

Child welfare

Ken DeCerchio gave the presentation summarized below.

TAKEAWAYS

Rates of drug overdose deaths and drug-related hospitalizations are associated with higher child maltreatment reports and foster care placements.

Barriers to accessing substance use treatment within the child welfare system include a shortage of family-centered treatment options and a lack of understanding among caseworkers, court officials, and other providers about how medication assisted treatment works.

Coordinated service delivery between child welfare and substance use treatment providers would likely improve outcomes.



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Interactions between human services programs and the opioid crisis

The September 2019 Annual Poverty Research and Policy Forum, “Human Services Programs and the Opioid Crisis,” was convened by the Institute for Research on Poverty at the University of Wisconsin–Madison, in partnership with the Office of Human Services Policy, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. The forum focused on how the opioid crisis has affected the delivery of human services, and what role those services can play in ameliorating the negative effects of opioid misuse on individuals, families, and communities. This article comprises four brief summaries of breakout sessions about how human services programs can address the effect of the opioid crisis on their objectives.

Forum participants met in one of four breakout sessions to discuss how human services programs can address the effects of the opioid crisis on their objectives. The four sessions covered:

- Child welfare;
- Self-sufficiency supports;
- Early childhood care; and
- Adolescents and young adults.

In each session, there was a presentation and group discussion. The following summaries present, for each session, a description of the issue; summary of the presentation; and research and policy implications.

Description of issue

In the United States, counties that have increases in overdose deaths and drug hospitalization rates tend to also have increases in rates of child maltreatment reports, rates of substantiated reports, and foster care placements.¹

Parents who misuse substances tend to experience multiple issues, including domestic violence, mental illness, and histories of trauma. Treating substance misuse without also addressing these other issues is unlikely to result in families staying together. Having services to support both the parent’s recovery and the child’s safety and well-being are associated with successful family reunification after an out-of-home placement.²

Conversely, for substance use disorder treatment to be successful, caseworkers must also address family issues and parenting; this type of treatment is often referred to as “family centered.” Family-centered treatment services may include family therapy, parenting classes, childcare, and developmental services. A residential treatment program is considered family centered if children are permitted to

reside with their parent while the parent receives treatment (for most programs that allow this, the option is available only for younger children). In general, child welfare agencies have little access to family-centered treatment services or programming, particularly for outpatient programming.³

Parents who misuse substances tend to experience multiple issues, including domestic violence, mental illness, and histories of trauma. Treating substance misuse without also addressing these other issues is unlikely to result in families staying together.

Medication assisted treatment or MAT, combining medication with counseling and behavioral therapies, has proven a particularly effective treatment for opioid use disorder.⁴ However, this type of treatment is not always understood or accepted by child welfare staff and judges, or even by some in the substance use disorder treatment field. This could lead to medications being tapered off prematurely or not being accompanied by necessary support services. Families may also receive mixed messages about appropriate treatments, which could make it more challenging to engage them in the recovery process.

Summary of presentation

The presentation highlighted opportunities to strengthen cross-system collaboration for infants and families affected by substance abuse, and examples of innovative policies and practices in states and communities.

There are several federal laws and policies that provide possible mechanisms to improve outcomes for families affected by opioid use disorder:

- The **Child Abuse Prevention and Treatment Act (CAPTA)** addresses child abuse and neglect. In 2016, CAPTA was amended by the Comprehensive Addiction and Recovery Act to clarify that the population covered by the legislation included infants affected by *all* substance use, not just illegal substance use, as had been previously required; specify which data states must report; require “Plans of Safe Care” to include the needs of both the infant and the family; and specify additional monitoring and oversight by states to ensure that Plans of Safe Care are implemented and that families have access to appropriate services.
 - **Plans of Safe Care** can be customized to meet the needs of different communities, settings and families. A plan could include, for example:
 - Primary, obstetric and gynecological care;
 - Substance use and mental health disorder prevention and treatment;
 - Parenting and family support;
 - Infant health and safety; and
 - Infant and child development.
- The **Family First Prevention Services Act of 2018 (FFPSA)** allows foster care maintenance payments to continue for up to 12 months for an eligible child placed with a parent in a licensed residential family-based substance abuse treatment facility.⁵ Facility services must be trauma-informed and include parent skills training, parent

education, and individual and family counseling. The FFPSA also provides optional funding for one year of prevention services for mental health and substance abuse, and in-home skill-based programs for parents, families, and the children who are candidates for foster care.

