

WASHINGTON STATE DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
HEALTH AND RECOVERY SERVICES ADMINISTRATION  
DIVISION OF ALCOHOL AND SUBSTANCE ABUSE



Improving the Statewide Adolescent Treatment System of Care

# Strategic Plan

January 2008

## Introduction to the Adolescent Strategic Plan



The Division of Alcohol and Substance Abuse (DASA) is proud to have been one of only 16 states awarded a National Adolescent Substance Abuse Treatment Coordination Grant sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The primary goal of the grant is to enhance treatment capacity by providing accessible, affordable, and effective substance abuse treatment for youth and their families.

Washington State pursued this grant, because we understand the need to keep pace with developments in the chemical dependency treatment field and strengthen our comprehensive system of care. This grant provided an opportunity for us to thoroughly evaluate the services we fund and develop a plan that will meet the emerging needs of youth who struggle with substance abuse disorders and their families.

The needs of adolescents impacted by substance abuse are complex. Their recovery depends on quality care that is integrated and coordinated with other service providers in schools, mental health agencies, medical communities, and other social service systems. Recovery is enhanced when everyone works together to build a strong network of care for them and their families.

This reports draws on the wisdom of youth and families, treatment providers, system collaborators, and a very dedicated statewide steering committee. Together they produced this blueprint to provide that essential framework to improve effectiveness, quality of care, and treatment outcomes.

DASA and all our community partners are committed to serving the youth and families of Washington. The future of adolescent treatment is very promising, and I invite you to join us on this journey to make their lives better.

*Doug Allen, Director  
Division of Alcohol and Substance Abuse*

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We would like to say thank you to each of the people involved in this project. Your dedication to the wellness of youth with substance abuse disorders and their families has been demonstrated by all the effort you put forth. You have produced an essential framework that will be used to improve the effectiveness, quality of care, and treatment outcomes for the youth of our state.

We appreciate and are proud of your efforts.

We would also like to thank the Department of Substance Abuse and Mental Health Services Administration (SAMHSA) for their foresight to offer these grants (State Adolescent Substance Abuse Treatment Coordination Grant -TI-17366).

Special thanks to their staff, Jutta Butler and Randy Muck, for their continued guidance and support during this two-year process.

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“DASA has provided strong leadership and direction for the provider community over the years. Innovations like the Teen Line and CSAT Youth Grant website provide assistance with accessing available beds within the system.”

## Strategic Plan

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Prepared by Northwest Frontier ATTC  
December 17, 2007

### Executive Summary

The Washington Division of Alcohol and Substance Abuse (DASA) is committed to providing accessible and effective treatment services for youth and their families. To that end DASA has undertaken the task of identifying system improvement needs, developing a strategic plan to enhance the state treatment system, and ultimately to increase the capacity, effectiveness and cultural competence of the treatment provider network. The Strategic Plan summarizes what has been learned from a number of resources: consumers, treatment providers, and referral sources, a review of DASA-supported research, and a statewide steering committee.

The report includes a snapshot of the existing adolescent treatment provider network (Section I), a summary of the treatment system's strengths and limitations as identified in the statewide needs assessment (Section II), a synthesis of stakeholder priorities as determined by the Statewide Steering Committee composed of the Statewide Leadership Council and its four subcommittees (Section III), a graphic version of the proposed infrastructure for a statewide system of care (Section IV), and a set of both short and long-term action steps for infrastructure enhancement and adolescent treatment improvement (Section V).

### I. Capacity of the Adolescent Substance Abuse Service Delivery System

DASA funds both residential and outpatients services throughout the state. There are a total of 14 detoxification and stabilization beds, 138 residential treatment beds, and 36 recovery house beds for a total of 188 beds statewide. In addition, 137 outpatient clinics provide clinical services and 4 youth-oriented drug courts provide treatment supervision to the adolescent population. Those services provided care for 5,765 youth during 2005, approximately 29% of the estimated 19,545 youth who had diagnosable substance use disorders during that year. The private pay capacity and services provided were not calculated in this report.

### II. Needs Assessment Findings

To ascertain the needs for system improvement DASA conducted, with assistance from RMC Research and Northwest Frontier ATTC, a treatment improvement survey to assess provider use of best practices; an analysis of DASA youth-related research conducted between 1997 and 2005; and a focus group study that queried existing treatment staff, agencies who make referrals to treatment, parents of youth who have accessed services, and adolescents who had enrolled in a treatment service. These studies enumerated a set of strengths and a set of limitations of the existing system.

**System Strengths:** DASA has provided strong leadership and direction for the provider community over the years. Innovations like the Teen Line and CSAT Youth Grant website provide assistance with accessing available beds within the system. Outpatient services are readily accessible in most parts of the state. Juvenile justice agencies and drug courts have provided support to parents as well as avenues to more readily access residential services. The quality of residential treatment and the availability of family services within those programs are appreciated by providers, referral sources and families alike.

**System Limitations:** A number of gaps were found as a result of reviewing available literature and conducting focus groups in nine different cities throughout the state. Examples of some of the limits to system effectiveness include:

- Residential capacity is insufficient to accommodate needs in a timely way.
- Access to some levels of care can be confusing to families.
- Continuity of care between residential and outpatient lacks coordination.
- Cross systems coordination between schools, juvenile justice, mental health and other youth serving agencies needs to be stronger.
- Recovery support resources are not well developed.
- Family involvement in treatment, especially outpatient, is minimal.
- Funding and reimbursement rates are not sufficient to cover the costs of delivering care.
- The knowledge and skills of the workforce need targeted development.

### III. Statewide Steering Committee Priorities

Stakeholder groups synthesized priorities into six strategic domains. Each domain contains three to five priorities for infrastructure and system improvement. The domains include:

- A. Building a better qualified workforce by developing curriculum, faculty and agency leaders that can prepare and retain CDPs specializing in adolescent treatment.
- B. Enhancing existing agency capacity to provide and secure reimbursement for integrated services to youth having both mental health and substance use disorders.
- C. Establishing recovery support services throughout the state by developing guidelines and incentives for development of recovery-oriented systems of care for youth and their families or support networks.
- D. Reimbursing a variety of evidence-based and innovative treatment and recovery support services that when bundled can serve to stabilize and sustain recovery in teens seriously affected by a substance use or co-occurring disorder.
- E. Continuing to study the effectiveness of residential, outpatient and continuing care treatment in order to identify treatment and recovery centers of excellence.
- F. Improving treatment access, especially in rural areas, that makes treatment and recovery support available within the local area.

### IV. Vision for Adolescent Treatment Infrastructure

The vision incorporates both strengths and limitations of the system into a graphic representation of a Integrated System of Care. It is a system promoted by multiple media and provides a full spectrum of coordinated recovery-oriented services. Guidelines for service delivery are based on empirical support and emphasize continuous learning and efficacy. Reimbursement rates are referenced to the actual costs of delivering service and on research-based principles of effective care. On going attention is paid to both pre-service and in-service workforce development activities that emphasize the knowledge, skills and attitudes most likely to contribute to treatment effectiveness. Community coordination links components of health, social service, education, housing and vocational training systems in the development of case management services essential to successful recovery.

