



THE UNIVERSITY *of* NORTH CAROLINA
GREENSBORO

NC ADOLESCENT SUBSTANCE ABUSE TREATMENT GRANT PARENT AND PROVIDER PERSPECTIVES FOCUS GROUP SUMMARY REPORT

FINAL REPORT AND SUMMARY, Spring 2009

Center for Youth, Family, and Community Partnerships

**The University of North Carolina at
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Disclaimer

The opinions reflected in this report do not necessarily reflect the opinions of the authors or the project staff, but reflect the perspectives of families and services providers across the state of North Carolina.

Questions, Comments, Concerns

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NC Adolescent Substance Abuse Treatment Grant

Parent, Provider and Youth Focus Group Summary Report

INTRODUCTION

History

In 2005, the state of North Carolina (NC) was awarded the NC State Adolescent Substance Abuse Treatment Coordination grant funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) Division of the U.S. Department of Health and Human Services. At that time, the state partnered with the Center for Youth, Family, and Community Partnerships at the University of North Carolina at Greensboro to assist in implementing the project. The central focus of the grant project is to develop a sustainable infrastructure for substance abuse treatment coordination that will strengthen the capacity of the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (NC MH/DD/SAS) to work with service providers that help youth in need of substance abuse treatment and their families.

The five main goals of the project are as follows:

1. To incorporate substance abuse treatment into the existing mechanism and process of collaboration (among service systems, youth and their families, colleges and universities, and community organizations, including faith-based groups) for serving children and youth at risk of out of home placement and their families;
2. To generate a comprehensive array of effective, accessible, and affordable services for youth with substance abuse and/or co-occurring problems that are evidence –based;
3. To provide support for dissemination, training, and delivery of evidence-based services;
4. To develop a workforce for adolescent substance abuse treatment in collaboration with colleges, universities and private providers; and
5. To develop a mechanism for the evaluation of the project.

To meet the goals of this project, the NC Adolescent Substance Abuse Treatment Coordination staff, led by the Center for Youth, Family and Community Partnerships (CYFCP) at the University of North Carolina Greensboro (UNCG), developed a strategy to interview the citizens of NC in order to gain their perspectives on the state of the field around four key areas, including:

- General awareness of the problem of adolescent substance use and abuse;
- Availability of treatment programs;
- Accessibility to programs; and
- Substance choices for use and abuse within various communities across the state.

Methodology

During the spring of 2007, UNCG convened a multidisciplinary group of staff that included family members who have experienced substance abuse in their own families, experts in family and adolescent advocacy, psychologists, researchers, and substance abuse providers. This diverse group developed a list of questions that would be asked as part of each focus group conducted. A separate list was created for focus groups targeted for family members and providers (Appendix A) across the state. A list of geographically diverse communities across the state and communities was identified. The ethnic makeup of a community and the average income of a community also were factors in the decision to target particular communities so that a diverse sample could be obtained, including at least two focus groups within primarily Latino communities. The staff decided on the following 8 locations in North Carolina for the focus groups: Greensboro – Guilford County, Webster – Swain County, Elizabethtown – Bladen County, New Bern – Craven County, Roxboro – Person County, Durham – Durham County, Morganton- Burke County, High Point – Guilford County. A visual display of North Carolina and the counties within which the focus groups took place is provided in Appendix B.

After receiving Institutional Review Board (IRB) approval to conduct the focus groups in the above referenced counties, the UNCG staff team worked with local System of Care (SOC) Coordinators and Family Partners in each community to help recruit potential participants. These partners in each community were compensated \$400.00 for their facilitation services. All participants provided informed consent prior to taking part in the focus group and families received a \$25 gift card for their time. UNCG staff determined that the two focus groups (family-based focus group and provider-based focus group) would be conducted on the same day in each community selected. The family-based focus group was held at a convenient time for families (determined by the local SOC coordinators and family partners in the community); provider-based focus groups were held during lunch hours to encourage a large turnout of providers. Providers were given a lunchtime meal for participating in the focus groups (but did not receive a gift card). A target capacity of 14 participants for each focus group was determined, however if the room setting allowed for additional participants, those participants also would be included.

All focus groups were conducted between May 2008 and October 2008. There were 72 providers across 7 focus groups, and 128 family members across 10 focus groups. Each focus group was audio recorded, transcribed verbatim and imported into Atlas.ti, a software package that allows for qualitative analysis of textual data (Muhr, 1993). Following an initial reading of the transcripts, preliminary themes were identified and discussed by multiple staff members. Next, those themes were used to systematically examine, group and code the transcripts in ATLAS.ti. A summary report of the findings and themes was then created and disseminated back to local SOC coordinators and family partners to be shared with the participants and other interested parties in each community.

FINDINGS

The findings are presented with an emphasis on youth, family and provider personal experiences and insights into the strengths, gaps, and needs within the adolescent substance abuse field. The focus group questions serve as the framework for the findings reported below. Major themes illuminated by the analysis are discussed as they relate to each question.

"...I THINK IT'S LIKE AS YOU GET OLDER THE MORE, IT'S LIKE MORE PRESSURE FOR YOU TO DO IT AND FOR INSTANCE, I WAS IN SCHOOL ONE DAY AND I ASKED IF, THIS GUY JUST STARTED TALKING ABOUT SMOKING WEED AND HE ASKED ME IF I DRINK OR ANY OF THAT AND I SAID, 'NO' AND HE SAID, 'THAT'S REALLY RARE NOW'."

– YOUTH PARTICIPANT

Perceived Level of Community Substance use

Despite the focus group location or audience, participants perceived substance abuse to be high and “*a major concern*” for communities across the state. Participants in some counties reported that adolescents were experimenting with substance abuse at younger ages and that it was “*more serious than people think*” and “*a very real problem among adolescents.*”

Substances Used

The four most popular substances mentioned by participants were alcohol, marijuana, prescription pills, and tobacco. Methamphetamine use was reported to be a problem primarily in rural communities. Ecstasy and other ‘party drugs’ were mentioned on rare occasions and primarily in urban communities. Crack use was reported to be fairly evenly distributed throughout the state and not specific to either rural or urban communities.