- In 2018, CAPTA was amended again by **the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act** to authorize grants to states to improve and coordinate their response to ensure the safety, permanency, and well-being of infants affected by parental substance use. The grants provide support to states to collaborate and improve Plans of Safe Care between child welfare agencies, social services agencies, substance use disorder treatment agencies, hospitals with labor and delivery units, medical staff, public health and mental health agencies, and maternal and child health agencies. Funds may also be used to develop and update monitoring systems to more effectively implement Plans of Safe Care.

There are also innovations in child welfare, substance use disorder treatment, and courts to strengthen collaboration and improve outcomes for children and families:

- **Sobriety Treatment and Recovery Teams (START)** provide child welfare intervention for families with children up to age 5 and child protective services involvement. The teams offer a family-centered approach that provides coordinated service delivery between child welfare agencies and substance use disorder and mental health treatment providers. The goal is to help parents achieve recovery, and to keep children in the home when that is safe and possible. One study found that participation in START was associated with a higher sobriety rate (66 percent for women in START compared to 37 percent for their non-START counterparts), and with a lower rate of removal to foster care for children in the program (21 percent compared to 42 percent).⁶
- **In-Depth Technical Assistance (IDTA)** for infants with prenatal substance exposure seeks to expand the capacity of states, tribes, and their community partner agencies to improve the safety, health, permanency, well-being, and recovery outcomes for families affected by substance use disorders. This 18- to 24-month program offered by the National Center on Substance Abuse and Child Welfare strengthens the collaboration among child welfare and substance use disorder treatment systems, the courts, maternal and infant health care providers, and other family-serving agencies.
- The **National Quality Improvement Center for Collaborative Community Court Teams**, funded by the Children’s Bureau, (QIC-CCCT) addresses the needs of infants and families affected by substance use disorders and prenatal substance exposure. The QIC-CCCT provides training and technical assistance to 15 demonstration sites to:
 - Implement the provisions of the Comprehensive Addiction and Recovery Act amendments to the Child Abuse and Prevention Treatment Act;
 - Expand court teams’ capacity to address the needs of infants, young children, and their families affected by substance use disorders and prenatal substance exposure;
 - Sustain effective collaborative partnerships; and
 - Disseminate lessons to other providers.
- The recent release of **Family Treatment Court Best Practice Standards** provides family treatment courts and their collaborative partners with action-oriented benchmarks for implementing best practices to improve outcomes for children,

parents, and families affected by substance use and co-occurring disorders who are involved in the child welfare system.

Research and policy implications

Increases in opioid misuse are associated with increased child welfare involvement. While evidence of this relationship is suggestive, it does not establish causality. It is possible that other factors—for example, a high rate of depression within a community—account for both higher substance use and child maltreatment. However, qualitative interviews and data on child removals related to parental alcohol or other drug use do support the close connection between substance use and child welfare involvement. Child welfare agencies are struggling to respond to the rising caseloads. While these agencies have addressed parental drug misuse in the past, the opioid crisis introduces new challenges. For example, because opioid misuse often affects multiple generations in a single family, family placement options are often limited for children involved in opioid-related child welfare cases. This has led to shortages of foster home openings in many areas. Opioid-related child welfare cases may also be particularly complex for several reasons. For example: opioid overdose is more common than overdose from other drugs, and more likely to result in death; lack of access to family-centered services can challenge parents' ability to succeed in recovery while safely caring for their children; and a lack of understanding among child welfare staff and judges about the established effectiveness of medication assisted treatment could undermine recovery.

