State of California

YOUTH SERVICES POLICY MANUAL

February 18, 2016

California Department of Health Care Services

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Youth Services Policy Manual

1. INTRODUCTION

In 1998, the California Legislature enacted the Adolescent Alcohol and Drug Treatment and Recovery Program Act (Assembly Bill 1784, Baca, Chapter 866, Statutes of 1998). This legislation initiated funding for adolescent Substance Use Disorder (SUD) treatment in California with approximately $5 million annually designated to support comprehensive alcohol and other drug treatment for adolescents. Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) administers the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) to states to support a variety of services to prevent and treat a SUD.

The purpose of the Youth Services Policy Manual (YSPM) is to provide instruction for the delivery of SUD services for adolescents in California funded by Federal and State funds. The YSPM sets the minimum standards for delivery of services along with considerations for services across the Continuum of Care (COC).

It is also hoped that this policy manual will serve as an educational resource for policymakers and professionals working in other youth services systems and a guide for juvenile and family court judges for choosing and placing adolescents in effective programs.

Figure 1: Institute of Medicine Continuum of Care Model

2. TARGET POPULATION

2.1   The target population for this manual is adolescents between the ages of 12 and 18, who are determined eligible for SUD services. Eligibility must be determined by qualified adolescent health professionals and validated screening tools. For a definition of these terms, see the ==Appendix==.

       2.1.1   Individuals between the ages of 18 through 25, Transitional Age Youth (TAY), have unique needs. ==See section 5.9 for TAY service delivery.==

       2.1.2   Admission priority shall be based on program design, client assessment, and clinical judgment.

3. OUTCOMES

Adolescents are a sensitive population that require a comprehensive level of care to obtain the best possible outcome for themselves, their families, and their community. A comprehensive level of care means that the system must serve the adolescent as a whole. This includes addressing family and community influences, home environment, and integrating physical and behavioral health into the SUD services. To meet these unique needs, counties, providers, and programs shall, at a minimum, assess the following:

3.1   System-Level Outcome

       3.1.1   Increased adolescent-specific programs/treatment capacity;

       3.1.2   Increased awareness of and access to adolescent specific services;

       3.1.3   Increased quality of services;

       3.1.4   Achievement and maintenance of a COC for adolescents;

       3.1.5   Promote safe and healthy behaviors and environments for adolescents, their families, and their communities;

3.2   Adolescent Outcomes

       3.2.1   Remission of a SUD;

       3.2.2   Improved level of functioning in major life domains including SUD recovery, education, employment, family relationships, social connectedness, and physical and mental well-being;

3.2.3   Placement and safe treatment in the most appropriate, least restrictive settings.

4. THE CONTINUUM OF CARE

A fundamental principle in working with adolescents is that SUD services are within a holistic COC. The COC begins with services that promote wellness and prevention of a SUD and continues through treatment to recovery and recovery support services. The COC is a comprehensive approach to address SUD and includes activities that can be grouped into the following major strategies discussed below in detail:

4.1   Wellness promotion

4.2   Primary prevention

4.3   Early intervention

4.4   Treatment

4.5   Recovery services

Each aspect of the COC plays an important role in the prevention, treatment, and recovery of adolescents with SUDs.

Patients do not move through the SUD COC in only one direction. Due to the chronicity of SUDs and the related risk of relapse, individuals often move across and within the different SUD services, depending upon their particular needs. Many adolescents will utilize the services on the COC multiple times at different points in their recovery.

As an adolescent moves through the COC, counties and providers are required to use the Recovery-Oriented Systems of Care (ROSC) approach. ROSC is an approach that looks at the needs of a young person at every level of substance abuse and SUDs. Moreover, it is a network of services and supports to address the full spectrum of substance use problems, from harmful use to chronic conditions.

According to SAMHSA, ROSC for adolescents supports adolescent-guided and self-directed approaches to care that build upon the strengths and resilience of adolescents, their families, and their communities to sustain their health, wellness, and recovery from SUDs. In addition, a ROSC for adolescents emphasizes the importance of adolescent-guided and family-centered care; employs a broad definition of family; is culturally, age, and gender/gender identity appropriate; reflects the developmental stages of adolescence and

young adulthood; acknowledges the nonlinear nature of recovery; promotes resilience; is strengths-based and proactive; and identifies recovery capital.[1]

When delivering youth SUD services, counties, providers, and programs must coordinate the relationships between promotion, prevention, treatment, and recovery support when serving the adolescent population. These relationships are frequently overlooked, opportunities for collaboration are missed, and outcomes are compromised. This section defines each component of the COC and outlines the service requirements.