Perception of Drugs

Among all participants across locations, perceptions of substances and substance use could be distilled into two common and related themes. First, there was a perception that some substances are “ok” while others were “bad” substances for adolescents to use. Participants acknowledged that a popular belief has emerged that alcohol and tobacco use are more accepted because they are legal substances, and that marijuana is even considered a ‘soft drug’ and not necessarily a problem substance. Instead, there is a perception that it is normal to experiment with this substance during the adolescent period. Youth perceptions of their peers using marijuana supports this theme, and as one youth from Guilford county stated, “*I know a few, a few friends that I have that like, do marijuana and stuff but it’s not really a problem cause they don’t do it around school or anything, they’ll leave or something like that, I just don’t follow them, but I mean we’re still friends, it’s not a problem with me.*”

Further, there is a perception that use of prescription drugs is ‘ok’ as a recreational drug. This perception appeared to be justified by the fact that a medical doctor prescribed it. “*The pharm parties you mentioned earlier, I know they were popping pills, and they like – oh, there’s nothing wrong with it, it’s prescription.*” In contrast, drugs such as crack and heroin were considered to be the “*heavy-weight*” or dangerous drugs because they were more clearly illegal to use.

These misperceptions regarding what were considered problematic substances also seemed to cause confusion regarding the definition of substance use versus abuse. A provider in Durham pointed this out by stating, “*I think a great barrier is recognizing, especially for young teens, that, what the, what the behavior is whether it’s typical teen behavior or whether it’s behavior that’s really out on the fringe because it’s associated with drug or alcohol use that’s unsafe.*” This confusion seemed to contribute to difficulty determining if substance abuse services were needed.

Further, participants indicated that the perceptions of substance use being either the stigmatic crack user or the cool or ‘in’ alcohol drinker are reinforced by the portrayal of substance use in the media and popular culture. Both youth and families across communities recognized the influence of media on the popular perceptions of substances and use. While talking about media portrayal of substances, one youth recognized, “*...television, commercials, you know it’s mostly every kinda thing you could imagine, like magazines, everything has some kind of substance in it...*” Similarly, one parent argued that it is difficult to

change the image in a young person's head regarding the popular image of a drug user or seller, and she acknowledged, "...in my mind it [the media] means nothing because that's not for them. But to your teenage child it's everything."

Family Involvement

The role family's play in the use of substances was a frequently discussed topic among all participants across communities. It was repeatedly reported that parents or caregivers often provide substances like alcohol or tobacco for young people to use at the home or other locations. The reason behind this behavior stemmed from parents feeling more comfortable knowing that the adolescents had a "safe place" to use the substances and was being supervised. One family member explained, "*So that's a big fad now cause they, they for graduation they pooled a bunch of rooms and those kids, those underage kids they had alcohol, but the parents feel safe because they don't have to drive, they got a room...*"

On the other hand, it also was frequently mentioned that parents often abuse substances themselves or with their children, making it more available for and seemingly acceptable to the adolescent. Providers reported this as a general frustration, with one provider from New Bern, NC, stating, "*...it seems like we're fighting a losing battle when you come in and teach prevention education and I'm saying you, this, this is bad to be using these drugs at this age um, when their parent at home is, is condoning it.*"

There were a few parents who reported playing an active role in preventing their child from using substances by either checking in with the child frequently or openly talking about the negative effects of substance use. These efforts were felt to be successful at reducing the child's opportunity to use or shifting their perception of substance use. One provider participant who also was a parent stated, "*... for my own kids we talk about this a lot, but for my youngest son,...he really got it when I showed him the pictures of the brain resonance, pictures of what alcohol does to an adolescent at certain ages...and he immediately self-corrected on his own a lot of his patterns of behaviors.*"

Socioeconomic Status, Race and Culture

The role that socioeconomic status (SES), race and cultural background play in the use of drugs also was frequently discussed among participants. Further, because the focus groups conducted were ethnically and economically diverse, good insight was provided regarding this issue. While some participants held the common belief that race was the deciding factor in what substances were used, others felt that SES and race worked together to make the distinction. Overall, participants reported that those of lower SES were more likely to use marijuana and alcohol while those of higher SES were more likely to use prescription drugs or ecstasy. Further, since the adolescent range used in this research was from 0 to 26 years old, the culture of colleges and universities arose as a source of adolescent substance use and abuse. Specifically, alcohol, marijuana and prescription drug use were highlighted as being a central part of the college student culture and the general "college experience".

Further, among the two focus groups that occurred primarily with members of the Latino community, conversation occurred that included not only differences between the Latino and American cultures regarding adolescent substance use, but also what role it plays in the lives of those individuals who are not American citizens. Latino youth who participated pointed out a couple of issues regarding

"BECAUSE I SMOKE CIGARETTES, MY DAUGHTER THOUGHT IT WAS OK. . . WHEN I WAS TALKING TO HER ABOUT SMOKING SHE SAID, 'WELL MOM, YOU SMOKE CIGARETTES AND YOU'RE ADDICTED TO NICOTINE,' AND THAT WAS HER RESPONSE WITH ME, SO THAT, YOU'RE RIGHT, THE KNOWLEDGE OF REALIZING THAT WHAT WE DO SORT OF HELPS THEM SAY, 'WELL IT'S OK'."

- FAMILY PARTICIPANT

"SOME OF THESE KIDS ARE AMERICAN AND BECAUSE THEIR FAMILIES ARE BEING TREATED AS SECOND-CLASS CITIZENS, THE KIDS BECOME RESENTFUL AND THEY SAY, 'I HAVE TO BELONG SOMEWHERE, LOOK AT THE WAY THEY'RE TREATING MY PARENTS.' ...SO OF COURSE WHEN A PERSON WHO IS RECRUITING COMES ALONG IT'S A PERFECT COMBINATION."

–LATINO PROVIDER

adolescent substance abuse and culture. First, they explained the fact that some young people come to the United States from other countries by themselves in order to go to school or stay with extended family. That cultural transition was acknowledged as a difficult one. For example, in Mexico, the drinking age is 18 and according to many youth participants, "...we don't have like strict rules, that, ok, nobody's going to pull you over you know like, the police are not going to do anything." Coming to the United States where the drinking age is 21 and the law enforcement is stricter, some of the youth felt that this, along with the perceived pressure of succeeding for the sake of not only his/her self but the family, makes the transition and not drinking or abusing drugs easier because the goals and rules are clear. However, one youth participant mentioned, "*I do know some people that they coming like from Mexico, some young people that they come by themselves and it is a struggle because they cannot*

handle that liberty that they have here and they miss their family and they start to abuse drugs." So, the cultural transition that accompanies the immigration process was felt to either be a positive or negative experience, possibly depending on the youth's purpose for coming and coping skills.

