Substance Abuse Treatment Needs of Adolescents in Southwest Ohio

The Health Foundation of Greater Cincinnati with Deloitte Consulting

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# Table of Contents

For More Information ................................................................. vii

Acknowledgements ........................................................................ ix

Introduction ...................................................................................... 1
  Ohio’s Expenditures for Substance Abuse Treatment ........................................ 2
  Overview of the Fourteen-County Region .................................................. 3

Primer on Adolescent Substance Abuse Treatment ................................. 7
  Specialized Needs of Adolescents versus Adults ........................................ 7
  The Adolescent Substance Abuse Treatment Continuum ......................... 8
  Assignment of Adolescents to the Treatment Continuum ......................... 9

Adolescents in Need of Treatment ..................................................... 13
  Estimated Adolescent Substance Use Rates in the Nation .......................... 14
  Estimated Adolescent Substance Use Rates in the Fourteen-County Region .... 16
  The Disparity between Prevalence and Treatment .................................... 18
  Disparities in the Fourteen-County Region ............................................. 19
  The Effects of Untreated Adolescent Substance Abuse ............................ 20
    Economic Effects .............................................................................. 21
    Individual Effects ........................................................................... 22
    Future Effects ............................................................................... 23

Local Treatment and Gaps .................................................................. 25
  Treatment Programs Currently Offered ................................................. 25
  Adding and Enhancing Local Treatment Services ................................... 27
    Planning ......................................................................................... 28
    Prevention ..................................................................................... 29
    Treatment ..................................................................................... 29
    Aftercare ....................................................................................... 29

Current Funding Picture ................................................................. 31
  General Funding Issues ...................................................................... 31
    Allocation Is Based on Population Rather than Need ............................. 32
    Payments to Boards Typically Lag Payouts to Providers ...................... 33
    State General Revenue Funds Have Decreased ................................... 34
  Medicaid and Insurance Coverage ....................................................... 34
    Medicaid Coverage Is Limited to Certain Types of Treatment .............. 35
    Medicaid Payment Schedules Are One-Size-Fits-All .......................... 36
    Limits on Private Insurance ............................................................. 36
<table>
<thead>
<tr>
<th>Contents</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Public Views Substance Abuse as a Moral Issue rather than a Health Issue</td>
<td>37</td>
</tr>
<tr>
<td><strong>Current Capacity, Collaboration, and Data Issues</strong></td>
<td>39</td>
</tr>
<tr>
<td>Capacity</td>
<td>39</td>
</tr>
<tr>
<td>Waiting Lists Exist for Many Adolescent Services</td>
<td>39</td>
</tr>
<tr>
<td>Out-of-County Placement Affects Treatment Success</td>
<td>40</td>
</tr>
<tr>
<td>Few Residential Treatment Programs Exist</td>
<td>40</td>
</tr>
<tr>
<td>Lack of Transportation Affects Treatment Participation</td>
<td>41</td>
</tr>
<tr>
<td>Adolescent vs. Adult Treatment Models</td>
<td>41</td>
</tr>
<tr>
<td>Regions Lack Financial and Human Resources to Establish Adolescent-Specific Programs</td>
<td>41</td>
</tr>
<tr>
<td>Lack of Staff with Education in Adolescent-Specific Treatments</td>
<td>41</td>
</tr>
<tr>
<td>Dually Diagnosed Adolescents</td>
<td>42</td>
</tr>
<tr>
<td>Funding and Treatment Requirements Restrict Simultaneous Access to Both Types of Care</td>
<td>42</td>
</tr>
<tr>
<td>Referral Sources Drive the Type of Treatment Prescribed</td>
<td>43</td>
</tr>
<tr>
<td>Staff Are Not Educated in Dual-Diagnosis Identification and Treatment</td>
<td>43</td>
</tr>
<tr>
<td>Collaboration and Service Integration across Regions and Systems</td>
<td>43</td>
</tr>
<tr>
<td>Services Are Not Integrated Across Child-Serving Systems</td>
<td>43</td>
</tr>
<tr>
<td>Services Are Not Integrated Across Geographic Boundaries</td>
<td>44</td>
</tr>
<tr>
<td>Parental Distrust Can Affect Collaboration</td>
<td>44</td>
</tr>
<tr>
<td>Data Gaps and Standardization</td>
<td>44</td>
</tr>
<tr>
<td>Only Some Providers Have Implemented the Behavioral Module of MACSIS</td>
<td>45</td>
</tr>
<tr>
<td>The Claims Processing and Behavioral Modules Are not Linked</td>
<td>45</td>
</tr>
<tr>
<td>MACSIS Does not Accurately Capture Episode Data</td>
<td>46</td>
</tr>
<tr>
<td>Treatment Categories Are not Used Consistently</td>
<td>46</td>
</tr>
<tr>
<td>Lack of Standardized Operational Data</td>
<td>46</td>
</tr>
<tr>
<td><strong>Next Steps</strong></td>
<td>47</td>
</tr>
<tr>
<td>Policy and Funding</td>
<td>47</td>
</tr>
<tr>
<td>Data Collection Framework for Adolescent Substance Abuse Prevalence and Treatment</td>
<td>47</td>
</tr>
<tr>
<td>Coordination of Mental Health and Substance Abuse Treatment Services and Funding</td>
<td>47</td>
</tr>
<tr>
<td>Establish and Support Best Practice Models</td>
<td>48</td>
</tr>
<tr>
<td>State General Funds</td>
<td>48</td>
</tr>
<tr>
<td>Expand Medicaid Coverage</td>
<td>48</td>
</tr>
<tr>
<td>Multi-System Coordination and Collaboration</td>
<td>48</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>48</td>
</tr>
<tr>
<td>Conclusion</td>
<td>49</td>
</tr>
<tr>
<td><strong>References</strong></td>
<td>51</td>
</tr>
<tr>
<td>Adolescent Substance Abuse Treatment Planning Reports from the Boards</td>
<td>51</td>
</tr>
<tr>
<td>General References</td>
<td>51</td>
</tr>
</tbody>
</table>
Appendix: Demographics of the Fourteen-County Region ...... 55
Education ................................................................................................... 55
Median Income .......................................................................................... 56
Adolescent Poverty Rates ............................................................................. 56
Adolescent Birthrates .................................................................................. 57
Demographics of Adolescents Treated for Substance Use Disorders .......... 58
Sex Differences ........................................................................................ 59
Ethnic Differences .................................................................................... 60
Cultural Differences .................................................................................. 62
Urban and Rural Differences ........................................................................ 62
Age Differences ....................................................................................... 64

Meet the People Involved
Throughout this paper, we have included stories of people who interact with the substance abuse treatment system in a variety of ways. By sharing their stories, we hope to further illustrate the issues that arise when these systems interact. All of these stories are based on real individuals; however, some names have been changed to protect privacy.

Meet Carrie ................................................................................................... 5
Meet David ................................................................................................. 21
Meet Bethany .............................................................................................. 35
Meet John .................................................................................................. 41

Table of Illustrations
Figure 1: The 14-county Southwest Ohio region under review ..................... 1
Figure 2: The burden of substance abuse ($2.9 billion) across Ohio’s state programs .......... 3
Figure 3: Adolescent population and treatment rates for Ohio and the 14-county region, 2000 ................................................................. 4
Figure 4: Reported substance abuse treatment cases per 1,000 adolescents, 1999 ............. 4
Table 1: Definitions of treatment programs in the adolescent treatment continuum .......... 9
Figure 5: Steps to entering an adolescent with a substance use disorder into treatment .......... 10
Figure 6: The substance use and treatment continua ....................................... 11
Figure 7: Adolescent population as a percentage of total population in the U.S., Ohio, and 14-county region, 2000 .......................................................... 13
Figure 8: Estimated growth for the U.S. adolescent population, 1995-2010 .................... 14
Figure 9: Junior and senior high school students reporting drinking beer ................. 14
Figure 10: High school students reporting current alcohol use ............................ 15
Figure 11: Junior and senior high school students reporting illicit drug use ............... 15
Figure 12: Results of the Butler County ADAS 2000-2001 Survey .......................... 16
Figure 13: Greater Cincinnati students reporting monthly alcohol use .................. 17
Figure 14: Greater Cincinnati students reporting marijuana use ............................ 18
Figure 15: Prevalence of adolescent substance use vs. adolescents treated for substance use disorders, 2000 ................................................................. 19
Figure 16: Number of adolescents treated for substance use disorders by board regions, 1998-2001 ................................................................. 20
Table 2: Adolescent treatment services currently provided, by board ...................... 26
Table 3: Adolescent treatment services that need to be added or enhanced, by board region ................................................................. 28
Figure 17: Sources of funding for substance abuse treatment services .............................................. 32
Figure 18: High school dropout rates by region, 1995-1998 ................................................................. 55
Figure 19: High school graduation rates by region, 1997-2000 ............................................................ 56
Figure 20: Median income for U.S., Ohio, and county board regions, 1997 ........................................ 56
Figure 21: Percentage of adolescents living below poverty ................................................................. 57
Figure 22: Percentage of total births to female adolescents (ages 10-19), 1995-1999 ................................................................. 58
Figure 23: Adolescents treated for substance use disorders per 1,000 adolescents, 1999 .................... 58
Figure 24: Adolescent males comprising substance abuse cases vs. adolescent male population, 1999 ................................................................. 59
Figure 25: Adolescent population by ethnicity, 2000 ................................................................. 61
Figure 26: Adolescents treated for substance use disorders by ethnicity, 1999 ................................. 61
Figure 27: Adolescents treated for substance use disorders by age and region, 1999 ..................... 64
In 1997, The Health Foundation of Greater Cincinnati began a multifaceted project to identify the health issues and assess the healthcare needs of the Cincinnati area, encompassing 20 counties in Ohio, Kentucky, and Indiana (see the figure below).

Through this process, the Health Foundation identified four focus areas in which to concentrate its grantmaking efforts:

- Strengthening Primary Care Providers to the Poor
- School-Based Child Health Interventions
- Substance Abuse
- Severe Mental Illness

The Substance Abuse focus area has two strategies: Improving Adolescent Treatment Services Capacity across the Continuum of Care and Improving Community-Based Prevention Activities through the Use of Evidence-Based Best Practices. This report comes out of the work in the Adolescent Treatment Services strategy.

