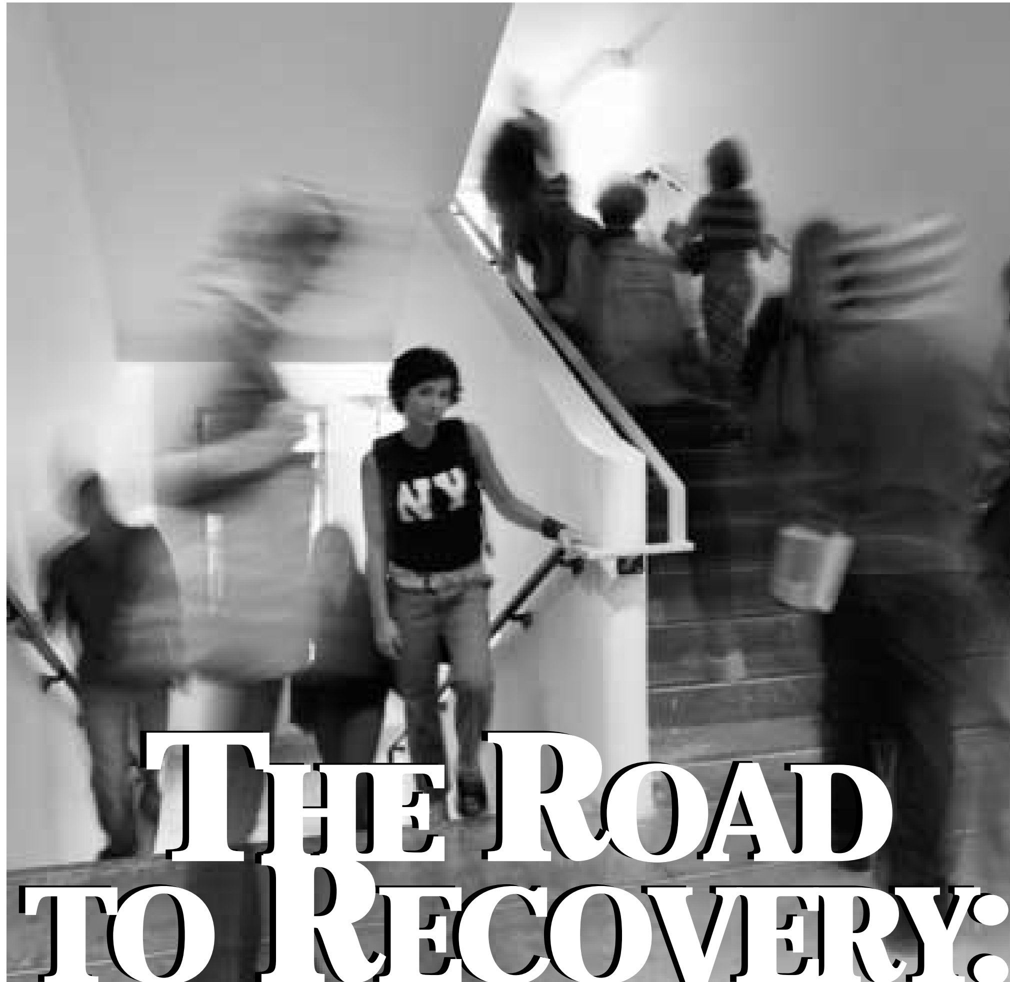
SUBSTANCE ABUSE TREATMENT FOR NEW YORK CITY TEENS



THE ROAD TO RECOVERY:

SUBSTANCE ABUSE TREATMENT FOR NEW YORK CITY TEENS

JUNE 2003

ACKNOWLEDGEMENTS

We express our appreciation to the 21 substance abuse treatment programs that devoted the time and effort to participate in CCC's study. We also wish to thank the individuals and organizations that helped educate CCC staff and the Task Force on adolescent substance abuse and substance abuse treatment programs in New York City. In particular, we are grateful to Kathleen Riddle, President, Outreach Project, for her patience and willingness to explain to CCC the minutia of program operations and financing and the challenges confronting adolescent service providers and Maria Morris Groves, Coordinator of Adolescent Services, the New York State Office of Alcohol and Substance Abuse Services for providing information on New York State's regulation of services.

We wish to thank all of our Task Force members who devoted their time and energy to traveling throughout the City to conduct interviews and who helped to develop the findings and recommendations presented in this report. CCC expresses a special thanks to the teenagers who participated in the three focus groups. We are grateful for their openness and willingness to share their experience, opinions, and ideas with us and we hope we have captured their comments accurately. We also wish to acknowledge the work of CCC's YouthAction NYC members, particularly Chris Gore and Julia Blue, and to thank them for their commitment and dedication to this study. Lastly, we acknowledge the superb organizational skills of Beth Caplick (CCC social work intern) and thank her for the many hours she devoted to this study from beginning to end.

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INTRODUCTION

Research documenting the prevalence of the use of drugs and alcohol by teenagers in the United States abounds,[1] and leaves no doubt that the consequences of this behavior exacts high costs on the lives of individual teenagers, their families, and the communities where they live. Consider the following statistics that show the rates of use and access to drugs and alcohol by teenagers and related behavioral consequences:

- 89% of twelfth graders and 48% of eighth graders reported having easy access to marijuana.[2]
- 64% of twelfth graders and 23% of eighth graders reported in 2001 that they had been drunk at least once in their lives.[3]
- 12, 810 juveniles were arrested for drug abuse violations in New York City in the year 2000.[4]
- Motor vehicle traffic injuries are a leading cause of injury death for 10 to 17 year olds.[5]
- "High school students who report drinking on at least one occasion are actually seven times more likely than nondrinkers to have had sex."[6]

Citizens' Committee for Children of New York, Inc. (CCC) has a long history of monitoring the delivery of services to New York City children and teenagers and advocating for an investment of public resources in child-serving systems. CCC's advocacy in the areas of children's mental health, juvenile justice, and child welfare in particular focused our attention on the prevalence of substance use and abuse among teenagers served in these systems. Our preliminary investigation into the issue revealed a real lack of information about the substance abuse treatment services available to New York City teenagers and their families.

In the Fall of 2001, CCC convened the Task Force on Adolescent Substance Abuse Treatment Services. As CCC's first foray into the field of substance abuse, the Task Force sought to identify the kinds of substance abuse treatment programs serving teenagers in New York City, to learn the pathways for teenagers to treatment services, and to understand the components of the treatment programs and the linkages between substance abuse treatment programs and other programs serving children and youth.

This report describes what CCC learned through interviews with substance abuse treatment programs and focus groups with teenagers participating in substance abuse treatment. Our intent in conveying this information is to educate New York City parents/caregivers, children and youth, elected and appointed officials, educators, lawyers, judges, caseworkers, health and mental health professionals, and child, family, and youth advocates about the availability of substance abuse treatment programs. We also seek to highlight the need for an adequate investment of resources in adolescent substance abuse treatment and prevention services and for improving the linkage between these services and other child and youth serving systems. Additionally, the report adentifies areas that require further investigation and monitoring.

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[1] Johnston, Lloyd, Ph.D., O'Malley, Patrick, Ph.D., Bachman, Jerald, Ph.D., The University of Michigan, Institute for Social Research, National Institute on Drug Abuse, and U.S. Department of Health and Human Services, *Monitoring the Future: National Results on Adolescent Drug Use – Overview of Key Findings, 2001* (2002), p. 5; U.S. Department of Health and Human Services, Substance Abuse Mental Health Services Administration, *2001 National Household Survey on Drug Abuse*, www.samhsa.gov/oas/nhsda/2k1nhsda/vol11.htm; U.S. Department of Health and Human Services, Center for Disease Control and Prevention and National Center for Health Statistics, *Health, United States, 2000 with Adolescent Health Chartbook*, pp. 78-81, 80 ("A Healthy People 2010 critical adolescent objective calls for a reduction in the proportion of adolescents reporting use of marijuana and other illicit substances in the past 30 days."); Citizens' Committee for Children of New York, Inc., *Keeping Track of New York City's Children*, pp. 133-134 (2002)(citing U.S. Department of Health and Human Services, Center for Disease Control and Prevention, *Youth Risk Behavior Survey*, 1999).

[2] The University of Michigan, Institute for Social Research, National Institute on Drug Abuse, and U.S. Department of Health and Human Services, *Monitoring the Future: National Results on Adolescent Drug Use – Overview of Key Findings, 2001* (2002), p. 8 (describing that teenagers surveyed reported "that they could marijuana fairly easily or very easily if they wanted some").

[3] *Ibid.* at 5.

[4] Office of National Drug Control Policy, Drug Policy Information Clearinghouse, *New York, New York: Profile of Drug Indicators*, p. 8 (November 2002)(reporting data for 2000).

[5] U.S. Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Health Statistics, *Health, Unites States, 2000 with Adolescent Health Chartbook*, (2000), p. 58 (reporting data for 1996-1997). "Healthy People 2010 has identified reduction of deaths caused by motor vehicle crashes and the reduction of deaths and injuries caused by alcohol-and drug-related motor vehicle crashes as critical adolescent objectives." *Ibid.*

[6] National Center on Addiction and Substance Abuse, Columbia University, *Dangerous Liaisons: Substance Abuse and Sex* (December 1999), p. 35 (Reviewed data from Youth Risk Behavior Survey for 1997 and the 1995 National Longitudinal Study of Adolescent Health. Data cited above was data adjusted for "influence of age, race, gender, and parents' education level."). *Ibid.* at pp. 33, 35.

METHODOLOGY

CCC convened the Task Force on Adolescent Substance Abuse Treatment Services in November 2001. The Task Force was comprised of 27 members, including CCC trained volunteers, CCC Board members, CCC staff, and YouthAction NYC members. (Appendix A).

To gain a better understanding of substance abuse treatment, CCC reached out to the substance abuse community in New York City and New York State. In November 2001, CCC hosted a policy briefing that featured a presentation by Maria Morris Groves, Coordinator of Adolescent Services, New York State Office of Alcoholism and Substance Abuse Services. CCC conducted informational interviews with substance abuse treatment programs, community-based organizations, academics, and the New York City Administration for Children's Services. CCC also attended the annual conference of the Alcohol and Substance Abuse Providers of New York State (ASAP) and regularly attended the ASAP Youth Committee meetings. In addition to these efforts, CCC reviewed professional literature and government publications.

Our field research was comprised of two components: (1) on-site interviews of substance abuse treatment programs and (2) focus groups of teenagers participating in treatment programs. Using the *Substance Abuse Treatment Facility Locator*[7] and the *New York State Directory: Adolescent Alcohol and Substance Abuse Providers*,[8] CCC identified 48 organizations that provide substance abuse treatment to adolescents in New York City. We sent to all of these providers letters of invitation to participate in our study and 21 agreed. A number of the providers that responded operated more than one type of program for adolescents. In these circumstances, we selected one of their programs for our interview in order to obtain representation of different levels of care.