Increased levels of substance abuse, including opioids, have affected many American families and the child welfare system. In response, federal law and policy updates are providing more flexible funding and new tools. In addition, child welfare staff and other service professionals are actively seeking better family-centered treatment options for parents. ■

Ken DeCerchio is Program Director at Children and Family Futures

¹R. Ghertner, M. Baldwin, G. Crouse, L. Radel, and A. Waters, "The Relationship between Substance Use Indicators and Child Welfare Caseloads," ASPE Research Brief, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, March 9, 2018.

²See, for example, B. A. Akin, J. Brook, M. H. Lloyd, and T. P. McDonald, "Effect of a Parenting Intervention on Foster Care Reentry After Reunification Among Substance-Affected Families: A Quasi-Experimental Study," *Child Maltreatment* 22, No. 3 (2017): 194–204.

³L. Radel, M. Baldwin, G. Crouse, R. Ghertner, and A. Waters "Substance Use, the Opioid Epidemic, and the Child Welfare System: Key Findings from a Mixed Methods Study," ASPE Research Brief, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, March 7, 2018.

⁴*Medication-Assisted Treatment for Opioid Use Disorder: Proceedings of a Workshop—in Brief* National Academies Press, 2018. <https://www.ncbi.nlm.nih.gov/books/NBK534504/>

⁵The Family First Prevention Services Act (FFPSA) reforms federal child welfare IV-E funding streams to allow states to provide families at risk of entering the child welfare system with up to 12 months of mental health services, substance abuse treatment, or in-home parenting training.

⁶R. A. Huebner, T. Willauer, and L. Posze, "The impact of Sobriety Treatment and Recovery Teams (START) on family outcomes," *Families in Society* 93, No. 3 (2012): 196–203.

Self-sufficiency supports

Tim Robinson gave the presentation summarized below.

TAKEAWAYS

Many individuals with opioid use disorder experience concurrent issues that can impede recovery, such as poverty, homelessness, and low educational attainment.

Training those who have completed treatment to be peer support specialists could help address staffing shortages.

Even after successful medical treatment of their addiction, many people still need to learn (1) skills to maintain their recovery; (2) life skills; and (3) job skills.



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Description of issue

Individuals with opioid and other substance use disorders often have concurrent issues such as poverty, bouts of homelessness, and low educational attainment. Many of them live in rural areas with limited employment and substance use disorder treatment options. These concurrent issues can create additional hurdles to achieving and maintaining recovery. Employment is a critical component of sustaining recovery. Staff who provide comprehensive services for individuals with a substance use disorder must work with local employers to identify jobs that provide a good fit for people in recovery so that they can succeed in the workplace. While there are some workforce development resources available through existing government programs, most do not offer services specifically tailored to those with a substance use disorder, and may even exclude those struggling with addiction from receiving services. Kentucky's Addiction Recovery Care program (ARC), described below, is notable for providing workforce development services specifically for individuals with a substance use disorder.

Summary of presentation

While Kentucky's rates of overdose death are among the highest in the nation, the state also leads in developing innovative strategies to address the opioid crisis. The state's ARC program provides a holistic approach to addiction recovery—incorporating clinical, spiritual, medical, and vocational elements—in the poorest and most isolated rural places. A “crisis-to-career” approach is central to the program's success. The four-phase program starts with intensive clinical and medical treatment (averaging 30 days); followed by sober living with a focus on recovery skills (averaging 45 days); vocational rehabilitation with a focus on life skills (60 days); and finally a job skills training program that lasts six to nine months. The crisis-to-career approach can be carried out in either a residential treatment setting or an outpatient treatment setting.

Employment is a critical component of sustaining recovery.

One of the challenges in operating programs is finding qualified staff; this can be particularly difficult in the poor and rural areas that are in the greatest need of services. ARC includes a staff training program that teaches program participants to be peer support specialists. Upon successful completion of the training program, program graduates are guaranteed a position at ARC or other locations including jails and homeless shelters. ARC currently has approximately 625 staff, of whom about half are in recovery and one-third are ARC graduates.