## V. Action Steps for Enhancing Adolescent Treatment

The Strategic Plan culminates in the identification of short and long-term action steps aimed at enhancing infrastructure and supporting effective treatment. Those action objectives are organized into seven arenas of activity:

- A. Establish and convene a statewide adolescent treatment advisory council that includes consumers, referral sources, providers and state administrators.
- B. Recruit and prepare a qualified entry-level adolescent treatment workforce by developing curriculum and faculty capable of preparing qualified CDP specialists in youth treatment for substance use disorders.
- C. Sustain a qualified workforce through the provision of competent clinical supervision and ongoing continuing education designed to meet the needs of treatment providers and the clients they serve.
- D. Identify the core elements and expected performance measures for an integrated recovery-oriented system of care.
- E. Improve standards of care based upon a history of quality treatment services as well as evidence-based research, and directing change through the contractual process with the expectation that providers will engage in continuous measurable improvement in their services..
- F. Incorporate recovery support services and recovery management to the extent feasible into the service designs of community treatment providers.
- G. Explore reimbursing eligible providers for services essential to recovery support and the implementation of evidence-based interventions.

This strategic plan is aimed at building upon the strengths of the existing system. It is suggested that change be incremental and based on known principles of implementation science. Infrastructure changes may need to take place first within state administration before community components of the strategy are implemented. It is expected that the realization of the goals in this plan will take years of focused leadership but that measurable improvements in the system can be achieved in the short-term.



“Youth and families need an ongoing voice in policy.”

—*Robyn Smith and Eleni Petropoulos, TeenLine*



“Washington State provides resources for acute inpatient care, residential treatment, recovery house and outpatient services.”

# Adolescent Treatment Infrastructure Development

Washington State Division of Alcohol and Substance Abuse

Prepared by Northwest Frontier ATTC

December 17, 2007

## Introduction

To assure the citizens of Washington State effective publicly funded treatment services for youth experiencing problems related to their use of alcohol and other drugs, the Division of Alcohol and Substance Abuse (DASA) has undertaken the task of identifying system improvement needs and developing a strategic plan to enhance the infrastructure and ultimately increase the capacity, effectiveness and cultural competence of the treatment provider network. DASA used funds from the Center for Substance Abuse and Treatment (CSAT) Adolescent Substance Abuse Treatment Coordination Grant to develop this strategic plan. This document summarizes what has been learned from consumers, treatment providers and referral sources who participated in focus groups throughout the state, a review of DASA-supported research, and a Statewide Steering Committee (SSC). The SSC was composed of four subcommittees (Certification, Licensure, Standards of Care; Resource and Access; Training and Workforce Improvement; and Youth and Family) and a Statewide Leadership Council that included a total of 128 key stakeholders.

This report is divided into five sections. It begins with a snapshot of the existing adolescent treatment provider network (Section I) followed by a summary of the treatment system's strengths and limitations discovered during a statewide needs assessment (Section II). There is a synthesis of stakeholder priorities as determined by the Statewide Steering Committee (Section III). The strategic plan culminates with a graphic version of the proposed infrastructure for a statewide system of care (Section IV) followed by a set of both short and long-term action steps for enhancing adolescent treatment (Section V).

## I. Capacity of the Adolescent Substance Abuse Service Delivery System

Washington State provides resources for acute inpatient care, residential treatment, recovery house and outpatient services. The types, quantity, existing capacity, the total persons served per annum, and the average length of stay at each level of care funded by DASA are described below.

- 14 Detoxification and Stabilization beds distributed in seven different facilities with the goal of meeting the acute and sub-acute detoxification needs of youth. The average annual admission of clients served from 2002-2007 is 433 with an average day length of 6 days.
- 41 Level One beds distributed in four different facilities. These programs tend to serve youth with a primary diagnosis of chemical dependency. The average annual admission of clients served from 2002-2007 is 477 with an average day length of 29 days.
- 97 Level Two beds spread in eight different facilities. These programs serve youth with a primary chemical dependency diagnosis and co-occurring barriers. The average annual admission of clients served from 2002-2007 is 840 with an average day length of 42 days.
- 36 Recovery House beds among in four different facilities. These are step down programs for youth who have completed a primary treatment episode. The average annual admission of clients served from 2002-2007 is 220 with an average day length of 51 days.

- The state certifies 137 Outpatient Clinics in 39 different counties. Some are managed by a parent organization with separate branch offices. Youth can be admitted with a diagnosis of substance abuse or dependence. They provide a range of services from Intensive Outpatient to continuing care. All the Outpatient programs are subcontracted through a County Coordinator system. In total, the outpatient system serves an average of 4,894 youth per year (this total includes clients that have been served in other levels of care).
- There are four Youth Drug Courts operating in four counties.

As outlined in the chart below the average number of adolescents receiving treatment over the past three years through DASA-funded support has remained fairly consistent. These numbers indicate that approximately 31% of youth needing treatment and who are eligible actually receive treatment services. That percentage exceeds the national average of approximately 10% (SAMHSA 2002), but significant need still exists for the state system to improve access and entry into treatment for those who qualify and request services.

### **Adolescent Treatment Gap Rates in Washington State for Publicly Funded Chemical Dependency Services (ages 12-17)**

Year	Needing & Eligible for DASA-Funded Treatment	Received Treatment with DASA-Funded Support	Number of Eligible Individuals Unserved	Treatment Gap Rate (Unserved Need)
2004	18,930	5,875	13,055	69%
2005	19,622	5,739	14,227	70.80%
2006	19,545	5,765	13,246	67.80%

- Data excludes adolescents covered by Behavior Health Plan, private-pay, and military insurance
- Source: Division of Alcohol and Substance Abuse; Tobacco, Alcohol and Other Drug Abuse Trends in Washington; 2004, 2005, 2006.

## **II. Needs Assessment Findings**

A statewide needs assessment was conducted during 2006 which included three separate studies designed to assess the strengths and limitations of the Washington State Substance Abuse Treatment System serving adolescents. This section summarizes the results of those studies, including:

1. Treatment Improvement Survey to assess adolescent treatment providers' use of established best practices.
2. Synthesis Report of DASA Supported Youth Related Research conducted from 1997-2005.
3. Series of state-wide Focus Groups designed to assess the strengths and limitations of the current system.

The focus group input was especially critical to the recommendations made here because the groups included representation of community stakeholders from all areas of the state and were people directly involved in the use of these services.

## Focus Group Study

The Resource and Access Subcommittee designed the focus group study to gather information from 4 target groups:

- Staff at treatment agencies who deliver substance abuse treatment services to adolescents.
- Staff at state, county, and community agencies that actively refer adolescents to substance abuse treatment.
- Adolescents who have participated in treatment.
- Family members of adolescents who have either attempted to access or have received treatment services.

The focus group questions were essentially identical across the four target groups and addressed 5 main topical areas: access to treatment, barriers to treatment, strengths in the adolescent substance abuse treatment system, weaknesses in the adolescent substance abuse treatment system, and changes/recommendations to improve the adolescent substance abuse treatment system. A two-person team consisting of an evaluator from RMC Research Corporation (RMC) and a Technology Transfer Specialist from Northwest Frontier Addiction Technology Transfer Center (NFATTC) conducted all of the focus groups. All sessions were audio taped, and the recordings used to assure accuracy of the written record.