In total, CCC interviewed 5 residential treatment programs, 4 day treatment programs, and 12 outpatient treatment programs. Although a small sample, the 21 programs CCC interviewed represent 44% of the teenage substance abuse treatment programs in New York City. In that light, the data generated by our interviews provides a general picture of the types of treatment available to New York City teenagers. In some instances in this report, data is presented by level of care and represents an even smaller sample. We recognize that this is not a representative sample, but it highlights possible programmatic differences between levels of care. Additionally, in the interest of time and in recognition of the heavy workloads of the administrators interviewed, many of the questions presented to the programs requested estimates. Throughout this report, we indicate when the data discussed represents estimates reported by the programs and when we averaged their responses. Otherwise, the data we report is based on the total number of programs that answered the question presented rather than the total number of programs interviewed.

CCC developed and field-tested a questionnaire to interview adolescent substance abuse treatment providers (Appendix B). The same questionnaire was used for all the programs interviewed regardless of the level of care provided. Task Force members were organized into two-person teams, trained to use the questionnaire, and administered the questionnaire in in-person interviews at each of the 21 sites. Most of the interviewees held administrative or supervisory level positions.

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[7] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Agency, *Substance Abuse Treatment Facility Locator*, www.samhsa.gov/public/content/resources/help_main.html.

[8] New York State Office of Alcoholism and Substance Abuse Services, *New York State Directory: Adolescent Alcohol and Substance Abuse Providers* (January 2002). OASAS published the first edition of the Directory in 2002. This is a statewide directory that lists the agencies operating adolescent treatment programs by county. For each agency listed, the Directory provides contact information, hours of operation, types of payment accepted, and a description of the programs, including educational and special programs. According to the introduction, the Directory is not "an exhaustive list of all providers who treat adolescents," but those listed reported that adolescents comprised at least 50% of their admissions. *Ibid.* at 1. The Directory also provides contact information for OASAS's central and field offices.

CCC staff and Task Force co-chairs worked with YouthAction NYC members for twelve weeks to prepare for facilitation of focus groups with teenagers participating in treatment. This preparation included exploration of teenage use and abuse of alcohol and drugs, interview and engagement skills training, and question development. We conducted three focus groups: an outpatient treatment group; a day treatment group; and a residential treatment group. Each focus group consisted of 7 to 10 teenagers who, at the time, were participating in treatment or were recent graduates. The groups were conducted on each of the program premises. Two YouthAction members and a CCC staff person jointly facilitated each group for approximately one hour and two Task Force members made written notes of the discussion. All of the questions and the order of their presentation were identical for each focus group. (Appendix C). CCC provided each focus group participant with a $15 stipend or gift certificate, depending on the preference of the program supervisors.

For purposes of this report, we use the term "substance abuse" to refer to the use of alcohol as well as illicit drugs.

FINANCING AND REGULATION OF ADOLESCENT SUBSTANCE ABUSE TREATMENT SERVICES

In New York State, the Office of Alcoholism and Substance Abuse Services (OASAS) is the state government agency responsible for licensing alcohol and substance abuse treatment services. Historically, OASAS has licensed/certified an array of services that fall into one of four levels of care: emergency services,[9] outpatient treatment services,[10] inpatient treatment services,[11] and residential services.[12] OASAS also licenses/certifies a number of specialized programs and prevention services.[13] In New York City, the Department of Health and Mental Hygiene (DOHMH) has responsibility for monitoring and evaluating alcoholism programs, planning, data analysis, and promoting prevention and education activities.

Several years ago, OASAS initiated a major review and revision of its regulations. "The goals of this initiative [were] to further the integration of alcoholism and substance abuse programming in New York State, streamline requirements, promote flexibility and consistency, reflect current minimum acceptable clinical standards, ensure the health and safety of staff and clients, and maintain third party revenue streams."[14] This effort produced statutory as well as regulatory changes. Prior to these changes, programs were licensed, operated, and maintained as either alcoholism or substance abuse programs. The new regulations eliminate this distinction by converting alcoholism and substance abuse treatment programs into a single regulatory category called "chemical dependence" services.[15] "Chemical dependence service" as defined by the regulations "means examination, evaluation, diagnosis, care, treatment . . . of persons suffering from alcohol and/or substance abuse and/or dependence . . . and include alcoholism and/or substance abuse services."[16] For the most part, the kinds of programs within each level of care continue, although they will now offer services to users of alcohol as well as drugs. The conversion also unified a formerly separate reimbursement structure for the programs.

Although the pre-conversion regulations had two youth specific licensing categories, outpatient chemical dependency for youth programs and residential chemical dependency for youth programs, there are only approximately 15 programs licensed under these categories statewide and almost all are located in upstate New York. Most of the agencies that operate programs that serve teenagers also serve adults and are licensed as adult programs. The adoption of the chemical dependency regulations in 2002 continued this practice. As a result, these adolescent programs are subject to the regulations that govern adult, not adolescent, programs.

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[9] Emergency alcohol and substance abuse services include: alcoholism and substance abuse detoxification services and alcohol crisis centers. New York State Office of Alcoholism and Substance Abuse Services, *Chemical Dependence Service Descriptions*, www.oasas.state.ny.us/hps/state/descriptions.htm.

[10] Outpatient services include: drug-free outpatient rehabilitative services, substance abuse medically-supervised outpatient services, outpatient alcoholism clinics, outpatient alcoholism rehabilitation, and chemical dependency programs for youth. *Ibid.*

[11] Inpatient treatment services include: substance abuse inpatient treatment and rehabilitation services, alcoholism inpatient rehabilitation services, and short term residential chemical dependency program for youth. *Ibid.*

[12] Residential services include: drug-free residential programs, recovery homes, halfway houses, supportive living, and long-term chemical dependency programs for youth. *Ibid.*

[13] *Ibid.*

[14] New York State Office of Alcoholism and Substance Abuse Services, *System Overview*, Section III, Consolidation; Regulatory Reform and License Conversion, www.oasas.state.ny.us/hps/state/overview_narrative.htm.

[15]. *Ibid.* New York State Office of Alcoholism and Substance Abuse Services, *System Overview*, Section III, Consolidation; Regulatory Reform and License Conversion, www.oasas.state.ny.us/hps/state/overview_narrative.htm.

[16] 14 NYCRR § 800.2(a)(3). The regulations define "chemical dependence" to mean "the repeated use of alcohol and/or one or more substances to the extent that there is evidence of physical or psychological reliance on alcohol and/or substances, the existence of physical withdrawal symptoms from alcohol and/or one or more substances, a pattern of compulsive use, and/or impairment of normal development or functioning due to such use in one or more of the major life areas including but not limited to the social, emotional, familial, educational, vocational, and physical. The term "chemical dependence" shall mean and include alcoholism and/or substance dependence. "Chemical dependence is identified through the substance dependence diagnostic criteria set forth in either the *International Classification of Diseases, Ninth Revision* or another Office-approved protocol." 14 NYCRR § 800.2 (emphasis in original).

INSURANCE COVERAGE FOR SUBSTANCE ABUSE TREATMENT

Most of the programs interviewed by CCC are operated by non-profit organizations. These programs generally rely on Medicaid reimbursement, self-pay fees, and state financial assistance to meet their operating expenses. Child Health Plus A (Medicaid) and Child Health Plus B are the two public health insurance programs in New York State that provide coverage to children and teenagers in low-income and working families. Child Health Plus B requires all children to enroll in a health plan. New York State has also mandated that most children and teenagers participating in Child Health Plus A enroll in a health plan. However, there remain some categories of Child Health Plus A eligible individuals who are not required or who have not enrolled in a health plan. For services provided to these youth, treatment programs are reimbursed by Child Health Plus A on a fee-for-service basis.

The insurance benefits for outpatient and residential substance abuse treatment under each of these programs is limited. If enrolled in a health plan under Child Health Plus A or Child Health Plus B, a child is entitled to up to 60 combined visits of outpatient substance abuse treatment and mental health services annually. Whether a program will receive reimbursement for services provided in excess of the visit limit depends on the child's insurance coverage. For children enrolled in Child Health Plus B, the insurance coverage no longer provides reimbursement once a child has exhausted the 60 visit limit. For children enrolled in a health plan under Child Health Plus A, a program may be able to obtain fee-for-service insurance reimbursement beyond the 60 visit limit as long as the services are "medically necessary and clinically appropriate."[17] Children enrolled in fee-for-service Child Health Plus A are likewise entitled to receive those services determined to be "medically necessary and clinically appropriate."

INSURANCE RELATED DIFFICULTIES

Despite the availability of insurance coverage for certain substance abuse services, many programs informed CCC about insurance-related difficulties. First, the programs we interviewed reported that many of the adolescents they serve are uninsured. Second, the programs have encountered difficulty in trying to become part of health plan provider panels. When unable to do so, the programs do not receive reimbursement for services provided to teenagers with insurance coverage. Together, these circumstances force programs to ask families to pay out-of-pocket for the treatment, which very few families can afford. Alternatively, many programs provide treatment services free-of-charge to uninsured teenagers, teenagers whose families are unable to self-pay, and insured teenagers whose health plans do not provide reimbursement. By absorbing the total cost of providing these services, many programs devoted to serving teenagers are threatened with serious financial strain and place their ability to continue operating in jeopardy.

[17] New York State, Model Medicaid Managed Care Contract, § 3.11(b) (1999).

INSURANCE REIMBURSEMENT FOR OUTPATIENT TREATMENT SERVICES

Before the conversion to chemical dependence services, the fee-for-service reimbursement rate for Child Health Plus A (Medicaid) for an outpatient treatment session in an alcoholism program was $57.60. This rate applied regardless of the length of the session and paid for outpatient treatment as well as day treatment services. In comparison, the reimbursement rate for licensed outpatient substance abuse programs was based on an agency's documented costs and varied by agency. Recognizing that insurance reimbursement fell far short of meeting the cost of providing services, OASAS provided state deficit financing to agencies to help close the gap. The amount of state deficit financing for each agency is determined through negotiations with OASAS.

With the conversion to chemical dependence services, OASAS reduced state deficit financing and developed three reimbursement rate categories for outpatient chemical dependence services that correspond to the volume of services provided by non-profit organizations. **Table 1** reflects the Medicaid fee-for-service outpatient reimbursement rates for community-based non-profit providers that do not have an Article 28 license.[17a] Again, these rates apply regardless of the length of the session and apply to outpatient clinic as well as day treatment services.

TABLE 1

Non-Article 28 Services	Overall Program Volume Level (Annual visits)	Non-Article 28 Downstate Fees	Non-Article 28 Upstate Fees
Low Volume Chemical Dependence Clinic	Less than 3,343	$127.27	$102.76
Normative Volume Chemical Dependence Clinic	3,344 thru 34,899	$77.03	$64.49
High Volume Chemical Dependence Clinic	More than 34,900	$72.37	$62.00

The rates identified in Table 1 apply to adult as well as adolescent outpatient treatment services. Through the Youth Committee of the New York State Association of Substance Abuse Providers Association, adolescent substance abuse programs have begun to advocate for an enhanced rate for special populations. These populations include adolescents, individuals diagnosed with mental illness and chemical addiction (MICA), and women and children. According to the agencies, the treatment of these populations entails more work, including case management services, care coordination, and aftercare services that aim to prevent relapse, the cost of which is not reflected in the current chemical dependence rates. The FY 2004 State Executive Budget recognized the need to establish adolescent specific rates as a priority.