4.1 Wellness Promotion

Promotion activities related to health and wellness are the first part of the COC. Rather than the absence of disease, illness, or stress, SAMHSA defines wellness as the "presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness."

Furthermore, SAMHSA identifies eight dimensions of wellness[2] as noted in Figure 2 on the following page:

4.1.1   Emotional - coping effectively with life and creating satisfying relationships;

4.1.2   Environmental - occupying pleasant and stimulating environments;

4.1.3   Financial - satisfaction with current and future financial situations;

4.1.4   Intellectual - recognizing creative abilities and finding ways to expand knowledge and skills;

4.1.5   Social - developing a sense of connection and belonging and having a well-developed support system;

4.1.6   Physical - recognizing the need for physical activity, healthy foods, and sleep;

4.1.7   Spiritual - expanding a sense of purpose and meaning in life;

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[1] "Recovery Oriented Systems of Care (ROSC) Resource Guide." SAMHSA (2010), http://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

[2] "The Eight Dimensions of Wellness." SAMHSA website: http://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness

4.1.8   Occupational - getting personal satisfaction and enrichment from one's work.

SAMHSA has identified effective tools and interventions designed to prevent and intervene early to avoid illness and promote healthy lifestyle behaviors and overall wellness. These tools and interventions include health education, health and wellness screenings, health management, and health navigators.

Figure 2: SAMHSA's Eight Dimensions of Wellness

EMOTIONAL
Coping effectively with life and creating satisfying relationships.

ENVIRONMENTAL
Good health by occupying pleasant, stimulating environments that support well-being.

FINANCIAL
Satisfaction with current and future financial situations.

INTELLECTUAL
Recognizing creative abilities and finding ways to expand knowledge and skills.

WELLNESS

SOCIAL
Developing a sense of connection, belonging, and a well-developed support system.

PHYSICAL
Recognizing the need for physical activity, diet, sleep, and nutrition.

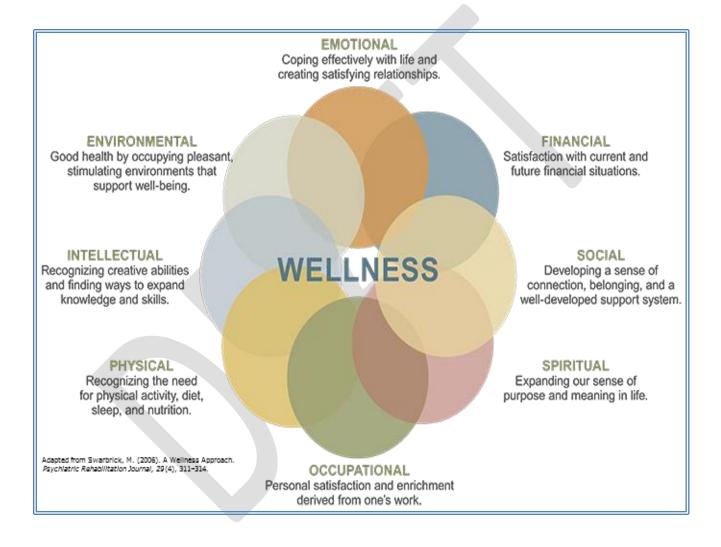SPIRITUAL
Expanding our sense of purpose and meaning in life.

Adapted from Swarbrick, M. (2006). A Wellness Approach. *Psychiatric Rehabilitation Journal, 29*(4), 311–314.

OCCUPATIONAL
Personal satisfaction and enrichment derived from one's work.

4.2   Primary Prevention

According to the Code of Federal Regulations (CFR), 45 96.121, primary prevention programs are directed at individuals who do not require treatment for a SUD. 45 CFR 96.125 requires the development and implementation of a comprehensive prevention program. The comprehensive prevention program must, at a minimum, include a broad array of prevention strategies. The comprehensive primary prevention program is also required to include activities and services provided in a variety of settings for both the general population, as well as targeting sub-groups who are at high risk for a SUD. To achieve the requirements set forth in 45 CFR 96.125, prevention programs shall adhere to the following:

4.2.1   All counties must develop a Strategic Prevention Plan (SPP) utilizing SAMHSA's Strategic Prevention Framework (SPF). The SPF uses a five-step planning process to guide states, jurisdictions, tribes, and communities in the assessment, capacity building, planning, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. The SPF is built on a community-based risk and protective factors approach to prevention:[3]

(a)   Assessment: the systematic gathering and examination of data related to substance abuse and related problems, as well as related conditions and consequences in the community.