The research team conducted focus groups from May through July 2006 with each of the populations in nine communities (Spokane, Tri-Cities, Yakima, Bellingham, Everett, Seattle, Tacoma, Port Angeles and Vancouver) across the state. Focus group participants were recruited using a multitude of methods, including:

1. A letter from the Director of DASA, Doug Allen mass mailed to all youth treatment providers, including all Tribal sites.
2. E-mails from DASA to County Coordinators who forward to all Outpatient Providers and other youth serving entities in their county.
3. E-mails from DASA Regional Administrators and Regional Treatment Managers,
4. Word of mouth through Statewide Leadership Council and subcommittee members,
5. Outreach to local community contacts by county and other adolescent treatment stakeholders.
6. Outreach through established collaborative meetings between DASA and Mental Health, Juvenile Justice, Office of Superintendent of Public Instruction, and Children's Administration.
7. Outreach to adolescent clients and their families by treatment agencies.

A total of 185 individuals participated in the focus groups including 49 substance abuse treatment providers, 43 referral agents, 62 adolescents, and 31 family members.

Focus group input was analyzed and synthesized into a report for the Statewide Leadership Council and subcommittee members to review and establish improvement priorities. The research team compiled the focus group information from all nine communities and identified the key themes reported across each of the four target groups. Those themes were categorized into 5 domains. The research team then engaged in a second pass through the data to confirm and record evidence of the themes and add any additional themes to the list. This analysis resulted in the identification of more than 100 themes across the five domains. Those themes were then synthesized into 29 problem statements. The Statewide Steering Committee composed of the Statewide Leadership Council and its subcommittees then prioritized the 29 problem statements into a list of the five greatest concerns or challenges. Those concerns are presented in section III of this report. The subcommittees were then convened again to develop strategies for addressing the five priority challenges. The Statewide Leadership Council elaborated on these initial ideas and generated additional strategies.

The summary below includes one section on the strengths identified by focus group participants and documented in the DASA research literature; and a second section which addresses nine issues or systemic problems identified by many of the groups who participated in the needs assessment. They range from access issues to needed service enhancements to funding and workforce development concerns. Actual recommendations for action appear later in Section V of the plan.

## Strengths of the Current System

### 1. Treatment Capacity and Access Issues

Treatment providers and referral agency staff participating in the focus group sessions note the availability of outpatient treatment services as a strength of the current system. Parents and youth report being able to readily access outpatient treatment services, usually within a couple of days. Treatment providers in several regions commend DASA's recent efforts to increase funding to allow providers to deliver outreach services in schools and communities. Treatment providers are now able to provide additional early intervention services. Strong leadership at DASA in the area of adolescent treatment services is seen as a strength of the current system.

Several treatment and referral agencies identify the new "Teen Line" website which is collaboratively developed and maintained by Teen Line and DASA, as a "very" useful source of information. The "Teen Line" provides up-to-date information regarding the availability of residential treatment slots. Having this information increases access and reduces wait times for residential care.

Family members identify the juvenile justice system as a key access point for "getting their child" into treatment. Often, youth are held in detention until a residential bed becomes available and families expressed how helpful it was to have their child detained is to ensure that the youth eventually enters treatment.

Many of the staff from referral agencies also view the ability to access treatment for youth without parental permission as a strength of the current system which improves access.

### 2. Collaboration and Networking

Focus group participants describe school intervention specialists as extremely helpful in both linking youth with treatment services and providing positive support for youth with substance use problems. Improvements made in the collaboration between treatment providers and the juvenile justice system were also recognized. Providers often talked about how supportive juvenile justice personnel are of treatment. The Washington juvenile justice system is viewed as having a strong rehabilitative approach versus punishment.



"This plan offers the state an opportunity to expand the existing network and create a State-of-the-Art treatment system."

—Steve Gallon, Director of NEATTC

Drug courts are viewed by both families and system collaborators as being a highly effective model for youth treatment. The model emphasizes collaboration and networking as a key component in the delivery of services.

### *3. Treatment Satisfaction and Quality of Treatment Services*

Many focus group participants express significant satisfaction with the quality of care provided by adolescent residential treatment facilities. Several of the residential treatment facilities were identified as having a strong family program component. Family members repeatedly expressed how important it is for them to be involved in all aspects of their child's treatment.

Several of the youth in the focus group talked about the advantages of being able to attend gender-specific groups. The girls identified the advantage of female-only groups as providing them with a "safe" environment to talk about sensitive issues. Many participants perceived that youth who are severely distracted by the complications of their disorder were better served in gender-specific program.

DASA-supported research has found these positive outcomes in the following areas for adolescents receiving treatment services: after treatment adolescents report more income earned from employment, adolescents report decreased use of alcohol and marijuana, fewer adolescents reported income earned from illegal behavior, school discipline problems decreased, and a lower percentage of adolescent patients were under legal supervision 18 months after treatment (DASA, 2005). The 2007 DASA Patient Speak Out Report concludes;

"In outpatient treatment, the proportion of youth patients reporting they were very or mostly satisfied with the service they received remained above 90 percent over the course of six years, in contrast to residential treatment where it has fluctuated sharply in the last four years with the rate dropping from 90 percent in 2006 to 82 percent in 2007."

## **Limitations of the Current System**

### *1. Treatment Capacity and Access Issues*

**Overall capacity:** Currently there is an insufficient number of state-supported acute care and residential treatment beds. Several groups identified significant wait times ranging from one to six months to access residential care. These reports are consistent with a 1997 DASA study where fifty-seven percent of parents interviewed reported having their child was placed on a waiting list for residential treatment services. Thirty-eight percent of the parents reported it took three months or longer for their child to get into treatment (Peterson, 1997). Wait times appear to be longer for publicly funded clients versus clients with private insurance. Only 36% of privately funded youth are placed on a waiting list, versus 63% of publicly funded youth (Peterson, 1997). Focus group respondents reported this wait time problem is compounded due to (in their perception) the current system lacking a standardized process for engaging and retaining youth between the time of assessment and admission to a residential service.

**Accessibility:** Parents find the system difficult to navigate and report a lack of readily available information on how to access services. Admission paperwork for residential care is difficult and time-consuming. Parents feel powerless to secure treatment for adolescents who refuse to attend. At the same time, providers note that youth get lost between assessment and admission to treatment. They report conducting assessments, recommending treatment, and discovering no follow-through by parents or referring agencies like schools or probation departments. Outpatient care was identified as being readily accessible, although a few communities did identify having "short" wait periods for obtaining assessments. Access improves once youth become involved in the legal system. Although there have been some recent increases in funding for outreach services, early intervention and outreach services to encourage early entry into the treatment system are usually the exception versus the norm.

**Access in rural areas:** Access to all levels of services is a significant issue in most rural communities. Youth living in rural areas have a difficult time accessing any services and often the only option they are offered is residential care in a facility that may be in another part of the state. When they return to their community, there is little, if any, additional treatment or recovery support services available. These findings correspond with national research indicating generally rural regions have more substance use and less treatment available (SAMHSA, 2004).