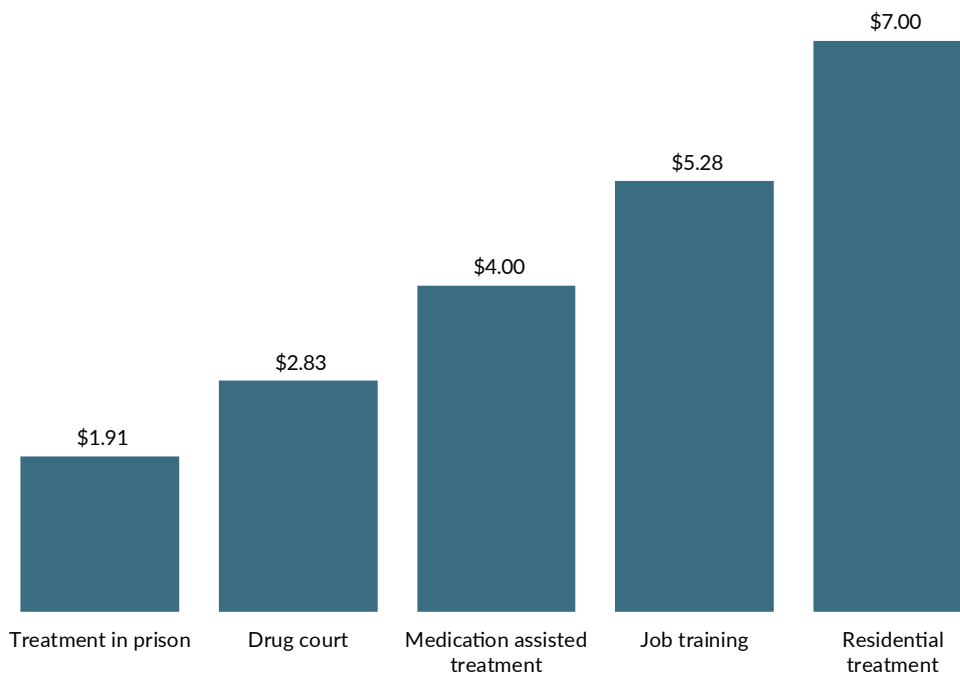
Figure 1 shows the return on investment for different types of programs. One dollar spent on substance use disorder treatment in prison produces approximately \$2 in value to taxpayers, while the same level of investment in job training produces a \$5 return. Combining job training with either medication assisted treatment (\$4 return to \$1 spent) or residential treatment (\$7 return to \$1 spent) could provide even greater benefits.

Policy and research implications:

ARC is participating in the Building Evidence on Employment Strategies for Low-Income Families project (BEES) study. The BEES project is being evaluated by the Office of Planning, Research, and Evaluation in the U.S. Department of Health & Human Services. The BEES project, operating from 2017 through 2022, is building evidence about employment interventions that work for those in poverty; they will have a number of reports as results become available.

Workforce development services provided through existing government programs do not generally have strategies in place for addressing concurrent addiction issues. As a result, it may be necessary for caseworkers to coordinate funding from two or more sources to ensure that their clients with substance use disorders have a clear pathway to self-sufficiency.

Figure 1. One dollar spent on treatment in prison produces approximately \$2 in value to taxpayers, compared to over \$5 for the same level of investment in job training and \$7 for residential treatment.



Note: Figure shows the value to taxpayers resulting from a one-dollar investment.

Source: S. Aos, "The Comparative Costs and Benefits of Programs to Reduce Crime," Washington State Institute for Public Policy, May 2001; D. McCarty, "Substance Abuse Treatment Benefits and Costs," Robert Wood Johnson Foundation, May 1, 2007; H. J. Harwood, R. L. Hubbard, J. J. Collins, and J. Valley Rachal, "The Costs of Crime and the Benefits of Drug Abuse Treatment: A Cost-Benefit Analysis Using TOPS Data," in *Compulsory Treatment of Drug Abuse: Research and Clinical Practice*, eds. C. G. Leaukefeld and F. M. Tims, DHHS Publication No. (ADM) 88-1578 (Rockville, MD: National Institute of Drug Abuse, 1988).