(b)   Capacity Building: the resources and readiness to support the priority areas that were determined during the assessment. These resources include, but are not limited to, fiscal, human, organizational, and community resources.

(c)   Planning: increases the effectiveness of prevention efforts by focusing energy, ensuring that staff and other stakeholders are working toward the same goals, and providing the means for assessing and adjusting programmatic direction, as needed.

(d)   Implementation: implements prevention programs, practices, or strategies.

(e)   Evaluation: the systematic collection and analysis of information regarding program activities, characteristics, and outcomes to reduce uncertainty, improve effectiveness, and make decisions.

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[3] "Strategic Prevention Framework." SAMHSA webpage: http://www.samhsa.gov/spf

4.2.2   SAPT funded primary prevention programs must employ, at a minimum, one staff person that possess a prevention certificate.

4.2.3   When implementing primary prevention programs, counties and their contracted providers are required to use a variety of strategies as appropriate for each targeted group. The Center for Substance Abuse and Prevention (CSAP) developed six strategies for prevention efforts as prescribed in 45 CFR 96.125:

   (a)   Information dissemination;

   (b)   Education;

   (c)   Alternative activities

   (d)   Problem identification and referral;

   (e)   Community-based process; and

   (f)   Environmental.

4.2.4   In alignment with the county SPP, the selected prevention strategies shall target populations with different levels of risk.

   (a)   Prevention strategies shall be classified using the Institute of Medicine Model of Universal, Selective, and Indicated prevention, which classifies preventive interventions by a targeted population.

   (b)   Selected prevention strategies shall assist in increasing protective factors and decreasing risk factors.

4.2.5   When implementing primary prevention programs, counties and providers must ensure that strategy selection is guided by the priorities derived from the needs assessment. Furthermore, selected primary prevention interventions must align with at least one of the six CSAP strategies and adhere to the following requirements:

   (a)   Be Evidence-Based Programs (EBPs) and/or innovative programs that best serve targeted populations.

   (b)   An EBP according to SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) website

"demonstrates effectiveness in empirical research that meets a standard of scientific rigor."[4]

4.3 Outreach and Engagement

Effective outreach can help engage adolescents and make it more likely that they will attend, actively participate, be retained, and complete early intervention, treatment, and recovery management services. Counties, programs, and providers shall adhere to the following outreach and engagement requirements:

4.3.1 Programs shall provide or arrange for outreach services that identify substance abusing adolescents and encourage them to take advantage of services offered across the COC.

(a) Outreach efforts shall target adolescents in at-risk environments.

4.3.2 Programs shall place high priority on engaging the adolescent's family in services throughout the COC. For more information on family centered treatment, see Section 5.7.

4.3.3 Programs shall place high priority on outreach activities linking with public systems serving adolescents who may be abusing substances, including, but not limited to, schools, child welfare, public health, mental health, juvenile justice, and community-based organizations.

(a) Outreach activities shall also include educating professionals and policy makers in these systems so they become referral sources for potential clients.

4.4 Screening

4.4.1 Qualified adolescent health professionals must screen for and identify adolescents at risk for a SUD/MH issue with a validated screening tool. For more information on the definition of a qualified health professional, see the Appendix. In addition, professionals must assess the adolescent's needs and refer them to further assessment and/or other services, as appropriate.

(a) Providers shall place priority on identifying all at risk adolescents.

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[4] "National Registry of Evidence-based Programs and Practice," SAMHSA website: http://www.nrepp.samhsa.gov

4.4.2 As a part of all medical care visits, primary care providers (PCPs) should provide health education and screenings to adolescents for behavioral and SUD-related health issues that include but are not limited to:

   (a)   Trauma

   (b)   Suicide risk

   (c)   Depression

4.4.3 Programs and PCPs should establish collaborative relationships to ensure that at-risk adolescents are being screened, referred to appropriate services, and can adequately navigate the SUD services system across the COC.

