prevention?
40. Does the program monitor clients with checkups following discharge?

Given that adolescents who return to use do so within the first six months following treatment (Brown, 1993; Brown, Vik and Creamer, 1989), programs should educate youth and their families about continuing care and recovery supports, focus on their importance and identify possible resources throughout treatment (Meyers, et al, 2010). Additionally, all youth require continuing care/community linkage plans that they (and their families as appropriate), are actively involved in developing. Linkages with alternative peer groups, mentoring resources, family supports, etc., should begin prior to discharge to promote post-treatment service engagement and ongoing recovery. Ideally, the system would provide reimbursement to fund home-based case management services to help link youth to pro-social community-based resources and activities (based on their individual skills and interests), including sports leagues, churches, mentoring programs, after school programs, vocational training and part-time jobs, etc. A range of recovery management support options both for children and for families is also needed including using peers in recovery to facilitate support groups (e.g., NA and AA meetings just for teens), regular recreational outings for teens in recovery, sports events and/or leagues for teens in recovery, etc. To foster continued recovery and resiliency, behavioral health programs in schools that provide a community-based intensive day treatment alternative to partial hospital programs and that contain a quality education program and a recovery school should be developed as a standard part of the treatment/recovery continuum. When using periodic clinical check-ups post discharge, specific re-engagement in treatment procedures should be implemented when indicated.

KE 9: Treatment Outcomes
41. Does the program collect its own data related to client outcomes (e.g., results of post-discharge follow-up surveys) and/or provide such data to the state?
42. Does the program analyze its internally gathered data in an effort to measure the effectiveness of its treatment services?
43. Has the program conducted its own formal evaluation of the program's effects on client outcomes?
44. Has an independently conducted formal evaluation of the program's effects on client outcomes been performed?
45. Did the formal evaluation of the program's effects on client outcomes utilize a scientifically rigorous research design (i.e., either random assignment to conditions or carefully matched treatment and comparison groups)?

Since funding has grown increasingly competitive, it should be tied to an organization's ability to demonstrate impact. Transformation of the system should include movement towards performance-based contracting wherein programs must demonstrate that services are efficient and of high quality with quantitative evidence of effect. Programs should:

1. identify program-specific outcomes and indicators;
2. include measures of recovery that encompass measures of abstinence, remission and other indicators of post-treatment AOD use and related problems; measures of progress toward global health and measures of positive community integration (White, personal communication);
3. collect, analyze, and report on outcomes; and
4. utilize performance results to adjust or make programming decisions. Given that this important area will incur staff costs, funding allocations should include dollars for data collection, analysis, reporting, and utility.

Note: At this writing, the Key Dimensions and Components are being updated by the Treatment Research Institute through funds of the National Institute of Drug Abuse. According to Dr. Meyers, Project Co-Investigator, there will be increased emphasis on mental health services, recovery and resiliency, and developmentally-informed practices (Dr. Meyers, personal communication). Updated information will be made available to the committee when completed. Importantly, however, Dr. Meyers states that the original dimensions have been kept.

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INITIAL SYSTEMIC RECOMMENDATIONS AT A GLANCE

Implementation to upgrade the Child/Adolescent Substance use service system depends on political will of those who influence major systemic improvements, addition of research and training supports, securing appropriate and flexible funding, and regulatory review/revision.

Implementation necessarily involves review of practice guidelines, service regulations and funding mechanisms with adjustments in each to create a substantive system of care that is clinically and fiscally accountable and responsive to need in 2011 and beyond.

Programmatic: Youth-focused ROSC **Services should be**

Accessible: eliminate artificial eligibility requirements and ensure access regardless of insurance status; deliver service through qualified providers and offer in settings that are natural and comfortable to children and youth; identify/expand/create recovery/resiliency-based support services for adults, children, and their families within their communities, include peer support services and pro-social socializing activities.