For more information about the Health Foundation, our grantmaking interests, or this paper, please contact us at (513) 458-6600 or toll-free at (888) 310-4904. This report and others, as well as information about the Foundation’s grantmaking interests, can also be found at http://www.healthfoundation.org.
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The Health Foundation of Greater Cincinnati with Deloitte Consulting
Introduction

The use of alcohol and other drugs by Ohio adolescents ages 12–17 remains high at approximately 15.8% (Wright & Davis, 2000). However, data provided by regional alcohol and drug addiction services boards indicate treatment services are inadequate to reduce adolescent substance use. Roughly 8% of adolescents who abuse alcohol and other drugs are being treated. Most of these treatment programs were designed for adults and do not take into account the unique physical, mental, and social needs of adolescents. And while counties are trying to improve the array of services provided to adolescents, they face barriers such as limited funds and a lack of qualified staff.

In December 2001, The Health Foundation of Greater Cincinnati contracted with Deloitte Consulting to complete an analysis of the adolescent-specific strategic plans of seven regional boards covering a 14-county region of Southwestern Ohio (see Figure 1).

Key Points for the Section
- Approximately 8% of adolescents who abuse alcohol and other drugs are being treated.
- For every dollar spent on substance abuse treatment and prevention, $7 are saved in healthcare costs.
- On average nationally, only 4% of a state’s substance abuse expenditures went directly toward substance abuse treatment and prevention, while 96% was spent on other systems paying for substance abuse, such as criminal justice, education, public safety, and health.
- In 1998, Ohio spent $2.9 billion (10.2%) of its total budget on substance abuse-related expenditures.
The analysis focused on the balance between the need for services in the 14-county region and the infrastructure and services available to address this need. Specifically, this report:

- reviews the current need for services in the 14-county region,
- assesses the current services provided and service gaps in the 14-county region,
- reviews the facilitators and barriers to improving the services provided, and
- recommends “next steps” for closing the gap in adolescent treatment services and infrastructure.

The adolescent substance abuse treatment strategic plans used for this analysis were developed under individual Health Foundation grants to the seven local Alcohol and Drug Addiction Services (ADAS) or Alcohol, Drug Addiction and Mental Health Services (ADAMHS) boards that oversee the 14-county region. The plans included a needs assessment, services review, and immediate-term strategic objectives for each regional board. Deloitte Consulting also used additional data sources—including national and state reports, surveys, and interviews—to complete the picture of adolescent substance abuse.

Ohio’s Expenditures for Substance Abuse Treatment

For every dollar spent on substance abuse treatment and prevention, $7 are saved in healthcare costs (Ohio Department of Alcohol and Drug Addiction Services [ODADAS], 1996). Yet, the bulk of Ohio’s expenditures on substance abuse are spent on the side effects of substance abuse—like healthcare, remedial education, and crime—rather than prevention, early intervention, and treatment. This is a reactive rather than proactive approach. Without prevention and treatment, the economic impact of substance abuse will remain high.

A national study conducted by the National Center on Addiction and Substance Abuse (CASA) at Columbia University (2001) found that of the $620 billion spent by state governments in 1998, $81.3 billion (13.1%) were directly or indirectly linked to substance abuse and addiction. Of these funds, approximately $25 billion were attributable to adolescent substance abuse.
On average nationally, only 4% of a state’s substance abuse expenditures went directly toward substance abuse treatment and prevention, while 96% was spent on other systems paying for substance abuse, such as criminal justice, education, public safety, and health (National Center on Addiction and Substance Abuse at Columbia University [CASA], 2001).

In 1998, Ohio spent $2.9 billion (10.2%) of its total budget on substance abuse-related expenditures (see Figure 2). Of this, Ohio spent only $42 million (1.4%) on substance abuse prevention, treatment, and research—less than 2¢ per dollar. The remaining expenditures were spent on the many programs, such as criminal justice, mental health, education, and health, that are affected by untreated or ineffectively treated substance abuse (CASA, 2001).

![Figure 2: The burden of substance abuse ($2.9 billion) across Ohio's state programs]

Overview of the Fourteen-County Region

In 2000, the 14 counties in this study comprised approximately 15% (294,739) of Ohio’s total adolescent population between the ages of 10 and 19 (U.S. Census Bureau, 2000). Proportionally, the 14-county region accounted for 14% of Ohio’s 14,072 adolescent substance abuse treatment cases in 2000 (ODADAS, 1999) (see Figure 3). Thus, the 14-county region is proportionally representative of Ohio in terms of both
the adolescent population and the number of adolescents treated for substance use disorders.

Sources: U.S. Census Bureau, 2000, and ODADAS, 1999

The 14-county region ranged from 1 reported substance abuse treatment case per 1,000 adolescents in Warren and Clinton Counties to almost 20 reported cases per 1,000 adolescents in Paint Valley (see Figure 4).

Further analysis of the 14-county region (see Appendix for detailed information) indicates the region is also similar to Ohio and the U.S. in overall adolescent demographics.

- 6 of the 14 counties represent rural areas (city populations of less than 50,000 people).
- 8 counties have small metropolitan areas (cities of 50,000 to 1 million people).
- The ratio of male to female adolescents is approximately 50:50.
More than 60% of adolescents are white.

Median household incomes range between $35,000 and $45,000, compared to an Ohio median of approximately $36,000 and a U.S. median of approximately $39,000.

Notable demographic differences include:

- The 14 counties have a high school graduation rate of about 80%, compared to a 90% graduation rate for all of Ohio.
- Butler, Clinton, and Warren Counties have only 10% of adolescents living in poverty compared to 20% for Ohio and the U.S.
- Less than 5% of the adolescent population in 13 of the counties is comprised of ethnic minorities, while about 35% of the adolescent population in Hamilton County, the state of Ohio, and the U.S. represent ethnic minorities.
- In 10 of the 14 counties, almost 20% of adolescent females give birth, compared to the Ohio average of 14%.

The findings in this document related to current demand for services, service gaps, and infrastructure gaps are likely to be representative of the broader needs of other counties and regions in Ohio as well as the state as a whole.

The remainder of this report describes the current opportunities and challenges related to adolescent substance abuse treatment in this 14-county region and in Ohio. It also outlines steps that can be taken to maximize the success of adolescent substance abuse treatment and prevention programs. These steps will not only help youths and families in need, they will enable Ohio to minimize the costs and effects of substance abuse to taxpayers and society.

Meet Carrie

Carrie is only 17 years old and has already been through more in her life than most people twice her age. She is an admitted alcoholic and has done every drug of abuse imaginable. She hates being addicted to alcohol and other drugs, but she is, and all she wants is someone to help her. She really wants to get into a treatment program, but she is too embarrassed. The philosophy among her peers is that nobody goes to a treatment facility unless they are forced to go by judicial authorities. In her own high school, Carrie knows at least 10 other kids her age who have serious substance abuse problems. But nobody is aware that they need help.
Primer on Adolescent Substance Abuse Treatment

The adolescent substance use continuum begins with abstinence and moves from use to abuse to addiction. The frequency and volume of consumption and the consequences of use determine whether an adolescent is a casual user or an addict. The consequences can include increased violence, depression, and emotional withdrawal. By the time a person reaches the addiction stage of the continuum, his or her brain chemistry has been altered and he or she has difficulty recovering without treatment. Because adolescents are at a critical stage of physiological development, any use—however minor or infrequent—can have serious physical and mental effects on the adolescent.

Key Points for the Section
- Adolescents with substance use disorders can be described as users, abusers, or addicts depending on the frequency of use, length of time frequency has been maintained, the consequences of such use, and the family history of substance use.
- Adolescents with substance use disorders are typically treated with the same types of programs as adults. This fails to take into account the unique physiological, psychological, and environmental needs of adolescents. Consequently, adolescents often relapse after treatment.
- Adolescents should be treated based on multiple factors including current usage levels, family support, and peer environment.

Specialized Needs of Adolescents versus Adults

Quite often, adolescents with substance use disorders are treated as if they were “little adults” and receive the same assessment and treatment protocols as adults. However, adolescents differ greatly from adults in their physiological development, cognitive abilities, emotional and psychosocial development, values and belief systems, and dependence on family and peers.

In fact, these characteristics vary among adolescents depending on age. As a result, a 13-year-old should be treated differently than an 18-year-old. For example, young adolescents tend to think only about the present without realizing or acknowledging the potential consequences of their acts. Older adolescents are more aware of potential consequences but are willing to take risks. They are motivated by the need to be accepted among peers of both sexes. To be most effective, the substance abuse treatment for these youths would take these motivational differences into account.

Failure to recognize and accommodate the specific needs of adolescents may actually do more harm than good by not
correcting the underlying environmental, psychosocial, or physiological factors that are sustaining the disorder. Adolescent programs are more successful when they take into account the environment—including family and peer interactions—that affects the disorder.

The Adolescent Substance Abuse Treatment Continuum

In an ideal system, providers would offer an array of treatment programs to adolescents with substance use disorders. However, demand and cost constraints limit which treatment programs are actually provided in a given community.

Programs for adolescents range from prevention programs that are relatively low in cost and intensity (i.e., time and frequency of participation required) to residential treatment programs that require long-term, full-time participation and are very costly. After any outpatient or more intensive treatment, individuals with a substance use disorder are usually involved in a continuing care (or “aftercare”) program that helps to prevent
Table 1: Definitions of treatment programs in the adolescent treatment continuum

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<thead>
<tr>
<th>Treatment Program</th>
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<tr>
<td>Prevention</td>
<td>Prevention programs encourage adolescents to abstain from substance use. Prevention is a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles.</td>
</tr>
<tr>
<td>Early Intervention</td>
<td>Early intervention programs are targeted to adolescents who have begun using one or more substances. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), these programs are usually delivered by non-specialists or paraprofessionals, emphasize self-help and self-management, reach large numbers of individuals, and are considerably less expensive than programs found later in the continuum (Winters, 1999).</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Outpatient treatment is the most common treatment provided to adolescents, includes a broad range of options, and does not require overnight stays. The intensity of treatment varies by the time commitment required. Professional counseling can last from 1 to 9 hours per week. Day treatment—or partial hospitalization—includes a combination of individual, group, and family therapy ranging from a few hours per week to focused sessions up to five days per week.</td>
</tr>
<tr>
<td>Detoxification</td>
<td>Detoxification is reserved for adolescents who are under the influence at the time of their initial assessment and require medical monitoring as they stop using an addictive substance (e.g., alcohol, cocaine, valium). This treatment typically involves a 3-5 day inpatient program with 24-hour intensive medical monitoring and management of withdrawal symptoms. Although adolescents often do not experience physiological withdrawal symptoms, certain situations may warrant adolescent detoxification (Winters, 1999).</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Inpatient treatment includes 24-hour intensive medical, psychiatric, or psychosocial treatment under the supervision of a trained professional.</td>
</tr>
<tr>
<td>Residential</td>
<td>Residential treatment is a specific type of 24-hour treatment that involves group home therapy with other adolescents who suffer from substance use disorders. Adolescents may be assigned to residential treatment for as little as 30 days to as long as 1 year.</td>
</tr>
<tr>
<td>Continuing Care or &quot;Aftercare&quot;</td>
<td>When youth first return to family, peers, and their neighborhood after completing treatment, they are at high risk for relapse (Winters, 1999). Therefore, they participate in aftercare programs to reduce this risk. These programs, which are usually structured and time-limited group activities, help adolescents move back to their routine environment.</td>
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Assignment of Adolescents to the Treatment Continuum

When adolescents with substance use disorders seek treatment, whether voluntarily or because of a mandate from another entity such as the criminal justice system, they initially undergo an assessment. This assessment, usually performed by a counselor or social worker, evaluates the adolescent’s substance use as well as any factors that affect that use. Based on the assessment, the counselor or social worker assigns the adolescent to the most appropriate available treatment program(s) and the adolescent enters the substance abuse treatment continuum (see Figure 5). For example, an early stage addict may be assigned to outpatient treatment. However, an early stage addict who lives with an adult...
addict may be assigned to a residential treatment program so that the adolescent is temporarily removed from an environment not conducive to recovery.