4.4.4 The provider shall choose a validated, developmentally appropriate screening tool, designed for adolescents, to uncover indicators of substance abuse and related problems. For more information about validated screening tools, see the Appendix or visit SAMHSA.gov. The screening tool must, at a minimum, have the following characteristics:[5]

   (a)   Flexibility (approximately ten or fewer questions);

   (b)   Gender/gender identity and culturally appropriateness;

   (c)   Trauma sensitivity;

   (d)   Easily administered;

   (e)   Easily understood by client;

   (f)   Identification of the need for further assessment or intervention for both mental health and substance use;

   (g)   Specificity: correctly identifying those at risk yet avoiding "false positives"; and

   (h)   Capacity to address alcohol and other drugs.

4.4.5 Adolescents with possible SUDs, as identified through the screening, shall be referred to a qualified adolescent SUD treatment or recovery

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[5] Geffen, David. "Screening, Brief Intervention & Referral to Treatment" (computer slide set). Pacific Southwest Addiction Technology Transfer Center, Integrated Substance Abuse Programs, University of California at Los Angeles. 2015

services provider for a more comprehensive assessment for possible SUD diagnosis.

(a)   Adolescents not referred for further assessment, but who remain at risk, shall be referred to developmentally appropriate prevention or early intervention services.

(b)   If an adolescent is referred to services within the COC, the qualified health professional, or a professional within their office, is required to follow up with the service provider to ensure that contact was made. Furthermore, this process must be documented within the adolescent's file.

4.5   Early Intervention

Early Intervention (EI) is assessment and brief education/counseling for at-risk adolescents whose problems and risk factors appear to be related to substance abuse. According to American Society of Addiction Medicine (ASAM) level .05, EI activities are considered sub-clinical or pre-treatment. See Table 1 on page 15 of the YSPM for more information on ASAM criteria.

EI explores/addresses problems of SUD related risk factors, and assists adolescents in recognizing the harmful consequences of substance use. The ultimate goal of EI is to reduce the effects of substance abuse by identifying and engaging those in need of services. SUD service providers must adhere to the following requirements during the identification and delivery of EI:

4.5.1   Adolescent SUD service providers are required to establish, maintain, and implement written procedures to develop outreach, collaboration, and partnerships for coordination and referral with other agencies and organizations.

(a)   All collaborations/partnerships must be documented in writing (e.g., interagency agreements, memorandum of understanding, local statute, or local policy).

4.5.2.   Potential partners include, but are not limited to:

(a)   Clinics and emergency rooms;

(b)   Criminal justice/judicial system;

(c)   Mental health programs;

(d)   School health care centers;

(e)   Social welfare services; and

(f)   Private practice counselors/practitioners.

4.5.3   Adolescent SUD service providers shall establish and maintain written procedures that include the following information:

(a)   When and where assessments will occur;

(b)   Identifying who will administer the assessments;

(c)   Appropriate delivery of EI and other services; and

(d)   When and how referrals are to take place.

4.5.4   Eligible providers must provide or directly supervise all EI services delivered by qualified adolescent health professionals.

(a)   Eligible providers are physicians, nurse practitioners, physician assistants, Licensed Practitioners of the Healing Arts (LPHA) and psychologists.

(b)   It is recommended that physicians have specialty training and/or experience in addiction medicine.

4.5.5   The following are the assessment requirements for adolescent SUD programs:

(a)   An assessment is not a single event during the adolescent's admission to the program. It is an ongoing process, and it shall be used in the treatment and recovery planning for each individual admitted to treatment.

(b)   Adolescent SUD services providers are required to complete a comprehensive, individualized, biopsychosocial assessment for all adolescents who are being admitted into treatment or who display indications of possible substance use-related problems, as a result of a brief screening.

(c)   A qualified adolescent health professional must perform the assessment.

(d)   The assessment must be conducted with appropriate consent in accordance with state and federal law.[6]

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[6] 45 C.F.R. §§ 164.502(g)(3)(i); FAM § 6929(b)(f)(g)

4.5.6   The DHCS approved assessment tool must be specifically for adolescents, have established reliability and validity, and capture data related to the major life domains of an adolescent. In addition, it must also be strength-based in order to accurately assess the adolescent's unique abilities and needs.