## *2. Treatment and Recovery Barriers*

A number of barriers exist that limit either treatment entry or transition from one level of care to the next. The primary treatment and recovery barriers identified in the focus groups and in the synthesis of the literature include:

- Youth may lack motivation for treatment or have active substance using parents and family members who discourage involvement.
- Long wait times for residential care.
- Transportation – a major issue for rural communities.
- Lack of coordination between schools, probation services, and treatment providers.
- Treatment services are not always culturally responsive.
- The system is confusing and frustrating to parents and they report often feeling “unsupported” and “alone.”
- Referral agencies report having difficulty placing youth with Fetal Alcohol Syndrome and/or developmental disabilities in treatment.
- Recovery support services are lacking in many communities.
- Access to informed services for co-occurring disorders is minimal or difficult.

## *3. Customer Satisfaction*

There was a strong perception among parents and youth participating in the needs assessment that residential services are of higher quality and more successful than outpatient. This is also supported by a process evaluation of the “Becca” bill that found, “overall chemical dependency treatment was viewed as moderately to very effective, with residential treatment viewed as more effective than outpatient” (Peterson, 1998). Youth and parents perceived outpatient services as unstructured and of limited value in helping youth discontinue their substance use and move into recovery. Perceptions of youth and parent regarding treatment effectiveness may be influenced by inappropriate matching of youth with more severe addiction with services that are less effective for this population. With lengthy wait times for residential services clients are often referred and served in outpatient regardless of acuity. Youth strongly recommended additional urine testing in outpatient and encouraged treatment providers to focus more on skill-building versus drug education and/or seeking to help youth understand “why they use drugs.”

## *4. Treatment Access and Retention*

Admissions, retention and completion rates during the past five years reveal trends in the service delivery system and create a baseline with which improvement projects can be compared. Following is a summary of those trends for outpatient and residential services. More complete data tables appear in Appendix A.

**Outpatient:** Statewide admissions have declined from a peak of 5,028 in 2003 to 4,715 in 2007, a 6% drop. Most of the decline has been within Regions 3, 4 and 5. Ninety-day retention rates have remained steady over the same period at about 59%. There is some variability across regions, with Region 4 consistently having above average retention at approximately 70%. The state average completion rate is 39%. Again, Region 4 outperforms other regions with an average approaching 55%. Completion is defined as “services at this ASAM level of care have been completed” (DASA Target Dictionary).



“The work of the last three years has taught me that adolescents are system dependent and are reliant on us to supply them with a coordinated system of care.”

—David Jefferson, Youth Grant Manager

**Residential:** Completion rates vary by residential level of care. Five year averages are 66% for Level 1, 68% for Level 2, and 59% for Recovery Houses. Given the additional structure, security, and intensity of care, it is understandable that residential completion rates will be superior to those observed for outpatient services.

### *5. Need for Improved Continuity of Care*

DASA-supported research studies consistently find that youth who attend continuing care and/or community support groups following intensive treatment episodes have 50% higher rates of recovery (DASA, 1997; DASA, 1994) than those who do not. Yet a common theme emerging in the focus groups was the identification of a frequent disconnect between residential care and outpatient/continuing care. It appears that some youth completing residential care do not enter continuing care services, nor do they receive the recovery support services they need to sustain sobriety. Some of the reasons given for this disconnect include: 1) many rural areas do not have nearby access to outpatient treatment services, 2) there is a lack of communication between residential treatment programs and outpatient treatment programs, 3) the lack of recovery support services, 4) adolescents attending residential programs that are long distances from their own regional treatment system, 5) public funding pays for episodes of clinical care but does not cover community recovery services, and 6) the lack of coordinated care that would support youth in receiving the services they need.

Another recurring theme expressed by many of the focus group member, across all four target group, is the lack of services for youth with co-occurring disorders and integration between mental health and substance abuse services. A DASA study conducted in 1997 found that on average 65% of the youth in residential facilities had received previous mental health services and that over 40% of the sample was taking some form of prescribed medication for mental health disorders (Peterson, et. al., 1997).

### *6. Collaboration and Linkage between Agencies Serving Adolescents*

The adolescent substance abuse treatment system is described by focus group members as being fragmented with minimal coordination between local agencies. There is significant variance in the degree of coordination by city, county, and region and also by types of service. Recommendations were made for enhancing communication and coordination between treatment providers, juvenile justice, health care, schools, vocational services, and mental health centers. One vehicle would be to increase the current limit on outpatient case management (five hours of billing per patient per month).

### *7. Family Involvement and Participation in Treatment*

Family involvement in treatment is a key to successful outcomes. However, treatment providers and referring agency staff find it difficult to engage families in treatment. Some family members are resistive and providers do not receive incentives to provide family services. Current rules allow reimbursement for family services on an outpatient basis but there is not a dedicated fund for services. Residential providers are expected to pay for family services using funds from their daily bundled rate. Stakeholders believe DASA needs to explore ways to make family services an integral component of youth treatment.

## 8. Funding Infrastructure and Billing Issues

Currently there does not appear to be sufficient resources to support a continuum of care to address the comprehensive needs of adolescent substance users and their families. There is substantial need to:

- Increase reimbursement rates for all levels of care to reflect the true cost of providing treatment services.
- Increase the number of state-supported residential treatment slots.
- Provide reimbursement for services such as case management, pre-treatment services to engage clients, transportation, vocational services, and motivational incentives to increase retention rates.
- Make more recovery and transitional housing available.
- Develop and support recovery support services.
- Deliver and reimburse more family treatment services.

Existing rate structures do not provide sufficient funds to increase the wages of Chemical Dependency Professionals (CDPs). One of the factors contributing to a shortage of qualified adolescent specialists is the low salary rates among treatment providers.

## 9. Workforce Development

There is a clear need for more adolescent treatment specialists and models of care designed specifically for youth. Specialists are needed who are knowledgeable and have the skills necessary to provide services that engage and retain youth in greater numbers than is currently the case. Many existing providers need training in how to most appropriately address youth with disruptive behavioral problems and provide treatment that is developmentally appropriate.

Participants in the needs assessment process frequently cited the following as potential treatment improvements:

- Assure individualized treatment planning that includes “wrap-around” services to support long-term recovery.
- Provide integrated services that address mental health, family health, substance use, and other physical health issues.
- Do screening and diagnostic assessments that address the multiple problems facing substance-abusing youth, including co-occurring mental health issues.
- Use evidence-based practices developed specifically for adolescents.
- Provide programs that are gender-specific and culturally competent.
- Provide vocational training services for older adolescents.
- Develop treatment teams (substance abuse, mental health, probation, etc.) in rural areas, to better address the multiple needs of youth.

## III. Statewide Steering Committee Priorities

All four of the Statewide Steering Committees representing government entities, treatment providers, consumers, and referral sources, participated in two rounds of meetings in 2007 to review, prioritize and develop strategies for the Strategic Plan. This section synthesizes and highlights the priority changes recommended by the SSC separated into six different areas: workforce development, services for co-occurring disorders, recovery support services, reimbursement, effectiveness of care, and improvement in treatment access.

