California's approach to misuse of alcohol and other drugs by adolescents and young adults continues to demonstrate a pattern of ineffectiveness. It is characterized by grossly inadequate funding for prevention and treatment that is often irrationally separated into substance abuse and mental health silos. The strategies that it supports are based predominantly on adult models and ideologies that are often counterproductive in youths. As a result of these shortcomings, we have suffered through decades of disappointment in our efforts to aid youth who are harmed by alcohol and other drugs. We have had too little progress in ending the long train of tragedies experienced by each succeeding generation. The Blueprint below outlines key concepts and principles of addiction medicine for establishing an effective, evidence-based approach to adolescent and young adult drug and alcohol treatment in California. The California Society of Addiction Medicine believes that we must now press for fundamentally new directions on behalf of youth.
1. **Addiction is a brain disease.**

Research shows that addiction begins in the brain's disordered response to drugs, leading to craving, loss of control, and resultant family and social disruption.

The majority of adults with addiction began using substances of abuse during adolescence, when the brain and personality were still undergoing development.

2. **The adolescent brain matures at 25 years old.**

The ability to restrain impulsivity and to contemplate the consequences of behavior improves as the brain matures.

Young brains are more vulnerable to addiction, resulting in dependence developing more easily and more quickly the earlier the onset of use.

Psychosocial development is delayed and distorted by substance abuse.

All adolescent addiction occurs in an immature brain, and disrupts the normal process of further brain maturation.

Individuals who begin drinking before the age of 15 are four times more likely to develop alcohol dependence than those who begin drinking at 21.

3. **Adolescents are at the highest risk of addiction.**

More than 90% of adults with current substance use disorders started using before 18; half of those began before 15.

Of the 2.1 million people meeting criteria for alcohol or drug dependence in 1999, 22% were adolescents and 21% were young adults.

A family history of addictive disease, trauma (psychological, physical, sexual), pre-existing psychiatric disorders, brain-based disorders (ADHD, learning disabilities, etc) and difficulty regulating emotions, cognitions and behavior all increase an individual's risk for using substances.

The 80,000 foster care children in California are at especially high risk of substance abuse, many having entered the foster care system because of parental addiction, child neglect or abuse. Lack of continuity due to frequent change of placement and complete loss of services and support upon emancipation at 18 years old (5000/year) contribute to an inordinate rate of homelessness in this population.

4. **Prevention must Deter, Delay and Detect Use.**

The primary goal of prevention is to deter and delay onset of use.

The secondary goal of prevention is early detection of high risk use and intervention to prevent further progression. As with all medical conditions, early diagnosis greatly enhances the effectiveness of treatment. SBIRT (Screening, Brief Intervention, Referral and Treatment) is a proven framework for early diagnosis that should be fully integrated into the continuum of care as a critical strategy for secondary prevention.

The tertiary goal is treatment for substance dependence to mitigate its impact on physical health and psychological maturation.

Parents and community need to be active participants in helping youth deter and delay use, and detecting when treatment is needed to prevent further harm.

5. **Early Diagnosis is the Key.**

SBIRT (Screening, Brief Intervention and Referral to Treatment) needs to be incorporated into all Student Assistance Programs, college and university student health clinics, primary care settings, and counseling centers.

Pediatric and adolescent medicine practitioners need
to develop annual wellness exams that span adolescent years with age appropriate educational material, SBIRT services, and psychological surveys in addition to weight, blood pressure and physical examinations.

6. **Intervention and Treatment**

_save lives._

Six months after intake, 56% of those in treatment recorded 30 consecutive days of abstinence from drugs and alcohol (Kaiser).

Treatment also saves money. For every $1 invested in treatment, NIDA estimates that $12 are saved in the costs of health care and crime (1999).

Two national studies reported a 48 percent reduction in primary drug use, a 53 percent reduction in alcohol and drug-related medical visits, and an 80 percent reduction in criminal activity. (ONDCP, 2002; CSAT, 2000)

Evidence-based treatment modalities exist and should guide treatment programs.

7. **Youth Treatment must be Comprehensive.**

Substance dependence is a chronic medical condition requiring ongoing support and monitoring, especially with youth and young adults. As with other chronic conditions, treatment works, but does not cure.

A statewide network of residential treatment centers should be established for those who are unable to be treated effectively in intensive outpatient programs. Treatment programs must provide a broad continuum of care, including outreach, screening, assessment, treatment planning, counseling, youth development, family interventions, inpatient and residential programs, drug testing, structured aftercare, positive contingencies and support for the recovering community.

Long-term outcome studies are required to continue improvement of treatment approaches.