Existing employment programs for formerly incarcerated individuals could provide a model for assisting those in recovery with finding work. For example, RecycleForce provides recycling services in Indianapolis in support of workforce training, development, and job placement for formerly incarcerated men and women. A randomized controlled trial found that the RecycleForce Enhanced Transitional Jobs Program reduced participant recidivism by 6.2 percentage points compared to the control group.⁴■

Tim Robinson is CEO of Addiction Recovery Care in Kentucky.

⁴K. Foley, M. Farrell, R. Webster, and J. Walter, *Reducing Recidivism and Increasing Opportunity: Benefits and Coats of the RecycleForce Enhanced Transitional Jobs Program*, *Research Brief*, MDRC, New York, June 2018.

Early childhood care

Sangeeta Parikshak gave the presentation summarized below.

TAKEAWAYS

Early childhood care providers are on the front lines of the opioid crisis.

About half of Head Start programs reported they had strategies related to opioid misuse in place.

Promising strategies include: providing staff with awareness and sensitivity training; strengthening connections between early childhood care providers and hospitals, child welfare agencies, and treatment facilities; and providing referrals to mental health services.



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Description of issue

Home visiting and center-based early childhood care and education programs provide services to at-risk expectant parents and families with young children. Programs provide information, support, and training about child health, development, and care. Increasingly, these early childhood care providers are seeing the effects of opioid use disorder and are thus in a good position to support such families. They can help by connecting families to services for substance misuse, including resources that might be able to reduce the risk that child welfare services will remove children from the home.

Home visitors can help mothers identify and address the concerns they have about bonding with babies born with neonatal abstinence syndrome. They can also guide mothers in caring for their babies' physical, cognitive, social, and emotional development. Care providers can help families engage in discussions of the issue, problem-solve, and plan for the future.

Parikshak's presentation focused primarily on the Head Start program, which includes both home visits and center-based care. The purpose of Head Start and Early Head Start is to promote the school readiness of low-income children by enhancing their cognitive, social, and emotional development. In addition to education services, Head Start programs provide health, nutrition, social-emotional, and family services.

Summary of presentation

Research suggests that disadvantaged populations are disproportionately affected by the opioid crisis.¹ Head Start staff who serve at-risk parents and their children are thus on the front lines of the opioid crisis. Specific challenges they encounter include:

- A shortage of bus drivers to provide transportation to childcare centers, because applicants cannot pass drug tests;
- Pregnant women in the program are misusing opioids and other substances, and home visitors lack training on how to discuss the risks for their unborn baby;
- Parents are reluctant to admit to substance use for fear of losing custody of their children;
- Staff lack training in how to respond when a parent who appears to be using substances comes to pick up their child; and
- Infants and children are entering care with neonatal abstinence syndrome, drug-related developmental delays, and trauma-related behavioral challenges, which require special training to deal with effectively.

A 2016 survey asked a sample of Head Start program managers about any strategies they had related to opioid misuse. The survey found that:

- Nearly half of responding Head Start managers had strategies related to opioid misuse;

- Of programs with strategies, nine out of 10 had strategies targeted to parents and other caregivers; about two-thirds had strategies that targeted staff; and just under half had strategies that targeted children;
- Strategies included:
 - Awareness and sensitivity training;
 - Closer partnerships with hospitals, child welfare, and local treatment facilities to provide coordinated care;
 - Interventions within the program to improve the parent-child bond;
 - Monthly support groups for grandparents;
 - Needle-exchange program to reduce hepatitis C;
 - Training staff to carry and administer Naloxone to counter the effects of opioid overdose; and
 - Mental health consultant support and referral.

The Head Start Early Childhood Learning and Knowledge Center provides additional resources on substance misuse for early childhood program staff.²

Research and policy implications

While early childhood care programs such as Head Start are well-positioned to mitigate the effects of opioid use disorder on families with young children, there are often insufficient resources to provide such services. Strategies such as coordinating funding from two or more sources to support the total cost of services can boost available resources. For example, in Pennsylvania, federal Head Start, Early Head Start, and state Pre-K funds are combined with childcare assistance funds to provide full-day, year-round services to low-income infants, toddlers, and preschoolers. Programs used these funds to hire community coordinators to work with home visiting programs and provide targeted training on how to discuss substance use with families, for example. Some programs piloted a seven-week program, “Families in Recovery,” which aims to strengthen parenting skills for those recovering from substance use disorder.

