HEALTH SERVICES AGENCY
ADMINISTRATION

COUNTY OF SANTA CRUZ

HEALTH SERVICES AGENCY

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July 20,1998

AGENDA: August 11, 1998

BOARD OF SUPERVISORS
County of Santa Cruz
701 Ocean St., Fifth Floor
Santa Cruz, CA. 95061

SUBJECT: **REPORT ON TREATMENT OPTIONS FOR ADOLESCENT DRUG ABUSE**

Dear Members of the Board:

Background:

During budget hearings your Board received testimony about drug abuse by teenagers in the County. Specifically, the Board heard concerns from parents and community members on the increased use of heroin and amphetamines by young people and the limited community treatment options for both detoxification and rehabilitation. Based on this testimony and the data from the Health Services Agency validating an increase in the use of these dangerous drugs, your Board directed the Health Services Agency and County Administrative Office to begin working on options for addressing treatment deficits in the community. You also directed that the Board consider the formation of a task force to assist in this effort at today's meeting. Since that time, staff from Probation, HRA, Children's Mental Health Services, the Alcohol and Drug Program, and other parties have begun to work together to develop a sound model for delivery of care to high risk youth, and to begin formulation of options for filling critical treatment gaps.

Activities:

Since your Board provided this direction, our working group has met three times, worked with two different consultants on data collection and treatment options, coordinated its activities with the Criminal Justice Council, SCNET (Santa Cruz Narcotics Enforcement Team), and the Together for Youth Collaborative and has developed the attached report on options for addressing the treatment gaps in the current system. The attached report is a first step toward developing final recommendations for your Board.

The report includes several components:

- Defining the Problem
- Defining the Optimal Treatment System/Continuum
- Critical Gaps in CARE
- Short and Long Term Options and Obstacles
- Process To Refine Recommendations

Consultants will assist County staff in researching innovative program models for delivery of care, researching funding options for services, and developing final recommendations to be presented to your Board. Rather than creating an additional task force, staff recommends that our working group serve as the coordinating group for this project, and that interested Board members be invited to attend our meetings. With regard to public input, we will seek the advice of existing commissions, including the Alcohol & Drug Abuse Commission, the Mental Health Advisory Board, and the Human Services Commission. With the involvement of the Commissions and the working group, we do not believe an additional task force is advisable.

Recommendations:

It is, therefore, RECOMMENDED that your Board take the following actions:

1. Accept the attached Report and direct work to continue with further recommendations to be returned to your Board on October 20, 1998.

Sincerely,

Charles M. Moody
Health Services Agency Administrator

RECOMMENDED:

Susan Mauriello
County Administrative Officer

cc: Auditor-Controller
County Administrative Office
County Counsel
HSA Administration
Community Mental Health
Probation
HRA Administration

PRELIMINARY STUDY OF TREATMENT OPTIONS RELATED TO ADOLESCENT DRUG ABUSE

BACKGROUND

The Board of Supervisors, in response to public concern related to adolescent drug abuse, directed county staff to begin developing recommendations for addressing this problem. Staff members of the County Administrative Office , the Health Services Agency, the Probation Department, the Human Resource Agency, the Alcohol and Drug Program, and Children's Mental Health have worked together and have consulted with community-based programs providing drug abuse and other services to adolescents. This, the first of two reports to be presented to your Board, provides data on the problem, an optimal treatment continuum, short and long-term approaches to filling treatment gaps, and a recommended process for finalizing recommendations to your Board.

SECTION I - DEFINING THE PROBLEM

Defining and understanding the problem of adolescent drug abuse is critical to developing an effective solution. Heroin and methamphetamines have received particular attention owing to their severe consequences and the rapid increase in their use by local youth. Heroin is a powerful narcotic which has a strong analgesic effect and produces intense euphoria. Heroin is highly addictive and users risk respiratory failure from overdose, as well as various diseases (e.g., HIV, hepatitis) associated with the use of dirty needles and impure drugs. Owing to the fear of HIV and the increasing purity and decreasing cost of heroin in recent years, many new users begin by smoking or inhaling heroin. However, heroin is highly addictive even when smoked or inhaled, and many of these users progress to injection use within a few weeks or months.