Second, Latino youth were asked whether they saw a difference between Latino and non-Latino peers and drug use. One participant responded, "*I see it differently only cause, like for us, like in our country, they usually raise us like, it's something, it's a big deal you know, but like in American people it seems so normal, like I see people smoking in front of you and it's like not a big deal for them...*" Latino providers provided valuable insight into issues surrounding substance abuse in their community centering around social acceptance. The issue of social acceptance was suggested as a cause of adolescent substance abuse in the Latino community. Providers explained that Latino youth drug use and/or gang membership are centered around their need to belong in a society where they may feel like they don't fit neatly into one group.

As a more general part of social acceptance, the Latino providers tried to explain the Latino culture regarding family problems or issues and the differences between that and U.S. culture. "...*people here in, in U.S., as a U.S. general, uh, when you, when you are 18 you go by your own. We as a Latino-American people, we stay together no matter you have 20 or 30 or 40-year old. So if you're in trouble with drugs we will not talk about it but we will going to help you....But we will not talk about it. We will not share our experience with the, our neighborhoods. It's our problem.*" Latino participants all agreed and reiterated that drug abuse is like sex, it is "*taboo*" and not talked about and even denied to a certain extent. This raises important implications for the likelihood of seeking substance abuse treatment among this population.

Drug Impact

All participants were asked whether substance use directly affected their lives. The majority of participants indicated that they have been directly and negatively impacted by substance use. Criminal behavior, medical problems, and family and/or marital problems were a few of the areas that were most frequently mentioned as negative outcomes of substance use based on participant feedback. While substance use had slightly varying impacts on participants, most of them fell into at least one of these categories.

Criminal behavior was most frequently recognized as a result of substance use and seemed to most directly affect families. A pattern that emerged was that criminal behavior was mostly associated with

'heavy-weight' drug use such as crack and cocaine. Most frequently, the criminal behavior was a means to obtain goods or money to support the 'habit.'

Medical problems were another commonly mentioned consequence of substance use reported by participants. Medical issues such as cirrhosis of the liver, heart attack, overdoses and withdrawal sickness were mentioned by participants. One family participant described his mother's use of marijuana, "*I know my mom was sick and I seen the things that happened on her when she was, she was, she was ill, she had cancer and I seen where it benefitted, helping her but the I also seen that once she got down off of that, off of, what it done to her, how it made her change. It actually made her worse but it was to help her with the pain.*"

The use of substances for medical purposes and the dangers associated with such use also were discussed. A provider participant described how family doctors often prescribe "*heavy duty pain medications*" for a common sports injury and suggests that the medical community "*look at their prescription habits.*"

Family and marital problems were other ways that substances impacted the lives of participants. Several participants reported marital break-ups because of partner use and acts related to the use. When children were involved, struggles were discussed surrounding single-parenthood and the desire for the child not to follow a cycle.

"...SO I THINK A LOT OF PROVIDERS ARE REALLY STRUGGLING ON HOW TO REFER ADOLESCENTS AND FAMILIES TO THE TREATMENT OUTPATIENT COMPONENT BECAUSE THEY'RE PRETTY MUCH NON-EXISTING."

Adolescent Services Available

While the prevalence of available adolescent substance abuse services differed greatly by demographics, one overarching consensus was that the services are not proportional to the problem and that more are needed to reach an equitable, continuous level of care.

Geographical Region

One of the strongest patterns found in the qualitative analysis was that the adolescent services available depended greatly on the type of community. The urban areas were recognized as having many services available, even for adolescents. However, it was within the urban areas that awareness of those many services was not widespread and as a result, some of the services were underutilized. A family participant from High Point recognized that, "*...they have a lot of community support agencies...and they offer a lot of, substance abuse counseling, one-on-one mentoring and assistance with substance abuse and there's plenty, I mean plenty in the community, I just think like you said, people are not aware of the services.*"

As for the rural areas, they were often recognized by their residents as being "isolated" from services and providers. The available services mentioned required transportation and were often in another town or county. One provider participant stated, "*There is actually no, prevalent in our knowledge outpatient services within, actually the three county area...*" With the small community size of rural areas, many family members as well as providers made it clear that trust was an issue when trying to serve such a population. "*Most people work up there are from the community. And sure enough you go run and say something and next thing you know...everybody knows who you are,*" stated a rural family participant.

Money and Insurance

Access to money and insurance were consistently recognized as the key variables to the ability to access services. Specifically from the provider perspective, private or public insurance determined availability and quality of service provision for adolescents.

Some providers noted that public insurance actually helped people get better services than those with private insurance that may or may not cover substance abuse treatment and were usually more tedious to work with. However, other providers explained that specifically Medicaid caused funding issues and resulted in a “*true loss*” in some cases. Family participants pointed out that money was sometimes required beyond private insurance (e.g., deductibles and co-pays), which made getting services prohibitive for those that did not have the finances necessary.

One participant explained, “...*North Carolina does not have clarity for addiction treatment so folks who have insurance policies, private insurance policies...those that do often have such ridiculously high copays and deductibles that its essentially unusable and so that many of the kids who, who have those resources are actually in worse shape than the kids who are on Medicaid...*”

However, for those with the means, out-of-state treatment services for adolescents were discussed as being readily available. Programs in San Diego and Tennessee were specifically mentioned by participants as being used. One parent participant recalled that a program in Tennessee “*had a bed*” so she didn’t have to worry about the waitlist problem. She also mentioned that the Tennessee provider, “*had an adolescent program where he could finish school, they have a full time teacher who coordinates with his, the child’s teacher and he was able to graduate and walk in graduation.*” The local provider did not offer an adolescent program and would not have interfered in her son’s education.

Co-Occurring Disorders

Co-occurring disorders were recognized by families and providers as either preventing or assisting in the availability of adolescent services. A few participants reported that some providers avoid substance abuse treatment because of the difficulty of treating substance abuse in general and adolescents specifically. Further, the participants mentioned that adding a mental illness to that situation is like, “*the kiss of death,*” to some providers.

Participants also reported that some providers would not accept some adolescents with additional mental health issues into treatment because of the difficulty of treating. Participants also noted that some mental health medications were not permitted in treatment, often adding additional stress to the treatment situation. Thus, substance abuse providers are reluctant to treat mental health issues, and mental health providers are reluctant to treat substance abuse issues.