For children with neonatal abstinence syndrome, strong connections between hospitals and early intervention services like Early Head Start are important. Cross-referrals between home visiting programs and Head Start programs can also help children and families get the services they need.

The need for early childhood programs to have a strong focus on mental health and substance use cannot be underscored enough. Programs are often not equipped to provide training on substance use disorders for their early childhood workers. ■

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¹UW–Madison Institute for Research on Poverty, “The Opioid Epidemic and Socioeconomic Disadvantage,” *Fast Focus* 32-2018, March 2018. Available at: <https://www.irp.wisc.edu/resource/the-opioid-epidemic-and-socioeconomic-disadvantage/>

²The Head Start Early Childhood Learning and Knowledge Center is available at: <https://eclkc.ohs.acf.hhs.gov/>

Adolescents and young adults

Sarah Bagley gave the presentation summarized below.

TAKEAWAYS

The rate of youth opioid use is relatively low and has been decreasing in recent years.

The rate of youth opioid-related deaths is increasing, particularly those due to synthetic narcotics like fentanyl.

While the need for services targeted to adolescents is rising, the availability of those services is limited.

Strategies to address opioid misuse among adolescents and young adults need to include early intervention, treatment of co-occurring disorders such as anxiety and depression, and support for those in recovery.



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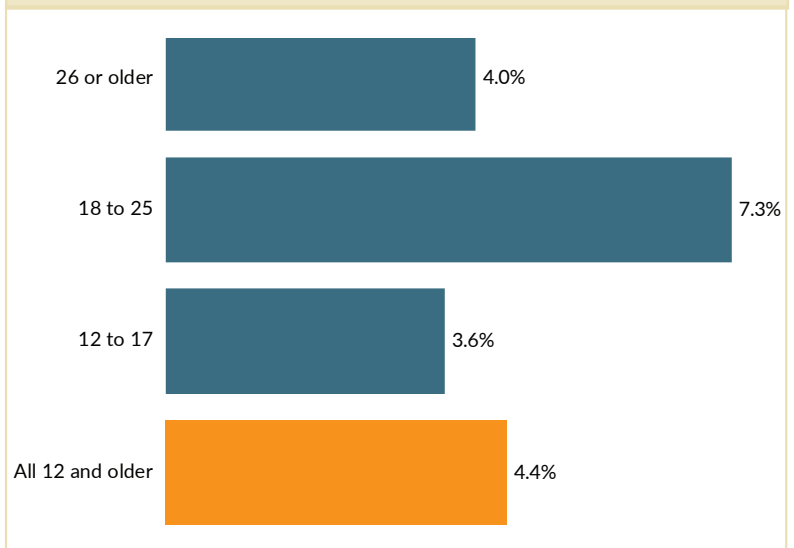
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Description of issue

School-age children deal with the same issues related to opioid misuse as younger children, including the continuing effects of neonatal abstinence disorder and the effects of opioid use disorder on their parents and other family members. As children mature, their risk for opioid misuse also grows. A 2016 survey found that 3.6 percent of adolescents between the ages of 12 and 17 reported misusing opioids over the past year (Figure 1). The rate doubled for older adolescents and young adults between the ages of 18 and 25, then declined again after age 25.¹ Nearly all of this reported misuse is of prescription opioids rather than illegal opioids. The rate of substance misuse among youth does appear to be on the decline; for example, among high school seniors, past-year misuse of pain medication other than heroin decreased from a peak of 9.5 percent in 2004 to 3.4 percent in 2018.²

Figure 1. Past year opioid misuse is highest among those who are between the ages of 18 and 25.



Note: Figure shows 2016 estimates of opioid misuse, defined as heroin use or the misuse of prescription pain reliever.