Un fortunately, relapse is common among adolescents and should not be viewed as failure. Rather, it is a part of the early recovery process that needs to be factored into the treatment plan. Relapse should be viewed by treatment professionals as an opportunity for learning; for example, it can help teach young people that they do not have control over their substance use (Winters, 1999).

The different stages of substance use generally (although not always) correspond with one part of the treatment continuum. For example, detoxification and residential treatment programs are generally used for adolescents who are in the addiction stage. However, adolescents who are in the abuse stage and who are under the influence at the time of an assessment may be initially assigned to a detoxification program before receiving outpatient treatment.

Just as the treatment required increases in intensity (i.e., time and one-on-one interaction) with the increased level of abuse, the costs of the treatment episodes also increase dramatically. It is much less expensive to identify and treat an adolescent with a substance use disorder early in the development of the disorder.
rather than later, when inpatient or residential treatment is required (see Figure 6).

* A treatment episode is the prescribed treatment length for a particular adolescent, which varies with each case. The cost data provided here are average estimates and assume that a treatment episode involves the following average time spans: early intervention—10 hours; outpatient—12 1-hour sessions; intensive outpatient—3 hours per day for 30 days; inpatient—8 days; residential—90 days. Data for early intervention, outpatient, and residential treatment were provided by Hamilton and Butler Counties. Data for inpatient treatment were provided by the Substance Abuse and Mental Health Services Administration [SAMSHA], 2000.
Adolescents in Need of Treatment

According to 2000 U.S. Census data, there are approximately 40 million adolescents (10-19 years of age) in the U.S., representing 14.3% of the total U.S. population. By contrast, the percentages for Ohio and the seven board regions are up to 1% higher (see Figure 7). This indicates that Ohio and each of the boards studied in this report may experience more cases and expenses associated with adolescent substance abuse treatment than the national average.

Figure 7: Adolescent population as a percentage of total population in the U.S., Ohio, and 14-county region, 2000

Key Points for the Section
- Ohio represents 4% of the U.S. adolescent population, but 7% of the U.S. adolescent substance abuse cases.
- Studies indicate that the prevalence of substance use is much greater than the number of cases treated annually. Only 5% of Ohio adolescents with substance use disorders are treated.
- The U.S. spends over $414 billion per year on the effects of untreated addiction to alcohol and other drugs.
- Alcohol-related accidents are the number one killer of teens.
- When left untreated, adolescent substance abuse can cause several serious problems including:
  - suicide
  - physical diseases
  - failure in school and work
  - crime

The U.S. adolescent population is expected to grow 4.3% to almost 41.5 million adolescents by 2005 and then level off through 2010 (see Figure 8). As the adolescent population grows, the prevalence and associated social and economic costs
Adolescents in Need of Substance Abuse Treatment

of substance use disorders can be expected to grow proportionally if current substance usage rates continue.

Source: U.S. Census Bureau, 2000

**Estimated Adolescent Substance Use Rates in the Nation**

According to the 2000-2001 PRIDE survey of 75,804 junior and senior high students across the nation, the usage rates of alcohol and other drugs among these students are high (PRIDE, 2001) (see Figure 9).

![Figure 9: Junior and senior high school students reporting drinking beer](image)

Overall, an estimated 14.8% of adolescents—or 5.8 million adolescents—in the U.S. meet criteria for a substance use disorder (Substance Abuse and Mental Health Services Administration [SAMHSA], 1999). In addition, alcohol consumption by minors accounts for 25% of all alcohol
consumed in the U.S. Currently, 8 million high school students use alcohol (CASA, 2002) (see Figure 10).

![Figure 10: High school students reporting current alcohol use](chart10)

Source: CASA, 2002

Illicit drug\(^1\) use among junior and senior high students is also high, although growth in usage seems to have slowed since the alarming increases seen in the mid-1990s (Office of National Drug Control Policy, 2001) (see Figure 11).

![Figure 11: Junior and senior high school students reporting illicit drug use](chart11)

\(^1\) Illicit drugs include: marijuana, cocaine, amphetamines, barbiturates, inhalants, hallucinogens, narcotics, and steroids.

Source: Office of National Drug Control Policy, 2001

The 1999 National Household Data Survey conducted by SAMHSA indicates that prevalence of adolescent substance use in Ohio is similarly high. According to the survey, 15.8% of Ohio youth ages 12 to 17 reported using alcohol in the past 30 days, with 10% of the total youths reporting binge drinking (drinking five or more drinks on at least one occasion). It should be noted that the Ohio rate is 1% higher than national estimates of 14.8%. Meanwhile, 6.9% of Ohio adolescents reported smoking marijuana in the past month (Wright & Davis, 2000).
Estimated Adolescent Substance Use Rates in the Fourteen-County Region

At the local level, if Ohio prevalence estimates hold true, 46,569 adolescents in the 14-county region are abusing substances. No comprehensive surveys have been conducted for the entire 14-county region due in large part to the cost of administering and analyzing the results of such a survey. However, some county- and regional-level data exist.

The Butler County Alcohol and Drug Addiction Services (ADAS) Board (2001) conducted an adolescent substance use survey of 5,575 10th and 12th grade students from all public and parochial high schools in the county in 2000-2001 (see Figure 12).

Figure 12: Results of the Butler County ADAS 2000-2001 Survey

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

10th graders
12th graders

The 12th grade students in Butler County scored above national rates for annual prevalence of LSD use, and the 10th grade students scored above national rates for both LSD and marijuana use.

For its strategic plan, the Clermont County Mental Health and Recovery Board used the results of the 1997–1998 PRIDE survey of the 6th and 8th grade students in Clermont County. This survey found that marijuana, cocaine, LSD, and cigarette use among 6th and 8th grade students in the county within the year prior to the survey was higher than state and national rates. Additionally, Clermont County 6th and 8th grade students reported alcohol use at rates close to state and national averages (Clermont County Mental Health and Recovery Board, 1998).
The Coalition for a Drug-Free Greater Cincinnati (CDFGC) conducted a personal drug use survey in 2000, which collected data from 47,236 students in grades 7–12 in the Greater Cincinnati area. This survey found that alcohol continues to be the number one drug of choice among 7th through 12th grade students (see Figure 13).

The CDFGC survey also found that alcohol use was increasing. Regular use of alcohol among these students increased from 26% in 1999 to 30% in 2000. Students who reported use of alcohol were 3 times more likely to carry a gun, 4 times more likely to get into trouble with police, and 3 times more likely to be absent more than 10 days from school than students who reported no use of alcohol (Coalition for a Drug-Free Greater Cincinnati [CDFGC], 2000).

The CDFGC study indicated that regular usage rates of marijuana among 7th–12th grade students living in the Greater
Adolescents in Need of Substance Abuse Treatment

Cincinnati area remained constant from 1999 to 2000, but were still higher than national averages (see Figure 14).

![Figure 14: Greater Cincinnati students reporting marijuana use](image)

Source: Coalition for a Drug-Free Greater Cincinnati, 2000

Students who reported use of marijuana were 10 times more likely to carry a gun, 5 times more likely to carry another type of weapon, 7 times more likely to get into trouble with police, and 5 times more likely to be absent more than 10 days from school than students who reported no use of marijuana (CDFGC, 2000).

Most students in the Greater Cincinnati area reported using alcohol and other drugs at high school parties. “It’s everywhere,” one 11th grader said, talking about the abundance of alcohol. “And some of the parties you go to, that’s all it is—sitting around and drinking” (Pilcher, 2000).

The Disparity between Prevalence and Treatment

Although nearly 5.8 million American adolescents—or 14.8% of the total adolescent population—are currently estimated to be using alcohol or other drugs, only 3.4% receive treatment (Office of Applied Studies, 1999). According to the 1999 SAMHSA Treatment Episode Data Set (TEDS), the number of adolescent substance abuse cases treated in 1999 in the U.S. was 197,695—or 3 adolescents per 1,000 who have a substance use disorder.

Ohio estimates that 259,910 adolescents are binge drinking or abusing other drugs. However, in 2000, only 14,072 Ohio adolescents (or 5 adolescents per 1,000 with a substance use disorder) were treated (ODADAS, 2000). Although this
indicates that Ohio is doing better than the national average, there are still many adolescents with substance use disorders not receiving treatment.

Disparities in the Fourteen-County Region

At the local level, similar gaps were found during the boards’ strategic planning processes. The number of adolescents estimated to be using alcohol and other drugs is approximately 158 adolescents per 1,000 in the 14-county region. However, the number of adolescents treated for substance use disorders is significantly lower, ranging between 1 and 12 cases per 1,000 adolescents (see Figure 15).

Adolescent treatment rates in the 14-county region varied greatly (see Figure 16). The Paint Valley region, Hamilton County, and Butler County treat the most adolescents with substance use disorders, probably due to the larger number of adolescents residing there. As described in the appendix, other demographic factors—such as rural and urban characteristics, ethnicity, and

Figure 15: Prevalence of adolescent substance use vs. adolescents treated for substance use disorders, 2000

* Data from Warren and Clinton Counties are from 1999.

Source: Adolescent Substance Abuse Treatment Strategic Planning Reports from the Boards, 2000 and 2001
sex—may also influence the number of adolescents treated in each region.