On the other hand, some providers reported the need for a co-occurring mental health diagnosis in order for insurance companies to cover treatment. One provider admitted, “*In some instances I have to give a co-morbid mental health diagnosis because the insurance company doesn’t cover straight up...you know, alcohol abuse or cannabis abuse.*”

Lack of Qualified Professionals

Qualified professionals and licensed staff are central features to adolescent service provision. The lack of adolescent services was attributed to a shortage of such staff. Various reasons such as credentialing issues and continually changing license requirements were acknowledged as being points of frustration for professionals. “...*I had actually gotten the hours to take the substance abuse certification test but they changed the regulations. You have to have a Masters in order to be a licensed clinical substance abuse*

counselor so...people out there with a Bachelors just like me who have the hours to take the certification test but can't."

Specifically in rural areas, providers noted that staff had moved to more urban areas where salary was better. Another provider participant acknowledged that, "...I can go to Wilmington or I can go to Charlotte and maybe double my income and leave these rural areas and people are making choices to do things like that to leave these small counties..." Additionally, provider burnout was recognized as another reason for a shortage of staff in North Carolina.

Follow Up Services

Follow up services available to help reintegrate youth back into their lives after treatment were frequently mentioned as a gap in services available. Both provider and family participants reported the need for a stronger continuum of after-care to help reduce relapse and ensure the youth's success. "But then you're also sending them back into a community that has no services, so, and then you end up with a lot of higher relapse and different things like that," stated a family participant regarding adolescent re-entry following treatment outside of the local area. The need for follow up services also highlighted the need for

more local services within communities so that readjustment could be smooth and occur within the adolescent's own community.

A provider participant put it best by simply saying, "...if they come back to the same place where nothing has changed in the place, they're gonna go right back to what they were doing, if they go back to the same high school, if they go back to the same community it's going to be very difficult..."

Process of Finding Adolescent Services

Participants were asked to explain the process of finding services for an adolescent in their area. The general pattern was an initial contact with a local agency or organization that would then provide a list of possible providers, leaving the family to choose and initiate the next steps. In only a couple of descriptions were families guided through the process and assisted continuously. A disconnect between agencies was the cause of much frustration in the process for both the families and providers. In addition, the lack of services available to adolescents

complicated the process for both families and providers. Overall, the need for a more accessible, streamlined process was recognized.

Five main themes emerged in the discussion of this topic. First, the initial step of acknowledging the need for treatment was reported as sometimes being a point of contention between youth and families. Second, the awareness of who to call and what the steps were beyond that point was low, even among providers. Third, the type of insurance and access to money was determined to be a deciding factor of where to start. Fourth, the general lack of adolescent services available made the process difficult to navigate and limited the options in some places. Lastly, disconnect or miscommunication between and within agencies was acknowledged as a central factor in the process.

"SO NOW WE NEED TO LOOK AT WHAT IS THE DEFINITION ACTUALLY OF SUBSTANCE ABUSE? HOW MANY JOINTS DO I NEED TO SMOKE BEFORE ITS CONSIDERED ABUSE? HOW MANY DRINKS DO I NEED TO TAKE BEFORE I'M AN ABUSER? OK, IT AIN'T AFFECTING HIS JOB, IT AIN'T AFFECTING HIS SCHOOL. HE'S STILL AN A-B HONOR ROLL STUDENT."

– FAMILY PARTICIPANT

Based on participant responses, those who had gone through the process were aware of what to do, but pointed out numerous gaps in the process. Those who had not personally experienced it were generally unaware of the process.

Perception of Need – Normal Use Versus Abuse

Some participants reported the agreement between family and youth regarding the need for treatment as being the first true step in the process. However, this was frequently noted as a point of contention. One provider participant acknowledged that, *“There’s a split between people in the family perceiving is it a problem or not.”* It is important to note that participants reported the agreement issue as going both ways.

In some cases, the parents wanted the adolescent to get treatment and the youth did not agree and would not participate. A provider recalled, *“I’ve had the parents show up for the assigned treatment and the kid’s absconded.”* In other cases, the youth was ready but the family did not want to participate, which one provider concluded as, *“the parents who are most likely to be in trouble themselves are the least likely to be in there...”*

“I MEAN, OF COURSE WE KNOW ALL THE POWER OF INFORMATION TOO, HOW TO DEAL WITH THIS STUFF IS ANOTHER GREAT BARRIER. I MEAN, WE, WE’RE SITTING AT THE TABLE NOW WITH I’M SURE TONS OF DEGREES AND WE CAN’T, WE’RE STRUGGLING TELLING YOU WHERE TO GO OURSELVES.”

– PROVIDER PARTICIPANT

Awareness

Once the decision to get treatment was made, participants reported various starting points in the process from contacting the LME, calling the hospital, social services, or calling 2-1-1 or a similar local information number. However, many participants were not aware of any of these as options and stated that *“getting arrested”* was the best and quickest way to get services because the court system would handle the process. Other participants responded that word of mouth is a frequent process used. One family participant made the point, *“Yea, there’s no advertisement, you just find out from somebody you know.”* A provider participant recognized that while the local hotline number was advertised around town, it was often in shopping malls and eating areas that have limited access to some residents. As a result the provider concluded that if you can’t get to those areas, *“...you don’t have ways of seeing the information or being out in the community. So I’m sure that there are, a big part of our population doesn’t have access to that.”* It also was recognized that some of the local hotline numbers were not accessible to non-English speaking populations.

Specifically, youth participants were not aware of any services or a process to get services. They reported that speaking to a parent, calling a hospital, or consulting the internet were some resources they would utilize to find help for a friend.

Money and Insurance

When asked what the process was for finding adolescent substance abuse services in their community one family participant responded, *“Well, how much money do you have?”* Participants made it clear that the process was determined by access to insurance and/or money. Some family participants mentioned that calling the insurance company was the first step in the process, which was assuming that the person in need has insurance. Some provider participants made it clear that the local management entity (LME) or referral agency should provide referrals according to the funding source.

However, within private insurance, other participants mentioned that only certain types of treatments were available and upfront payment was required since most policies did not cover substance abuse treatment fully. One provider pointed out that private insurance “rarely pays for mental health and substance abuse treatment.” Other participants stated that those with money could find either out-of-county or out-of-state residential programs instead of having to go through the local process.