The assessment shall, at minimum, also include the following:

(a)   Substance use patterns;

(b)   Mental health;

(c)   Physical health;

(d)   Social and emotional development;

(e)   Spiritual history;

(f)   Family/peer relationships;

(g)   Safety issues;

(h)   Criminal justice involvement;

(i)   School/education/cognitive/developmental level;

(j)   Communication and self-help/independent living skills;

(k)   A survey of assets, vulnerabilities, and supports;

(l)   Other abilities and strengths;

(m)   An evaluation of risk to self and/or others. The program shall assess and identify safety issues, including risk of suicide or other self-injury, current and/or history of physical and sexual abuse or trauma, and perpetration of physical or sexual abuse on others; and

(n)   A medical history and a health screening for mental health, dental issues, and other physical health concerns.

4.5.7   Assessments must be conducted in compliance with Sections 5.1, 5.2, 5.3, 5.4, 5.5, 5.6, 5.7, and 5.11.

4.5.8   In addition, the assessment shall incorporate contextual factors based on the adolescent's life circumstances and/or as stated by the family/caregiver.

4.5.9   In conjunction with acting on the health screening information, programs assessing an adolescent shall seek advice from their medical director and/or from public health professionals, whenever appropriate. If the health screening identifies an issue that warrants further evaluation, the program shall provide or arrange for a referral to an appropriate care site and take steps to assist the adolescent in accessing/receiving necessary care.

4.5.10   If an adolescent is referred to services within the COC, the qualified health professional, or a professional within their office, is required to follow up with the service provider to ensure contact was made. Furthermore, this process must be documented within the adolescent's file.

4.5.11   Using the information from the assessment, the qualified adolescent health professional service provider shall do the following:

(a)   Diagnose the severity of the substance use condition.

(b)   Determine the ASAM level of medical necessity for the adolescent so that the individual can enter the system at the appropriate level.

(c)   Identify and make appropriate referrals based on response to treatment.

(d)   Document the adolescent's unique abilities and strengths in the treatment plan.

4.5.12   If the assessment indicates high risk of danger to the adolescent or others, the qualified adolescent health professional shall make an appropriate referral immediately and the family/guardian shall be notified, as appropriate. For more information, see Section 7 - Health and Safety Issues.

4.5.13   Programs shall develop, and keep current, lists of local adolescent health providers and assist adolescents with accessing necessary health care services in accordance with the health assessment findings. At a minimum, these lists must include resources that offer education on healthy behaviors and how to reduce the risk for certain health conditions including, but not limited to:

(a)   Family planning/reproductive health;

(b)   Sexually transmitted disease prevention;

(c)   Emotional well-being and suicide prevention;

(d)   Tobacco cessation; and

(e)   Other relevant health related topics.

4.5.14   The initial assessment shall be completed as soon as possible, and no later than 30 days after admission. Programs shall attempt to gather as much information as possible, and update the assessment as more information is obtained. Building trust and rapport with the adolescent may take time, before he/she will reveal more detailed and honest information.

4.6   Diagnosis

Diagnosis is the process of determining the nature of an illness and the decisions and opinions derived from the determination. It requires a thorough evaluation, which includes an assessment, and may include lab testing of blood or urine to identify drug use. The following requirements must be adhered to when diagnosing an adolescent with a SUD.

4.6.1   As part of the comprehensive assessment described in Section 4.5, adolescents shall be assessed to determine if they meet the diagnostic criteria of a substance related disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM) most recently accepted by the state.

4.6.2   With the exception of an adolescent described in Section 4.6.3 below, all adolescents accepted for treatment in outpatient, intensive outpatient, and addictive disorders from the DSM most recently accepted by the State, must meet the ASAM criteria definition of medical necessity for services. See Table 1 and the Appendix for more information on ASAM criteria and the definition for medical necessity.

4.6.3   If the presenting substance abuse history is not adequate enough to substantiate a diagnosis, ASAM criteria states that the program may use documentation submitted by collateral parties (e.g., family members, legal guardians, schools, probation, other significant associates, etc.) to verify admission to outpatient treatment. This documentation may be notes documented in the assessment or through progress notes. See Table 1.