Clearly, the number of adolescents treated for substance use disorders is far lower than the number of adolescents who have reported they are using alcohol and other drugs. There are many reasons why the majority of adolescents with substance use disorders do not receive treatment. The following is only a partial list of reasons identified by the seven regional boards:

- lack of insurance coverage or limited coverage for substance abuse treatment, especially the associated family counseling, residential care, and detoxification;
- lack of knowledge about available treatment;
- unavailable nearby treatment;
- unwillingness to admit that there is a problem;
- parents who have substance use disorders themselves; and
- lack of transportation to treatment (especially in rural areas).

The Effects of Untreated Adolescent Substance Abuse[^3]

The age when adolescents start using alcohol and other drugs is a powerful predictor of later alcohol and other drug problems, especially if that use begins before age 15 (Schneider Institute for Health Policy, 2001). Substance abuse significantly harms adolescents physically and emotionally, both now and later when they become adults. It also contributes to many of the most serious and expensive problems in society today, including crime,
domestic violence, suicide, sexually transmitted diseases, unplanned pregnancy, fetal alcohol syndrome, and failure in school and the workplace.

**Economic Effects**

The economic cost of alcohol, tobacco, and other drug abuse is staggering, with the U.S. spending over $414 billion per year on untreated addiction. An estimated $166.5 billion were spent in 1995 on the effects of alcohol abuse (making alcohol the most costly drug of abuse) and $109.9 billion in costs were spent on the effects of other drug abuse. Of the money spent on alcohol abuse, 46% was spent on the costs associated with illnesses while the rest was spent on the side effects to society.

Of the money spent on drug abuse, 58% was spent directly on dealing with crime. In 1997, more than 2.5 million arrests were made for alcohol offenses and more than 1.5 million arrests were made for drug offenses. Overall, almost 75% of all prisoners in 1997 were involved with alcohol or drugs in some way in the time leading up to their arrest. Additionally, alcohol was found to be a key factor in up to 68% of manslaughters, 62% of assaults, 54% of murders and attempted murders, 48% of robberies, and 44% of burglaries. A majority of rapes, fights, and assaults leading to injury, manslaughter, and homicide involved drinking by the perpetrator, the victim, or both (Schneider Institute for Health Policy, 2001).

The health problems caused by alcohol and other drug abuse contribute significantly to the nation’s healthcare costs. In 1993, substance abuse cost society about $1,608 for every person in the U.S. In fact, 25–40% of all Americans in general hospital beds (i.e. not in a maternity or intensive care unit bed) are being treated for complications of alcoholism (National Clearinghouse for Alcohol and Drug Information [NCADI], 1994).

Untreated abuse of alcohol and other drugs is more expensive than three of the nation’s top 10 causes of death. It is:

- six times more expensive than America’s number one killer, heart disease;
- six times more expensive than diabetes; and
- four times more expensive than cancer (Schneider Institute for Health Policy, 2001).

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**Meet David**

David is a 16-year-old high school student who lives in Butler County. At the age of 13, David was put on academic probation for using marijuana. He was referred to treatment, which he attended sporadically and therefore was discharged. Two years later, he moved past marijuana and began daily use of alcohol, marijuana laced with opium, Xanax, and cocaine. David does not just use one of these drugs or only use them on the weekends—David uses a combination of different drugs every day of every week.
Some data are known about costs of underage drinking. According to research by CASA (2002), “the financial costs of underage drinking approach $53 billion in accidents, drowning, burns, violent crime, suicide attempts, fetal alcohol syndrome, alcohol poisoning and emergency medical care.”

**Individual Effects**

More than 100,000 deaths in the U.S. each year are attributable to excessive alcohol consumption (Schneider Institute for Health Policy, 2001). In addition:

- Alcohol-related car crashes are the number one killers of teens (NCADI, 1995).
- Suicide is the second leading cause of death among people 15–24 years of age, with high rates of alcohol involvement found among suicide victims (NCADI, 1994).
- Alcohol use is associated with homicides and drownings—the other two leading causes of death among youth (NCADI, 1995).
- More than 1,000 children die each year by inhaling the fumes of common household products (inhalants) to get high (NCADI, 1999).

Without treatment, alcohol and drug use can also have serious effects on the emotional and psychological well-being of adolescents. The abuse of alcohol and other drugs is associated with a variety of negative consequences, including school failure, accidents, violence, and suicide.

Alcohol and other drug use can impair adolescents’ ability to make judgments about sex and contraception, placing them at increased risk for unplanned pregnancy, sexual assault, or becoming infected with a sexually transmitted disease (including HIV).

Another risk linked to alcohol and other drug use is suicide. Suicide is now the second leading cause of death among people ages 15 to 24. One study found that 70% of young people who frequently used alcohol or other drugs attempted suicide (NCADI, 1995). Another study determined that 20-35% of suicide victims had a history of alcohol abuse or were drinking shortly before their suicides. Unfortunately, the role of substance abuse treatment in reducing suicides is often understated (NCADI, 1995).
School failure, including low grades and dropping out, is also associated with adolescent alcohol and other drug use. A National Clearinghouse of Alcohol and Drug Information (NCADI) study (1995) of students at two- and four-year colleges and universities reported these findings:

- At both two- and four-year institutions, the heaviest drinkers earned the lowest grades.
- Almost 33% of the students at four-year institutions reported missing class due to alcohol or other drug use.
- Nearly 25% of students reported performing poorly on a test or project due to alcohol or other drug use.
- Alcohol was a factor in 40% of all academic problems and 28% of all dropouts.

**Future Effects**

If these adolescents are not treated for their substance use disorders, it is very likely that they will have even larger problems as adults. Alcohol- and other drug-related problems in the workplace cost U.S. companies over $100 billion each year (NCADI, 1999b). Studies show that workers who abuse alcohol or other drugs:

- are far less productive,
- use three times as many sick days,
- are more likely to injure themselves or someone else, and
- are five times more likely to file worker’s compensation claims (NCADI, 1999b).

The use of alcohol and other drugs is also linked to a long list of other serious health problems. The National Institute of Drug Abuse (NIDA) (2000) research has shown that almost every drug of abuse—including alcohol—harms some tissue or organ. With more than 4 million adolescents under the legal drinking age consuming alcohol in any given month, alcohol is the drug most frequently used by 12- to 17-year-olds and is the one that causes the most negative health consequences. The long-term effects of heavy alcohol use include:

- vitamin deficiencies,
- stomach ailments,
- skin problems,
- sexual impotence,
- severe liver damage,
• heart and central nervous system damage, and
• memory loss (NCADI, 1999b).

Marijuana is the most widely used illicit drug in the United States and tends to be the third drug—after alcohol and nicotine—most often used by teens. The physical effects of marijuana use, particularly on developing adolescents, can be severe. Long-term effects of using marijuana include: an enhanced cancer risk, an increased infertility risk in both men and women, and psychological dependence requiring larger quantities of the drug to get the same effect (NCADI, 1999a).

Other drugs, such as cocaine, crack, and inhalants, also cause significant health problems in people who use them. In fact, many young people, including first-time users, are left with serious respiratory problems and permanent brain damage from the use of inhalants (Focus Adolescent Services, 1999).
Local Treatment and Gaps

While preparing their adolescent substance abuse treatment strategic plans, the seven regional boards outlined the services currently provided within their respective regions. They also indicated the specific gaps in their services as well as how they hope to improve adolescent services for their counties in the future.

**Treatment Programs Currently Offered**

As noted in the strategic plan developed jointly by two of the boards, “different programs use the same terminology with very different implications (i.e., outpatient treatment, case management) [making] it difficult to determine what services exactly are available to various populations and which of these are more effective than others” (Recovery Services of Warren and Clinton Counties and Paint Valley Alcohol, Drug Addiction and Mental Health Services Board, 2000). With such discrepancies within a few counties, it is even more difficult to compare services across

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**Key Points for the Section**

- Prevention, assessment, individual counseling, and group counseling services are offered by most of the boards.
- Most boards indicated the concern that adult models of services are being used to treat adolescents.
- All boards identified needs for treatment programs for dually diagnosed adolescents (substance use and mental health).
- Most boards also identified the need to increase the involvement of family and community in adolescent treatment programs.
- “Aftercare” services such as sober support groups and transition programs to reintroduce the adolescent to his/her home environment were also areas that were identified as needing improvement.
Local Treatment and Gaps

the 14 counties in this study. However, a general overview of adolescent services is provided (see Table 2).

Key:
● Adequate adolescent-specific services available in the board region
▲ Some adolescent-specific services available in the board region
.Down Very few or no adolescent-specific services available in the board regions
○ Only adult services available in the board region to treat adolescents

From Table 2, it becomes clear that there are certain adolescent-specific services provided within all board regions at some level:

• prevention (e.g., education, awareness),
• substance abuse assessments, and
• non-intensive outpatient services (including individual counseling and group counseling).

Source: Adolescent Substance Abuse Treatment Planning Reports from the Boards, 2000 and 2001
Availability is less consistent for intensive outpatient treatment and aftercare programs. Services that are typically not provided or are available on a limited scale include:

- assessment and treatment of dually diagnosed adolescents (i.e., those with co-occurring substance use disorders and mental illnesses),
- family counseling,
- intensive outpatient services and day treatment,
- detoxification,
- inpatient services,
- residential treatment,
- sober-support and self-help groups, and
- therapeutic schools.

### Adding and Enhancing Local Treatment Services

In reality, the “gaps” in treatment do not all need to be filled because not all counties need to provide all of these services. Some treatment, such as detoxification, is seldom required for adolescents. In addition, the adolescents in one region may predominantly fall into one particular part of the continuum of use, and the services funded by that board should meet the needs of those adolescents. When a resident requires a service not provided by his or her county, that county can send the resident to an out-of-county facility, preferably one close to home. This will allow family and friends to participate in treatment.

As part of the strategic planning process, each of the boards conducted a needs assessment to determine which specific adolescent services have the highest need in their areas, and
Local Treatment and Gaps

therefore which services should be added or enhanced (see Table 3).

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<th>Clermont</th>
<th>Hamilton</th>
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Table 3: Adolescent treatment services that need to be added or enhanced, by board region

As indicated by Table 3, there are many common needs across the seven-board region. For example, all of the boards indicated a need for assessment and treatment programs for adolescents dually diagnosed with a co-occurring substance use disorder and a mental illness. Also, all boards indicated a need for improved aftercare services, particularly self-help and sober-support groups for adolescents. Other common themes regarding improvement opportunities are discussed below.

**Planning**

- Develop adolescent-specific services that are separate from those provided for adults.
- Develop integrated substance abuse assessment and case management across adolescent service systems (e.g., substance abuse treatment, criminal justice, mental health, schools).
Prevention

- Enhance prevention programs to include awareness and understanding of environmental influences and information on the effects of substance use.
- Improve community awareness of substance use and treatment and improve acceptance of community-based treatment programs.