[17a] The reimbursement rate for services provided to teenagers enrolled in Child Health Plus B is determined through negotiations between the health plans and each substance abuse program.

INSURANCE REIMBURSEMENT FOR LONG-TERM RESIDENTIAL TREATMENT FOR ADOLESCENTS

With respect to inpatient and residential treatment services, insurance coverage and reimbursement is even more limited. Four out of the five residential programs we interviewed reported that the average length of stay for adolescents was at least six months to one year. Child Health Plus B offers a combined 30 days for inpatient mental health services, inpatient detoxification, and inpatient rehabilitation. However, inpatient detoxification is not typically warranted by, or appropriate, for an adolescent.

Child Health Plus A (Medicaid) provides coverage for short-term residential treatment for adolescents. However, the majority of residential programs serving teenagers in New York City are intermediate to long-term residential programs that are ineligible for Medicaid reimbursement. To cover the cost of providing residential substance abuse treatment for teenagers these programs relied exclusively on public assistance payments from New York City. Specifically, the New York City Human Resources Administration (HRA) allowed eligible adolescents to apply for public assistance as a head of household and would not take into account income earned by parents, grandparents, or siblings of the applicant. Once enrolled in public assistance, a residential treatment program received public assistance funds to cover the cost of an adolescent's room and board. In September 2002, HRA terminated this practice and now conditions an adolescent's eligibility for public assistance on whether their blood relatives living in the same household are certified as public assistance eligible. Although this policy change is consistent with state and federal law, it has seriously threatened the financial viability of adolescent residential substance abuse programs that cannot afford to continue to provide services without reimbursement for room and board. In recognition of this potentially devastating situation, the Governor, OASAS, and the Office of Temporary and Disability Assistance (OTDA) invested $1.7 million in funds from October 1, 2002 to June 30, 2003 to help treatment providers minimize their revenue losses and continue operating. At the time of writing this report, the State confirmed that this funding would be available through April 2004 and that efforts were under way to make the programs eligible for Medicaid reimbursement.

SUBSTANCE ABUSE TREATMENT OPTIONS FOR NEW YORK CITY TEENS

In this study, we interviewed three types of programs: outpatient clinic treatment programs, day treatment programs, and residential programs. Of adolescent treatment episodes in New York City between 1997 and 1999, 63% were comprised of outpatient treatment episodes, 29% residential treatment episodes, and 4% inpatient treatment episodes.[18]

Outpatient treatment clinics represent the least intensive level of care and provide assessment and treatment services to youth and their families in an ambulatory setting. Three quarters (9/12) of the outpatient clinic treatment programs interviewed reported that youth received services approximately 3-5 hours per week. Half (6/12) of the outpatient clinic treatment programs reported that the average length of stay for youth is 3-6 months and one third (4/12) of the programs reported that the average length of stay ranged from 6-12 months.

Day treatment is a more intensive outpatient service than outpatient clinic treatment. Youth enrolled in day treatment attend the programs five days per week for several hours a day. In addition to assessment and treatment services, the programs provide educational services to participating youth. Day treatment programs interviewed reported that the length of stay for youth ranged from 6-15 months.

Residential programs represent the most intensive level of care CCC interviewed. According to OASAS regulations, the planned length of stay in a short-term residential program is 45 to 60 days and 60 days to 15 months for a long-term program.[19] The residential programs interviewed

[18] Pacquin, M.W., Perry, P., Lambert-Wacey, D. & Eaton, E. (2001). *Quantitative and Qualitative Analyses of Trends in Access to and Utilization of Alcohol and Substance Abuse Treatment for Adolescents in New York City.* New York State Office of Alcoholism and Substance Abuse Services.

[19] 14 NYCRR § 820.2 (b)(1)-(2).

reported that the length of stay for youth ranged from 3 to 15 months. Programs also noted that for some youth the length of stay may be dictated by court order.

WHO IS OBTAINING ADOLESCENT SUBSTANCE ABUSE TREATMENT

The programs interviewed estimated that the average age of boys and girls receiving treatment is 16.6 years and 16.2 years respectively. Although similar in age, programs estimated that boys comprise an average of approximately 66% of the client population and girls represent an average of approximately one-fourth the client population.[20] The focus group participants ranged in age between 14 and 18, and reported that they began to use marijuana or alcohol between the ages of 11 and 15. Both the treatment programs and teen focus group participants reported that marijuana and alcohol were the most commonly used substances for teenagers participating in treatment. These findings are consistent with national research that shows that children as young as 12 and 13 years old report using cigarettes, marijuana, and alcohol.[21]

Programs estimated that an average of 30% of the teenagers participating in treatment had a history of prior substance abuse treatment. The estimate was higher for teenagers in residential treatment, with those programs reporting that almost half had had prior treatment. In comparison, the outpatient treatment programs estimated that an average of 15.7% of the teenagers they serve and 11.5% of the teenagers served by day treatment programs had history of prior treatment.

The interviews showed that substance abuse is an issue that cuts across child serving systems. Programs estimated that an average of 28.9% of the teenagers had a history of involvement with the child welfare system, 19.7% with the mental health system, and roughly 35% of teenagers had involvement with the juvenile or criminal justice systems. With regard to education, more than half (13/21) of the programs estimated that an average of 50% of their client population was not regularly attending school at the time of admission, and 53% of these programs estimated that more than 80% (average) of the teenagers were not attending school at all at the time of admission. Most of the teenagers in the focus groups similarly reported excessive truancy or school-related problems prior to entering treatment.

This data suggests that the profile for a teenager participating in substance abuse treatment in New York City is likely to be a 16 year old, who uses marijuana or alcohol, does not attend school regularly, and may have a history of juvenile or criminal justice involvement as well as involvement in the child welfare system.

ADMISSION TO TREATMENT

OASAS regulations provide a broad prohibition against discrimination on the following grounds: "sponsorship, race, creed, sexual orientation, color, national origin, gender, disability, marital status, HIV status, pregnancy, or the lack of family or significant other willing to participate in the treatment process."[22] Programs licensed as youth outpatient or youth residential chemical dependency programs may consider a teenager's "past criminal or delinquent behavior" when assessing a teenager's appropriateness for admission, but these factors as well as the others may not constitute the "sole basis for denying admission"[23] or constitute grounds for automatic exclusion from admission.[24]

Programs interviewed had few criteria that excluded an adolescent from eligibility for admission to treatment. Involvement in the criminal justice system, juvenile justice system, or child welfare system, truancy, or certain mental health disorders did not constitute grounds for excluding an adolescent from admission to the substance abuse treatment programs interviewed. Age, mental health status, and physical disabilities that the premises could not accommodate were cited as possible reasons for denying an adolescent admission.

[20] Although each agency's response to this question equaled 100%, the responses varied from agency to agency. Consequently, the results reported above reflect an aggregation of responses for all male estimates and all female estimates separately.

[21] Robert Wood Johnson Foundation, *Substance Abuse – The Nation's Number One Health Problem,* Key Indicators for Policy Update (February 2001), pp. 28-29 (reporting data for 12-17 year olds).

[22] 14 NYCRR § 823.7 (a) (outpatient chemical dependency services for youth); see also 14 NYCRR § 819.3(e)(chemical dependence residential services); 14 NYCRR § 822.3(e) (chemical dependence outpatient services). The prohibition against discrimination in the youth residential chemical dependency are considerably less specific stating "[n]o youth shall be denied admission . . . because of the nature of his or her referral . . . , the lack of family or significant other willing to participate in the treatment process, or on the basis of any other arbitrary criteria." 14 NYCRR § 820.4(d)(1).

[23] 14 NYCRR § 823.7 (b).

[24] 14 NYCRR § 820.4 (d)(2).

Almost half the programs (47.6% or 10/21) reported that they considered an adolescent's age and developmental maturity when determining eligibility and appropriateness for the program, but only slightly more than half provided treatment to younger teens. Over 86% (18/21) of the programs interviewed served teenagers between the ages of 14 and16, and 90% (19/21) provided treatment to teenagers aged 17 to 21. Slightly more than half of the programs (52.4% or 11/21) interviewed provided treatment to 11-13 year olds, 82% (9/11) of these were outpatient treatment programs. A number of providers noted the need for more treatment services for school-age children and younger adolescents.

Fifty-seven percent (12/21) of the programs reported that a mental health diagnosis may render a teenager ineligible for their program, depending on the type and severity of the illness. According to OASAS regulations, participation in treatment programs requires a chemical dependence diagnosis.[25] The regulations also make clear that a mental health disorder cannot be the only reason for denying admission.[26] Programs acknowledged that many teenagers admitted to substance abuse treatment present with co-existing mental health disorders. According to the OASAS provider directory, only seven treatment programs specifically serve teenagers with dual diagnoses of mental illness and chemical addiction, also known as MICA. Six of these programs are located in Manhattan and one in Staten Island.[27] Eighty-one percent (17/21) of the programs reported that they provided on-site mental health services to youth. We learned that the type and role of the mental health professionals employed by the programs varied, but were unable to ascertain from the data how these resources were allocated across agencies. We learned, for example, that some programs employed psychiatrists on a part-time basis to conduct assessments and referred youth to community-based mental health clinics for psycho-pharmacological treatment and psychotherapy. Programs also employed social workers and psychologists to provide mental health services. However, the extent of the co-location of a full array of mental health services in substance abuse treatment programs requires further investigation.

Consistent with OASAS regulations, all of the programs interviewed conducted comprehensive assessments of youth entering their programs, but only 40% (8/20) reported using a standardized assessment tool. In many cases, the tools were standardized across the agency rather than accepted by an accredited body or organization. The programs assessed most, if not all, of the following areas: chemical dependency/treatment history, educational history, family history, legal history, leisure/extracurricular activities, medical history, mental health history, social/peer relationships, and sexual/physical abuse history. Eighty-six percent (18/21) of the programs required the youth to obtain a physical examination. All of the residential programs reported that they provided primary health services on-site, while the majority of other programs referred youth to community-based services.

Ninety percent (90% or 19/21) of the programs required teenagers to submit to urinalysis. Almost eighty percent (78.9% or 15/19) of the programs required urinalysis upon admission. Seventy-four percent (14/19) of the programs required urinalysis on a random basis and 47% (9/19) provided the teenager with notice of when the urinalysis would be conducted. One program explained that, after admission to treatment, urinalysis offers a way to monitor whether a teenager is moving towards abstinence or requires further engagement in the treatment process.

[25] 14 NYCRR § 820.4 (a) (youth residential treatment); 14 NYCRR § 823.6 (b)(1) (youth outpatient); 14 NYCRR

§ 822.4(a)(4)(F)(chemical dependence outpatient services); 14 NYCRR § 819.4(a) (4)(iii)(F)(chemical dependence residential services).