The benefit of private insurance was a disputed topic between family and provider participants. Family participants frequently aligned private insurance with better services and more resources and held it to be a privilege. However, the provider participants frequently associated it with less community support access and more work for the family. For example, a provider participant explained the role of the community support services qualified professional as an acting “*case manager*” to assist the family in navigating the system and setting up evaluations and services. When discussing the role of insurance they stated, “*Some have private insurance although private insurance, specifically Blue Cross Blue Shield type polices does not cover community supports to aid this person at finding, accessing the treatment they need.*” Also, other providers mentioned limitations of private insurance such as not covering certain types of treatment, requiring upfront payment, and long waiting periods because of paperwork.

Public insurance, on the other hand, was preferred by providers because it allowed for more treatment hours in some cases and was a quicker process than that of private insurance. There was also concern by both provider and family participants regarding those who could not receive even public insurance, leaving them with no assistance at all.

Disconnect and Communication

One of the largest issues in the process to finding adolescent substance abuse services was the general disconnect within and between agencies. Differing rules and regulations between agencies were reported as making collaboration difficult. This was especially noticed in partnerships between schools, the justice system and providers. Multiple providers also pointed to agencies having different mission statements and purposes, which prevents cooperation as well.

Additionally, differing rules defining an adolescent were reported by providers as making it difficult to categorize for administrative purposes. For instance, a provider remarked, “*Some of the people I get in my group are 21, according to Medicaid they’re still an adolescent, according to the justice system they’re an adult so I think there needs to be some more blended terminology to make it more cohesive.*” However, there were a few providers that felt they had strong relationships with other agencies, which made it easier to find necessary services for those they were serving.

Within agencies, family participants felt there was a disconnect between providers and consumers regarding assistance with a personal touch and without judgment. One family participant recalled, “*I know I’ve made mistakes in my life, but if I have to come and have to deal with your attitude about you being mad about what I did, you don’t wanna help me then I’ll just, I’ll just go home and have to figure something out.*”

An overall need for better “*care coordination*” was called for as a way to streamline the process to getting services.

“IF CHILD AND FAMILY TEAMS ARE WORKING TOGETHER, AND THIS HAS TO BE AN INTEGRAL PART TO CHANGE ALL OF THE THINGS THAT WE’RE SAYING MIGHT BE WRONG. IF THEY’RE DOING THEIR PART, CHILD AND FAMILY TEAMS WILL SOLVE SOME OF THIS...BUT WITHOUT THAT WE RUN INTO, CAUSE WE DO IT, ‘WELL NO THEY’RE GONNA FIND IT,’ AND THEN THEY’RE GOING, ‘WELL NO YOU FIND IT.’”

– PROVIDER PARTICIPANT

Service Waitlist

Participants were asked about the waitlist for adolescent services. Generally, across the state, both providers and families described the waitlist as “kind of long” with time periods ranging from 1-8 weeks. One provider stated, “*It’s definitely not in accordance with the need of the person in trouble.*” Involvement in either the court system or social services was recognized as the quickest way to access services according to participants.

Insurance

Insurance was discussed by providers as an important component to determining the waitlist in some cases. Providers revealed that waiting for private insurance to clear is prohibitive to receiving services and that public insurance is more beneficial in the waitlist process. One provider discussed the waitlists associated with Blue Cross Blue Shield insurance and stated, “*It’s much easier to actually right now to go through the public system than it is to go through the private system for intake purposes.*” However, other provider participants explained that the public insurance process of getting an assessment signed off by a doctor and having to send paperwork to the state to get authorization often takes just as long as private insurance.

Informal Community Supports

Informal supports were recognized by all audiences as an important piece when dealing with adolescent substance abuse. The phrase, “*It takes a village to raise a child*” was frequently used in regards to the need for informal supports to exist in the communities. Numerous private non-profit programs that operate in specific locations were recognized as existing, but the most frequent and consistent informal supports available were Narcotics Anonymous/Alcoholics Anonymous (NA/AA) recovery groups and the faith community. However, beyond those, the availability of informal supports ranged depending on geographical region, culture and funding.

While NA/AA recovery groups were most frequently reported to be the informal supports available, they often were not felt to be specific to adolescents. It was repeatedly stated that the atmosphere of the meetings was “*intimidating*” to a youth because the majority of those in attendance were often adults and some participants even believed that it was restricted to adults only. Alateen, the teen specific branch of the AA/NA groups, was not known or mentioned as available in many areas.

The faith community was the second most frequent informal support available across the counties visited. Churches often were recognized as not only providing space for NA/AA groups to meet, but also for running their own outreach ministries. Most of the programs mentioned by the participants were not directly related to substance abuse, but were targeted at youth in general in the form of afterschool programs, Friday night gatherings, along with a few faith-based 12 step programs.

While churches were regularly mentioned as a support, a few participants also mentioned that some churches “*don’t want to be involved with a lot of street issues.*” Specifically, a provider from the Latino community mentioned that, “*...the church played a*

“PLUS, IF YOU’RE SOMEONE WHO IS DEPENDING ON STATE FUNDS...YOU PROBABLY DON’T HAVE A JOB OR IF YOU DO, OR IF YOU DO, YOU HAVE LIMITED INCOME, PROBABLY LIMITED TRANSPORTATION. HOW REALISTIC IS IT IF YOU HAVE AN ADOLESCENT IN YOUR HOME THAT NEEDS TREATMENT TO GET THEM BACK AND FORTH FROM ASHEVILLE OR CHARLOTTE OR SOMEHWERE?”
–RURAL FAMILY PARTICIPANT

big, big, big role in our lives and in the families,” but went on to say that the churches, “...*try to heal your soul and not your life.”*

Beyond NA/AA recovery groups and the faith community, various community specific programs were mentioned, but obtaining funding was considered to be a barrier.

Geographical Region

Much the same as formal services available for adolescent substance abuse, informal supports available were different between rural and urban settings. Rural areas often were said to have nothing beyond NA/AA and the faith community. Participants felt the lack of community supports was a problem stating, “*Yea, cause its leads all to them being bored and not having nothing to do. It’s trouble, you know, they find trouble because they ain’t have nothing to do.”*

Urban participants acknowledged many informal supports in the community, but the underutilization of them because of a perceived unwillingness or inability on the family’s part to access them. One provider commented, “*we have programs up one side and down the other. We have special days, we have extended hours, and just about every center we’ve built has a specific teen center inside of it. But, those parents are not saying, ‘You are going to the center,’ or, ‘I’m going to take you to the center.’ we’re still at a, at a, at a loss there.”* The provider went on to say there are teens that come, but that more would be nice.

