Adolescent Focus Group

1. What should a continuum of care look like?

- Would it look different than for adults?

After the treatment phase they would need more recovery services or after care. They need to be more connected to academics, sports, transportation, peer support services, family. Need to be made aware of range of services and how to access them. Needing to be addressed are issues of stigma at school and consent (being forced by parent against will into treatment or parent not wanting family secrets exposed).

- Caseload for youth and outcomes?

Fresno is a large diverse county. Communities may need to be looked at individually due to different types of populations (ethnicities, gangs). In assessment it will be necessary to identify gang affiliation. Provider should attempt to engage the adolescent and make treatment something they want to do.

There are gaps in support due to lack of parent engagement (eg. parents don't want caregivers to come to home).

Follow up/continued contact with JJC post release adolescents is important to keep them on track and stop or slow recidivism.

Providing services at schools allows greater parent involvement and utilization of supports and resources such as law enforcement, transportation and access to services.

2. What are essential levels of care (eg. Outpatient, Intensive Outpatient and Residential)?

Schools sites need to work with off-site programs as well because kids need support outside of school too. Schools should collaborate for proper referrals if the adolescent needs a higher level of care or needs other services.

- How many kids have major SUD problems?

More than we know. Many adolescents use on a daily basis before and after school. Most schools are linked with police departments and probation. Residential is a big issue because at this time there are no County funded adolescent residential programs other than JJC. Residential treatment is offered through private pay or insurance.

There may be a potential break in the continuum because adolescent treatment goes up to age 21 but most kids at schools are 19 years old or younger.

School Attendance Review Board (SARB) refers a lot of adolescents to treatment.

3. What is the role of prevention & early intervention in the continuum of care?

Treatment needs a closer alliance with prevention. It was stated that first use can start at 8, 9, 10 year old which make a good argument for increasing awareness of prevention services.

4. What are key service elements (ex. family involvement and academic engagement?)

Providing a safe zone where kids can talk freely without fear of repercussions for self and family (ex. INS, CPS). Youth on probation have difficulty feeling safe. (How would this be affected by mandated reporting?)

Youth treatment should be provided with structure and regularity because kids need consistency.

Family involvement:

Probation youth in group homes or foster care do not have family support. Youth in group homes sometimes do worse because they are exposed to more detrimental behaviors and situations.

Parents who need services often will not take advantage of resources because they do not want to draw attention. Parents with transportation issues are hard to engage.

It is a good idea when a youth is admitted into treatment to have family members agree to attend a minimum number of collateral sessions to ensure engagement.

5. Addressing State constraints on school based services that require a stronger emphasis on SUD treatment and provision of care independent of the school year?

State concern with school based programs regarding medical necessity.

Most school based programs do not offer summer services.

6. Prior authorization by County DBH – Should this be for all services or only residential levels of care?

One concern is that the length of time from central access contact to treatment would be increased. The providers see this as very time sensitive.

No wrong door; adolescent should be able to request services anywhere. Limited transportation.

Some providers think that their intake would be more expedient and the County should monitor for compliance.

How much does the County want to micro manage intake? This would create another level of liability to the County if someone falls through the cracks or it a medical director approves treatment and the County denies it.