Methamphetamines are a powerful, easily manufactured form of amphetamine which produces agitation, hyper-vigilance, sleeplessness, appetite loss, and feelings of grandiosity. Methamphetamines are typically inhaled, ingested or injected. Users risk cardiac arrest and stroke from overdose, impulsive dangerous behaviors resulting from a sense of paranoia and grandiosity, extreme depression after a methamphetamine binge, and diseases resulting from infected needles and impure drugs.

Both heroin and methamphetamines are highly addictive drugs which require progressively larger doses to achieve the same effect, and can quickly dominate a person's life, creating severe social, educational, economic, legal and health problems.

Many sources of data were reviewed to confirm the presence of a serious level of drug abuse among the County's teenagers. The County Office of Education, in cooperation with the HSA Alcohol and Drug Program and local schools, surveys drug use among school youth every two

years. The survey with the latest validated data is for FY 96-97. Heroin is one of the drugs generating the most significant concern. The utilization data related to heroin includes the following:

- 6% of 11th graders countywide have tried heroin compared with 2.1% of 10th graders and 1.8% of 12th graders nationwide
- Locally, 2% of 11th graders and 1% of 9th graders have used heroin in the past month. This translates into 200 9th to 12th graders using heroin in the past month. This is a very conservative figure because it does not include school drop outs and is based on self reporting.
- In a nationwide survey, heroin use between 1993 and 1997 increased from 1.3% to 2.1% for 10th graders, and from 1.1% to 2.1% for 12th graders.
- 6.4% of the 1996-97 County treatment clients under age 18 had heroin as a primary drug problem, compared with 2.4% in 1994-95.
- 18% of Santa Cruz County Adult Jail inmates tested positive for heroin in 1995, compared with 9.2% for LA, Sacramento, Orange, Alameda, Riverside and San Bernardino counties in the same study.

The local school survey, though very conservative, points to an increasing level of heroin use in local young people and a higher than national level of use by local teens. At the request of the task force, national data was gathered by William Mercer & Associates, consultants in health, mental health, and substance abuse. The Bay Area, Southern California and the Southwestern states have higher levels of heroin use and availability than the rest of the nation. While the primary source of heroin is considered to be through Mexico, methamphetamines are considered locally produced in low cost labs. While the task force is focused on development of treatment options and is not charged with addressing the production and distribution of drugs, the Criminal Justice Council's Drug and Alcohol Task Force has indicated that it will investigate issues within the County associated with the local production and distribution of drugs.

Nationwide data reviewed by the Mercer group indicates that between 1994 and 1995, 4 of 21 major metropolitan area had significant increases in total drug use, with the San Francisco Bay Area increasing the most (57%), followed by New Orleans (40%), Los Angeles (10%) and Seattle (7%).

Nationally, from 1990 through 1995, the number of heroin-related episodes doubled (from 33,900 to 76,000), as did the rate per 100,000 population (from 15 in 1990 to 33 in 1995). Between 1994 and 1995, heroin use in the San Francisco Bay Area increased 67%, representing an increase 43% higher than the next highest Metropolitan area (Seattle, 24% increase). The San Francisco Bay Area also leads the nation in heroin-related episodes with 386 per 100,000 in population in 1995.

Nationally, between 1991 and 1994, methamphetamine related episodes rose 261% and amphetamine related episodes increased 322%. Although there was no increases noted between 1994 and 1995, this was thought to be attributable to a lack of supply, versus a decrease in

demand for these drugs. The number of metamphetamine treatment facility admissions is highest in the western states, with California leading the way. In the far west, the rate per 100,000 persons admitted for methamphetamine abuse in 1994 is double that reported in 1992. California also leads the nation in methamphetamine laboratory seizures with 33% of the total in 1995, or 108 out of 327 seizures, a strong indicator that California leads the nation in use of these drugs.