[26] 14 NYCRR § 823.7 (b)(youth outpatient services); 14 NYCRR § 819.3(e)(7) (chemical dependence residential services); 14 NYCRR § 822.3(e)(7)(chemical dependence outpatient service).

[27] New York State Office of Alcoholism and Substance Abuse Services, *New York State Directory: Adolescent Alcohol and Substance Abuse Providers* (January 2002).

TEEN FOCUS GROUP FINDINGS AND RECOMMENDATIONS

In order to learn about the experience of teenagers who participate in substance abuse treatment, CCC convened three focus groups during the Spring of 2001. Each focus group represented a different level of treatment – outpatient, day treatment, and residential treatment. With support from CCC staff, YouthAction NYC members developed and presented a series of questions to each focus group (Appendix C). In addition to responding to the questions presented, the focus group participants offered recommendations for improving the delivery of substance abuse treatment services to adolescents in New York City. Here's what the teen focus group participants shared with CCC:

Profiles of Teenagers Participating in Focus Groups:

- Ranged in age from 14-18 years old
- Started using between 11 and 15 years of age
- Marijuana – most common drug used by teens in treatment
- Most teens had a family history of substance abuse
- Most teens were skipping classes and/or school to use drugs and alcohol
- Some teens had previous treatment experience

Getting to Treatment:

- Teens were not thinking about stopping use or looking for treatment before admission
- Many teens did not know adolescent substance abuse treatment existed
- Most teens in residential treatment were referred by the legal system
- Many teens in day treatment and outpatient treatment were referred by parents upon schools' recommendations

The Treatment Process:

- Teens prefer to have a "say" in treatment planning
- Treatment has taught teens the value of compromise
- Teens regarded their relationship with their counselors as very important, but not all agreed that counselors had to have participated in treatment themselves
- Teens valued peer feedback expressed during group treatment
- Most teens opposed joint treatment with adults believing that their issues and the substances they use differ from adults
- Teens recommended that treatment participants engage in school-based peer education about the consequences of drug and alcohol use and the availability of adolescent substance abuse treatment programs
- Teens in residential programs wanted better access to recreational activities

Benefits of Substance Abuse Treatment:

- Educational goals changed from truancy and dropping out to earning GED or a high school diploma
- Teens reported improved family relations when programs successfully engaged parents/caregivers
- Teens identified strong need to educate parents/caregivers about adolescent substance use and abuse and treatment programs

Concerns About Life After Treatment

- Teens worry about returning to using after treatment given prevalence of drugs in their communities
- Teens believed that remaining in, and/or changing, schools guards against return to drug use
- Teens worry that family relationships that have improved with treatment will deteriorate
- Teens expressed desire to remain connected to programs for post-treatment support
- Many teens wanted to be connected to Teen Alcohol Anonymous, Teen Narcotics Anonymous programs post-treatment, and community-based youth development programs upon leaving treatment

COMPONENTS OF ADOLESCENT SUBSTANCE ABUSE TREATMENT

Almost all of the programs (95% or 20/21) reported that teenagers participated in the treatment planning process. Following admission, the treatment of each youth is guided by an individual treatment plan tailored to their specific needs and identified goals. Teenagers in two of the focus groups reported that they worked with their counselors to develop their treatment plans and monitored their progress in meeting identified goals. Some youth in the third focus group felt that they had little input into the development of their treatment plans and were frustrated by these circumstances.

All programs provided individual and group counseling facilitated by a counselor, and almost half (10/21 or 47.6%) offered peer counseling. Abstinence, earning a high school diploma or GED, strengthening family relationships, and developing social skills were the top treatment goals identified by the programs we interviewed. Programs offered a range of services to help the youth achieve these goals as well as others set forth in individual treatment plans. Many of the teenagers in the focus groups described the initial challenges of engaging in individual and group treatment and acknowledged that once engaged they derived benefits from both modalities of treatment. Some teenagers expressed a particular appreciation for group counseling, stating their belief that as former users of drugs and alcohol they can identify with each other, offer support in the recovery process, and challenge each other when needed.

Less than half of the programs interviewed reported that for purposes of group counseling they separated teenagers according to age or gender. Many of the teenagers in the focus groups supported this approach and indicated that the participation of the opposite sex enhanced the group process, but recognized the benefit of occasional single-sex sessions. Almost one quarter of the programs (24% or 5/21) reported that teenagers participated in group counseling with adult clients. The majority of teenagers in the focus groups expressed strong opposition to participating in groups with adult clients. According to the focus group participants, teenagers are confronted with different challenges than adults and often do not use the same drugs. As one teenager expressed, "we're figuring out how to deal with school, our parents, and peer pressure. And, most teenagers here were using alcohol or pot." She went on to question what she would have in common with an adult man who has lost his job because of a cocaine habit, and others in the group agreed with her position.

CONNECTING TEENAGERS TO SUBSTANCE ABUSE TREATMENT REMAINS A CHALLENGE

The Substance Abuse and Mental Health Services Administration (SAMHSA) tracks admissions and the primary sources of referrals to adolescent substance abuse treatment programs that receive public funding. In 1998, 138,000 admissions for adolescent substance abuse treatment occurred nationwide. [28] According to SAMHSA, the criminal justice system, self or individual referral (including family members), and schools represented the most common sources of referrals for these admissions. Combined, these three referral sources accounted for approximately 75% of the total number of adolescent admissions.[29] SAMHSA also reported that the number of youth between 12 and 17 years of age admitted to treatment had increased 46% between 1993 and 1998.[30] The admissions from criminal justice referrals increased by 39% during the same time period and accounted for "almost half (49 percent) of all youth treatment admissions."[31] SAMHSA attributed the rise in admissions to an increase in marijuana use, increased availability of treatment for youth using marijuana, and increased referrals to treatment rather than detention for marijuana offenses.[32]

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[28] Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *The DASIS Report: Coerced Treatment Among Youths: 1993-1998*, (September 2001), p. 2.

[29] *Ibid.*

[30] *Ibid.*

[31] *Ibid.*

[32] *Ibid.*

All the treatment programs interviewed reported that they conducted outreach activities. In addition to identifying the sources of referral, CCC inquired about the outreach efforts to other systems and organizations conducted by the substance abuse treatment programs. According to the programs, outreach activities took many forms including: community-based and school-based presentations, distribution of fliers, listings in phone directories, and maintenance of websites. The targets of outreach for the treatment programs varied.

Sixty percent or more of the substance abuse treatment programs reported that probation officers, schools, and child welfare agencies represented the top three targets for their outreach efforts and 57.1% targeted mental health programs. However, as depicted in **Table 2**, little correlation exists between the outreach conducted and the sources of referrals to New York City adolescent substance abuse treatment programs, with the exception of the juvenile justice and legal system. The first column of Table 2, "Target of Outreach," identifies the persons or places to which substance abuse treatment programs conducted outreach. The next column indicates the proportion of all the programs we interviewed that targeted the persons or places identified in the first column. The third column, "Proportion of Treatment Programs that received referrals from identified target" shows the response treatment agencies received from the outreach target. The last column indicates the estimated proportion of referrals to the programs we interviewed that emanated from the persons and places to which outreach was targeted.

TABLE 2

Target of Outreach	Proportion of treatment programs that directed outreach to identified target	Proportion of treatment programs that received referrals from identified target	Estimate of referrals received from identified target as a proportion of total referrals
Probation Officers	90.5% (19/21)	65% (13/20)	30%-90%
Schools	76.2% (16/21)	90.5% (19/20)	0%-10%
Family/Superior Court	71.4% (15/21)	Comparison Data Not Available	Comparison Data Not Available
Child Welfare Agencies	61.9% (13/21)	73.7% (14/19)	0%-10%
Mental Health Programs	57.1% (12/21)	94.4% (17/18)	0%-10%
Health Clinics	47.6% (10/21)	Comparison Data Not Available	Comparison Data Not Available
Hospitals	47.6% (10/21)	94.7% (18/19)	0%-10%
Youth Development Organizations	47.6% (10/21)	Comparison Data Not Available	Comparison Data Not Available
Faith-based organizations	38.1% (8/21)	90.5% (19/20)	0%-3%

Seventy-six percent of the treatment programs interviewed reportedly conducted outreach to schools, but schools constituted only 0%-10% of the estimated referrals for almost all of the programs. We learned anecdotally that one factor that may account for the low rates of referrals is that often a school's first line of intervention is to inform parents/caregivers about a suspected problem and to recommend that the teenager be enrolled in a substance abuse treatment program. A closer look at the data compiled by CCC showed that 75% (3/4) of the day treatment programs estimated that at least 40% and up to 70% of their referrals came from parents/caregivers. Two of the residential treatment programs estimated that over 30% of referrals came from parents/caregivers. In comparison, the majority of outpatient treatment programs estimated that referrals from parents/caregivers comprise only up to 10% of their total referrals.

Although 61.9% (13/21) of the treatment programs interviewed directed outreach to child welfare agencies, 73.7% (14/19) programs estimated that only 0%-10% of their referrals emanated from the child welfare system. This finding is significant. Research suggests that children of a substance abusing parent are at increased risk of developing a substance abuse problem of their own.[33] The National Center on Addiction and Substance Abuse has reported that "children who grow up in families with a history of parental alcohol or drug abuse are twice as likely to drink and nearly four times more likely to use illicit drugs as children from families without a history of drug or alcohol abuse."[34] This is of particular concern for children placed in foster care.

The Child Welfare League of America has reported that national studies indicate that between 40%-80% of child abuse and neglect cases involve a parent/caregiver with an alcohol or drug related problem.[35] In 1997, the General Accounting Office reported to Congress that approximately 75% of confirmed child abuse and neglect cases in New York City involved a substance abusing parent or caregiver.[36]

[33] Robert Wood Johnson Foundation, *Substance Abuse: The Nation's Number One Health Problem – Key Indicators for Policy* (Update February 2001), p. 62.

[34] The National Center on Addiction and Substance Abuse, Columbia University, *Substance Abuse and the American Adolescent – A Report by the Commission on Substance Abuse Among America's Adolescents* (August 1997), p. 78 (citing Chassin, L. and Rogosch F. and Barrera, M. (1991). *Substance Use and Symptomatology Among Adolescent Children of Alcoholics.* Journal of Abnormal Psychology, 100(4), 449-463).

[35] Child Welfare League of America, *Alcohol and Other Drugs,* www.cwla.org/programs/bhd/aod.htm (citing Young, N.K., Gardner, S.L., & Dennis, K., *Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy (1998)* Washington, DC: CWLA Press).

[36] United States General Accounting Office, *Parental Substance Abuse: Implications for Children, the Child Welfare System and Foster Care Outcomes – Testimony Before the Subcommittee on Human Resources, Committee on Ways and Means, House of Representatives, State of Jane. L. Ross, Director, Income Security Issues, Health, Education, and Human Services Division (October 28, 1997)*, p. 4; *see also* The National Center on Addiction and Substance Abuse, Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets* (January 2001), p. i (indicating that approximately 70% of child welfare abuse and neglect cases involve a substance abusing parent).