Treatment

- Take treatment access issues (e.g., transportation, funding, family support levels) into account when planning a treatment program for an adolescent.
- Coordinate best practices and treatment programs across all treatment providers in the region.
- Provide a full array of programming targeted to the dually diagnosed.
- Involve family—and, if possible, peers and other individuals from the adolescent’s immediate environment—in treatment programs.
- Provide more intensive services (e.g., inpatient services, group homes, residential facilities) at the local or regional level for adolescents who need to be removed from their immediate environment to ensure successful treatment.

Aftercare

- Enhance aftercare support programs to include services that assist adolescents in returning to family, school, and peer environments.
Current Funding Picture

Clearly, there are gaps in the treatment continuum for adolescents in the 14-county region described in this report. However, effectively addressing these gaps requires adequate funding, including insurance and Medicaid coverage.

The local boards unanimously agreed on many key challenges they face in the current funding infrastructure. These challenges greatly affect the ability to expand and enhance services.

The consistency of these findings across the board regions in this study—which included urban and rural counties, high and low case rates, and different median incomes—suggests similar funding challenges exist across Ohio. The following sections describe each of these challenges in detail using information shared by the local boards.

**General Funding Issues**

As described by each of the regional boards in this study, funding limitations present one of the greatest challenges to providing an appropriate, accessible continuum of treatment. The boards are responsible for spending some federal, state, and local funds through service contracts with the county’s providers, who are also able to apply for governmental and other funding. Although

![Key Points for the Section]

- Regional boards unanimously agree they face overall funding challenges in these areas:
- county population rather than need dictates funding allocation,
- Medicaid and insurance coverage,
- difficulties in managing payment cycle time,
- decrease in state funding,
- inadequate Medicaid coverage,
- one-size-fits-all Medicaid payment schedules, and
- lack of insurance parity.
- One of the biggest challenges is maximizing the funding available for substance abuse treatment and prevention in the face of economic pressures to cut budgets. For fiscal year 2002, ODADAS faced a decrease in General Revenue Funds of 18%.
- Medicaid in Ohio does not cover family counseling, residential treatment, day treatment, or detoxification services—all extremely important adolescent treatment programs.
- Insurance parity does not exist for substance abuse treatment, as almost no private insurance companies adequately cover this type of treatment.
Current Funding Picture

an array of funding sources—including federal, state, local, and third-party resources (see Figure 17)—are available to regional boards and local providers, these sources have varying eligibility criteria and payment rates. The exact array of funding used by each regional board and provider for adolescent services varies.

Unfortunately, there are seldom sufficient funds to meet the full cost of providing services through local and out-of-county providers. Little funding is available for developing other needed services or enhancing existing ones. Additional funding would allow counties to provide the needed adolescent substance abuse treatment. However, there are several fundamental challenges to the allocation and provision of funding that should also be addressed.

Allocation Is Based on Population Rather than Need

Currently, state and federal funds for substance abuse treatment are allocated to Ohio’s 50 regional ADAS and ADAMHS boards based on the most recent U.S. Census population estimates for the respective counties. Since these estimates are released every 10 years, boards were allocated funds based on 1990 census data through fiscal year 2001. So although the population of Warren and Clinton Counties grew by 27% in that time period, Recovery Services of Warren and Clinton Counties received the same allocation they had when their population was smaller.

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Figure 17: Sources of funding for substance abuse treatment services

**STATE FUNDING**
- State General Revenue Fund
- Medicaid State Match
- ODADAS Adolescent Grants
- Dept. of Rehabilitation and Corrections
- Indigent Drivers Fund
- Dept. of Youth Services

**FEDERAL FUNDING**
- Federal Per Capita
- TANF
- JOBS Block Grant
- SAFT Block Grant
- FFP Funds/Medicaid

**LOCAL FUNDING**
- Tax Levy
- Medicaid Local Match
- Local Block Grants
- County Juvenile Courts
- County Department of Jobs and Family Services

**OTHER FUNDING**
- Third-Party Grants (can come from state, federal, and private sources)

**VARIOUS STATE AND FEDERAL SOURCES (including grants):**
- Insurance
- Contracts with Local Schools
- Fundraising
- Donations
- Third-Party Grants

*Half of the funds for FY 2002 were based on Census 1990 data and the other half were based on Census 2000 data.*
forcing this board—and others like it—to provide services for more people with less money.

A population-based allocation also does not account for the level of need in a particular county. As described in the Appendix, there are many demographic factors that influence how many adolescents in a given community have a substance use disorder. Many government organizations, such as SAMHSA, use formulas that take these factors into account. Ohio’s current allocation model assumes that all populations throughout the state have an equal need for substance abuse treatment.

Based on a demand by the legislature and recognition that the population-based allocation needs to be changed, ODADAS has established a task force to assess alternative allocation models. However, the exact timing of implementation for a new allocation model has not been established. One challenge to moving to a need-based allocation model will be the ability of ODADAS and local counties to accurately capture need-related data (see the chapter entitled “Current Capacity, Collaboration, and Data Issues”).

Payments to Boards Typically Lag Payouts to Providers
Regardless of when funds are made available to the regional boards, the boards are required to pay providers for services rendered within 30 days. In stark contrast, Medicaid does not typically pay the boards for at least 90 days, and ODADAS sometimes does not issue quarterly per capita payments until up to three months after the quarter ends. Medicaid payments for services provided out-of-county have taken up to one year due to the lengthy review process required. In addition, services paid by referral systems, such as the Department of Jobs and Family Services and the Department of Rehabilitation and Corrections, can also be delayed because of review processes.

This lag in time between accounts payable and accounts receivable requires that the boards maintain a significant cash reserve. It also requires excessive administrative costs to monitor the status of payments and collect them as soon as possible. These factors reduce the amount of funding available while imposing unnecessary costs on the local authorities.
State General Revenue Funds Have Decreased
State General Revenue Funds (GRF) appropriations to ODADAS stagnated in 2000, with ODADAS receiving $34.7 million in GRF for fiscal years 2000 and 2001. Now, under the heightened need for budget cuts across Ohio, GRF appropriations for ODADAS for fiscal year 2002 have been cut by 18% (ODADAS, 2001).

While these cuts may seem to save Ohio now, they will lead to higher numbers of untreated people—both adolescents and adults. As was already discussed, untreated substance abuse leads to higher costs to society as a whole.

Medicaid and Insurance Coverage
In addition to state and local funding, a primary factor that affects whether adolescents and their families can access care is insurance coverage. According to a year 2000 survey conducted by the Child Policy Research Center (2000) across the Greater Cincinnati region, 15% of children are covered by Medicaid or the Children’s Health Insurance Program (CHIP), 78% of children are covered by private insurance, and 7% have no insurance.

Unfortunately, Medicaid and private insurance programs offer limited coverage for substance abuse treatment. Although substance abuse is treatable, it is effectively classified as a lower priority illness compared to other chronic illnesses like cancer and heart disease. If they do cover substance abuse treatment, insurance programs often limit coverage to certain types of treatment or certain numbers of visits. This leads to inadequate treatment and an increased chance of relapse.

If an individual is treated using state Medicaid dollars for payment, the board in the county where that individual lives is responsible to pay a match of $1 for every $2 of state Medicaid dollars used for that treatment. As a result, even if a person qualifies for Medicaid-funded treatment, that person’s community board may not have the funds available to provide the match.
Medicaid Coverage Is Limited to Certain Types of Treatment

Medicaid payments to providers, which are administered by the county boards, cannot be used to pay for family counseling, residential treatment, day treatment, or detoxification services—services that are critical, but often very expensive, components of the treatment continuum. Agencies providing services to people who need but cannot afford care must rely on available county board funds or other sources of funding or turn people away.

In reality, many individuals are given the less intensive—and less expensive—services covered by Medicaid instead of the appropriate level of care. When this happens, the substance use disorder is only partly and ineffectively treated.

In the case of residential treatment, which is typically very expensive and not covered by Medicaid, providers have created a solution, but it causes inaccurate case data. Providers often share the expense of treatment with other agencies or systems (such as the criminal justice system or the Department of Jobs and Family Services) rather than forgo treating an individual who requires residential care. The other agency refers the individual for treatment and pays room and board. The substance abuse treatment provider records the treatment as outpatient and case management services. Although this ensures adolescents receive the treatment needed and providers are paid for some of the costs, the episode is inaccurately recorded, impairing tracking and management of adolescents who receive this treatment.

Home-based therapy is another critical service for adolescents that is not covered by Medicaid (Fleming, 2001). Such therapy occurs in the adolescent’s “home” environment—which can be in the school, household, or local community—and involves key members of that environment in the treatment of the adolescent. Home-based therapy greatly reduces the chance of relapse for the adolescent. It also takes the treatment to the adolescent, avoiding the transportation issues that often prevent an adolescent from continuing treatment. Unfortunately, since Medicaid does not cover this service, many adolescents are prescribed other types of treatment. They then return to the unchanged environment that fostered the substance use disorder, leading to a higher relapse risk.

Meet Bethany

Bethany is a 13-year-old girl who lives with her parents and two siblings in northern Brown County. Bethany was referred to Brown County Counseling (BCC) for assessment and treatment after being suspended from school for marijuana possession and absenteeism. Although this was the first time Bethany was caught, the assessment revealed that she had been using marijuana and smoking cigarettes since she was 11 and that both of her parents were regular marijuana users. BCC tried to involve Bethany and her parents in family treatment. The family already lives well below the poverty level and cannot afford treatment, but Medicaid in Ohio does not cover family counseling. BCC has not seen the family since Bethany’s assessment.
Families also struggle with other cost factors associated with treatment, such as transportation, time off from work, or childcare that are not covered by Medicaid. Therefore, adolescents and families must pay these costs themselves—out of their own pockets or through other funding sources—or discontinue treatment. Quite often, it is easier to discontinue treatment than to incur the expense.

**Medicaid Payment Schedules Are One-Size-Fits-All**

The Medicaid payment limits for substance abuse treatment services have not changed in the past four years. The current payment schedules are cost-based, using data provided by the 50 ADAMHS and ADAS Boards and over 200 providers in Ohio to set statewide payment rate ceilings for each level of treatment.

Regional boards and providers are forced to use other funds to make up the difference between the Medicaid payment rate and the actual cost of providing services, which can be a big difference for some services. As a result, boards and providers have less money for services.

ODADAS has been researching a fee-based payment schedule since 1996 and is hoping to put such a system in place. This system would set unique fees for each provider rather than assuming that all providers can deliver services at the same cost. It would also reduce the staff time necessary to collect the funds.