(In the appendix to this report are a number of national and regional studies on drug use patterns in the nation.)

Additional Data Collection

Despite having some good data to validate the perception that heroin, methamphetamines, and other drugs are a serious problem among the county's teens, the task force and the CJC felt that additional data collection would be valuable. The Alcohol and Drug Program is working with Probation to survey drug use among youth in Juvenile Hall. In addition, the Sheriff expressed interest in conducting a survey of persons arrested which would cover many issues including drug use and drug access. The County Office of Education is scheduled to conduct another school based survey for the 1998-99 school year. The State data system for alcohol and drug services will also provide some statistics for county treatment participants on drug use by age, and state comparisons may be available as well.

These additional efforts at local data collection will help refine an understanding of the problem. It is also important to compare local data with state data and the Alcohol and Drug Program will be seeking state'comparison data to understand how widespread the problems are. Some of this information is expected to be available in the next 3 months for review.

The children and adolescents with drug problems who are discussed in this report fall into several groups whose needs, legal issues, and requirements for treatment are different. One large group of drug involved youth are court wards (Welfare and Institutions Code 602). These youth are in the juvenile justice system and placed into treatment by the Juvenile Court under the care and supervision of the Probation Department. Another group of children with substance abuse treatment needs are court dependents (Welfare and Institutions Code 300). These children have histories of neglect or abuse. Many of their parents are drug involved themselves. Child Protective Services, under the authority of the Juvenile Court, is responsible for their care and supervision. Some of these children are placed out of the home pursuant to State laws which define options for care and treatment. Finally, there are drug abusing youth with no court connections, the majority of which live with parents or relatives with a small number being runaways.

Probation, Child Protective Services, Mental Health, and Alcohol and Drug Services each have different roles, responsibilities, and funding for serving youth. To understand some of the intervention options discussed in this report, it is important to understand the roles of the different agencies and how they are funded.

Probation has the responsibility to protect the public and insure that court wards carry out the orders of the court. The court may order treatment and/or placement. Probation wards, when in placement, are eligible for Medi-Cal which covers their medical and mental health care. Non-treatment placement costs are covered by ADFC-FC foster care funds which is a State/Federal program which pays for group homes and foster care with local financial participation.

Child Protective Services has a different mission. Their primary role is to protect a minor from abuse and neglect, insure access to necessary care and supervision and, when possible, work towards re-unification with the parents. Children under their care usually are eligible for Medi-Cal which covers treatment costs while AFDC-FC pays for placement.

Finally, Mental Health and Drug and Alcohol Services fund some treatment for minors using state allocations and Medi-Cal. Without Medi-Cal, access to care can be very limited. Sliding scale fee programs may pay for care for some uninsured minors, but this type of care is limited. In addition, insurance coverage for substance abuse treatment is very limited. For example, the new Healthy Families insurance program (in itself a limited option as it is restricted to families below 200% of the Federal poverty level), funded by the State and the Federal government, only covers 30 inpatient days per year and 20 outpatient sessions.

SECTION II - DEFINING THE OPTIMAL TREATMENT CONTINUUM

The optimal treatment continuum for treatment of drug abuse needs to be culturally competent to meet the needs of all young people including Latino youth. This has been a focus for the County funded services and will need to be part of any services developed. The public sector treatment resources in the county are primarily under the direction of the County Health Services Agency. Private resources are limited to an inpatient adult program at Watsonville Hospital, a residential program in Scotts Valley called "The Camp" providing detox and treatment services, the Triad Methadone detox program, and private therapists specializing in drug-related counseling. There is also a community of recovery support services through important organizations such as Alcoholics Anonymous, Narcotics Anonymous, Dual Recovery Anonymous, and other self help programs. Private insurance has increasingly limited coverage and access to drug and alcohol services. Managed Care cost data indicates that prior to managed care, 10% of the health dollars were spent on behavioral health services. Recent data indicates that now 4% of the health dollar is spent on drug and alcohol and mental health care. This downward shift is indicative of shrinking access to care within the insured population.