Source: Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. Available at: <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm#fig28>

While the rate of youth opioid use is relatively low and dropping, the rate of overdose deaths for this population is increasing, as is the proportion of opioid overdose deaths.

Not all adolescents are at equal risk; those who have witnessed the overdose of a family member or who have peers who misuse prescription drugs are more likely to misuse opioids. Other risk factors include chronic pain or other physical health problems; a history of mental illness, such as depression; or other substance use. While some adolescents are misusing drugs prescribed to them, nearly half of adolescents between the ages of 12 and 17 who reported misusing pain relievers said they came from a friend or relative.³

Summary of presentation

Youth—adolescents and young adults—are often left out of the discussion about opioid misuse. While there has been much recent attention on pregnant women, infants, and young children, there has been much less research and policy focus on those between the ages of 12 and 25.

As noted, youth opioid use is fairly low and decreasing, but the story gets more complicated when we look at youth overdose deaths. The opioid-related overdose rate among 15- to 24-year-olds has more than quintupled over the past two decades. Much of this increase is attributable to Fentanyl and other synthetic narcotics.⁴

While the need for services targeted to adolescents is rising, the availability of those services is limited; fewer than one in three of current U.S. specialty drug treatment programs offer care to adolescents.⁵ As with older adults, medication assisted treatment has been shown to be effective, and to have higher treatment retention rates than behavioral health services alone.⁶ However, between 2000 and 2014, only a quarter of youth diagnosed with opioid use disorder received medication assisted treatment (buprenorphine or naltrexone) within six months of their diagnosis.⁷

Early intervention creates opportunities to lower opioid misuse; the risk of developing a substance use disorder rises as the age at which substance use begins falls. For example, children who begin to drink alcohol before age 15 are about five times more likely to develop an alcohol use disorder compared to those who begin to drink after the age of 19.⁸ Brief, early interventions provided in the context of routine medical visits have been shown to be effective.⁹

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Research and policy implications

Across the country, there are several examples of promising programs for youth, both to prevent substance misuse and to support those in recovery. For example:

- **Recovery high schools**, schools that are specifically designed for students recovering from substance use, are currently located in 14 states. Adolescents attending these schools were significantly more likely to report complete abstinence from substances six months after initial treatment than were their peers not attending such schools;¹⁰
- **Collegiate recovery programs**, available in most states, provide recovery support while students pursue a postsecondary degree;
- The **Strengthening Families Program**, available in all 50 states and in 36 countries, provides seven- to 14-week long skills courses to youths up to age 17 and their parents. The program is designed to encourage happier family relationships, improve mental health outcomes, and decrease youth alcohol and drug use. Twelve

randomized control trials have found positive results of the program among both youth and their parents. Youth assigned to the program had improved school performance, less depression and anxiety, and dramatically lower tobacco, alcohol, and drug use compared to those assigned to a control group.¹¹ Parents reported positive effects on their parenting skills, family life, and relationship with their child; and

- **LifeSkills Training**, a curriculum available for elementary, middle, and high school students, combines training in self-management skills, social skills, and substance-use resistance skills. A prescription drug abuse prevention module is available. Researchers found that participating in LifeSkills Training in grade seven reduced by 4.4 percent a child’s likelihood of initiating prescription opioid misuse prior to 12th grade. A combination of this training and the Strengthening Families program was shown to be particularly effective.¹²

Other programs currently operating in only one state or that are being piloted in a small number of locations include:

- **The Phoenix**, a sober, active community providing fitness programs in several states taught by instructors who are themselves in recovery. The “membership fee” is 48 hours of sobriety;
- **Bridge over Troubled Waters in Massachusetts**, offering street outreach, emergency shelter, and independent housing for young adults;
- **Familias Unidas** in Florida, providing substance use and sexual risk behavior prevention intervention for Hispanic youth and their families;
- **Youth Clubhouses** in New York, community-based centers offering peer-driven support services in a nonclinical setting;
- **Speak Now**, a Colorado social marketing campaign intended to encourage conversations between parents and teens around substance use and abuse;
- **CATALYST Clinic** at Boston Medical Center, offering integrated, comprehensive medical, behavioral health, and recovery support care to adolescents and young adults;
- **Start Talking**, a K-12 curriculum in Ohio providing tools to start conversation between parents, educators, community leaders, and youths about healthful lifestyles;
- **Michigan Youth Treatment Infrastructure Enhancement**, an initiative intended to help providers offer an effective continuum of care to youths between the ages of 16 and 21 and their guardians;
- **Teens Linked to Care**, a pilot program operating in three rural communities in Indiana, Kentucky, and Ohio to help schools address high-risk substance use and other health concerns through education, primary prevention, and early detection screening; and
- **Opioid Affected Youth Initiative** in Miami-Dade County, Florida, a U.S. Department of Justice initiative to develop data-driven, coordinated responses to address opioid use among those under the age of 25.

As with adults, treating co-occurring disorders among youths is important. Adolescents and young adults may be self-medicating for preexisting anxiety and depression. While medication can work well for opiate use disorder, it does not

always work well for other substance use disorders, and does nothing for underlying mental health issues. It is not reasonable to expect patients and their families to access treatment for multiple issues separately; coordination is key. This may involve sharing data across agencies and programs, which is not always easy to do. ■

Sarah Bagley is a primary care physician at the Boston Medical Center and Assistant Professor of Medicine and Pediatrics at Boston University School of Medicine.

¹Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results From the 2016 National Survey on Drug Use and Health*, HHS Publication No. SMA 17-5044, NSDUH Series H-52, Center for Behavioral Health Statistics and Quality. Available at: <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf>

²L. D. Johnston, R. A. Miech, P. M. O'Malley, J. G. Bachman, J. E. Schulenberg, and M. E. Patrick, *Monitoring the Future National Survey Results on Drug Use, 1975–2018: 2018 Overview, Key Findings on Adolescent Drug Use*, Institute for Social Research, The University of Michigan: Ann Arbor, MI, 2017.

³Substance Abuse and Mental Health Services Administration, *Results from the 2015 National Survey on Drug Use and Health: Detailed Tables*, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration: Rockville, Maryland, September 8, 2016. Available at: <https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015/NSDUH-DetTabs-2015.pdf>

⁴Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2017 on CDC WONDER Online Database, released December 2018. Available at: <https://wonder.cdc.gov/wonder/help/mcd.html>.

⁵S. E. Hadland, J. F. Wharam, M. A. Schuster, “Trends in Receipt of Buprenorphine and Naltrexone for Opioid Use Disorder Among Adolescents and Young Adults, 2001–2014,” *JAMA Pediatrics* 171, No. 8: 747–755.

⁶Hadland, Wharam, and Schuster, “Trends in Receipt of Buprenorphine and Naltrexone for Opioid Use Disorder.”

⁷Hadland, Wharam, and Schuster, “Trends in Receipt of Buprenorphine and Naltrexone for Opioid Use Disorder.”

⁸B. F. Grant and D. A. Dawson, “Age at Onset of Alcohol Use and Its Association With DSM-IV Alcohol Abuse and Dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey,” *Journal of Substance Abuse* 9 (1997): 103–110.

⁹S. K. Harris et al., “Computer-Facilitated Substance Use Screening and Brief Advice for Teens in Primary Care: An International Trial,” *Pediatrics* 129, No. 6 (2012): 1072–1082.

¹⁰A. J. Finch, E. Tanner-Smith, E. Hennessy, and D. P. Moberg, “Recovery High Schools: Effect of Schools Supporting Recovery from Substance Use Disorders,” *The American Journal of Drug and Alcohol Abuse* 44, No. 2 (2018): 175–184.

¹¹K. L. Kumpfer and C. Magalhães, *Journal of Child & Adolescent Substance Abuse* 27, No. 3 (2018): 174–179.

¹²R. Spoth, L. Trudeau, C. Shin, and C. Redmond, “Long-Term Effects of Universal Preventive Interventions on Prescription Drug Misuse,” *Addiction* 103, No. 7 (2008): 1160–1168.