Table 1: ASAM Criteria Continuum of Care Services for Adolescents

ASAM Level of Care	Title	Description	Provider
0.5	Early Intervention	Assessment and education for at-risk individuals who do not meet diagnostic criteria for SUDs or for those for whom there is not yet sufficient information to document a SUD diagnosis.	DHCS Certified/Licensed Providers
1	Outpatient Services	Less than 6 hours per week for recovery or motivational enhancement strategies to provide low-intensity, professionally directed SUD treatment.	DHCS Certified Outpatient Facilities
2.1	Intensive Outpatient Services	6-19 hours per week to treat multidimensional instability and provide high-intensity, professionally directed SUD treatment.	DHCS Certified Intensive Outpatient Facilities with interdisciplinary, appropriately credentialed treatment professionals.
2.5	Partial Hospitalization Services	20 or more hours per week for multi-dimensional instability not requiring 24-hour care, but complex enough to treat complex co-occurring mental and substance-related conditions.	DHCS Certified Intensive Outpatient Facilities with an interdisciplinary team of appropriately credentialed treatment professionals.
3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 5 hours of clinical service per week to stabilize SUD symptoms, increase motivation, develop recovery skills and prepare for outpatient treatment.	DHCS Licensed Residential Providers staffed by allied health professional available on-site 24 hours a day or as required by licensing regulations.
3.5	Clinically Managed Medium-Intensity Residential Services	24-hour care with trained counselors to provide a supportive environment in order to help clients develop recovery skills to avoid relapse or continued substance use.	DHCS Licensed Residential Providers with licensed or credentialed clinical staff who work with the allied health professional staff in an interdisciplinary team approach.
3.7	Medically Monitored High-Intensity Inpatient Services	24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting for clients with significant problems in Dimensions 1, 2, or 3.	Chemical Dependency Recovery Hospitals or Free Standing Psychiatric Hospitals with a Professional Interdisciplinary Team.
4	Medically Managed Intensive Inpatient Services	24-hour service delivery in an acute care, inpatient facility with daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling to engage patient in treatment.	Inpatient Licensed Facility with acute care medical staff and life support equipment, acute care general hospital or psychiatric hospital.
OTP	Opioid Treatment Program *(See Section 4.9.3 Medication Assisted Treatment.)*	Daily or several times weekly opioid agonist medication and counseling available to maintain multi-dimensional stability for those with severe opioid use disorder.	DHCS Licensed OTP or OBOT Providers. Licensed Prescriber with an interdisciplinary team trained in the treatment of opioid use disorders, including a medical director, counselors, and professional staff.

4.7   Placement

Placement of an adolescent who meets DSM criteria is the next phase in the COC. Placement describes the settings in which services will take place, the level of care that patients will receive in particular settings, and when services will be received. Appropriate placement identifies how SUD care settings must be matched to adolescent's unique needs and characteristics.

Individuals and agencies shall make placement decisions for adolescents needing treatment as follows:

4.7.1   When determining the appropriate location for the adolescent, see Section 5 – Service Delivery Requirements.

4.7.2   Place adolescents in appropriate treatment, consistent with the ASAM criteria for placement. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions – Third Edition provides a guideline for determining treatment setting and service matching.

4.7.3   Make every effort to keep an adolescent in the least restrictive environment.

(a)   The adolescent may be moved to a higher or lower level of care as needed.

4.7.4   Seek to ensure that the adolescent and other clients will not be adversely impacted by their interactions within the program.

4.7.5   When a program is unable to admit an adolescent diagnosed with a SUD into treatment due to insufficient capacity, the program must identify and refer the adolescent to another adolescent program equipped to meet his/her unique needs.

(a)   If an adolescent must be referred to another treatment program, the process must be documented within the adolescent's file.

(b)   If an alternative program is not identified and/or accessible, the adolescent must receive interim services until placement is achieved.

(c)   See Section 6.1 for interim services requirements.

4.8   Treatment and Recovery Planning[7]

The comprehensive treatment and recovery plans serve as a roadmap for the adolescent's treatment and recovery process. These plans are required to be strength-based, client-led, and based on the findings in the adolescent's individual assessment, including stage of change.[8] They must integrate the other types of services the adolescent is receiving and service areas including, but not limited to, juvenile justice, education, child welfare, and behavioral health.

4.8.1   With the exception of early intervention programs, programs must develop written, individualized treatment and recovery plans for each adolescent based on information collected in the comprehensive assessment. As a part of the monitoring process, the state reserves the right to review the plan.

4.8.2   The treatment and recovery plans shall clarify needs and must be developed in conjunction with the adolescent and his/her family, as appropriate. Planning shall help the adolescent recognize and appreciate his/her unique strengths.

4.8.3   The treatment and recovery plans shall address multiple problems experienced by the adolescent including, but not limited to, mental health, education, family, medical illness, legal issues, and the complementary services needed to address these problems. The treatment plan must include the following:

(a)   A statement of problems to be addressed;

(b)   Goals which address each problem;

(c)   Action steps which will be taken by the provider and/or adolescent to accomplish identified goals;

(d)   Target dates for accomplishment of action steps and goals;

(e)   A detailed description of the services to be provided along with the frequency and duration of those services.