In developing an "ideal" continuum of care for the youth of the County, two different types of needs were identified. There are an estimated 70 youth currently in Probation with significant addiction issues, limited motivation to deal with the challenges of treatment, and the need for structured, supervised and sometimes locked treatment settings. Probation is heavily involved in monitoring this group of youth. These youth have histories of significant illegal activity linked to their drug use.

Another set of services is needed for youth not as addicted nor court involved. In general more community based, less restrictive treatment options may be appropriate for these young people.

The continuum typically begins with the least restrictive services (prevention and outpatient programs) and moves to more structured and restrictive services including locked care with Probation involvement for minors where criminal activity is an issue. An Appendix chart illustrates this continuum.

Current County Services

Prevention

HSA Prevention services planned for 1998-99 were detailed in a report submitted to the Board of Supervisors during budget hearings, and include public education and awareness campaigns; training for students, parents, professionals and community members; alcohol and drug-free recreational and cultural events; and prevention planning and program development. Increased focus on prevention strategies for heroin and amphetamineswill be incorporated into the prevention program in the coming year. Schools and law enforcement also provide significant prevention activities to youth. The County contributes about 1/3 of the funds used in the community for prevention. The prevention service providers and interested community members have formed a collaborative, Together For Youth, which has a comprehensive prevention plan. Together For Youth has a goal of raising $2 million over the next two years to fund the critical service needs identified in this plan. A thorough report on the restructuring of the Drug and Alcohol and Mental Health programs is scheduled to come before the Board on November 2, 1998, and will include a more detailed discussion on prevention activities.

Early Intervention

The County Alcohol and Drug Program also funds Early Intervention services through a range of contract agencies. Early intervention services are treatment services aimed at youth who are in the experimentation or early abuse stage of drug use. They usually include 1 to 4 individual, group, or family sessions to educate, motivate and refer to more treatment if needed. Youth are usually identified by teachers and the schools and referred to the contract agency supporting their school. Contracted agencies and school districts plan to provide early intervention services to approximately 900 youth and families during 1998199.

Outpatient/Day Treatment

For 1998199, Youth Services (part of Santa Cruz Community Counseling Services) will provide approximately IO Outpatient/Day Treatment slots, two 12-student day treatment classrooms in Santa Cruz, and one 24-student day treatment classroom in Watsonville. Youth Services projects serving approximately 120 youth in 1998199. Triad Community Services projects providing outpatient services to 60 adolescents in Scotts Valley and 100 adolescents in the San Lorenzo Valley for 1998199. In Watsonville, Pajaro Valley Prevention and Student Assistance expects to provide outpatient counseling to 144 adolescents in 1998199. In addition, Probation funds day treatment services through Fenix for some of their court wards.

Residential Treatment

The Probation Department has the responsibility of placing young people in out of home care who are court wards due to delinquency (Section 602 of the Welfare and Institutions Code). It has been through this process that some youth have been placed in residential care. Probation utilizes nine out-of-county, and three in-county drug treatment programs. With the exception of the Redwoods treatment program, the others are non-profit group home treatment programs and utilize AFDC-FC as the funding source. Currently, twelve youth are placed in out-of-county programs; nine are in in-county programs, and seven are awaiting placement. There are currently five young people in Redwoods who are drug dependent and getting treatment for this as well as mental health issues.

Since out of county placements are very difficult for families, family involvement and engagement is a critical component of success for helping young people placed out of the county.

Probation has established a special site day treatment and service center for Probation wards. Treatment services for high risk court wards who are addicted should be part of a full continuum including intensive Probation supervision, site-based day treatment and residential treatment. Young people need to be able to move up and down the continuum based on their unique needs. Specifically, site-based day treatment provides a school program, drug testing and treatment, supervision by Probation staff, and wrap-around services including substance abuse education, recreation, vocational services and extensive family involvement. Electronic monitoring could be provided out of this type of center and hours of operation would need to extend into the evenings and weekends.