In 1998, the New York City Council recognized the impact of substance abuse on families and the high risk of substance abuse among teenagers placed in the child welfare system and provided the New York City Administration for Children's Services (ACS) with $7.9 million to address this situation. With this funding, ACS invested in the development of substance abuse services for adolescents placed in congregate care and collaborated with foster care agencies to develop the *ACS Congregate Care Substance Abuse Standards.*[37] The *Congregate Care Substance Abuse Standards* established the "minimum standards for congregate care programs for addressing substance abuse, and provides guidelines for casework practice and clinical service intervention for adolescent clients."[38] In recent years, the Mayor has repeatedly targeted the funding for congregate care substance abuse services for elimination and the City Council has restored it. Most recently, the Mayor's Executive Budget for FY'03-04 proposed a $7.6 million cut to this program. The vulnerability of this funding year after year results from a failure to baseline it in ACS's budget or to find an alternative source of ongoing funding. In this regard, it highlights the need to stabilize the financing for adolescent substance abuse services.

In response to the strong correlation between parental substance abuse and foster care placement, ACS and OASAS produced the *Operational Protocol for Client Referral and Communication between Child Welfare Staff and Alcohol and Other Drug Treatment Providers.* Developed in collaboration with substance abuse and foster care providers, the Protocol established guiding principles to enhance cross-system collaboration and knowledge, to facilitate referrals, and to help parents/caregivers to address the impact of substance abuse on their children and work towards their child welfare permanency goals. Borough-based training of child welfare providers, child protective workers, and substance abuse providers on the Protocol is scheduled for 2003, although the possibility remains that the city's fiscal crisis may hamper this process.

[37] *Administration for Children Services Congregate Care Substance Abuse Standards*, Addendum to ACS Foster Care Standards, Appendix G-2 (December 2001).

[38] *Ibid.* at Preface.

Finally, ACS developed and disseminated to child welfare agencies and substance abuse programs the *ACS/OASAS Cross-Systems Guide to Access the Substance Abuse Treatment Community,* a desk guide that provides organizational charts of ACS and OASAS, descriptions of services, and contact information for these agencies as well as other related organizations. Although these efforts focus mainly on adult substance abuse, the cross-systems training may lead to increased referrals from child welfare agencies to adolescent substance abuse treatment programs as well.

Less than half of the treatment programs identified health clinics, hospitals, youth development and faith-based organizations as places where they directed outreach activities. Health clinics and hospitals are important points of contact for teenagers and have the potential to serve as more frequent sources of referrals to substance abuse treatment programs. New York law establishes the right of teenagers to obtain certain health, mental health, and substance abuse services without parental consent.[39] These laws recognize confidentiality as an important consideration for many adolescents in seeking health, mental health, and substance abuse services. Through a study conducted in 2000 that examined adolescent health services in New York City, CCC learned that many teenagers avail themselves of the protection afforded by state law and seek health services on their own.[40] This means that health clinics serve as important places of contact with teenagers who may not be involved with another system and health visits create an opportunity to screen and detect adolescent substance abuse problems. *The Guidelines for Adolescent Preventive Services (GAPS)*, issued by the American Medical Association, recognizes this opportunity. The GAPS encourage adolescent health providers to screen adolescents for high risk behaviors, including substance abuse, that may jeopardize their immediate and long-term health and safety.[41]

Almost 50% (10/21) of the programs reported that they do not run at full capacity each month. This was true for six outpatient treatment programs, two day treatment programs, and two residential programs interviewed. Programs attributed this to such factors as a lack of, or poor, outreach, difficulty retaining staff, and limited parental/caregiver support. The teen focus groups uniformly reported that most teenagers with an alcohol or substance abuse addiction do not believe that they have a "real problem." The teenagers also indicated that most of them did not know that adolescent substance abuse treatment services existed.

The limited outreach to, and referrals from, health clinics, and youth development and faith-based organizations highlight the isolation of the substance abuse treatment programs from other programs that serve children and families and the need to direct outreach into community locations frequented by adolescents and their parents/caregivers. The weak linkage between substance abuse treatment programs and health clinics and hospitals provides a case in point. Although substance abuse programs reported that they conducted school-based presentations, many of the teenagers we interviewed were not regularly attending school but may have had contact with community-based services, including health clinics and hospitals. In addition, all three teen focus groups called attention to the serious need to educate parents/caregivers about teenage substance use and available treatment programs. Faith-based organizations with access to parents/caregivers may be able to partner with substance abuse prevention and treatment programs to accomplish these ends. Although CCC did not inquire about the availability of funding for outreach or community networking, the data reported by the programs interviewed shows that outreach is an area in need of improvement.

[39] N.Y. Pub. Health Law § 2504(4) (emergency health care); N.Y. Pub. Health Law § 2305(2) (testing and treatment for sexually transmitted diseases); N.Y. Pub. Health Law § 2780(5) and § 2505 (4) (HIV/AIDS testing and treatment); N.Y. Mental Hyg. Law § 33.21 (c)-(d) (outpatient mental health counseling and treatment services); and N.Y. Mental Hyg. Law § 21.11(a); see also Citizens' Committee for Children of New York, Inc., *Promoting Teen Health and Reducing Risks: A Look at Adolescent Health Services in New York City,* (2002).

[40] *Ibid.*

[41] *Ibid.* at 7- 9 (reprinted American Medical Association, *Guidelines for Adolescent Preventive Services,* Recommendation Monograph)

TREATMENT SERVICES YIELD POSITIVE RESULTS FOR TEENS AND FAMILIES

Teenagers identified family engagement as a key to their treatment success. The teen focus groups each identified improved family relationships as one of the major benefits of their substance abuse treatment. The teenagers acknowledged the efforts of counselors to accommodate the schedules of their parents/caregivers and to engage their parents/caregivers in the treatment process. The teenagers recognized that engaging parents/caregivers is not always easy. They attributed this to their parents/caregivers' busy schedules, frustration, embarrassment, and, in some cases, lack of understanding about teenage substance abuse. Significantly, each focus group identified the need to increase efforts to educate parents about the causes, warning signs, symptoms, and treatment for teenage substance abuse.

The OASAS chemical dependence regulations encourage programs to involve parents and/or significant others in a client's treatment.[42] Two-thirds of the programs interviewed reported that they required the consent of a parent or guardian as a condition of a youth's admission to their program. Many programs also recognized exceptions to this rule. State law provides an exception to the parental consent requirement when a doctor determines that "parental or guardian involvement and consent would have a detrimental effect on the course of treatment of a minor who is voluntarily seeking treatment, or if a parent or guardian refuses to consent to such treatment, and the [doctor] believes that such treatment is necessary for the best interests of the child . . ."[43]

[42] The chemical dependence regulations direct outpatient programs to seek to involve parents and caregivers in a teenager's treatment. 14 NYCRR § 823.8(a). Although less directive, the residential chemical dependency regulations implicitly encourage family involvement by mandating that programs provide other services, "family services and/or counseling for family members and significant others, either directly or in cooperation with ambulatory programs in the community." 14 NYCRR § 820.6(b)(8). This requirement also applies to outpatient chemical dependency programs. 14 NYCRR § 822.2(d)(7).

[43] 14 NYCRR § 823.8(outpatient services); 14 NYCRR § 820.4 (c).

Almost all (20/21) programs interviewed provided family counseling. More than half of the programs conducted family and parent support groups. Five programs conducted groups specifically for siblings of teenagers in treatment. As one administrator described, the sibling groups constituted an important preventive intervention.

TREATMENT HELPED TEENAGERS REFOCUS EDUCATIONAL GOALS

The teenagers regarded staying in school and obtaining an education as a protective factor against future alcohol or drug involvement. The teenagers in the focus groups reported that their substance use had interfered with school performance and attendance. The majority of teenagers in the residential treatment program and day treatment program admitted that they had not regularly attended school prior to entering treatment. Many of the teenagers from the outpatient treatment group reported a decline in school performance as a result of their substance abuse and that their referrals to treatment originated through school communications.

Substance abuse treatment programs for youth offer a variety of education services. Youth participating in day treatment and residential treatment attend classes on the program premises five days per week. Youth attending these on-site educational programs may be working towards a high school diploma or a General Equivalency Degree (GED). Outpatient treatment programs interviewed by CCC also offered educational services, such as tutoring and in some cases GED preparation, to youth. Several teenagers reported that before treatment they had abandoned plans to graduate from high school or earn a GED. Many of the teenagers in the residential and day treatment programs reported that the small class sizes, accessibility of their teachers, and the mandatory attendance requirements of on-site classes provided them with a new appreciation for school and led to a new found desire and determination to complete high school or earn a GED.

One education-related concern expressed by teenagers in the day treatment program was making the transition back to their original school or to a new school at the end of treatment. The concern related in part to the size of schools as well as the peer pressure to return to using they were likely to confront. Program administrators reported ongoing difficulty in engaging schools to help make these transitions occur in a timely and supportive manner.

Each of the focus groups independently recommended that substance abuse treatment programs arrange for youth in treatment to make school-based presentations in elementary, junior, and high schools. The teenagers believed that this kind of peer-education would help other youth decide to stop or refrain from beginning to use alcohol and drugs. They also regarded it as a way to inform youth about substance abuse treatment and its benefits.

TEENAGERS WANT AFTERCARE SUPPORTS AND SERVICES

The teenagers in the focus groups expressed concern about the challenge of making the transition into their communities and families after treatment without the support of the program. Top concerns related to losing the gains made through treatment, such as improved family relationships, and resisting the temptation to access readily available drugs and alcohol in their communities. Some of the teenagers who had, or were on the verge of, graduating from treatment discussed the value of being able to visit or call their former treatment counselors for support when needed. And, more than one teenager recommended that graduates be linked to community-based support groups, such as Teen Alcoholics Anonymous or Narcotic Anonymous, and youth leadership and recreational programs in their communities.

Ninety-five percent (20/21) of the programs interviewed reportedly conducted aftercare planning with youth. Through aftercare planning, the programs work with youth to identify goals for life after treatment and link them to services that will help them achieve those goals. Less than half of the programs provided a full array of support services and were more likely to make referrals to community-based services. Although insurance does not provide reimbursement for aftercare services, one third or more of the programs interviewed provided at least one of the following aftercare support services: peer support groups, family support groups, referrals to outpatient treatment, and vocational services. Thirteen programs reported that a staff person, often the primary counselor, is assigned to follow-up with youth after they leave treatment, but many programs reported that follow-up occurs informally and is largely dependent on the youth remaining in touch.

RECOMMENDATIONS

Substance abuse is an issue that cuts across child and family serving systems – the child welfare system, the legal system (family court, the juvenile court and criminal court), the education system, the health and mental health systems, and the welfare system. The cost of untreated substance abuse among teenagers is born not only by the individual teenagers and their families, but also by their communities and public systems.[44] Efforts must be made to strengthen the linkages between adolescent substance abuse services and other services for children, youth, and families. These kinds of efforts will enhance the understanding of substance abuse and its impact on youth development, promote cross-system training, and lead to earlier intervention and prevention and safer, healthier, more productive outcomes for New York City youth and families. Presented below are recommendations developed by CCC based on the findings described in this report.