Culture

Culture emerged as important when discussing informal community supports. Within the Latino community, both providers and youth acknowledged no structured informal support programs available outside of NA/AA and the faith community. However, the Latino community as a whole was described as being an informal support in and of itself.

As was explained earlier, for many in the Latino community, formal services are either not used because of the cultural taboo of substance abuse or because of a lack of insurance sometimes due to legal status. In order to compensate, professionals in the community work together and build informal networks. One Latino provider described one specific coalition, “*...we have what is called the Latino Community Coalition Meeting, where we meet once a month and we exchange knowledge and, and reference to all of, you know, all of this, to help the community. So basically it’s like we try to do the best we can with all the people that we know to help the, the community.”*

Funding

As a part of informal supports, several participants referred to funding as a barrier to starting or continuing a community program. Many participants were not aware of where to get funds or how to track progress of a program, leaving the program to either end shortly after it begins or not to begin at all. A provider explained the difficulty of getting funds for programs, “*The problem about these fundings, the funding, especially the grants, is you know, they always want you to have this sustainability plan. Well, ok, on paper we can write a lot of things that look like a sustainability plan but in fact, we really need funding on a regular basis and not through grants, you know.”*

“...IF YOU TAKE SOMETHING AWAY FROM KIDS, YOU’RE TRYING TO TAKE THE SUBSTANCE ABUSE, YOU GOTTA PUT THINGS IN THEIR LIVES. YOU GOTTA PUT POSITIVE PROGRAMS, AND YOU KNOW, FAMILY ORIENTED STUFF...YOU GOTTA HAVE THESE THINGS. YOU CAN’T JUST SAY TO THE KIDS, ‘I DON’T WANT YOU TO DO DRUGS.’ I MEAN THERE’S GOTTA BE OTHER THINGS IN PLACE FOR THESE KIDS...”

– PROVIDER PARTICIPANT

Barriers to Obtaining Adolescent Services

Participants were asked specifically about what they saw as barriers to accessing services. While numerous barriers were mentioned, five were consistently found throughout all of the responses. Transportation and finances (both money and insurance) were the two most frequently mentioned barriers to getting adolescent substance abuse services. Beyond that, the overall lack of adolescent services available, missing family support and involvement, and the stigma of substance abuse all were regularly recognized as barriers to services. Each of these barriers are discussed in more detail below.

Transportation

Transportation was one of the most frequently mentioned barriers to accessing both formal and informal services. However, the degree to which transportation was a barrier seemed to vary based on geographical regions. Participants from rural areas often named transportation as one of the top two barriers. Rural areas often were recognized as not having a public transit system and as being more isolated from services, making transportation more important and the lack of it more of a barrier. Participants from urban areas did not name transportation as one of the top barriers, and in some cases, did not mention transportation at all.

Money and Insurance

Across all locations, lack of money and insurance were named as top barriers to both youth and families accessing services and providers providing services. For family participants, having money and insurance were key barriers to getting formal adolescent services as well as utilizing informal supports. One family participant recalled, *“Some programs like...they had like, I think swimming lessons or something for it was, it was a four day camp, it was a week long camp for members, I think it was like \$65. If you’re not a member I think it was \$75. I have four kids....How in the world can I afford \$75 a piece?”* For formal services, it was mentioned repeatedly that private insurance often charges a co-pay, sometimes making it prohibitive. While public insurance did not require extra funds for the families, if they could not get public insurance, then they had to pay out of pocket, which frequently was not possible.

For providers, money and insurance were barriers to being able to provide the substance abuse services needed for adolescents. One provider reported that many of the young people they served had Medicaid, which prevented them from being able to *“bill down.”* As the provider explained, *“...we had to make a call, the board did, because we couldn’t continue to take that heavy loss and so we did, reluctantly, have to pull out of the SA (substance abuse) side of adolescent treatment.”*

Providers also pointed to a lack of state funding for programs, specifically prevention programs, because, *“There’s nothing like that to stop this. It’s just all reactive.”* One provider suggested that, *“the privatization and the focus on so many dollars as opposed to providing treatment”* was the central funding barrier in the provision of adolescent substance abuse services.

Family Support and Involvement

The support and involvement the family can offer was recognized by both provider and family participants as crucial to successful treatment of an adolescent. However, the lack of family support or

“AND ANOTHER THING I FELT LIKE IS THAT I KNOW THE SYSTEM, SORT OF, AND I WAS KIND OF AT A LOSS FOR, OK, WHAT IS AVAILABLE? AND IT WOULD BE SO NICE IF IT WERE JUST WRITTEN DOWN SOMEWHERE, FOR SOMEBODY TO HAND YOU A PAMPHLET AND IT COULD HAVE EVERY SINGLE, YOU KNOW, SERVICE THAT’S AVAILABLE IN THE STATE AND IN THE REGION FOR SUBSTANCE ABUSE.”

– FAMILY PARTICIPANT

involvement was acknowledged by all audiences as a barrier to successful adolescent substance abuse treatment. One family participant pointed out, “...I think family support is a big, is a big key too. Like if, if a child don’t have family support behind him and trying to set him loose, he think that probably he don’t have nobody to help him try to work to a goal he got, he’ll just give up.”

From the perspective of the families, one of the central barriers to their full support and involvement in treatment or services being provided was the scheduling. “...And then when they’re there, you have to work in their time frame, it’s not flexible at all. And parents have to work and so um, it’s difficult to ask a parent to get off. They need to provide the basics for their children and their family and then we ask them to get off early because this place opens 9 to 5 or 8 to 5 and so they need a little bit more flexibility in their schedule,” explained a family participant.

Providers also acknowledge the scheduling issue and some suggested ways to work around it. In general, one provider participant stated, “And then you run into barriers like transportation, time off from work and so you really need an active, comprehensive, case-management component when you refer one adolescent into treatment because to effectively deal with it, you’re gonna have to address those issues with the family.” The need for such an involved “case-management component” as the participant called it possibly points to a perceived gap in services. While each side frequently blamed the other, a general consensus was reached that more coordination between the provider, the adolescent and the family is needed for successful treatment.