A key concern expressed by community groups and parents is that access to group home programs is not available to youth who have not gotten in serious trouble with the law. Parents, not surprisingly, want to help their children get access to care before they get into serious trouble. Since private insurance does not pay for these residential programs and the cost is $3800-$6500 per month, few families are in a position to access this resource.

Intensive Case Management Models

Besides the use of residential care for Probation linked youth, the County created, in January, 1997, a special treatment and intensive supervision team funded with Medi-Cal, Title IV E funds, and county funds. Called the GROW team, it was created as an alternative to group homes which were costly and often did not result in successful behavior change when youth returned home. This team works with minors who might otherwise be in placement. Of the 35 young people in that program, 28 or 80% are drug dependent or addicted and could benefit from access to short-term residential program if/when they relapse. Probation also refers approximately 3 minors per month to The Camp in Scotts Valley if they have private insurance.

In summary, the community has a service continuum from prevention to school based day treatment for adolescents to address chemical dependency issues along with a limited set of private sector services for youth. All other treatment occurs in specialized group home programs funded through Probation or AFDC-FC funds. Although some Redwoods beds are used for treatment of chemical dependency, this is not the primary treatment focus for the program. Locked care is not readily available except in inpatient programs out-of-county for well insured youth or via Ranch Camps which include some chemical dependency services. One example of a residential program with a group continuum of care is the "Thunder Road Program" located in Oakland which accepts local court wards for drug treatment. Thunder Road has a semi-secure chemical dependency hospital license with a step down to residential care, both long and short term, followed by community aftercare including outpatient and case management. As part of the effort to understand innovative program models, the Task Force will be visiting this program before the report back on October 6, 1998.

In addition, the Federal Center for Substance Abuse Treatment (CSAT) is promoting an innovative treatment program for methamphetamine use, called the MATRIX program which was developed and is currently operational in Los Angeles. The Task Force requested assistance and information from CSAT on this program.

The services provided by the County and it's contract providers appear to be very helpful to the youth that are involved. The capacity of the outpatient and day programs, however, seem to be limited compared to the identified need for services. Indeed, some of the capacity of the programs is at risk since funding through Minor Consent Medi-Cal has been capped by the' State at FY 93-94 levels. Youth services was most dramatically impacted by this cap and will be reducing day treatment and outpatient slots for care this next year by approximately 30%. This reduction could not come at a more difficult time in terms of community need.

SECTION Ill - CRITICAL GAPS IN CARE

Based on the research to date of the task force, there are some obvious gaps in the existing continuum of care for adolescent drug treatment. Each of these gaps is listed below with a brief discussion of the missing service:

- Residential Treatment Beds, with variable length of stay for crisis, relapse prevention, and long-term treatment
- Detox services for teens, both residential and outpatient.
- Case management and %/rap-around" follow-up care
- Intensive Probation supervision and Youth Drug Court
- Site Based Intensive Day Treatment Linked to Probation
- Mobile Crisis Assessment/accessible centralized intake system
- Locked treatment beds for treatment resistant youth and/or youth in relapse

Residential Care

As discussed above, some existing "drug focused" group homes, in and out-of-county, serve court wards, but not others. In addition to the legal status limit, these programs are long-term and often out of county with limited family involvement. One of the key factors for success of drug abuse treatment of youth is extensive family involvement. This has been one of the cornerstones of success of the Redwoods program and has been a critical success factor in outpatient and day treatment programs as well. For this reason, a strong preference exists for local residential options which could serve both court wards and 'voluntary" placements. In addition, there is a strong interest in short term crisis beds for relapse and "re-focusing" at risk youth who are trying to work on their recovery in the community.