EXPAND OUTREACH AND EDUCATION ABOUT ADOLESCENT SUBSTANCE ABUSE AND TREATMENT OPTIONS

Through this study, CCC identified the need to improve outreach and education about substance abuse and substance abuse treatment options for New York City teens. The teen focus groups discussed the lack of knowledge among teenagers and their parents/caregivers about the warning signs or symptoms of adolescent substance use or abuse and where to go to get help. CCC recommends that the New York State Office of Alcohol and Substance Abuse Services, the New York State Legislature, the Governor, the Mayor, the New York City Council, and the New York City Department of Health and Mental Hygiene work to implement the suggestions of the teen focus groups. To that end, CCC recommends that:

- The New York State Legislature, the Governor, OASAS, the Mayor, the New York City Council, and the New York City Department of Health and Mental Hygiene fund the creation of peer education programs that enable teenagers who are participating in treatment, or who have completed treatment, to talk to their peers about the availability of treatment and the potential dangers of using drugs and alcohol. Providing peer education would further the recovery of adolescents in treatment and help to prevent other teenagers from using or continuing to use;
- The New York City Department of Health and Mental Hygiene spearhead an effort to improve the linkages between adolescent substance abuse treatment programs and health and mental health clinics and to work with the New York City Department of Education and the New York City Administration of Children's Services to promote cross-agency coordination and planning related to adolescent substance abuse issues; and
- The New York City Department of Health and Mental Hygiene develop on-line and written resources to educate parents/caregivers about the signs and potential consequences of adolescent substance use or abuse and how to access treatment services.

EASE TRANSITION TO LIFE AFTER TREATMENT

CCC's study revealed that making the transition from treatment can prove to be a difficult task for many teenagers, particularly those participating in residential and day treatment programs. It is likely that after treatment most teenagers are faced with the challenges of returning to the environment where they began using drugs and/or alcohol and avoiding temptations to return to old ways. Part of this transition requires re-entry into school. As this report's findings indicated, treatment enabled many teenagers to refocus their educational goals and work towards earning their high school diploma or GED, goals they had abandoned while using. However, treatment programs reported that there is often a lapse of time between when a teenager in treatment ends treatment and is able to enroll in school. Teenagers also acknowledged their need for continued support after treatment. However, treatment programs reported that they do not receive reimbursement for case management or other support services provided to teenagers who have completed treatment. Although many programs attempted to follow-up informally, very few could afford to provide aftercare services. As a result, teenagers and their families are often left to

[44] See The National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: the Impact of Substance Abuse on State Budgets* (January 2001)(examines the cost of untreated substance abuse on state spending across systems).

handle their transition on their own. In light of these circumstances, CCC recommends that:

- The New York State Department of Education, the New York City Department of Health and Mental Hygiene and the New York City Department of Education develop ways to ensure a seamless transition from treatment to schools for adolescents leaving residential and day treatment programs; and
- OASAS, the Governor, the New York State Legislature, the Mayor, the New York City City Council, and the New York City Department of Health and Mental Hygiene develop reimbursement for aftercare services provided by substance abuse treatment programs or identify other funding mechanisms for these services.

IMPROVE INSURANCE COVERAGE FOR ADOLESCENT TREATMENT SERVICES

Although adolescents in New York State are eligible for one of two public health insurance programs that offer some coverage for substance abuse treatment, the scope of the benefits and the adequacy of the reimbursement rates are limited. As it stands now, the scope of benefits under Child Health Plus A (Medicaid) and Child Health Plus B do not include coverage for long-term residential substance abuse treatment for teenagers. For the benefits that are covered, such as outpatient treatment, substance abuse programs have reportedly experienced difficulty becoming members of health plan provider panels and as a result are unable to obtain reimbursement for services provided to adolescents enrolled in Child Health Plus A and Child Health Plus B. Finally, a number of programs CCC interviewed expressed concern about the adequacy of the reimbursement rates recently adopted by OASAS for outpatient treatment services provided by non-hospital affiliated providers and a lack of reimbursement rate for long term residential treatment. To address these concerns, CCC recommends that:

- OASAS adopt an outpatient Medicaid reimbursement rate that covers the cost of providing quality treatment and support services to adolescents;
- New York State adopt a Medicaid reimbursement rate for long-term residential chemical dependence programs serving adolescents;
- The Governor, the New York State Legislature, OASAS, and the New York State Department of Health monitor the implementation of the recently adopted reimbursement rates for outpatient chemical dependence programs to determine their adequacy; and
- OASAS and the New York State Department of Health investigate the ability of substance abuse treatment programs to become members of health plan provider panels.

CONCLUSION

Nationwide approximately 1.1 million youth between the ages of 12 and 17 needed substance abuse treatment in 2000, but only 11.4% of these youth received it.[45] In New York City, CCC identified 48 programs that provide treatment to teenagers with alcohol and substance abuse problems. Most of these programs rely on insurance reimbursement, state financial assistance, and, in some cases, on funding from New York City to operate. In the midst of conducting our study in the Spring of 2002, the Mayor's preliminary budget proposed to eliminate city funding for 3 teenage substance abuse programs, including the day treatment program that provided participants for the teen focus groups. Implementation of these proposals would have resulted in the forced closure of these vital programs. Although these proposals were not included in the final adopted budget for FY 2002-2003, adolescent substance abuse programs may become targets again as New York City and New York State struggle to reduce large budget deficits over the next few years.

[45] Substance Abuse and Mental Health Service Administration, Office of Applied Studies, *National and State Estimates of Drug Abuse Treatment Gap*, (August 2002), www.samhsa.gov/oas/Txgap/chapter2.htm (Appendix A).

Our study has shown that few substance abuse treatment options exist for New York City teens and that the information about these options is limited. These are serious concerns. When left undetected and untreated, substance abuse poses serious risks for teenagers. From a health and safety perspective, research has shown that substance abuse contributes to injury and in some cases death. It may also lead to involvement in other systems, most significantly the juvenile and criminal justice systems. And, as the programs and teenagers we interviewed reported, a strong correlation exists between substance abuse and declining interest and participation in high school. Citizens' Committee for Children of New York urges the Governor, the New York State Legislature, OASAS, the New York State Department of Health, the Mayor, the New York City Council, and the New York City Department of Health and Mental Hygiene to invest in adolescent substance abuse treatment and prevention services and improve the coordination between these services and other child serving systems. In the absence of these efforts, the costs to adolescents, their families, New York State, and New York City will remain too high.

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APPENDIX A

ADOLESCENT SUBSTANCE ABUSE TASK FORCE MEMBERS

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* YouthAction NYC is a CCC program that challenges young people in New York City to make the city a better place for children, youth, and their families. Through field work, lectures and discussions, YouthAction members learn to identify and research problems that affect their lives and the lives of other New Yorkers. YouthAction members also learn to develop solutions, make recommendations for change, and hold elected officials accountable for their decision-making. YouthAction NYC is open to 10th, 11th, and 12th grade students from public and private schools.

APPENDIX B

CITIZENS' COMMITTEE FOR CHILDREN OF NEW YORK, INC.
TASK FORCE ON ADOLESCENT SUBSTANCE ABUSE TREATMENT SERVICES

OUTPATIENT TREATMENT PROGRAM
SITE VISIT QUESTIONNAIRE

Thank you for taking the time to meet with us to discuss the substance abuse treatment services that you provide to adolescents. Citizens' Committee for Children of New York, Inc. (CCC) is a child advocacy organization that has been advocating for New York City's children for 57 years in the areas of health, mental health, child welfare, housing, child care, education, income support and youth services. We are interviewing 22 treatment programs as part of a study of adolescent substance abuse treatment in New York City. Information collected during this visit will be used in the study and in CCC's advocacy efforts on behalf of adolescents and adolescent substance abuse treatment providers. Please know that **no administrator, staff person, client, or resident will be identified by name in any CCC publication or advocacy efforts. For purposes of this interview, an adolescent refers to an individual between 11 and 21 years of age.** When answering the questions, please check all that apply.

GENERAL INFORMATION (to be completed by CCC Task Force Members Prior to Visit)

Name of Program ____
Address:

Name and Title of Program Representative(s) Interviewed:

____

____

Phone:

Name(s) of CCC Volunteer(s) completing questionnaire:

____

____

ORGANIZATIONAL STRUCTURE

1. Please indicate the types of substance abuse services provided to adolescents in New York City by your agency (check all that apply):
   - ❑ Day treatment (IOP)
   - ❑ Outpatient treatment
   - ❑ Prevention (primary)
   - ❑ Long-term residential treatment
   - ❑ Short-term residential treatment (less than 9 months)
   - ❑ Other, please explain ______________________________

2. Is your outpatient treatment program licensed to provide the following services (check all that apply):
   - ❑ Alcohol treatment services
   - ❑ Chemical dependency services
   - ❑ Mental health services
   - ❑ Primary and preventive health services
   - ❑ Other, please describe: ______________________________

3. Does your outpatient treatment program have a contractual relationship with any of the following organizations:
   - ❑ Child welfare agency
   - ❑ Faith-based organization (e.g. churches, temples, synagogues, etc.)
   - ❑ Hospital
   - ❑ Managed care organizations
   - ❑ Mental health clinic
   - ❑ Primary care clinic
   - ❑ School
   - ❑ Other, please explain ______________________________

4. How many adolescents does your outpatient treatment program serve at full capacity?
   - ❑ 0-25
   - ❑ 26-50
   - ❑ 51-100
   - ❑ 101-150
   - ❑ More than 150

5. Does your outpatient treatment program run at full capacity every month?
   - ❑ Yes If yes,
     - (a) Does your outpatient treatment program maintain a waiting list for adolescents?
       - ❑ No
       - ❑ Yes.
     - (b) Approximately how many adolescents are currently on the waiting list?
       - ❑ Less than ten adolescents
       - ❑ Ten to twenty adolescents
       - ❑ Twenty to thirty adolescents
       - ❑ More than thirty adolescents
     - (c) Approximately how long is the wait for an adolescent to enter your outpatient treatment program?
       - ❑ Up to one week
       - ❑ One –Three weeks
       - ❑ One month
       - ❑ Two-Three months
       - ❑ Three-Six months
       - ❑ More than Six months
   - ❑ No If no, what accounts for the unfilled capacity?