Stigma and the Need for Education

Another barrier frequently mentioned was the stigma that accompanies substance abuse treatment and the general lack of education regarding the disease. This was cited as making it difficult for adolescents to confront substance abuse, but also for families to accept it. One provider explained it as, “And then of course if the kid goes into treatment then automatically, they’re the junkie in school you know?” More frequent education about substance use and substance abuse treatment was suggested as a way to reduce the stigma and increase support from family and communities. One provider suggested, “I think the communities as a whole, even including the faith community, people need to be educated, families need to be educated...so until we get that education piece all across the board, whether it be...and it’s got to come from every area because that will eliminate the barriers, there’s less stigma, and people thinking this is ok but that’s not ok.”

A youth participant was asked what the barriers to getting help would be and responded, “Afraid of getting in trouble with the cops.” Fear was mentioned by a couple of youth participants regarding law enforcement and drug use. Education for youth regarding different drugs, what drug addiction is and ways to deal with it was suggested by one of the youth participants.

Requests Made to the State of North Carolina

Participants were asked to talk about requests that they had for State of North Carolina in regards to adolescent substance abuse services and issues. Four categories of requests were repeatedly made. First, funding from the state to support prevention, early intervention, informal support services as well as expansion of service providers throughout the communities and within the schools was requested. Second, a more thorough continuum of care was identified as necessary. Third, providers specifically asked for assistance in workforce development to address the shortage of professionals. Fourth, strong requests were made to decriminalize the disease of addiction and to invest in treatments instead of prisons.

Funding

Funding was the number one request made by all audiences to the state of North Carolina. Participants requested funding for all avenues of adolescent substance abuse services. Prevention efforts, informal community supports and service providers were the three areas to which funding was felt to be needed. Each area is described below.

Prevention Efforts

Numerous participants suggested funding for prevention efforts, which were described as very limited. Among the many requests for prevention, one family participant commented, *“Um, I say, um, give more money to the schools. If they wanna start with the children, start them young in the elementary, day care, and put money there, and, and bring people in to talk to the kids then.”*

The schools were the central focus of recommended prevention efforts. Many people referenced programs like D.A.R.E., towards which mixed reviews existed. However, unlike D.A.R.E., suggestions were made to begin earlier than 5th grade and to incorporate people who had gone through substance abuse before, providing a real world aspect and open dialogue.

Informal Supports

Both provider and family participants felt that more funding should be given to support informal community programs that would benefit the adolescent population. Requests were made for such things as summer camps or recreational programs such as sports leagues that were free or affordable for everyone in the community. It also was specifically mentioned that some programs should be more teen specific so as to meet their needs and be developmentally appropriate. Funding for mentoring programs was recognized as a need. Many family participants felt that mentoring relationships were excellent ways for adolescents to build trusting relationships with someone to whom they can talk about their daily lives and problems. One family participant also felt that law enforcement officers could be a good informal support if they would, *“stop to talk to people.”*

Service Providers

Many provider participants and some family participants requested that funding be given to service providers in order for more services to be available. More specifically, providers requested funding so that they could make services more affordable and equally available to everyone. One provider explained, *“...I just feel like it would be better for the whole community if the services were equally available because I know middle class families can't pay the out of pocket expenses that go along with their substance abuse treatment program so then they miss out, and the people who have way extra amount of money they are able to pay for things but it doesn't quite cover maybe what Medicaid can pay for so just if we could have across the board something that would be available to everyone that was equitable.”*

Provide a Continuum of Care

Many providers requested from the state a stronger continuum of care. A continuum of care simply points toward the full range of necessary services to treat adolescent substance abuse. One provider

“I DON'T KNOW BUT I JUST REALLY THINK THAT THERE NEEDS TO BE SOME CLEAR STATISTICS AND SOME THINGS SHOWN TO OUR, OUR PEOPLE IN CHARGE TO LET THEM KNOW THAT THIS IS AN ISSUE AND IT'S NOT SOMETHING THAT'S GOING AWAY AND IT'S GOING TO MAKE A HUGE IMPACT NOT ONLY TODAY BUT IN OUR FUTURE. BECAUSE THE CHILDREN WHO ARE HERE GROWING UP WITHOUT SERVICES TO ASSIST THEM ARE OUR FUTURE.”

–PROVIDER PARTICIPANT

participant explained that, “...the State needs to help us all partner together to reach our children and to reach our families and provide the continuum of care so that if a child needs an assessment and outpatient, great, that’s available. But if they need residential then that’s available in the community where they are, cause we’re shipping our kids out...” Another provider called specifically for the stronger American Society of Addiction Medicine (ASAM) continuum of care levels. Another provider participant requesting a stronger continuum of care acknowledged that without it, “you’re never gonna have good human outcomes for these kids.”

Workforce Development

Workforce development was a highly requested area as well, especially because of the overall shortage of licensed professionals in NC resulting in fewer services available. One provider participant commented, “...we need a lot more help with recruiting and developing the workforce I think that is the number one issue in our community.” Provider burnout, issues with shifting credentialing requirements, and moving from rural to urban areas were all reasons family and provider participants recognized as contributing to the shortage of qualified professionals.

Decriminalize the Illness

Many provider and family participants requested that we move toward decriminalizing the illness of addiction. One provider put it simply by stating, “...we as a State need to make a decision about decriminalization of an illness. That’s the first one, cause we’re spending way too much money within the legal system treating this as a legal issue rather than as an illness.” Many participants agreed that often times those being sentenced, “...should be going to drug treatment you know, instead of prison.” In addition, it was requested that instead of building another jail or prison in a community those funds be used to construct a building to house teen programs and act as a “safe haven”.

Evidence Based Practices in Use and Needed

Provider participants were asked what evidence-based practices were in use or needed in their individual communities. Overall, there was only one site out of the seven visited who reported no use of any evidence-based practices. Some that were reportedly being used in the other communities were Global Appraisal of Individual Needs (GAIN), Cannabis Youth Treatment (CYT), MATRIX, Seven Challenges, and MET/CBT. Other approaches mentioned included Reasoning and Reacting and MAJORS.

Provider participants also were asked what evidence-based practices were needed in their communities. The GAIN and WRAP/Support Recovery were the only evidence-based practices that were specifically requested by providers. More generally, one provider requested an evidence-based practice that could be plugged into classroom curriculum and another requested some form of standardized assessment that could be used consistently across the agencies in the community.

