CASCW POLICY BRIEF

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Child Well-Being in Minnesota:

Substance Abuse Treatment Among Minnesota Youth in Foster Care: Implications for Policymakers

Using policy to ensure that child welfare-involved adolescents and transitional-age youth are receiving the substance abuse treatment and support they need.

Center for Advanced Studies in Child Welfare

University of Minnesota

What is the Field of Child Welfare?

The child welfare field includes human services in the areas of child protection, foster care, and adoption. This work is carried out in a state-supervised, county-administered governmental system as well as through non-profit agencies, and is supported by research and evaluation from government, academic institutions, and non-profit organizations. The collective goal of child welfare is to promote the safety, permanency, and well-being of children, youth, and families.

Substance Abuse Among Youth

In 2012, 120,239 adolescents aged 12 to 17 entered substance abuse treatment in the United States, with marijuana and alcohol accounting for 89% of adolescent admissions[1]. Admission rates have been shown to increase with age. In fact, 17-year-olds accounted for approximately one-third of all adolescent admissions in 2012[1].

Studies have found that adolescents with a substance use disorder (SUD) are at a greater risk than their non-substance abusing peers for experiencing negative outcomes as adults. These negative outcomes include a shorter time to arrest period[2], significantly higher odds of alcohol and drug use in adulthood[3], and significant physical and mental health consequences including early death[4].

Child Welfare and Youth with Substance Use Disorders

The National Center on Substance Abuse and Child Welfare estimates that between one- and two-thirds of families in the child welfare system are affected by SUDs[5]. Many of these cases are due to parental use; however, substance use among adolescents and transitional-age youth in foster care is a pressing issue requiring greater attention among child welfare workers and policy makers. Diagnosable SUDs have been consistently found to be higher among youth involved in child welfare than in the general population[6].

Child Welfare Youth and Substance Use in Minnesota

In 2012, 11,453 Minnesota youth spent some time in out-of-home care. Approximately 39% of these youth were between 13 and 17 years of age, and just over 13% were age 18 or older[7]. The median length of stay for Minnesota youth in 2011 was approximately 8 months[8].

Multiple placement changes take a toll on children's emotional and physical health. Minnesota, unfortunately, has one of the highest foster care re-entry rates in the nation[9] and ranks in the bottom half of all states in terms of providing substance abuse treatment for those in need of it[10]. Children in care due to behavior problems or substance abuse are most likely to re-enter care[9], likely as a result, in part, of unmet substance abuse treatment needs. Only 1 out of every 10 Minnesota youth with a substance abuse disorder will receive treatment; of these youth, only about one-quarter will receive an optimal level of treatment[10].

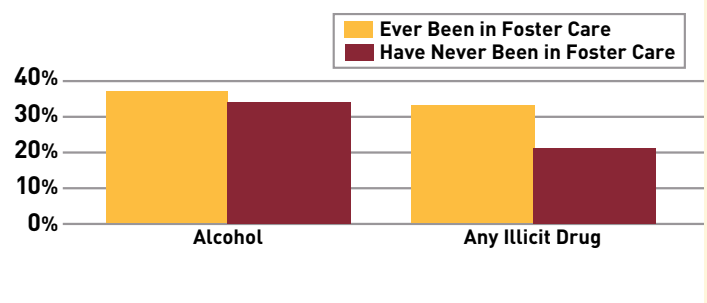
Given the substantial treatment needs of Minnesota youth in the child welfare system, state policy should prioritize closing this gap, particularly among child welfare-involved adolescents and youth.

Coordination between Agencies

Policy Issue: When a child enters the child welfare system, the child welfare agency collaborates with the child and his or her parents or guardians to identify service needs, including youth substance abuse treatment. Unfortunately, parents and adolescents often fear punitive action if substance use is disclosed[11]. Further, while child welfare agencies have access to medical data, health care records, and school records[12], child welfare practitioners are likely to agree with the statement that the confidentiality of client records is a substantial barrier to collaboration[11]. Numerous other factors have been shown to make communication between professionals about youth's substance use difficult including: differing agency cultures, differing beliefs about drug use and appropriate treatment[11], and inadequate interprofessional training[13]. However, collaboration between child welfare agencies, substance abuse treatment agencies, schools, and the criminal justice system is integral to providing youth with the necessary treatment.

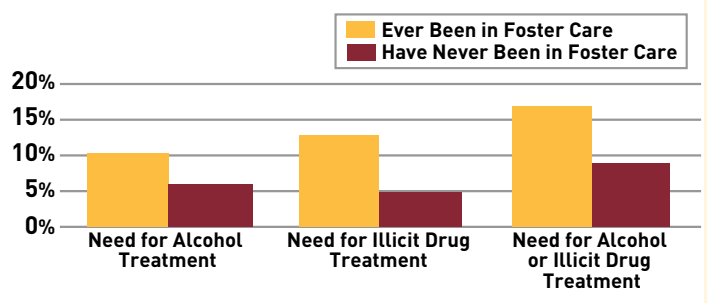
Policy Solution: Integration models should be promoted to facilitate communication between professionals in the field of child welfare. When the various agencies and systems involved in child welfare cases share resources and information, adolescents struggling with a SUD have increased access to

Table 1: Percentages of Past Year Alcohol and Illicit Drug Use Among Youths Aged 12 to 17: 2002 and 2003



US Department of Health & Human Services. (2005, February 18). *The NSDUH report: Substance use and need for treatment among youths who have been in foster care*. Retrieved from http://www.samhsa.gov/data/2k5/fosterCare/fosterCare.pdf

Table 2: Percentages of Youth Aged 12 to 17 in Need of Substance Abuse Treatment: 2002 and 2003



US Department of Health & Human Services. (2005, February 18). *The NSDUH report: Substance use and need for treatment among youths who have been in foster care*. Retrieved from http://www.samhsa.gov/data/2k5/fosterCare/fosterCare.pdf

treatment. For example, joint planning between child welfare agencies and schools is associated with a higher odds of adolescents receiving substance abuse treatment[14].