- A. Building a better qualified workforce for the adolescent treatment system.** Infrastructure change needs to address educational programs, supervision practices, credentialing, recruitment and retention strategies. These are high priority:

1. Develop curriculum and faculty that will adequately prepare CDPs with an interest in treating youth. Course work needs to be competency-based and include adolescent development, essential tasks in assessing, and recovery oriented services for youth, and training in the use and development of activities attractive and useful to youth.
2. Develop a CDP specialty credential in youth services. Provide incentives for potential CDPs to specialize in adolescent recovery services.
3. Ensure clinical supervision that assists clinical staff in further developing their skills, assures quality of care, and improves treatment outcomes. Establish field placement sites or training centers of excellence where students and interns receive specialized training and practice in delivering services to youth.
4. Encourage staff retention strategies that incorporate adequate compensation, ongoing continuing education, and recognition of excellence among providers of adolescent treatment.

**B. Youth with co-occurring mental health and substance use disorders** require services sensitive to their unique recovery needs. The following infrastructure recommendations involve the development of policies and procedures that will:

1. Assure access to competent assessment and care in both mental health and substance abuse systems, including the use of adolescent co-occurring disorder recovery coaches to help guide the development of effective community-based services.
2. Fund empirically supported services for parents, other family members, and guardians of youth with co-occurring disorders.
3. Align funding sources and mechanisms that allow for adequate and timely payment for co-occurring disorder services.
4. Expand the availability of secure facilities for youth with co-occurring disorders and who are judged to be a danger to self or others.

**C. Recovery support services** represent a relatively new addition to the existing network of treatment services. Recovery support services are delivered over a longer period of time than more acute and intensive forms of care. They provide a source of community integration, skill building, relapse prevention and a means to improve existing recovery rates. In order to establish such support services in a recovery oriented system of care it is suggested that DASA:

1. Create guidelines for the development of community-based recovery-oriented systems of care for youth and families, including the recruitment and training of recovery mentors.
2. Provide incentives for the establishment of recovery support services in community organizations that already provide services to youth (treatment facilities, schools, community colleges, job corps, parks and recreation departments, juvenile justice facilities, health clinics).
3. Assure coordination among agencies that provide services to youth.

**D. Adequate reimbursement rates** are essential to the development of a qualified workforce and the delivery of needed recovery support services. Infrastructure improvements are needed to assure:

1. Reimbursement for individual, groups, family treatment, accredited alternative programs (wilderness or adventure-based activities) case management, outreach, clinical supervision, pretreatment services, continuing care, and recovery support.
2. Experimental reimbursement rate for an episode of bundled services (counseling, family treatment, case management, recovery mentoring).
3. The cost of clinical supervision is incorporated into the reimbursement rate for all services.
4. Publicly funded treatment services are as accessible and provide comparable lengths of stay as compared to private pay programs.

- E. Continue to study the effectiveness of residential, outpatient and continuing care treatment and recognize those treatment agencies** that achieve excellence in providing treatment access, service delivery and outcome. The state's infrastructure should assure that:
1. Programs and staff that activity engage youth in services are identified and studied and findings disseminated throughout the adolescent treatment network.
  2. Service improvement is an expectation of all state-funded service providers. Training and technical assistance is available for agencies wanting to improve their business and treatment processes.
  3. Services are age and developmentally appropriate.
  4. Criteria for Adolescent Treatment Centers of Excellence are identified and agencies encouraged to achieve such status.
  5. Adjustment is made to the length of stay expectations to be more in line with treatment outcome data, thus maximizing the cost-benefit of the services delivered. Limit length of stay averages in some settings (residential to 90 days), extend length of stay averages in other settings (outpatient and continuing care to 90-180 days).
- F. Treatment access, especially in rural areas, needs to be improved** by establishing an integrated system of care within each administrative region of the state. Infrastructure changes are needed to assure the availability of:
1. A continuum of care that makes recovery-oriented care available within the local area.
  2. A recovery network of services within each locale that connects youth-serving health, justice, education, mental health and social service agencies and professionals into a coordinated system.
  3. Awareness and understanding of substance use disorders and recovery among all agencies and professionals that provide health and human services to youth.



“Including parents in an adolescent treatment plan is crucial. I am honored to speak for parents who care about teens and community.”

—Chris Volkmann, Family Author

## IV. Vision for an Adolescent Treatment Infrastructure in Washington State

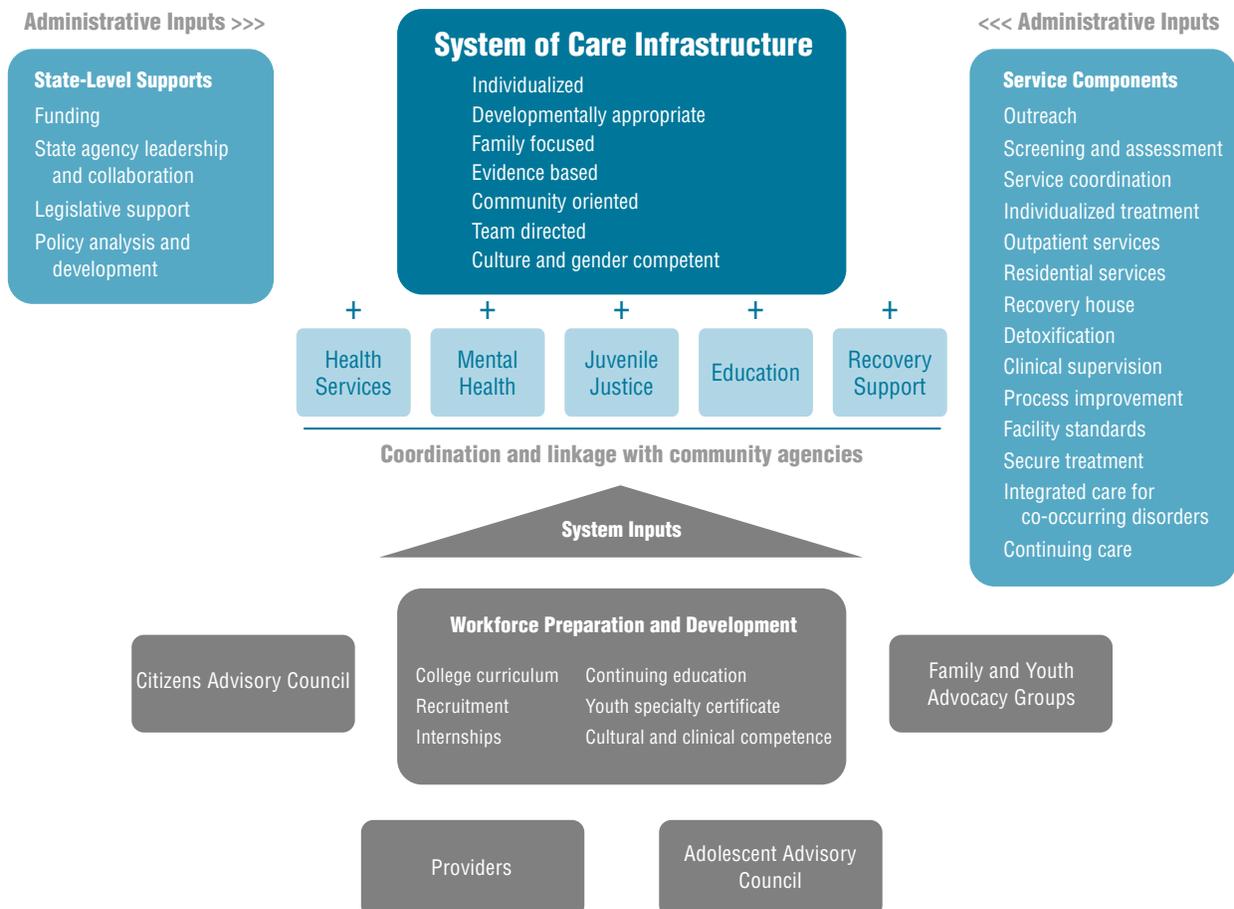
Findings from the needs assessment and the resulting identification of stakeholder priorities suggest a vision for an adolescent infrastructure. The vision is summarized by Diagram 1 on the following page.