**Limits on Private Insurance**

Families with private insurance also have difficulty paying for substance abuse treatment. Unfortunately, many private insurance companies do not cover treatment for substance use disorders or they provide very limited coverage.

A similar problem exists for treatment of mental health disorders. To address this issue, Congress passed the Mental Health Parity Act in 1996, laying the groundwork for insurance parity by requiring health plans to cover severe mental illnesses without imposing lifetime or annual limits higher than those imposed for other health services. Unfortunately, the national Mental Health Parity Act does not apply to substance abuse treatment (SAMHSA, 1998).
Only four states—Vermont, Connecticut, Maryland, and Minnesota—have enacted “comprehensive parity” laws that require insurance plans to cover both mental health and substance use disorders equally with other health services (National Mental Health Association [NMHA], 2001). Less comprehensive parity laws with some coverage for substance abuse have been enacted in Arkansas, Illinois, Indiana, Kentucky, North Carolina, Rhode Island, and Virginia.

As of October 2002, Ohio had not yet passed a parity law and had dismissed House Bill 33, a bill that would have created parity in health plans for the coverage of mental illness and substance abuse. An insurance parity law could require that the 78% of Ohio’s children who have private insurance be covered for treatment for substance use disorders. Insurance parity legislation should also cover the full continuum of services, such as outpatient, inpatient, residential, and family-based treatment.

**The Public Views Substance Abuse as a Moral Issue rather than a Health Issue**

Without adequate funding, it is difficult for communities to treat substance abuse. Therefore, key to the successful treatment of adolescents (as well as adults) with substance use disorders is the recognition by the public—taxpayers, community members, educators, healthcare professionals, and legislators—that a substance use disorder is a disease just as mental disorders or physical illnesses are diseases. Individuals do not choose to be dependent on or addicted to substances. Instead, they suffer from an underlying health disorder that, when combined with environmental exposure, leads to addiction (Daugherty & O’Bryan, 1987). Although public opinion is turning, many still believe that substance abuse is a choice, and, as such, the user should bear all the costs. Therefore, people are less likely to support public funding or insurance parity for substance abuse treatment. Until society recognizes that substance abuse is a health issue that affects everyone, boards and providers will continue to face barriers to getting adequate funding.
Current Capacity, Collaboration, and Data Issues

Although the challenges of funding, Medicaid, and insurance coverage are significant, there are several other factors that affect the ability of the 14 counties to provide adequate treatment to adolescents with substance use disorders.

**Capacity**

Even when funding is available, other factors affect whether an adolescent actually uses the services. As indicated by waiting lists, many counties do not have adequate capacity to treat the number of adolescents needing a particular type of treatment. Meanwhile, the number of out-of-county placements for certain services, such as residential treatment, indicates some need for services to be made available locally.

If treatment is not provided nearby, adolescents must find their own transportation to the nearest treatment location with an opening. This inhibits family and peer participation in treatment because of transportation costs. In addition, county boards are under no obligation to provide payment for non-Medicaid funded services provided out-of-county. Also, providers funded by the county boards may not have any openings available for non-county residents.

**Waiting Lists Exist for Many Adolescent Services**

_The Greater Cincinnati Community Health Status Survey 1999 revealed that 45% of Greater Cincinnati area households with a household member who sought treatment for an alcohol or other drug problem had to wait more than 10 days between the time an appointment for services was scheduled and the time services were received (The Health Foundation of Greater Cincinnati, 2000)._ 

Butler County currently provides substance abuse treatment services to 400-500 adolescents. At any given time, there are typically over 200 adolescents waiting an average of 15-25 days

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**Key Points for the Section**

- Many counties do not have adequate capacity to treat the number of adolescents needing a particular type of treatment.
- Capacity constraints can lead to access issues as well as affect treatment success.
- Adolescents are treated using adult treatment models, which do not take into account the unique physiological and psychological needs of adolescents.
- Recent studies have determined that between 41% and 65% of adolescents with substance use disorders also have mental health disorders (USDHHS, 1999).
- Although MACSIS collects an array of data, there are several issues that prevent the data from being fully useful in analyzing and addressing adolescent treatment needs. A more comprehensive standardized data set and reporting system would allow the state and counties to compare needs, treatment success, and best practices.
for treatment slots to become available for outpatient and intensive outpatient services.

Recovery Services of Warren and Clinton Counties and the Paint Valley ADAMHS Board indicate their primary bottleneck occurs between the intake processes and the initiation of treatment. This is because treatment groups in these counties are scheduled at certain intervals and adolescents must wait for the next group to begin.

**Out-of-County Placement Affects Treatment Success**

There are two primary reasons that adolescents are sent to out-of-county treatment services:

1) the home county does not provide the required treatment, or
2) the adolescent and family prefer to seek treatment away from the community for personal or other reasons.

In either case, out-of-county placement affects treatment success and continuity of care. Home-county providers are typically not notified of the out-of-county placement until after the treatment is underway or complete and the adolescent has returned home. This prevents the home county from connecting the adolescent to local alternative or supplemental treatment—including aftercare—that will ensure the success of treatment.

**Few Residential Treatment Programs Exist**

Residential treatment programs are one example of services that are in great demand, yet few programs are available statewide. Some adolescents have to travel three hours or longer to reach residential treatment, cutting them off from the family and friend participation in treatment. The distance causes additional challenges in transportation and access. It is also difficult to reintegrate the adolescent with his or her home environment in a way that addresses the factors that fostered the substance use disorder.

The need for residential services in the 14-county region can be partly measured by the waiting list for the new residential program in Butler County. After only six months of operation, the Butler County residential program had a two-month waiting list.
Lack of Transportation Affects Treatment Participation

However, other factors affect access to care, particularly in rural areas. If adolescents are not close to a treatment provider, it is difficult for them to keep their treatment appointments. There is little or no public transportation available to help rural adolescents reach treatment. When adolescents and their families face difficulty in accessing treatment, they often discontinue treatment.

Geographic distribution of services should be taken into account when planning the location and array of treatment services provided. Recovery Services of Warren and Clinton Counties indicated that all of their services have been carefully placed so that all rural communities are within 25 minutes of some sort of treatment program. However, other boards indicated that services are often not conveniently located for adolescents requiring treatment. Transportation challenges are so great that some boards chose home-based treatment services as their primary improvement strategy.

Adolescent vs. Adult Treatment Models

Often, adolescents are treated using adult treatment models, which do not take into account their unique physiological and psychological needs. Two reasons for this are lack of resources and lack of education for staff.

Regions Lack Financial and Human Resources to Establish Adolescent-Specific Programs

According to the boards, the primary reason that adolescent-specific treatment programs are not available is the lack of financial and human resources. Adolescent treatment programs require careful planning. Then, the new program must be staffed, started up, and marketed to other child-serving systems. Typically, providers taxed for time, money, and resources find it easier and faster to use adult models to provide adolescent treatment. With adequate financial and human resources, regions could develop effective adolescent-specific programs.

Meet John

John is a 45-year-old who serves on his county’s community board. John began using alcohol and other drugs regularly when he was a teenager because “everybody else was doing it.” Unfortunately, once he began, he never stopped—until almost 15 years later. His dependence on alcohol almost ended his marriage and nearly destroyed his family. “If only someone had been there for me to help me, I would have half a life more to live.”

Lack of Staff with Education in Adolescent-Specific Treatments

It is difficult for boards and providers to find qualified people to staff their adolescent programs. Existing staff typically specialize in adult treatment models, with little or no education or
experience in treating adolescents. In fact, the seven boards cited educational training in adolescent-specific treatment as a significant need in the region. Ideally, programs would have adolescent- and adult-specific staffing so that both groups could receive appropriate treatment from qualified providers.

**Dually Diagnosed Adolescents**

All of the boards agreed that treatment of adolescents who have both a substance use disorder and a mental illness is a daunting challenge. Recent studies have determined that between 41% and 65% of adolescents with substance use disorders also have mental health disorders (U.S. Department of Health and Human Services [USDHHS], 1999).

People dually diagnosed with both disorders need to be treated through integrated methods. However, as will be discussed below, it is currently very difficult for adolescents to receive this kind of treatment.

**Funding and Treatment Requirements Restrict Simultaneous Access to Both Types of Care**

Currently, ODMH and ODADAS function as separate entities with different funding mechanisms, policies, and reporting requirements, making it difficult for adolescents to obtain coordinated treatment for both substance use and mental health disorders simultaneously.

First, the treatment philosophies of the two systems are different. Mental health disorders are often treated with pharmacotherapy, but substance abuse treatment may require that the person be free of all substances, including valid prescription medications and over-the-counter drugs. Therefore, adolescents in substance abuse treatment are often discouraged (or even prohibited by some programs) from taking the mental health medications they need. The risk of relapse of both disorders in these cases is greatly increased.

Another challenge is that funding for mental health and substance abuse treatment are managed separately. If an adolescent is dually diagnosed, treatment for each disorder must be provided separately for billing and reporting purposes. This prevents the adolescent from receiving integrated treatment for both disorders in a timely fashion. It also means that the state
systems require two interactions where one blended interaction would suffice, doubling the administrative time and expense of treating the one person.

**Referral Sources Drive the Type of Treatment Prescribed**

Referral systems such as courts and schools have a great impact on whether an adolescent is treated for a mental illness or a substance use disorder. Unfortunately, these sources are typically not trained to diagnose which type of care is most appropriate for the adolescent’s needs. Instead, they make a best guess and formally refer the adolescent for one or the other type of treatment instead of both.

**Staff Are Not Educated in Dual-Diagnosis Identification and Treatment**

A final challenge is that most counties do not have staff trained to conduct dual-diagnosis treatment for adolescents or adults. As specified by several boards in their strategic plans, establishing at least one cross-trained professional to conduct dual-diagnosis treatment is a priority for the next few years.

**Collaboration and Service Integration across Regions and Systems**

In their strategic plans, each of the seven boards indicated that the interagency collaboration among child-serving systems that the Health Foundation required for the planning grants was critical to the success of planning efforts. However, the boards also acknowledged that collaboration was difficult. Often, child-serving systems (e.g., schools, substance abuse treatment centers, child welfare systems, juvenile justice, healthcare organizations, etc.) develop their own treatment policies and programs without taking advantage of the best practices and treatment systems of other providers. This leads to fragmented services. It also leads to confusion on the part of clients and providers when services interact across systems.