     ____

     ____

     ____

6. Does your outpatient treatment program have a specific geographic catchment area?
   - ❑ No
   - ❑ Yes What is the catchment area? ______________________________

7. Please indicate the sources of referral to your outpatient treatment program and estimate the proportion of referrals made by each source:
   - ❑ Faith-based organizations (e.g. churches, temples, synagogues, etc.) ______%
   - ❑ Child welfare agencies ______%
   - ❑ Hospitals ______%
   - ❑ Mental health clinics ______%
   - ❑ Parents/caregivers ______%
   - ❑ Parole/probation officers ______%
   - ❑ Police officers ______%
   - ❑ Private practice mental health professionals ______%
   - ❑ Private practice physicians ______%
   - ❑ Schools ______%
   - ❑ Self ______%
   - ❑ Social service organizations ______%
   - ❑ Other, please explain ______________________________

     ____

     ____

8. What methods of outreach to adolescents does your outpatient treatment program conduct?
   - ❑ Community-based presentations
   - ❑ Distribution of fliers
   - ❑ Distribution of literature
   - ❑ Phone directories
   - ❑ Radio/television advertisements
   - ❑ School-based presentations
   - ❑ Website
   - ❑ Other, please explain ____

     ____

9. Where does your outpatient treatment program direct its outreach efforts:
   - ❑ Child welfare agencies
   - ❑ Faith-based organizations (e.g. churches, temples, synagogues, etc.)
   - ❑ Family/Superior Court
   - ❑ Health clinics
   - ❑ Hospitals
   - ❑ Mental health clinics
   - ❑ Mental health practitioners
   - ❑ Police precincts
   - ❑ Probation officers
   - ❑ Schools
   - ❑ Youth development centers
   - ❑ Other, please explain ____

     ____

     ____

CLIENT CHARACTERISTICS

10. Approximately what proportion of adolescents participating in your outpatient treatment program are:
    Male __________ % Female __________%

11. Please specify the average age of adolescents by gender in your outpatient treatment program?
    Average age for males __________
    Average age for females __________

12. Please estimate the proportion of gay, lesbian or bisexual adolescents in your outpatient treatment program:
    _________%

13. Please rank in order of prevalence the substances most commonly used by adolescents who enter your outpatient treatment program:
   - ❑ Alcohol
   - ❑ Opiates
   - ❑ Cocaine
   - ❑ Marijuana
   - ❑ Inhalants
   - ❑ Other, please specify
   - ❑ Stimulants
   - ❑ Tranquilizers
   - ❑ Sedatives
   - ❑ Hallucinogens
   - ❑ PCP

   ____

   ____

14. Please estimate the proportion of adolescents who participated in substance abuse treatment prior to entering your outpatient treatment program: ________%

15. Please estimate the proportion of adolescents in your outpatient treatment program who are involved or have had involvement in the systems listed below:
   - ❑ Child welfare system _______%
   - ❑ Criminal justice system _______%
   - ❑ Juvenile justice system _______%
   - ❑ Mental health system _______%
   - ❑ Other, please explain

   ____

   ____

16. Please estimate the proportion of adolescents in your outpatient treatment program that have a learning disability: _________%

17. Please estimate the proportion of adolescents in your outpatient treatment program that have a concurrent mental health diagnosis (i.e. substance abuse dependence or addiction and a psychiatric diagnosis): _____ %

18. Please estimate the proportion of adolescents in your outpatient treatment program with a diagnosis of mental retardation or a developmental disability: _____%

19. Please estimate the proportion of adolescents that were not attending school at the time of admission to your outpatient treatment program: _____%

ELIGIBILITY/ASSESSMENTS

ELIGIBILITY

20. What is the age range of adolescents eligible for your outpatient treatment program (check all that apply)?
   - ❑ 11-13 years old
   - ❑ 14-16 years old
   - ❑ 17-21 years old
   - ❑ Other, please explain ____

   ____

21. Does your outpatient treatment program serve clients other than adolescents?
- ❑ No
- ❑ Yes, please explain

____

____

22. Assuming an adolescent's chronological age and substance abuse profile satisfy your outpatient treatment program's eligibility criteria, which of the following considerations may render him or her ineligible for admission?
- ❑ Developmental/emotional age
- ❑ Homelessness
- ❑ Juvenile or criminal justice involvement
- ❑ Lack of health insurance
- ❑ Language proficiency
- ❑ Mental health diagnosis
- ❑ Not enrolled in school
- ❑ Physical disabilities
- ❑ Placement in foster care
- ❑ Truancy
- ❑ Other, please explain ____________________

____

____

23. Does your outpatient treatment program provide specialized treatment for MICA (mentally ill chemically addicted or dually diagnosed) adolescents?
- ❑ Yes
- ❑ No

ASSESSMENT

24. Which of the following are assessed by your outpatient treatment program when deciding to admit an adolescent?
- ❑ Chemical dependency and treatment history
- ❑ Educational history
- ❑ Family history
- ❑ I.Q.
- ❑ Legal history
- ❑ Leisure/extracurricular activities
- ❑ Medical history
- ❑ Mental health/behavioral issues
- ❑ Physical examination
- ❑ Physical/sexual abuse screening and history
- ❑ Social/peer relationships
- ❑ Other, please explain ____________________

____

____

25. Does your outpatient treatment program use a standardized substance abuse assessment tool?
   - ❑ No
   - ❑ Yes. If yes,
     (a) What is the name of the assessment tool? ______________________
     ____
     (b) May we have a copy?

SUBSTANCE ABUSE TREATMENT

26. Please identify the goals for adolescents in your outpatient treatment program (please check all that apply) and indicate the top three goals your program addresses?
   - ❑ Build life skills
   - ❑ Develop conflict resolution skills
   - ❑ Develop social skills
   - ❑ Develop job skills
   - ❑ Earn a high school diploma or GED
   - ❑ Help adolescents to develop a lifelong commitment to abstinence from drugs and alcohol
   - ❑ Remain at home while in treatment
   - ❑ Strengthen family relationships
   - ❑ Other, please explain ______________________
     ____
     ____

27. Do adolescents participate in the development of their own treatment plan?
   - ❑ No
   - ❑ Yes. If yes, please describe the treatment planning process
     ____
     ____

28. How many hours per week does an adolescent typically attend your outpatient treatment program?
   - ❑ 0-2 hours/week
   - ❑ 3-5 hours/week
   - ❑ 6-10 hours/week
   - ❑ 11-20 hours/week
   - ❑ 21-40 hours/week
   - ❑ Over 40 hours/week

29. What is the model of substance abuse treatment provided by your outpatient treatment program to adolescents (please check all that apply)?
   - ❑ Religious/faith-based treatment
   - ❑ Substance abuse counseling
   - ❑ Substance abuse counseling with MICA services

❑ Therapeutic community
❑ Therapeutic community with MICA services (e.g. mental health component)
❑ 12-step
❑ Other, please explain:

____

____

____

30. What modalities of treatment does your outpatient treatment program provide to adolescents (please check all that apply):
❑ Couples counseling
❑ Family counseling
❑ Group counseling
❑ Individual counseling
❑ Multi-family group counseling
❑ Peer counseling
❑ Other, please explain:____

____

____

31. Does treatment provided to adolescents include specific content on social/peer relationships?
❑ No
❑ Yes. If yes, please describe activities or exercises employed by your outpatient treatment program in this area:

____

____

____

32. Does your outpatient treatment program separate adolescents by the following categories for group counseling or other group activities:
❑ Not separated according to categories
❑ Age
❑ Gender
❑ Language (i.e. Spanish-speaking youth, Chinese-speaking youth, etc.)
❑ Sexual orientation
❑ Type of drug used
❑ Other, please explain ____

____

____

33. Does your outpatient treatment program treat adolescents together in the same groups with adults?
❑ Yes
❑ No

34. What is the recommended length of stay for adolescents entering your outpatient treatment program?
❑ Less than three months
❑ Three to six months
❑ Six to twelve months
❑ Twelve to fifteen months
❑ More than fifteen months
❑ Other, please explain ____________________

35. What is the average length of stay for adolescents who enter treatment with your outpatient treatment program?
❑ Less than three months
❑ Three to six months
❑ Six to twelve months
❑ Twelve to fifteen months
❑ More than fifteen months
❑ Other, please explain ____________________

36. Does your outpatient treatment program assess the outcomes for adolescents who complete treatment?
❑ No
❑ Yes. If yes, please explain how your program measures outcomes:

____

37. Please estimate the proportion of adolescents who leave the outpatient treatment program before completing treatment each year:
❑ 0-15%
❑ 16-30%
❑ 31-45%
❑ 46-60%
❑ more than 60%

38. Please estimate the proportion of adolescents who complete outpatient treatment each year ______% and describe how your outpatient treatment program defines completion:

____

39. Does participation in your outpatient treatment program require an adolescent to terminate drug or alcohol use?
- ❑ No
- ❑ Yes

40. Does your outpatient treatment program require adolescents to submit to urinanalysis?
- ❑ No
- ❑ Yes. If yes,
  - (a) does your outpatient treatment program have a written protocol for obtaining a urine specimen?
    - ❑ Yes. May we have a copy of the protocol?
    - ❑ No
  - (b) When are adolescents required to submit to urinanalysis (check all that apply):
    - ❑ Upon admission
    - ❑ On a random basis once admitted to treatment
    - ❑ At specified intervals throughout treatment
    - ❑ Other, please explain ______________________________

____

____

SUPPORT SERVICES

41. Does your outpatient treatment program provide on-site mental health treatment in addition to substance abuse treatment to adolescents in your program?
- ❑ Yes Which mental health professionals provide these services to adolescents:
  - ❑ Psychiatrists
  - ❑ Psychologists
  - ❑ Social Workers
  - ❑ Other, please specify: ______________________________

____

____

- ❑ No. Does your outpatient treatment program refer adolescents to community-based mental health services?
  - ❑ No
  - ❑ Yes. If yes,
    - (a) does your outpatient treatment program designate a staff person to follow-up on referrals made for mental health services?
      - ❑ No
      - ❑ Yes
    - (b) How long does it take for adolescents to get a mental health appointment in a community-based mental health clinic?
      - ❑ Less than 7 days
      - ❑ 2-3 weeks
      - ❑ 1 month
      - ❑ 2 months to 3 months
      - ❑ More than 3 months

42. Does your outpatient treatment program provide on-site psychopharmacological treatment to adolescents?
   - ❑ Yes
   - ❑ No. If no, does your outpatient treatment program refer adolescents to community-based pharmacological treatment?
     - ❑ No
     - ❑ Yes

43. Does your outpatient treatment program provide on-site primary health care services to adolescents?
   - ❑ Yes. If yes, which health professionals provide health services to adolescents:
     - ❑ Doctors
     - ❑ Nurses
     - ❑ Nurse Practitioners
     - ❑ Physician's Assistants
     - ❑ Other, please explain ______________________________
       ____
       ____
   - ❑ No. Does your outpatient treatment program refer adolescents to community-based health services?
     - ❑ No
     - ❑ Yes. If yes,
       - (a) does your outpatient treatment program designate a staff person to follow-up on referrals made for health services?
         - ❑ No
         - ❑ Yes
       - (b) How long does it take for adolescents to get an appointment in a community-based health clinic?
         - ❑ Less than 7 days
         - ❑ 2-3 weeks
         - ❑ 1 month
         - ❑ 2 months to 3 months
         - ❑ More than 3 months