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[7] FAM § 6929(e).

[8] "Stages of Change Model." AddictionInfo.org: http://www.addictioninfo.org/articles/11/1/Stages-of-Change-Model/Page1.html

4.8.4   The treatment and recovery plans shall have specific quantifiable goal/treatment objectives related to the adolescent's SUD diagnosis and multi-dimensional assessment. The treatment and recovery plans must, at a minimum, adhere to the following:

(a)   The plans will identify the proposed type(s) of interventions/ modality and include the proposed frequency and duration.

(b)   The plans and timeframes for completion of treatment and recovery will be consistent with the qualifying diagnosis. The plans will be signed by the adolescent and the program's medical director or other corresponding and credentialed service provider (e.g. LPHA, LCSW, psychiatrist, etc.).

(c)   Services and therapeutic approaches identified in the treatment and recovery plans shall reflect the chronological, emotional, and psychological age, and be in compliance with ==Section 5 – Service Delivery Requirements.==

(d)   The components listed above must be mutually agreed upon by the clinician, the adolescent, and, if appropriate, the adolescent's family or caregiver.

4.8.5   A self-administered physical health questionnaire, for the adolescent and/or the parent/guardian, must be used and discussed with the adolescent by a qualified and appropriately trained staff member as a part of the treatment and recovery plans.

(a)   Treatment and recovery plans shall contain specific goals for achieving physical health and emotional well-being based on the identified priorities of the plans.

4.8.6   The initial treatment and recovery plans shall be completed within 30 days of admission. Progress in treatment shall be regularly monitored, and the treatment and recovery plans will be modified as needs arise and/or at various stages of the adolescent development and recovery.

(a)   A plan must be reviewed and modified as appropriate if there is a change in treatment modality or other significant event at various stages of the adolescent's development and recovery.

(b)   In the absence of such changes, the plans shall be updated every 90 days.

4.9   Treatment[9]

Once an adolescent is identified as having a SUD diagnosis, he/she receives services in a treatment program that offers the appropriate level of care for his/her diagnosis. Treatment strategies for adolescents depend on the particular substance an adolescent is using. A comprehensive treatment plan must be developed and, at a minimum, is required to consider the following:[10]

4.9.1   Cognitive behavioral therapies: Selected cognitive behavioral therapy interventions must be Evidence-Based Programs (EBPs) and/or innovative programs that best serve the adolescent. Behavioral therapies are used to engage adolescents in SUD treatment, to encourage them to modify harmful behaviors, and to reduce or eliminate their use of substances.

4.9.2   Psycho-education: Education about substances and the impact of these substances on the mind and body help an adolescent better understand the addiction process. These approaches and therapies are often used in different combinations to provide the appropriate set of treatment services and a variety of tools to address their unique needs.

4.9.3   Health Issues: Medications may be helpful with a number of stages of treatment and recovery for both opioid and alcohol addiction, including in treating withdrawal, helping individuals to stay in treatment, maintaining recovery and reducing risk of relapse. For additional information and requirements associated with Medication Assisted Treatment (MAT) for adolescents, see Section 5.13.

A person accessing treatment may not need to utilize all of these strategies; however, each strategy plays an important role. These systems are embedded in a broader community, and the support provided by various parts of that community also play an important role in supporting the recovery of adolescents with SUDs. The details and requirements of these services are outlined in Section 5 - Service Delivery Requirements.

4.9.4   Counseling

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[9] National Association of State Alcohol and Drug Abuse Directors, Inc. (2014). *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide.* Available from: http://nasadad.wpengine.com/wp-content/uploads/2014/09/State-Adolescent-Substance-Use-Disorder-Treatment-and-Recovery-Practice-Guide-9-24-14.pdf

[10] National Institute on Drug Abuse. (2014). *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide.* Available from: http://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/evidence-based-approaches-to-treating-adolescent-substance-use-disorders

Counseling services consist primarily of counseling and education regarding addiction-related problems. Individual and/or group counseling are fundamental parts of treatment and recovery services. Providers and adolescents work collaboratively to define barriers, set priorities, establish goals, create treatment plans, and solve problems. The following requirements are designed to support the goals of sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care:

(a) In order to develop a successful therapeutic relationship and facilitate positive behavior change, SUD counselors shall work collaboratively with adolescents to provide an approach that is delivered in accordance with the requirements in Section 5.