**Services Are Not Integrated Across Child-Serving Systems**

Many child-serving systems—including schools, healthcare providers, community groups, and courts—provide or refer adolescents to substance abuse treatment services. Unfortunately, the regional boards found that many child-serving systems have policies that are inconsistent with substance abuse treatment programs.
For example, at the direction of the Department of Education, each Ohio school system has established a policy for referring adolescents with substance use disorders to treatment. Typically, adolescents who are caught with or under the influence of a substance are expelled. To shorten the length of the expulsion, adolescents must receive immediate treatment. The assessment to determine the level of treatment can take hours or days depending on the adolescent’s history, extent of use, and complexity of problems. In addition, adolescents are faced with waiting lists for treatment. Finally, the adolescent’s family may not have the resources to pay for immediate treatment. The child is either not allowed back in school—which further hampers academic success and increases the likelihood of substance use—or a school has to readmit a child who has not complied with policy.

**Services Are Not Integrated Across Geographic Boundaries**

Regions can share certain types of treatment programs, such as residential treatment, that may not have enough demand in one county but have enough in a three-or-four county region. Keeping treatment programs close to home helps reduce the barriers to accessing these services and helps involve family and friends in treatment. When these programs are provided regionally, boards and providers from each county could work together to keep each other informed so the adolescent stays linked to services in his or her county.

**Parental Distrust Can Affect Collaboration**

Providers must have parental permission before they can treat a child. If a parent wishes to avoid contact with the substance abuse treatment system or has had a bad experience with the substance abuse treatment system or a referral system (such as schools or the juvenile justice system), that parent may not grant permission. If parents agree to allow treatment, their distrust may filter down to their adolescents, which can hamper successful treatment and recovery. As systems collaborate to address adolescent substance abuse treatment, they must be aware of how parents and adolescents view the systems and work with parents and adolescents to build trust.

**Data Gaps and Standardization**

The collection of accurate, timely, and useful data can support good decisions by providers, regional boards, ODADAS, and
ODMH to address adolescent treatment needs. In 1999, ODADAS and ODMH launched a new management information system called the Multi-Agency Community Services Information System (MACSIS). MACSIS includes two components: the Medicaid claims processing module and a behavioral module. The claims processing module collects information—such as name, universal client identification number, social security number, ethnicity, provider, diagnosis, and billing amount. The behavioral module includes some overlapping data such as the client identifier, birth date, sex, and provider identifier—as well as information such as the referral source, education level, mental health status, pregnancy status, income sources, and disposition at discharge.

Although MACSIS collects an array of data, there are several issues that prevent the data from being fully useful in analyzing and addressing adolescent treatment needs. A more comprehensive standardized data set and reporting system would allow the state and counties to compare needs, treatment success, and best practices.

Only Some Providers Have Implemented the Behavioral Module of MACSIS
The behavioral module for MACSIS is a separate system developed and installed by each service provider in Ohio. The installed systems are then thoroughly tested before being formally accepted by ODADAS and ODMH. Until all providers in a particular board region are using the behavioral module, ODADAS and ODMH cannot provide regional data reports from this module, as the data would be incomplete.

Unfortunately, few board regions have fully implemented and tested the behavioral module of MACSIS. Providers have implemented the behavior module more slowly because it is not linked to claims and payment. As a result, it is difficult to obtain complete adolescent case data. Consequently, ODADAS, the boards, and providers do not have complete information on which to base decisions about treatment programs.

The Claims Processing and Behavioral Modules Are not Linked
Unfortunately, the claims processing and behavioral modules are not linked because of claims that privacy regulations require this degree of separation. Therefore, information such as sex,
Current Capacity, Collaboration, and Data Issues

location, and diagnosis from the claims processing system cannot be matched with drug of abuse, pregnancy status, and other data from the behavioral module. Without a link between these modules, providers, boards, and policymakers lack the complete data set that would enhance understanding of the population being treated.

MACSIS Does not Accurately Capture Episode Data

Even using the behavioral module, MACSIS does not capture data that reflect the full episode of treatment for a particular case. First, the system tracks status of the case at admission or closure, but not both simultaneously. When tracking a case of substance abuse, the system does not allow for multiple levels of care, such as intensive outpatient and detoxification. Individuals must be discharged from one level of care before another level can be administered. In addition, MACSIS only tracks either a substance abuse treatment or a mental health treatment, but does not indicate when a person is receiving treatment for co-occurring disorders. This makes it difficult to capture the full nature of the diagnosis for the individual and the multiple levels of treatment provided.

Treatment Categories Are not Used Consistently

When collecting data, providers use different categories of treatment programs to describe the care being given. Some use more specific categories of treatment, such as intensive outpatient and group counseling, while others track cases by broader categories, such as outpatient and inpatient services. Consequently, the data cannot be compared. In addition, usage rates of specific treatment programs cannot be analyzed to allow a region to adequately plan capacity and funding.

Lack of Standardized Operational Data

Each provider in each service system captures the operational information that it believes to be most critical. As identified by the Butler County ADAS Board in its strategic plan, it is very difficult to compare the revenues and expenditures from all child-serving systems because financial formats, accounting methods, fiscal years, and other definitions vary. Moreover, most providers only track services that are funded through Medicaid and other government sources without tracking the number of privately insured or uninsured cases treated, due in part to privacy and security regulations for adolescents.
Next Steps

Policy and Funding
There are several key areas that state and local policymakers—including the county ADAS and ADAMHS boards—can address to establish the infrastructure required to support adequate, timely, and successful adolescent substance abuse treatment programs.

Data Collection Framework for Adolescent Substance Abuse Prevalence and Treatment
Currently, ODADAS, boards, and service providers can only access the billing module of MACSIS, which includes partial episode data and limited information about operations. Increased standardization of operational data and performance measures as well as state-wide use of the behavioral module would help the agencies and ODADAS understand treatment being given and identify the areas in which treatment capacity and operations can be improved.

There is also no standard survey for the prevalence of substance abuse among adolescents between the ages of 10 and 19. Instead, agencies conduct their own needs assessments using different frameworks and criteria, yielding different and often incomparable data.

Coordination of Mental Health and Substance Abuse Treatment Services and Funding
Currently, funding sources restrict providers from treating co-occurring mental health and substance use disorders simultaneously. The services and funding mechanisms provided through ODMH and ODADAS should be integrated and streamlined to ensure timely treatment of dually diagnosed adolescents. ODMH has taken some steps toward this end by creating the Substance Abuse and Mental Illness Coordinating Center of Excellence (SAMI CCOE) at Case Western Reserve University. ODADAS joined with ODMH to fund nine boards throughout Ohio (including Butler County) to implement the Dual Disorder Integrated Treatment (DDIT) model supported by SAMI CCOE. However, neither the DDIT model nor the SAMI CCOE targets adolescents.
Establish and Support Best Practice Models

State and local policymakers can establish benchmarks for adolescent treatment. They can encourage the use of best practice models by funding demonstration projects.

State General Funds

State per capita funds allocated to ODADAS in 2002 were cut by 18%, after stagnating at $34.7 million for fiscal years 2000 and 2001. Unfortunately, cuts in treatment and prevention lead to untreated substance abuse cases and, subsequently, serious economic side effects for Ohio in terms of increased crime, school dropouts, loss of productivity, and healthcare costs. In addition, some counties—particularly suburban ones—would benefit from the state reviewing the population estimates it uses to allocate per capita funds between censuses to ensure that changes in county populations are taken into account as they happen rather than once every 10 years.

Expand Medicaid Coverage

Medicaid coverage for substance abuse in Ohio should include all levels of treatment based on a standardized assessment. Otherwise, insufficient treatment is provided to many adolescents who return to the substance abuse and other social services systems multiple times, costing Ohio more than the initial cost of the appropriate treatment.

Multi-System Coordination and Collaboration

All child services providers should work collaboratively to establish adolescent substance abuse treatment policies and programs that work across all systems. State agencies can take the lead by developing policies that increase collaboration and by rewarding local systems that work together.

Infrastructure

The local boards developed several action steps in their strategic plans to improve infrastructure and take advantage of opportunities. Although these will improve the infrastructure that supports adolescent substance abuse treatment throughout the 14-county region, these actions should be supplemented by other changes in state and local policy.
Next Steps

Action steps planned to improve the various board and provider infrastructure include:

- cross-training staff in adolescent-specific treatment;
- adapting substance abuse treatment to meet the needs of dually diagnosed adolescents;
- collaborating with providers and other regions on the best ways to capture new funding streams;
- improving overall access to services;
- improving interagency collaboration;
- developing adolescent-specific services independently of adult services;
- coordinating prevention and treatment programs to elicit collaboration rather than cross-purpose work;
- educating school personnel and other child service providers in assessment protocols and interventions;
- taking barriers (transportation, financing, parental support) into account when planning treatment; and
- improving staff recruitment and retention.

Conclusion

Across Ohio, many adolescents who use alcohol and other drugs are not getting the treatment they need for their substance use disorders. The effects of untreated substance abuse are costly and devastating, both in the present and into the future. Although the community ADAS and ADAMHS boards are trying to address the needs of adolescents with substance use disorders, they face many barriers that complicate and prevent adequate adolescent substance abuse treatment.

This report has discussed some of these barriers and ways to overcome them. Just as substance abuse affects all parts of society, the solutions should be developed and implemented by the entire community. The burden should not fall on just the ADAS and ADAMHS boards or just the treatment providers. Rather, it will take everyone—the boards, providers, adolescents, parents, families, policymakers, the criminal justice system, schools, and the rest of the community—working together to begin to effectively address adolescent substance use.
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General References


References


References


Appendix: Demographics of the Fourteen-County Region

This section provides an overview of the demographic characteristics of the 14-county Southwest Ohio region under review in this report.

Education

The high school dropout rates in 1998 for the U.S. and Ohio were 4.8% and 5.1% respectively. Most of the local board regions fell close to these rates and showed decreases in dropout rates from 1995 to 1998 (see Figure 18). However, Hamilton County had a significant increase in high school dropout rates from 2.2% in 1995 to 6.0% in 1998, which was well above both the U.S. and Ohio rates. Warren and Clinton Counties had the lowest rate at 3.6%.

![Figure 18: High school dropout rates by region, 1995–1998](image)

In conjunction with dropout rates, high school graduation rates indicate the overall well being of adolescents and the communities in which they live. In the U.S. and Ohio, graduation rates in 2000 were 86.5% and 87.7%, respectively (see Figure 19). Interestingly, the graduation rates for Ohio, as a whole, are significantly higher than the 14-county region. The
graduation rates for the 14-county region ranged between 76.1% and 82.1%.