Detox Services

For adults with addiction, Janus provides a residential detox program. There is no equivalent youth program. The Janus program's license restricts detox services to youth and it is uncertain if the State Department of Alcohol and Drugs would grant a waiver to use Janus beds for 16 and 17 year olds. If a crisis residential program is developed, detox might be part of that service. However, minors often do not have the severity of addiction to require residential or inpatient detox medically. There are protocols for physicians to detox minors using medications to reduce the side effects. These can be used on an outpatient or inpatient basis. Triad can detox minors from heroin using methadone, but they cannot use methadone maintenance for minors. Addicted minors who are court wards sometimes go through withdrawal in Juvenile Hall. The Juvenile Hall is not set up with observation rooms and medical staffing for detox. Since detox is the first step to recovery, it is important to build this resource into the proposed continuum.

Case Management and "Wrap Around" Services

One model which has proven effective with high risk youth is intensive case management tied to support services available 24-hours per day, in the family home, and coordinated with agencies such as Probation, HRA, and schools. Probation and HRA have partnered with HSA on intensive case management of high risk populations. These models include extensive family contact and assistance with benefits, jobs, and eliminating obstacles to success for the family and youth. The Probation GROW program is one example of this model which has had excellent success in community treatment and rehabilitation. The existing Alcohol and Drug program does not include case management as a funded service. There is limited case management for jail discharge planning and drug court for adults, but none for youth. To avoid extensive use of residential care, it is critical to build in these alternatives as discussed during budget hearings.

Probation Intensive Supervision, Day Treatment and Youth Drug Court

Because of the expense and life style associated with ongoing drug addiction, many youth become involved in the criminal justice system. Some minors need the structure and consequences of intensive Probation supervision to keep them motivated and engaged in treatment. Again, the

GROW program has been an effective model when paired with treatment/addiction services. A drug court for youth would be an additional enhancement to the service continuum as it would provide additional support for the minor and family. Santa Cruz County in now undertaking an adult drug court. Interest in applying for and adding a Juvenile Drug Court is strong within the Criminal Justice Council and organizations serving youth. CJC and HSA are both monitoring state and federal funding sources seeking grants to add a youth drug court.

An additional option being reviewed is the addition of intensive Probation supervision to one or more of the school based day treatment sites plus the addition of night and evening hours of services and supports for families. If existing programs can be strengthened, the need for residential beds will be decreased. The site based day treatment discussed above would be helpful for the most difficult to manage.

Mobile Crisis Assessment/ Accessible Intake System

The Alcohol and Drug contract agencies offer assessments for youth and their families, however, there is not a centralized intake system or mobile crisis assessment available in the family home. It is not surprising that some minors are very resistant to coming in for help and often in denial about drug and alcohol issues. Families have a difficult time getting these children to come with them to a clinic. Looking at the current system to improve it and make it more user-friendly to families has been suggested as a gap. Children's mental health does mobile crisis and assessments in the home, but these staff are not expert in chemical dependency and the capacity of this system to meet additional demands is uncertain. Nonetheless, the Task Force felt a "tune up" in the existing intake and assessment system should be pursued, particularly to respond to families in crisis.

Locked Treatment Beds

There are occasions when minors have difficulty entering and/or remaining in treatment. Evidence of this is seen in runaway figures from existing drug residential facilities, which are approximately 15%. Also the nature of drug addiction is that the user may need to experience the negative consequences of relapse a few times before developing the motivation to stick with the recovery program and internalizing the goal of being clean and sober as a good lifestyle choice. The Task Force felt that a few treatment beds were needed for a small number of difficult cases.

There are basically two options for locked beds and two options for secure beds. For locked beds, inpatient hospitalization and Probation Ranch Camp programs are the choices. Both types of beds are very expensive. The first secure bed option alternative is a residential crisis model with doors with alarms and adequate staffing for supervision. This model has been used for some mental health programs. The other secure model option is a new license category developed by the State called a CTF (Community Treatment Facility). This model has recently had regulations developed and the state has identified beds levels which each county might utilize. Santa Cruz was given an allocation of 3 CTF beds. The public entity responsible for developing these types of beds and how they will be funded is not clear at this time. The Task Force, however, will monitor their development.