Comprehensive/Appropriate to Need**:** reflect the full integration of primary prevention, assessment, early intervention, clinical treatment, and non-clinical recovery support services - a continuum that includes outreach, wellness promotion, and extended recovery/resiliency supports for the individual and family/community.

Coordinated/Systemically Integrated**:** provide children/families with integrated, coordinated care, regardless of the system or systems through which they receive it"; collaborate with all child serving systems to coordinate services for substance-affected children; coordinate children's services with programs serving adults with addiction concerns; develop payment mechanism for healthcare professionals to add their considerable skills to identification, intervention and referral services.

Effective/Practical**:** incorporate the benefits of research on child/adolescent services as well as emerging studies on effectiveness of other interventions to advise the development and implementation of services; services must make sense to the adolescent and clearly must be matched to strengths, needs and "ready, willing and able" factors for any chance of success.

Flexible**:** include all services previously defined on the service spectrum, particularly at the outreach/prevention/intervention levels; structure them to prevent obstacles to fluid movement among needed services; providers and supports must be equally flexible to adjust services across levels of care in response.

Age/Developmentally Appropriate**:** embrace a developmental framework, recognizing that adolescent service needs are significantly different from those of adults; serve children and youth before and during the time that treatment needs present; provide resiliency/recovery supports to them and their families.

Family Focused/Involved**:** provide structure/flexibility to involve family members as an utmost priority in the planning and delivery of services regardless of who the affected family member is; provide advocates to help families navigate increasingly complex service systems.

Recovery Focused: create equitable distribution of community and faith-based resources to provide developmentally appropriate and practical recovery capital to City neighborhoods; ensure seamless transition between intervention/treatment and recovery service; create at least one district high school

for students working a sober program; develop affordable sober houses/ other sober living facilities within the city for older adolescents/young adults

Prevention services should address school-based/community programming by focusing on programs aimed at the general population at key transition points; should be long-term with repeated intervention via age-appropriate "booster" programs; create improved/wider service deployment to school-aged populations across Philadelphia through increased collaboration among DBH, Providers and leadership in all Philadelphia school and child serving systems.

Recognize and establish the Intervention LOC as a viable service for substance-affected children and youth not meeting diagnostic criteria for treatment services.

Develop appropriate identification/information materials coupled with a distribution system to move these education materials to the public through multiple service and media venues.

Fiscal/Development:
Program funding is the more appropriate funding and reimbursement approach for affected youth and their families; at the very least convert program funding to real-time cost reimbursement. Flexible fiscal capital in service delivery is a prerequisite for developing recovery capital in children, adolescents and families.

Establish and sustain non-insurance based funding for children and youth income-ineligible for publicly financed insurance especially at prevention and intervention LOC's. Motivation/interest in any level of service for children/adolescents should be sufficient enough to meet any eligibility criteria.

Address workforce development issues including identity, salary, qualitative supervision infrastructure and professional development.

Training: Fund joint training and curriculum acquisition to establish a basis of evidence-based programming commensurate with the current suite of K-12 programming they provide; sponsor and collaborate with providers for large training grants. Continue to expand the clinical training opportunities provides through BHTEN and partner with providers who can also share their skills and experience at all levels of care. This is especially relevant for acquisition of evidence-informed treatment models and skills.

Documentation/Regulatory: Simplify, streamline regulations governing service to children to acknowledge developmental considerations; coordinate with other systems serving similar populations; remove redundant, obscure, outdated regulations in favor of those reflecting current practice and child-serving principles; simplify eligibility for payment; remove barriers to providing reimbursable services in settings other than licensed treatment facilities; halt and reverse the trend for increased documentation that is in many instances redundant and contraindicated by competing licensing and regulatory entities

Data/Outcomes: work with researchers and providers in a coordinated manner to develop and implement reasonable outcome and data collection methods that are goal directed and user and cost friendly; providers need OAS to obtain SCA needs data, NOMS and PAYS results, etc., and current and inclusive county data regarding substance use and treatment not restricted only to MA service recipients as many children and youth are served outside that funding/data stream.