The envisioned infrastructure supports a regionalized system of care. Each of Washington’s six regions or identified service delivery area is intended to contain as full a continuum of treatment services as is practical, thus allowing youth in treatment to remain within commutable distance to their primary residence. A regionalized system will facilitate smoother transitions from one level of care to the next and allow local recovery support services to be utilized at the earliest possible point in the treatment process.

As noted in the diagram the services within an integrated system of care include services provided by allied agencies in the community. Linking with health, mental health, juvenile justice, schools, and recovery support services is critically important to the success of any adolescent treatment system. Your service system should receive input and support from external contributors like pre-service counselor education programs, continuing education seminars and workshops, and a diverse statewide advisory panel of stakeholders. Administrative components of the infrastructure assure adequate funding of key services and clarification of treatment components and standards. Taken as a whole, this infrastructure can guide the improvement of adolescent treatment services across the state.

### Diagram 1

#### Washington State Youth Substance Abuse Treatment and Recovery System of Care Infrastructure



## V. Short and Long-Term Action Steps for Enhancing Adolescent Treatment

The strategic plan objectives described below are aimed at enhancing an infrastructure that supports effective adolescent treatment. Realization of those objectives will take time and resources. DASA will need to make a commitment to the infrastructure improvement process by taking short-term actions and planning for Long-term change that will result in a sustainable improvement in effective treatment. The recommended actions summarized below conform to the vision described above.

### A. Establish and convene a statewide adolescent treatment council

#### Short-term:

1. Identify potential members representing a cross-section of stakeholders.
2. Define role and responsibilities for the council.
3. Initiate quarterly meetings.

**Long-term:** Assure that input from the council is considered and acted upon when feasible.

### B. Recruit and prepare a qualified entry-level adolescent treatment workforce

#### Short-term:

1. Provide incentives or contracts for the development and maintenance of a pre-service training curriculum that conforms to the known elements of effective substance use disorder treatment for youth.
2. Prepare faculty in appropriate college and education settings to deliver a curriculum that qualifies participants to seek a CDP specialty certificate in youth services.
3. Establish standards for student placements and internships focused on developing competence in youth prevention, early intervention and treatment services.

**Long-term:** Provide incentives for colleges and institutions to offer specialty education and training in the knowledge, skills and attitudes essential to effective youth substance abuse disorder prevention and treatment.

### C. Continued development of a sustainable and qualified workforce

#### Short-term:

1. Establish standards for clinical supervision in treatment agencies that conform with research findings regarding the effective implementation of innovative and empirically supported practices.
2. Collaborate with treatment directors and system administrators in how best to implement true clinical supervisory practices.
3. Provide for the implementation of clinical supervision practices throughout the state in accord with the principles of implementation science.
4. Improve and make available continuing education events on a regular schedule throughout the state that enhances the knowledge and skills of program directors, supervisors, direct service staff, and staff of allied health and human services.. Attendees will be trained to deliver services that are evidence-based and culturally appropriate for youth with substance use and co-occurring disorders.

**Long-term:**

1. Develop an adolescent CDP credential that will identify those most qualified to work in youth oriented substance abuse and co-occurring disorder treatment settings.
2. Maintain an ongoing annual schedule of continuing education events for a variety of professionals who specialize in working with youth and families.

## **D. Core elements of an integrated recovery-oriented system of care**

**Short-term:**

1. Identify the desirable elements of an integrated continuum of recovery oriented services.
2. Establish expectations and measurable indicators at the state level for what constitutes an adequate system of care within each administrative region.
3. Assess the availability and existing coordination of the preferred continuum in each administrative region of the state.
4. Identify and prioritize needs across the state's administrative regions.
5. Plan to meet the highest priority needs within the limits of existing funding.
6. Develop methods of dissemination and education materials to help system. participants get access to information about the continually evolving system of care

**Long-term:**

1. Develop a plan to meet Long-term needs of each administrative region.
2. Conduct evaluation studies to determine which services contribute most to the success of a recovery-oriented network of services
3. Modify regional expectations based on performance data

## **E. Treatment guidelines and protocols**

**Short-term:**

1. Improve standards of care for youth service providers that incorporate research-based principles of effective recovery-oriented care.
2. Encourage agencies to complete the RWJ Improving Adolescent Treatment: A Self-Study Workbook for Adolescent Substance Abuse Treatment Providers (2006) as a means to assess adolescent treatment services alignment with key elements of effective adolescent care. Appendix B of this document provides an overview of the nine key elements of effective adolescent treatment. The self-study workbook can be downloaded at [www.reclaimingfutures.org](http://www.reclaimingfutures.org).
3. Identify and assertively promote statewide the utilization of treatment methods consistent with what is known about successful recovery-oriented youth treatment
4. Establish expectations for ongoing measurement and improvement of business and clinical processes, and treatment outcomes among treatment providers.
5. Provide technical assistance for the adoption and implementation of innovative empirically supported treatment methods and protocols.

**Long-term:**

1. Evaluate the effectiveness of select treatment methods and protocols so as to distinguish those most effective in facilitating recovery and improvement of youth functioning.
2. Establish a statewide collaborative relationship with agencies providing youth services in order to identify state-level changes and improvements that will improve access, engagement and retention of youth in treatment.

**F. Recovery management and support****Short-term:**

1. Pilot the development, delivery and evaluation of evidence-based recovery management services in a small number of counties or treatment agencies for specific populations of youth enrolled in substance use disorder treatment.
2. Determine the feasibility and cost of expanding recovery management services, based on the results and lessons learned during the pilot program.
3. Identify the need to provide training in recovery management to adolescent treatment agencies statewide.

**Long-term:**

1. Pending success of the pilot project, adopt recovery management as a standard and expected practice in the adolescent treatment community.
2. Provide for the funding or reimbursement of recovery management services at all levels of care within the adolescent treatment system.
3. Assure that pre-service and continuing education programs integrate recovery management theories and methods into educational curricula and training events.
4. Provide technical assistance to community treatment programs in the adoption and implementation of recovery management principles and methods.

**G. Funding and reimbursement changes****Short-term:**

1. Examine existing reimbursement protocols and determine degree to which services essential to recovery support are currently reimbursable.
2. Identify any non-reimbursable services that should be made reimbursable.
3. Experiment with a reimbursement rate for an episode of bundled services. (counseling, family treatment, case management, recovery mentoring) by developing several pilot demonstrations.
4. Determine the cost of incorporating clinical supervision into the reimbursement rate for all services.