44. Does your outpatient treatment program provide on-site HIV/AIDS services to adolescents:
   - ❑ Yes.Which of the following services are provided (please check all that apply):
     - ❑ Counseling
     - ❑ Education
     - ❑ Medical treatment
     - ❑ Testing
     - ❑ Other, please explain ______________________________
       ____
       ____
   - ❑ No. Do you refer adolescents to community-based organizations for HIV/AIDS services?
     - ❑ No.
     - ❑ Yes. Please indicate the HIV/AIDS services for which your outpatient treatment program makes referrals (please check all that apply):
       - ❑ Counseling
       - ❑ Education

❑ Medical Treatment
❑ Testing
❑ Other, please explain ____
____
____

45. Does your outpatient treatment program provide educational services for adolescents?
❑ No
❑ Yes. If yes,
(a) please specify the educational services your outpatient treatment program provides (check all that apply) and how many hours per week adolescents participate in these services:

❑ GED classes	# hours per week ________
❑ High school classes	# hours per week ________
❑ Tutoring	# hours per week ________
❑ Other educational activities, please specify	# hours per week ________

____
____
____

(b) Are any of the educational services in your outpatient treatment program provided by teachers certified in special education?
❑ Yes
❑ No

46. Does your outpatient treatment program designate a staff person whose primary responsibility is to provide educational advocacy to facilitate or maintain an adolescent's school enrollment?
❑ Yes
❑ No

47. For those adolescents enrolled in school, does your outpatient treatment program coordinate with counselors or other school staff as part of an adolescent's treatment?
❑ Yes
❑ No

48. Does your outpatient treatment program provide vocational services to adolescents?
❑ Yes. If yes, what services are provided (check all that apply):
❑ Job placement services
❑ Vocational counseling/assessment
❑ Vocational training
❑ Other vocational services, please explain ________________________________
____
____

❑ No. If no, does your outpatient treatment program link adolescents to vocational services in the community?
  ❑ Yes
  ❑ No

49. Does your outpatient treatment program provide recreational activities for adolescents:
❑ No
❑ Yes. What recreational activities are provided:
  ❑ Informal recreation time
  ❑ On-site game room/computer room
  ❑ On-site gym facilities
  ❑ Off-site gym facilities
  ❑ Other off-site recreational trips
  ❑ Structured/organized recreation groups
  ❑ Other recreational activities, please explain ______________________________

FAMILY INVOLVEMENT

50. Does an adolescent's admission to your outpatient treatment program require parental consent?
❑ No
❑ Yes. Are there circumstances when parental consent is not required for admission?
  ❑ No
  ❑ Yes. Please explain: ______________________________

51. During intake, does your outpatient treatment program interview (check all that apply):
❑ An adolescent alone
❑ Parents/caregivers alone
❑ Adolescent and parents/caregivers together

52. Does your outpatient treatment program have a confidentiality policy?
❑ No
❑ Yes. (a) If yes, may we have a copy of this policy?
(b) Is the policy communicated to (check all that apply):
  ❑ Adolescents
  ❑ Parents/caregivers
(c) How is the policy communicated (check all that apply):
  ❑ Verbally by a staff person
  ❑ Through literature
  ❑ Other, please explain: ______________________________

53. Does your outpatient treatment program provide the following services to families/caregivers of adolescents (check all that apply):
- ❑ Family counseling/treatment
- ❑ Family support groups
- ❑ Outreach to family members
- ❑ Parent/caregiver support groups
- ❑ Sibling psycho-educational groups
- ❑ Sibling support groups
- ❑ Other, please explain ______________________________

AFTERCARE SERVICES

54. Does your outpatient treatment program provide aftercare planning for adolescents completing the program?
- ❑ No
- ❑ Yes. If yes,
  (a) do adolescents participate in the development of their own aftercare plan?
  - ❑ No
  - ❑ Yes. Please describe the planning process

  (b) Does your outpatient treatment program designate a staff person to follow-up on aftercare plans for adolescents completing the program?
  - ❑ No
  - ❑ Yes

55. What aftercare services does your outpatient treatment program provide (check all that apply)?
- ❑ Educational support services (advocacy, tutoring, etc.)
- ❑ Family support groups
- ❑ Home visits
- ❑ Linkage to health care/insurance
- ❑ Mental health services
- ❑ Mentoring
- ❑ Outpatient substance abuse treatment referrals
- ❑ Peer support groups
- ❑ Recreational activities ______________________________
- ❑ Vocational support services (training, job placement, etc.)
- ❑ Other, please explain ______________________________

56. Are there any ways you would like to enhance the services you offer to adolescents? What are the barriers to implementing these changes?

____
____
____
____
____
____

STAFF TRAINING

57. Does your outpatient treatment program require staff to receive training in the following:
   - ❑ Adolescent development
   - ❑ Adolescent sexuality
   - ❑ Adolescent treatment
   - ❑ Engaging adolescents in treatment
   - ❑ Family engagement
   - ❑ Family treatment
   - ❑ HIV/AIDS
   - ❑ Substance abuse prevention
   - ❑ Substance abuse relapse prevention
   - ❑ Other, please explain ____

____
____

58. Does your outpatient treatment program require substance abuse treatment staff to be recovering alcohol or drug users?
   - ❑ No
   - ❑ Yes

59. What proportion of your substance abuse treatment staff have graduated from your program or another treatment program?
   - ❑ Less than 5%
   - ❑ 5-10%
   - ❑ 11-35%
   - ❑ 36-50%
   - ❑ More than 50%

60. Does your outpatient treatment program employ staff to provide treatment in the following languages:
   - ❑ Chinese
   - ❑ Russian
   - ❑ Spanish
   - ❑ Other, please specify ____

____
____

STAFF LEVELS AND FUNDING

61. Please indicate the staff positions in your outpatient treatment program and number of full-time (FT) and part-time (PT) staff in each position.

______________________________	FT ________	PT _________
______________________________	FT ________	PT _________
______________________________	FT ________	PT _________
______________________________	FT ________	PT _________
______________________________	FT ________	PT _________
______________________________	FT ________	PT _________
______________________________	FT ________	PT _________
______________________________	FT ________	PT _________
______________________________	FT ________	PT _________
______________________________	FT ________	PT _________
______________________________	FT ________	PT _________

62. Please estimate the proportion of staff with the following professional licenses or certification:

❑ C.A.S.A.C. ________%	❑ Other ________________________________%
❑ M.D.______________%	❑ Other ________________________________%
❑ C.S.W. ___________%	❑ Other ________________________________%
❑ Ph.D. ____________%	❑ Other ________________________________%

63. What proportion of funding for your outpatient treatment program is derived from:

❑ Patient Fees	______%	❑ State Funds	________%
❑ Public Insurance Reimbursement (Child Health Plus A/Medicaid) (Child Health Plus B) (Family Health Plus)	______%	❑ State Deficit Funding	________%
❑ Commercial Insurance Reimbursement	______%	❑ City Funds	________%
❑ Federal Funds	______%	❑ City Deficit Funding	________%
❑ Private Funds	______%	❑ Other, please explain:	

____

____

____

64. May we have a copy of the patient fee schedule used by your outpatient treatment program?

Thank you for your time. We will send you a copy of our final report.

APPENDIX C

QUESTIONS PRESENTED TO TEEN FOCUS GROUPS

Who Are The Participants and What Is Their Substance Abuse History?

How old are you?

What drugs/alcohol were you using before you entered treatment?

How were you referred to treatment? (family, court mandate, school referral, etc.)

Before coming here, did you know about substance abuse treatment programs? Did you know where to go for help with your drug/alcohol use problems? Do you think other teenagers know?

How long have you been participating in treatment at ___________?

Were you in treatment before you came to _______? Why did you leave?

Other than family members, do you participate in treatment with adults? Can you describe your experience in participating in treatment with adults?

Do you feel comfortable talking to your counselors about drug or alcohol use? About other issues of concern to you?

Do you participate in the development of your treatment goals and plans? How?

Do you receive information about the affects of drug or alcohol use on your body, mind, and relationships? How is it provided?

Do you think what you are getting from treatment helps you as a teenager who has used drugs or alcohol?

Family

Is your family involved in your treatment at ___________? Were they involved from the beginning?

Do any of your family members have a history of alcohol or drug abuse?

As a result of your treatment, how has your relationship with your family changed?

What circumstances encourage or make it difficult for your family to participate in treatment?

Education

Were you attending school when you entered treatment at _________?

What kind of educational services do you receive while participating in treatment?

Have your educational goals changed since you began treatment at __________? How?

If you think you may have health problem (HIV/AIDS, sexually transmitted disease, pregnancy), would you be able to get health services at ____________?

Support Services

Would it be helpful to have many services (substance abuse treatment, health, mental health, vocational) for teenagers incorporated into one program?

In addition to substance abuse treatment, what other services do you think treatment programs should offer teenagers?

Life After Treatment

Have you been connected by your counselor or other staff to services or programs in your community?

What concerns do you have about leaving treatment?

What about treatment will help you remain drug or alcohol free when you leave here?

Would you like to keep in touch with _______ after you complete treatment here?

What would help more teenagers using drugs and alcohol get help?

NOTES

NOTES

NOTES

CITIZENS' COMMITTEE FOR CHILDREN OF NEW YORK IS AN INDEPENDENT NON-PROFIT ORGANIZATION THAT SEEKS TO ENSURE THAT EVERY CHILD IS HEALTHY, HOUSED, EDUCATED AND SAFE.

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ABOUT CCC

Citizens' Committee for Children of New York (CCC) is an independent voice for New York City's children. CCC champions children who cannot vote, lobby, or act on their own behalf, especially those who are poor, have special needs or are particularly vulnerable. Our goal is to secure the rights, protections and services children deserve. Many of our activities directly affect the lives of individual children but most of our efforts are spent identifying the causes and effects of disadvantage and poverty, promoting the development of services in the community and working to make public and private institutions more responsive to children. CCC is unique among child advocacy organizations in that citizen members and staff work side-by-side assuming the roles of spokesperson, researcher, coordinator and watchdog for the City's children. Our staff and members include specialists in health, mental health, education, child care, housing, homelessness, income security, child welfare, juvenile justice and child and youth development.

CCC educates New Yorkers about children's issues, publishes reports and papers, collects and disseminates data, provides technical assistance and support to policymakers, service providers, parent and civic groups and monitors the implementation of federal, state and local policies. CCC directs its attention to budgets, legislation, regulations and management of children's programs. CCC provides a community presence by monitoring the availability and quality of services to children and families in New York City neighborhoods. CCC creates and joins coalitions, brokers competing interests and develops action plans to improve conditions for children. CCC helps New Yorkers turn their personal concern for children into action through our Community Leadership Course.

Kids First, New York is a citywide effort to mobilize parents, professionals, policymakers and other citizens to improve conditions for all New York City children. The Kids First, New York campaign adds another dimension to CCC's work to ensure that every child is healthy, housed, educated and safe.

CCC is a non-profit organization supported by individuals, foundations and corporations since 1944.