SUMMARY AND RECOMMENDATIONS

Perceptions of Substances Used and Impact

- The four most popular substances mentioned by participants were alcohol, marijuana, prescription pills, and tobacco.
 - Methamphetamine use was reported to be a problem primarily in rural communities while ecstasy and other ‘party drugs’ were mentioned on rare occasions and primarily in urban communities.
 - Crack use was reported to be fairly evenly distributed throughout the state and not specific to either rural or urban communities.
- There is a perception that individuals of lower SES were more likely to use marijuana and alcohol while those of higher SES were more likely to use prescription drugs or ecstasy
- Drugs impacted three main areas of life: criminal behavior, medical problems, family/marital problems.

Perceptions of Substance Abuse Services

- Providers indicated confusion among the field on use versus abuse.
- Services are not proportional to the problem and more services are needed, particularly in rural communities.
- There is a lack of qualified professionals and licensed staff, making adequate substance abuse services impossible to provide.
- Access to money and insurance are key barriers to service access. Public insurance was preferred by providers because it allowed for more treatment hours in some cases and was a quicker process than that of private insurance.
- Family participants felt there was a disconnect between providers and consumers regarding assistance with a personal touch and without judgment.
- Informal supports were rare, and while NA/AA recovery groups were most frequently reported to be the informal supports available, they often were not felt to be specific to adolescents. Providers in urban areas acknowledged many informal supports in the community, but that there is an underutilization of them because of a perceived unwillingness or inability on the family’s part to access them.
- There is a gap in transitional services that reintegrate youth back into their lives after treatment.
- Both provider and family participants reported the need for a stronger continuum of after-care to help reduce relapse and ensure the youth’s success.
- Top five key barriers to services were: Transportation and finances (both money and insurance), lack of adolescent services available, family involvement, and stigma of substance abuse.

Recommendations from Focus Group Participants

- There is a need for a more accessible, streamlined process to access services. This includes:
 - Better acknowledgement for the need for treatment;
 - Awareness of who to call and the steps necessary to access services;
 - Understanding the financial aspects of services (include insurance and alternate methods of payment);
 - Greater education regarding the types of adolescent services available;
 - Make advertising, education and all services provided more available and sensitive to Non-English speaking residents and cultures;
 - Better coordination and communication between and within agencies;
 - Greater coordination between the provider, the adolescent and the family; and
 - More frequent education about substance use and substance abuse treatment to reduce the stigma and increase support from family and communities.
- Requests were made for increased funding to support prevention, early intervention, and informal support services;
- Creation of an infrastructure that will increase the number of service providers throughout the communities and specifically within the schools;
- Creation of a more thorough continuum of care, including programs such as summer camps, recreational programs, and mentoring programs that are developmentally appropriate;
- Assistance in workforce development to address the shortage of professionals, with GAIN and WRAP/Support Recovery identified as the only evidence-based practices that were specifically requested by providers; and
- Need to decriminalize the disease of addiction and to invest in treatments instead of prisons.

References

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APPENDIX A

Focus Group A Questions

Parent/Caregiver Focused

1. Describe the level of substance use and abuse in your community.
2. Do you think any of your child's friends use drugs?
3. Describe how drugs impact your life directly.
4. Describe what services are available for substance abuse in your community.
5. Describe the process of how to find services in your county for substance abuse treatment.
6. When you call for services, describe the wait list for services.
7. Describe the available informal supports available for substance use issues in your community.
8. Describe what you see as the barriers to services.

Focus Group B Questions

Provider/Agency Focused

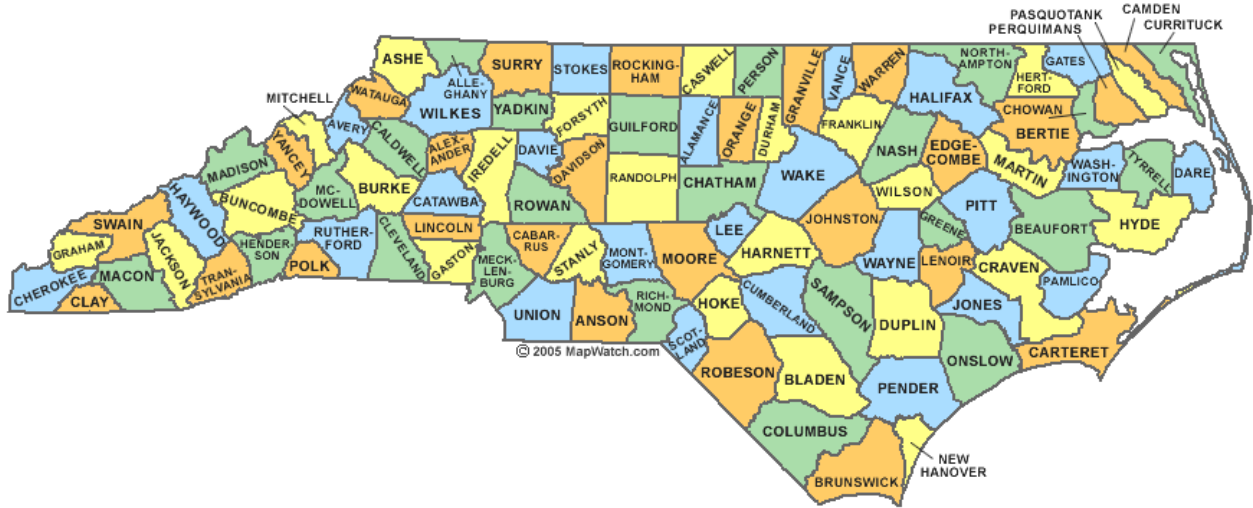
1. Describe the level of substance use and abuse in your community.
2. Describe what services are available for substance abuse in your community.
3. Describe the process of how to find services in your county for substance abuse treatment.
4. Describe the wait list for services in your community.
5. Describe the available informal supports available for substance use issues in your community.
6. Describe what you see as the barriers to services.
7. What types of training on evidence-based assessments and treatments would be helpful in your community?

Also as the staff began the focus groups it was decided that one additional question be asked of both sets of participants.

*8/9 What would you tell the state that your community needs?

APPENDIX B

Map of North Carolina by County



Locations for the focus groups:

Greensboro – Guilford County

Webster – Swain County

Elizabethtown – Bladen County

New Bern – Craven County

Roxboro – Person County

Durham – Durham County

Morganton- Burke County

High Point – Guilford County