**Long-term:**

1. Consider any legislation necessary to review reimbursable services and increase rates to ensure a full continuum of evidence-based recovery-oriented services for adolescents and their families.
2. Assure that insured and publicly funded treatment services are available equally and for equivalent lengths of stay to qualified patients.
3. Consider legislation that will support the continued movement toward and conformity to research-based care.

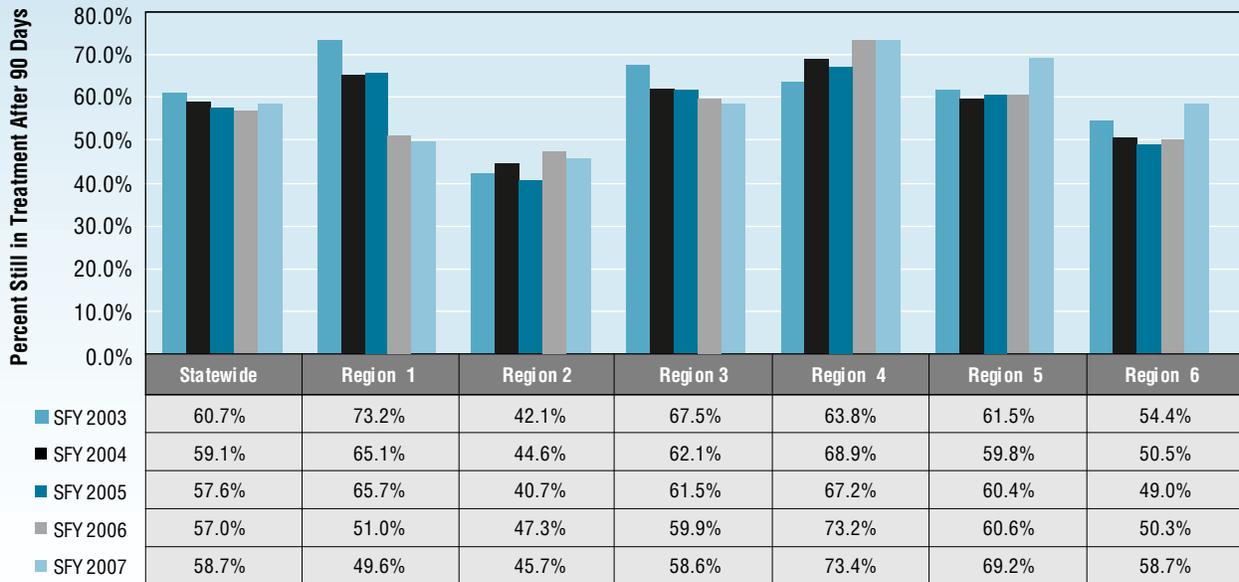
## References

- Office of Applied Studies (2002) *Report from the 2001 National Household Study on Drug Abuse Volume 1: Summary of National Findings*. Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).
- Brannigan, R, Schackman, B.R., Falco, M.F., & Millman, R.B. (2004). The quality of highly regarded adolescent substance abuse treatment programs. *Archives Pediatric Adolescent Medicine* 158: 904-909.
- Substance Abuse and Mental Health Service Administration (2007) Expert Panel on Juvenile Justice and Adolescent Substance Abuse Treatment. Rockville, MD.
- Peterson, P. (October, 1997) *Evaluation Report on the Appropriateness of Treatment: Youth Admitted to Residential Chemical Dependency Treatment Under the "Becca" Bill*.
- Peterson, P. P., Srebnik, D., Banta-Green, C., Baxter, B. (1997). *Treatment Outcome Evaluation: Youth Admitted to Residential Chemical Dependency Treatment Under the Provision of the "Becca" Bill: Final Report*. Seattle, Washington: University of Washington, Alcohol and Drug Abuse Institute.
- Peterson, Peggy L. (February, 1998). *Implementation of the "Becca" Bill: A Process Evaluation: Final Report*. Seattle, Washington: University of Washington, Alcohol and Drug Abuse Institute.
- Washington Division of Alcohol and Drug Abuse Division (December, 1994). *Adolescent Treatment Outcome Study Report*. Olympia, Washington.
- Reclaiming Futures National Program Office (2006) *Improving Adolescent Treatment: A Self-Study Workbook for Adolescent Substance Abuse Treatment Providers*. Portland, Oregon; Portland State University.
- Reclaiming Futures Treatment Fellowship (2007) *Improved Care for Teens in Trouble with Drugs, Alcohol, and Crime*. Portland, Oregon: Portland State University.
- Washington Division of Alcohol and Substance Abuse Division (August, 1997) *Washington State Division of Alcohol and Substance Abuse 18-Month Adolescent Outcomes Report*. Seattle, Washington.
- Washington Division of Alcohol and Substance Abuse. (2005). *Tobacco, Alcohol, & Other Drug Abuse Trends in Washington State*. Olympia, Washington: Washington State Department of Social & Health Services.
- Washington Division of Alcohol and Substance Abuse. (2007). *Patients Speak Out 2007*. Olympia, Washington: Washington State Department of Social & Health Services.



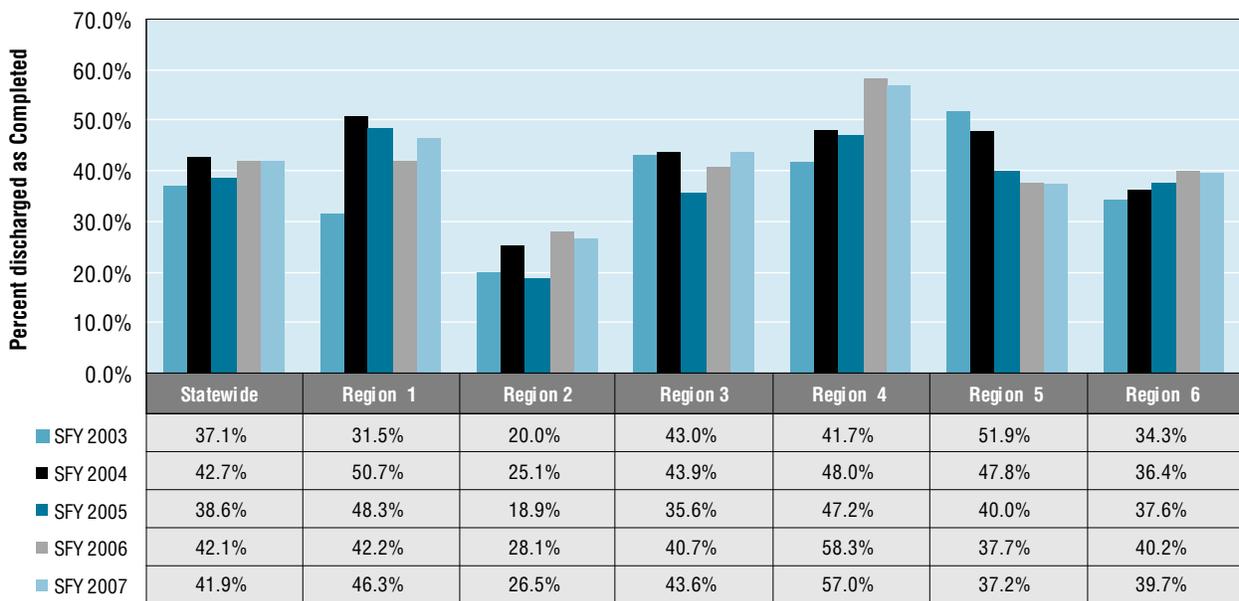
“Each of Washington’s six regions or identified service delivery area is intended to contain as full a continuum of treatment services as is practical, thus allowing youth in treatment to remain within commutable distance to their primary residence.”