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**THE FACTS**

1. The majority of adults suffering from alcohol and other drug dependence developed a pattern of substance abuse as youth (up to 18) and young adults (19-25).

2. There were 220,000 youth aged 12-17 in need of substance abuse treatment in California in 2001. Yet little treatment is available for youth outside the juvenile justice system. (UCLA DART, 2001 in Little Hoover Report, 2003)

3. Only 1 in 10 youth receives treatment of substance abuse, and of those who do receive treatment, only 25% receive enough to achieve results. (Schwab, 2004)

4. Up to 80% of adolescents with substance abuse exhibit co-occurring psychiatric disorders (ADHD, Depression, Opposition-Defiant Disorder, PTSD, Learning Disabilities, etc.).

5. As many as 85% of 5,700 California Youth Authority wards have substance abuse problems. (Little Hoover Report, 2003)
   a. Annual cost to incarcerate one child in CYA: $80,000 (Recidivism Rate=91%)
   b. Annual cost of outpatient substance abuse Treatment: $3,000 (Relapse rate after treatment=11%) (Schwab, 2004)

6. 70% of all deaths among youth ages 15-24 can be attributed to three causes: unintended injuries, homicide and suicide. The single common denominator among all three causes is the use of alcohol and other drugs. (Schwab, 2004)

7. 41% of eleventh graders in California, 31% of ninth graders and 17% of seventh graders have used alcohol or other drugs in the past 30 days. 10% of eleventh graders had three or more incidents of binge drinking (5 or more drinks) in the past 30 days. (California Healthy Kids Survey)

8. Tobacco is a major “gateway” drug for adolescents and must be included in all drug treatment programs.
8. **Youth Treatment must address both Mental Health and Substance Abuse.**

The co-occurrence of substance abuse and mental disorder is the norm among adolescents, requiring the complete and seamless integration of psychiatric care and CD treatment if help is going to be effective.

Up to 80% of adolescents with substance abuse exhibit co-occurring psychiatric disorders (ADHD, Depression, Opposition-Defiant Disorder, PTSD, Learning Disabilities, etc.).

A radically new, integrated system of early diagnosis, intervention and treatment of substance abuse needs to be created to foster California’s youth into a healthy future. Community mental health centers need to develop satellite clinics onsite in every middle school and high school in California.

Student Assistance Programs should become onsite mental health centers for the adolescent community, with the authority, if granted by parents, to conduct confidential drug testing, substance abuse and mental health, brief intervention and referral to treatment classes, groups and programs, not expulsion.

9. **Keep Youth in School and Out of Jail.**

Incarceration and school expulsion are risk factors for substance use and a barrier to effective treatment for addiction.

School achievement lowers risk of substance abuse.

As many as 80% of adolescents in the juvenile justice system have drug or alcohol problems, yet only 20% receive substance abuse treatment.

Every dollar invested in treatment yields $7 in savings related to crime alone, and $12 when health costs are factored in (NIDA).

10. **Parity is essential for effective treatment.**

Health insurance is a strong predictor of whether or not an adolescent will receive needed health care services.

Offering full parity for substance abuse treatment would increase insurance premiums by only 0.2%, about $5 per year.

Denial of parity is discriminatory, stigmatizing, and short-sighted.

Substance abuse and mental health treatment should be patterned after the public education system — universally available at no cost for all youth under 18.

11. **Alcohol and Drug Dependence is a Family Illness.**

Not all damage is done to the family member who is using alcohol or other drugs. Sometimes a parent’s addiction can leave a child psychologically damaged — traumatized, fearful, depressed, overly compliant, anxious or hopeless. Children of addicts and alcoholics may be distracted in school by their worries about a parent, their fears about what will happen when they return home, or simply by exhaustion from not being able to sleep at night. Student Assistance Programs can help rescue children of addicted parents from their fear, pain and isolation.

Since the children of addicted parents are themselves at very high risk of chemical dependence, they constitute the single most important target group for prevention efforts. Identification of adolescents at increased hereditary risk for addiction for more intensive education and monitoring would constitute good public health policy.

Since adolescents typically still reside within their family of origin, treatment for adolescent substance abuse requires a strong family therapy component. All adolescent treatment programs should be expected to provide family counseling as a core treatment modality.

12. **A Statewide Treatment Network for adolescents is required.**

While the goal is to intervene early enough to treat adolescents and their families in outpatient settings within their own communities, residential treatment is sometimes medically necessary.

By establishing residential centers throughout the state, individuals have the opportunity to be temporarily protected from difficult environments during early sobriety while less populated areas of the state can receive the benefit of full service treatment centers.

In order to build and maintain a statewide network of evidence-based adolescent treatment services, a dedicated revenue stream must be developed.