Most promising are models that colocate substance abuse treatment and child welfare agencies. Housing substance abuse treatment and child welfare agencies together increases participant access to services and communication between staff and is associated with reduced substance use for both parents and adolescents involved in the child welfare system[14,15]. In fact, in one 2011 study, the odds of an adolescent receiving substance abuse treatment when the child welfare and treatment agencies were housed in the same agency were 6.64 times higher than the odds of the adolescent receiving treatment if the agencies were not housed together.

How Are Adolescents Referred?

In 2012, 44% of adolescent substance abuse treatment admissions were referred to treatment through the criminal justice system, 18% of admissions were self- or individual referrals, and 15% were referred through schools, and the remaining 23% came from health care and community referrals.[1] However, while more referrals come from the criminal justice system, a national survey of middle school counselors found that school counselors are generally students' first point of contact for substance use problems[16].

Transition Planning

Policy Issue: As with the general population, substance use among child welfare-involved youth has been shown to increase after age 15[6,17]. However, while substance use tends to peak between ages 18 and 20 in the general population and decline gradually over time, preliminary evidence suggests that among former foster youth, substance use peaks much later, into their late twenties[18]. This suggests that transitional age foster youth aged 18 to 26 are in particular need of substance abuse treatment.

Narendorf and McMillen's (2010) study found that former foster youth living independently at age 17 reported higher alcohol and marijuana use than youth in all other living situations. Similarly, self-reported rates of substance use increased significantly more for youth who left foster care than for those who remained in care; youth were most vulnerable to substance use in the year after leaving care. Conduct disorder, parental substance use, a history of sexual abuse, and having peers who use substances are also associated with SUDs[6].

Policy Solution: Expanding SUD screening and education will increase youth access to necessary treatment. Currently, Minnesota statute recommends that youth in the juvenile justice system and youth considered to be habitually truant or a runaway be recommended for SUD screening[19]; parents and guardians must opt in to the screening[20]. Given the high risk of SUDs for youth already involved in the juvenile justice system, an opt-out procedure for screening would better identify youth in need of treatment.

Further, child welfare practitioners should be trained in SUD risk factors and appropriate screening methods to identify child welfare-involved children who are at risk of a SUD but are not currently considered truant or involved in the justice system. Finally, substance use and resource education should be promoted as a part of best practice for transition planning for older youth in the child welfare system.

Continuity of Care

Policy Issue: Mental illness and substance use disorders are positively correlated[21]. In Minnesota, children in state custody who receive Children's Mental Health Services (CMH) are offered Adult Mental Health Services (AMH) at age 18. In theory, this policy ensures that transitional-aged youth diagnosed with both a mental health and substance abuse disorder as well as youth accessing mental health services to treat a SUD will continue to receive services, particularly since youth in foster care now have access to health care coverage until age 26 due to the Affordable Care Act.

However, in practice the transition from CMH to AMH is a difficult, sometimes lengthy process. There is often a break in service and many youth struggle with the abrupt change in provider. In fact, across the country there is a sharp decline in mental health service use during a foster youth's transition to adulthood[22]. Further, while many youth with a SUD are also diagnosed with a mental health disorder, this is not true for all youth in need of SUD treatment.

Policy Solution: Integrating child and adult systems of care beyond mental health and expanding developmentally responsive services are essential steps to ensuring that transitioning youth gradually shift into adult systems of care without a break in service. The Minnesota Substance Abuse Disorder Model of Care Steering Committee (2013) confirmed the need to significantly expand and improve services for substance abusing teens. The committee highlighted the need for specific improvements in treatment delivery including the need for specialized adolescent treatment programs that provide a continuum of developmentally responsive care and the expansion of integrated mental health and substance use services[23].

Resources for Further Information & Continued Education

Download a legislator guidebook for substance use disorder treatment: http://www.ncsl.org/print/health/SAguidebook.pdf

View CASCW resources on substance abuse: http://cascw.umn.edu/portfolio_tags/substance-abuse/

Check out national and state resources on substance abuse and child welfare: https://www.childwelfare.gov/systemwide/substance/

For papers and reports generated by CASCW and CASCW partners, visit: http://z.umn.edu/cwpubs

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CASCW's mission is to improve the well-being of children and families who are involved in the child welfare system by: educating human service professionals, fostering collaboration across systems and disciplines, informing policymakers and the public, and expanding the child welfare knowledge base.

CASCW does not take partisan positions nor do we advocate for or against specific bills. Instead, CASCW offers background data, theory, and evidence-based practices that may be helpful to you as you consider these issues.

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