**Outpatient Retention Rate<sup>1</sup> at 90 Days by DSHS Region**



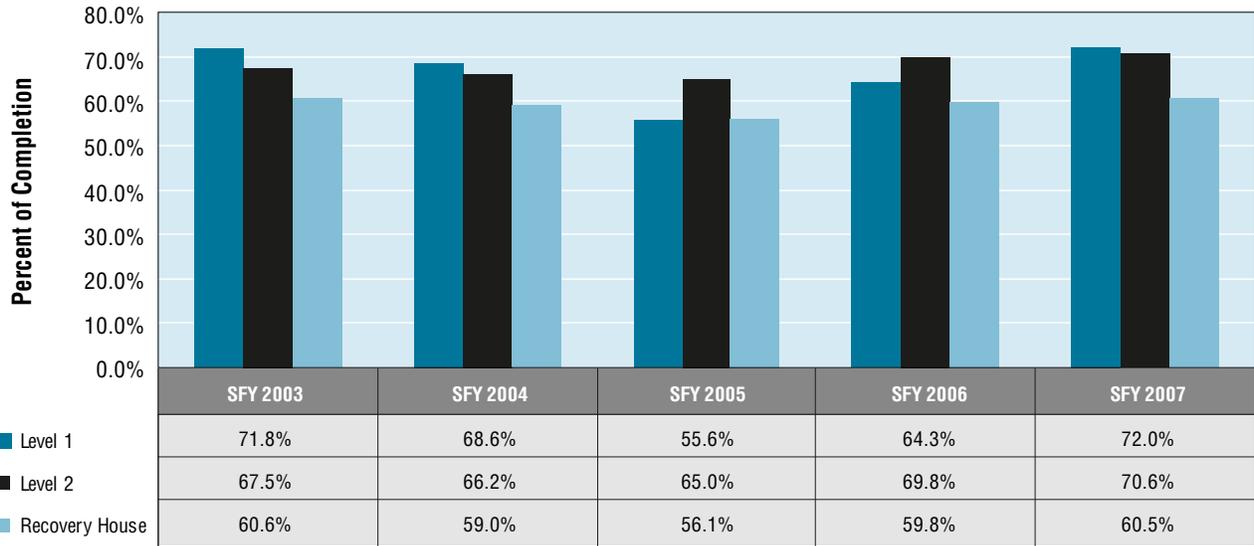
<sup>1</sup>Retention Rate = # of youth in treatment / # youth admitted

**Outpatient Treatment Completion Rate<sup>1</sup> by DSHS Region**



<sup>1</sup>Outpatient treatment completion rate = # of completed discharges / # of eligible discharges (eligible discharges are those reported as: Completed; Not Amenable to Treatment/Lacks Engagement; No Contact/Abort; Rule Violation; Withdrew Against Program Advice).

## Residential Completion Rate by Level of Care



Rob Vincent, Administrator ESD113 True North-Student Assistance & Treatment Services (left) and John Hughes, Sunnyside School, Safe & Effective Schools Director, attended the 2007 National Joint Meeting on Adolescent Effectives (JMATE). “It’s very important that we provide integrated systems of care that are developmentally appropriate,” said Rob.

The research and knowledge related to effective adolescent treatment is still in the early stages of development. Although, there have been a number of research studies conducted on specific models over the past decade, there have been only a few systematic evaluations that have attempted to define the essential elements of effective adolescent substance abuse treatment programs. One of the most recent systematic evaluations was led by Drug Strategies, in which a panel of expert researchers, policymakers, and treatment practitioners specializing in adolescent substance abuse combined their clinical knowledge with a thorough review of the existing literature to identify nine key elements of effective adolescent treatment (Brannigan, Schackman, Falco, Millman, 2004). Those elements are outlined in the following table.

**Table 1**

### Nine Key Elements of Effective Adolescent Treatment

<p><b>1. Assessment and Treatment Matching:</b> Programs should conduct comprehensive assessments that cover psychiatric, psychological, and medical problems, learning disabilities, family functioning, and other aspects of the adolescent’s life.</p>
<p><b>2. Comprehensive, Integrated Treatment Approach:</b> Program services must address all aspects of a teen’s life, including school, juvenile justice, mental and physical health, and the community.</p>
<p><b>3. Family Involvement in Treatment:</b> Research shows that involving parents in the adolescent’s drug treatment produces better outcomes.</p>
<p><b>4. Developmentally Appropriate Program:</b> Treatment programs and materials need to be tailored to adolescents, who are more concrete thinkers than adults and also have less-developed verbal skills.</p>
<p><b>5. Engaging and Retaining Teens in Treatment:</b> Program strategies and activities should build a therapeutic alliance – a climate of trust between the therapist and the client-which facilitates behavior change.</p>
<p><b>6. Qualified Staff:</b> Staff should be trained in adolescent development, co-occurring mental disorders, substance abuse, and addiction.</p>
<p><b>7. Gender and Cultural Competence:</b> Programs should address the distinct needs of adolescent boys and girls as well as cultural differences among minorities.</p>
<p><b>8. Continuing Care:</b> Programs should include relapse prevention training, aftercare/follow-up plans, and referrals to community resources.</p>
<p><b>9. Treatment Outcomes:</b> Rigorous evaluation is required to measure success, target resources, and improve treatment services.</p>

The nine key elements are supported even further by two recent publications which examine models of care: Improved Care for Teens in Trouble with Drugs, Alcohol and Crime (Reclaiming Futures Treatment Fellowship, 2007) and Expert Panel on Juvenile Justice and Adolescent Substance Abuse Treatment (Mayatech Corporation, 2007). Those documents point to four key areas of adolescent treatment infrastructure development which are essential to the development and sustainability of the nine key elements of care:

- A qualified workforce.
- An integrated “system of care” that utilizes a team approach to assure individualized services.
- Appropriate and adequate funding mechanisms to support a “system of care”
- Strong collaboration and linkages between the multiple adolescent services that comprise a comprehensive system of care.

To demonstrate how the nine key elements and four areas of infrastructure development are essential to each other, consider assessment and treatment matching. Qualified clinicians are essential to providing quality assessments. Thereafter, it is impossible to appropriately match services to individual needs without a comprehensive system of care that draws from the entire spectrum of available community services. That can only happen when strong linkages exist between multiple agencies.

The findings from the DASA Adolescent Treatment Coordination Needs Assessment provide additional support for focusing on the nine key elements and four areas of infrastructure development described above in order to improve the quality of care within Washington’s network of adolescent treatment providers.



“Although, there have been a number of research studies conducted on specific models over the past decade, there have been only a few systematic evaluations that have attempted to define the essential elements of effective adolescent substance abuse treatment programs.”



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