Intensive Day Treatment Capacity

The review of continuum of care and service gaps has studied levels of care, but not capacity. There are capacity problems in day treatment and other services where referrals bottle-neck. Intensive Day Treatment linked to schools is an effective model for keeping youth clean and sober and on track with their education. It is a key bottleneck, however, where additional capacity is needed. Funding shortfalls have actually reduced this resource this fiscal year. Consideration should be given to restoring this resource and strengthening it as discussed above.

Cultural Competence is essential throughout the optimal system and needs to be an ongoing focus of drug program design. Any new services or re-designed services must include cultural competence as part of the planning and design of care.

SECTION IV - SHORT AND LONG TERM OPTIONS AND FUNDING

Short-Term Solutions

Obviously the quickest way to fill some treatment gaps is to restructure and strengthen existing services and use some extra bed capacity in current drug and alcohol providers. Issues and costs associated with a restructuring approach, as discussed below, relate to each level of care that currently exists in the county. There are no locked beds in the county so this aspect will be discussed as part of the long-term options:

Residential Services

Because of resource shortfalls, all existing adult drug and alcohol residential programs have excess bed capacity. Fenix Services has vacant, unpurchased female beds for Latinas in south county. Si Se Puede has vacant, unpurchased male beds in south county. Sunflower house has vacant, unpurchased co-ed beds in north county. Janus has vacant, unpurchased coed detox beds which, with a state waiver, could be used for 16 and 17 year olds. Staffing would need to be richer due to special program and supervision needs. Adult programs might be able to be modified to accommodate teens, but only a small number of teens would be able to comfortably mix with an adult population. The advantages of this model is that it avoids the long and difficult facility search and location issues found with other approaches. There are culturally competent and clinically skilled providers in north and south county. These programs could accept voluntary placements with parental permission. A sliding fee scale could be established for parents. Linkages with the schools would be needed to insure continued education. There must be clean and sober school settings and modified program services to provide family counseling.

However, there are also some real disadvantages with this option. Court wards and dependents can only be in Community Care licensed facilities. It is extremely rare that the courts and licensing would allow mixing minors and adults in a placement. Another disadvantage is there would be no

placement beds for 14 and 15 year olds with serious drug problems. Also, research indicates a treatment setting just for youth has better care outcomes.

Existing providers and some local group homes have also expressed interest in converting their programs to a specialized substance abuse treatment group home linked to day treatment and school. For youth, who are not court wards or dependents, to access group home treatment, a time limited program called "voluntary placement" is required. This limits the placement time to 6 months total for the life of the child unless the parents can pay full costs for these services. The group home costs, while less expensive than a hospital, are still quite high ($3000-$4000 per month). Some cost sharing with the parents may be possible, however, the expense is still significant.

Detox Services

Modification of existing services seems to make the most sense to immediately meet current need. This need could be met by purchasing detox slots from Triad or beds with a State waiver from Janus. Medical outpatient detox could be performed by Triad.

Case Manaaement and "Wrap Around" Services

Unlike residential services, this is an easier service to add via County or contract personnel. An essential feature of wrap around services is that a case manager follows the high risk child through all levels of care and types of service, engages the family, provides in-home support and crisis intervention, works with schools and Probation when appropriate, and becomes an advocate for the minor concerning their recovery. Case management services are billable to Medi-Cal and/or Healthy Families Insurance.

Intensive Probation Supervision & Youth Drug Court

Similar to case management services this component of services can be added if funding is available. The effectiveness of this model which is used by the GROW program has been shown to work well with court wards. Youth Drug Court is a long-term goal and is dependent on funding for special staff and designated treatment slots to make it effective. Within existing resources, Probation and Courts are doing a "mini-pilot" of this model in south county.

Mobile Crisis Assessment/Easy to Access Centralized Intake System

As previously stated, assessment services are available through the substance abuse contract providers, specifically Pajaro Valley Student Assistance, Fenix, Youth Services, and Triad. In addition, Children's Mental Health has mobile crisis and assessment services. Issues related to improved access and care coordination will be addressed as part of the October presentation to your Board.