Median Income

Overall in 1997, the median income in Ohio was less than the median income in the U.S. Four out of the seven local board regions had a median income below that of the U.S. and three of the regions were below Ohio (see Figure 20). This indicates a large number of local adolescents were living in families that do not make as much as the average family in America did at that time.

Adolescent Poverty Rates

The percentage of adolescents living below the poverty line decreased at both national and state levels from 1995 to 1997 (U.S. Census Bureau, 2000). Similarly, the percentage of adolescents living below poverty in the 14-county region
decreased, except for Warren, Clinton, and Brown Counties, whose rates increased slightly (see Figure 21).

The 1995 and 1997 rates for adolescent poverty in the county board regions were generally consistent with national and state rates at about 15-20%. However, the percentage of adolescents living below poverty in Scioto County (part of the Adams, Lawrence, and Scioto board region) was 32% in 1997, which was well above both the state and national rates. Meanwhile, Butler, Clermont, Warren, and Clinton Counties fared much better with only 10% of adolescents estimated to live below poverty.

Although the number of adolescents living below poverty seems to be decreasing overall, these rates indicate that almost 59,000 adolescents in these regions live below the poverty level.

**Adolescent Birthrates**

Pregnancy is also a factor for young females with substance use disorders. In some cases, pregnant adolescents begin using alcohol and other drugs due to the emotional strain and unhappiness of their pregnancy. In other cases, adolescents become pregnant because of poor birth control decisions made while using alcohol or other drugs. Out of the seven local board regions, four averaged higher adolescent birthrates than Ohio did from 1995-1999. The average birthrate in Ohio varied between 14% and 15%, while the adolescent birthrates for Brown County, Adams, Lawrence, and Scioto Counties, and the
Paint Valley region ranged between 18% and 22% (see Figure 22).

![Figure 22: Percentage of total births to female adolescents (ages 10–19), 1995–1999](image)

Exact correlations cannot be made between the percentage of birthrates attributable to adolescents and the number of cases treated in each region. However, it is interesting to note that Paint Valley has one of the highest birthrates among adolescent women and also treats a higher ratio of female adolescents for substance use disorders than the rest of the local boards.

**Demographics of Adolescents Treated for Substance Use Disorders**

The number of adolescents treated for substance use disorders in 1999 varied greatly across Ohio and the U.S. (see Figure 23). Ohio treated an average of 5 adolescents per 1,000—almost twice the number reported across the U.S. (which is almost 3 cases per 1,000 adolescents). Meanwhile, Paint Valley treated approximately 20 adolescents per 1,000, which is more than 4 times the average rate reported in the U.S.

![Figure 23: Adolescents treated for substance use disorders per 1,000 adolescents, 1999](image)

*Data from the U.S., Ohio, and Warren/Clinton Counties are from FY 1999.
Source: Adolescent Substance Abuse Treatment Strategic Planning Reports from the Boards, 2000 and 2001*
Several characteristics, such as median income, poverty rates, education, and adolescent birthrates, correlate with adolescent health and well being. Because these factors are integrally related to the overall health of adolescents, they are related to the occurrence of substance use disorders in adolescents. In addition, geography, culture, age, and sex differences also affect substance use and treatment. Many studies have also revealed associations between adolescent substance abuse and criminal behavior, delinquency, irresponsible sexual activity, and mortality (Winters, 1999). By understanding the demographics of adolescent substance use in their area, communities can better anticipate, prevent, and treat current and future adolescents with substance use disorders. Unfortunately, there is no specific formula to help the community predict the number of adolescent substance abuse cases requiring treatment. However, communities should be aware of the demographics and risk indicators of their adolescents so they can anticipate and design treatment appropriately.

**Sex Differences**

U.S., Ohio, and local adolescent populations currently have a 50:50 ratio of adolescent males and females. However, male adolescent substance abuse cases ranges anywhere from 60–80% in each of the seven board regions (see Figure 24).

These findings are consistent with national epidemiological data that more adolescent males than females meet adult diagnostic criteria for an alcohol use disorder (Cohen, Cohen & Kasen, 1993). These data correlate with other findings to indicate that adolescent males are significantly more likely to experience substance use disorders and be treated for them than are females. However, sex differences in teen alcohol use have decreased.
According to The National Center on Addiction and Substance Abuse (CASA) at Columbia University, “although male students are more likely than female students to have tried alcohol before age 13 (37.4 percent vs. 26.8 percent), overall rates of current alcohol use among teens are only slightly higher among boys than among girls (52.3 percent for boys and 47.7 percent for girls” (CASA, 2002).

Several sex-related factors have an impact on the extent of an adolescent’s involvement in treatment and on the treatment approach that is most likely to be effective and appropriate. Male and female adolescents deal with different family, peer, and physiological issues, creating a need for different approaches for each sex.

For example, female adolescents with substance use disorders often need additional services. It has been found empirically that female adolescents with substance use disorders have experienced severe parental rejection or sexual or physical abuse within their families (Gross & McCaul, 1991). Family dysfunction may be more critical for females than males with substance use disorders, and the females need to be treated accordingly.

Ethnic Differences
To fully understand an adolescent’s substance use disorder, one must also understand the adolescent’s ethnic context. Norms, values, and beliefs (including those about health) differ across ethnicities and can have a significant impact on treatment.

The breakdown of ethnicity in the U.S. is about 65% white, 15% African American, 14% Hispanic, and 6% other (which includes Asian American, American Indian, Alaskan Native, and Pacific Islander). Census data indicate that the white population in the U.S. is decreasing, while the population of minorities (particularly Hispanics) is increasing (U.S. Census Bureau, 2000). However, these rates do not hold for Ohio or the 14-county region (see Figure 25). The adolescent population in the board regions is predominantly white, at 90% to 98%, with
the exception of Hamilton County which is approximately 60% white.

The U.S. and most counties in the 14-county region reported ethnic demographics of adolescents treated for a substance use disorder similar to those of the overall population (see Figure 26). However, adolescents treated in Hamilton County reflect a very different ethnic composition. While the county has an adolescent population that is 73% white, only 40.5% of adolescents treated for substance abuse in 1999 were white. The remaining cases were 57% black and 1% Hispanic, indicating that treatment services in Hamilton County should be tailored to meet the needs of ethnic populations.

Local communities should use caution when attempting to use national programs as models for their own treatment programs. Many best practice programs are targeted to a more ethnically diverse population than is found in this region.
Cultural Differences
Even with a predominantly white population, the 14-county region experiences strong cultural differences. For example, many of the counties are considered Appalachian counties. Appalachian families typically view adolescent substance abuse as a family issue and one that should be dealt with by the family and not by a public treatment program. Accordingly, prevention and outreach programs in these areas should be tailored to encourage adolescents and their families to seek treatment. Also, treatment programs must encourage family input and participation.

Urban and Rural Differences
For years, many people have believed that substance abuse was a phenomenon limited to large cities or urban areas. However, a 2000 study found young adolescents in small metropolitan and rural areas are even more likely to abuse alcohol and other drugs than those in large metropolitan areas (National Center on Addiction and Substance Abuse at Columbia University [CASA], 2000).

In fact, the study found that 8th graders in rural America were:

- 29% more likely to drink alcohol and 70% more likely to get drunk than those in urban areas,
- 34% more likely to smoke marijuana,
- 83% more likely to use crack cocaine,
- 50% more likely to use cocaine,
- over 50% more likely to smoke cigarettes, and
- nearly five times more likely to use smokeless tobacco.

The 10th graders in rural areas exceeded those in large urban areas for their use of: cocaine, amphetamines, crack, barbiturates, inhalants, hallucinogens, LSD, heroin, steroids, and tranquilizers—every drug except MDMA (Ecstasy) and marijuana (CASA, 2000).

The 12th graders in rural areas exceeded those in large urban areas for their use of cocaine, amphetamines, barbiturates, inhalants, crack, and tranquilizers. However, the use of marijuana, hallucinogens, LSD, MDMA, and steroids was higher in urban areas than in rural areas among 12th graders.
Heroin use was the same in rural and large urban areas (CASA, 2000).

While small metropolitan and rural communities have similar problems of adolescent alcohol, tobacco, and other drug use as urban areas, the consequences are not the same. Smaller communities do not have the capacity or resources to provide the same quantity and array of treatment programs that urban areas provide. In 1995, only 10.7% of hospitals in rural areas provided outpatient substance abuse treatment services, compared to 26.5% of hospitals in large metropolitan areas (Bird, Dempsey & Hartley, 1999).

Additionally, rural areas have fewer specialized substance abuse treatment services than metropolitan areas have. In fact, a recent survey indicated that only 6.6% of substance abuse treatment providers serving youth in rural areas indicated a specialization in the areas of alcohol and other drug abuse, as opposed to 17.8% of providers based in urban areas (Bonito, Condelli, Ennett & Fairbank, 1996).

While substance abuse treatment programs specifically designed for adolescents are in short supply nationally, the shortage is even more pronounced in rural areas. Only 11% of substance abuse treatment providers in rural areas provide services for adolescents, as opposed to 15% of substance abuse treatment providers in metropolitan areas (Bonito, Condelli, Ennett & Fairbank, 1996).

Another barrier faced by small metropolitan and rural communities is the issue of transportation. Most of the regional boards cited the distance that adolescents must travel for treatment as a significant problem. The lack of public transportation in rural communities contributes to this problem.

While all 14 of the counties studied are defined as either small metropolitan or rural areas by the U.S. Census Bureau, it is interesting to note that the Paint Valley region (which is comprised of three rural counties and two small metropolitan counties) has the highest rate of substance abuse cases treated with 19.9 cases treated per 1,000 adolescents.
Age Differences

There are stages of adolescence, from early to middle to late, that demonstrate significant developmental differences among adolescents. For example, young adolescents tend to think only about the present without realizing the potential consequences of their actions. Older adolescents are more aware of consequences, but are willing to take risks. They are motivated by the need to be accepted among peers of both sexes (Winters, 1999). Treatments for substance use disorders should accommodate the age and developmental needs of the adolescent.

Adolescent substance abuse treatment data from the boards for 1999 indicated that the majority of cases involved 15- to 18-year-olds (see Figure 27). For most counties, less than 20% of treatment for substance use disorders was provided to adolescents 14 years of age and younger. However, Hamilton County and Butler County indicated that about 30% of cases treated involved adolescents 14 years of age and younger. These counties have an even greater need to ensure that adolescent substance abuse treatment programs focus on the age of the youth. For example, 13-year-old adolescents should not be treated in the same way as 18-year-old adolescents.

*Data for Adams, Lawrence, and Scioto Counties are from 1997.

Source: Adolescent Substance Abuse Treatment Strategic Planning Reports from the Boards, 2000 and 2001