Long-Term Solutions and Options

Two program components will be reviewed in the long-term options section: residential treatment and locked treatment beds. New programs for these two types of care would take time to create even if there were adequate resources which historically has been the critical obstacle.

Residential Treatment Beds

A new residential treatment program, unlocked, using a county-operated model like the Redwoods Program or the group home model like Thunder Road would take more time to create. If the program is six beds or less, it could be located in the community and run as a group home with day treatment supports linked to schools. This small number of beds might be adequate if other levels of care were enhanced or created so that minors did not have to live there for extended periods of time. In fact, this residential model was used for the Proyecto Unidad grant which lost it federal funding in 1996-97. This approach would not necessarily require new construction or a special use permit, and would allow sharing of costs with federal and state funding sources with the residential, day treatment program, and case management. There would still be some county costs and parent costs but the burden would be shared. The placement could accept clients who are not court wards and dependents but only for the 6 month time limits discussed for voluntary placements.

A Redwoods south proposal with a focus on adolescent drug treatment is also being evaluated. This 18 bed model may require new construction and an appropriate site must be found. The old Sunflower Youth house site on San Andreas Road which is owned by the County may be a potential site, although this site is isolated and distant from other support services, and there are land use and other issues that must be resolved. There may be other potential sites as well but research has not been done. The funding for this kind of program is largely built on Medi-Cal and requires placement orders or voluntary placement to assure funding eligibility.

Locked Treatment Beds

As previously discussed there are two potential'options for locked beds. The hospital option would be very difficult to develop given the county size. Few hospital programs are available to purchase high quality chemical dependency services for youth. Those that exist are expensive and the quality of care is mixed.

The locked county-run program model is possible under the ranch camp Title 15 regulations. This option must be managed by Probation and is only available to court wards. A new state commission is evaluating expanding funding for counties who want to do ranch camp programs to reduce out of state placements. Probation is interested in this for court wards who are not committed to their recovery and need locked care to confront their addiction. A locked 90-180 day program which would allow court wards to return to the community when they seem committed to staying clean and sober. Ranch Camp programs must be county controlled and operated. The Criminal Justice Research Foundation is studying options for federal funding for local Probation

facilities. A bond issue on the November ballot might be a funding source but the main emphasis is on correctional services.

This level of care, though requiring only a few beds, is the most difficult to meet in the short term.

SECTION V - PROCESS TO REFINE RECOMMENDATIONS:

This report should be considered a "work in progress". To achieve an "ideal,, continuum of drug and alcohol treatment and support resources could take a decade of sustained commitment. However, identifying "best practices" and the most important local priorities is a critical first step in the process.

At the conclusion of Budget Hearings, your Board allocated $20,000 for the development of new treatment resources. These dollars are to be used for consultation and grant writing in preparation of the report for your Board in October. There are many important tasks to be completed for the October report. Additional data collection must be done and analyzed. Each treatment option needs a full cost and revenue analysis. Treatment advantages and disadvantages must be refined. Grant opportunities must be identified and, where appropriate, applied for. Priorities for filing treatment gaps must be set due to restricted resources available to the County. Input and advice on these concepts must be gathered from youth, advisory boards, CJC, other jurisdictions and providers.

The process to refine these options and present your Board with program and funding recommendations will include schools, providers, local communities, and advisory boards associated with youth. Our working group will continue to meet regularly and will send representatives to the Alcohol and Drug Abuse Commission, Mental Health Advisory Board, the Human Services Commission, Juvenile Justice Commission, Children's Commission, Children's Network, CJC Juvenile Justice Task Force, CJC Drug and Alcohol Task Force, The Parent Partnership, Together for Youth, Law Enforcement Chiefs Association, and County Office of Education.

In addition, the current providers of drug and alcohol services and mental health services as well as city and community leaders will be consulted for further input. Input from the schools will be provided through sending this report to each school district and the County Office of Education and requesting comments. Finally, as priorities are set and recommendations formulated for the October report, the working group will meet and consult with Board members and interested Board members will be invited to participate in the working group meetings.

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