(b) Individual counseling sessions shall be provided in person, by telephone, or via telehealth, as appropriate to the needs of the adolescent and the situation.

(c) Group counseling entails face-to-face contacts with one or more therapists/counselors working with two or more clients (but no more than twelve clients) at the same time, focusing on the needs of the individuals served. Group counseling cannot be conducted by telephone or via telehealth.

(d) With the exception of early intervention programs, each adolescent shall be assigned a primary counselor when admitted to treatment. The primary counselor and treatment team is responsible for building the adolescent's emotional trust and safety, recognizing the adolescent's individual strengths and assets, and assisting him/her to achieve success as defined within his/her treatment and recovery plan.

4.9.5 The program shall provide individual counseling sessions as clinically appropriate and as specified in the treatment and recovery plan. At a minimum, individual counseling must be provided during the following times:

(a) Admission to treatment to help orient the adolescent to treatment;

(b) The development and revision of the treatment and recovery plan;

(c)   As needed for adolescents who are uncomfortable with the group process or unready to discuss specific issues in a group setting;

(d)   Crisis intervention; and

(e)   Discharge planning.

4.9.6   If counselors are trained in addressing co-occurring mental and behavioral health disorders (see Section 5.11), they shall work with the adolescents on these issues as appropriate. If the counselors are not trained to address co-occurring disorders, the counselors shall work to fully address all of the client's mental health needs through appropriate referrals.

4.9.7   Programs shall provide clinically appropriate group counseling sessions that are consistent with relevant regulations and that are identified in the treatment and recovery plan.

4.10   Withdrawal Management

Adolescents in need of withdrawal management services shall be placed in the most appropriate available level of care for the provision of services, based on the Level of Withdrawal Management identified by ASAM Criteria for Withdrawal Services in Table 2. Programs must adhere to the following requirements to ensure a safe and effective withdrawal process for adolescents in treatment:

4.10.1   Appropriately trained staff with specific knowledge and experience in the management of alcohol and drug withdrawal shall monitor the withdrawal process under the direction of a physician or other appropriate health care professional.

4.10.2   All programs shall create, maintain, and adhere to written protocols consistent with ASAM's Level of Withdrawal Management. The components of withdrawal management services are as follows:

(a)   Intake: The process of admitting an adolescent into an SUD treatment program.

(b)   Observation: The process of monitoring the adolescent's course of withdrawal. Observation will be conducted as frequently as deemed appropriate for the adolescent and the level of care he/she is receiving. This may include, but is not limited to, observation and review of the adolescent's health status.

(c) Medication Services: The administration of prescribed medication related to SUD treatment services, or the assessment of the side effects or results of that medication. These services will be conducted by staff lawfully authorized to provide such services within their scope of practice or license.

(d) Discharge Services: The process of preparing the adolescent for referral into another level of care, and/or the linkage of the individual to essential community treatment, housing and human services.

4.10.3 All programs shall have a written protocol and train staff to adequately manage and/or make referral arrangements for adolescents who appear at the program site under the influence of alcohol or other drugs.
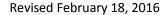
Table 2: ASAM Criteria Withdrawal Services-Detoxification

(Withdrawal Management)

Level of Withdrawal Management	Level	Description	Provider
Ambulatory withdrawal management without extended on-site monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	DHCS Certified Outpatient Facility with Detox Certification Physician Licensed Prescriber or OTP for opioids
Ambulatory withdrawal management with extended on-site monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.	DHCS Certified Outpatient Facility with Detox Certification Licensed Prescriber or OTP
Clinically managed residential withdrawal management	3.2-WM	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	DHCS Licensed Residential Facility with Detox Certification Physician Licensed Prescriber Ability to promptly receive step-downs from acute level 4
Medically monitored inpatient withdrawal management	3.7-WM	Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring.	Chemical Dependency Recovery Hospitals Free Standing Psychiatric Hospitals Ability to promptly receive step-downs from acute level 4
Medically managed intensive inpatient withdrawal management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Hospital, sometimes ICU Chemical Dependency Recovery Hospitals Free Standing Psychiatric Hospitals

4.11   Life Skills Development

Life skills are activities that build capacity of adolescents to make decisions and take actions that positively impact their lives and the lives of those around them. A primary goal is to promote psychological and physical well-being. Through the treatment and recovery process, adolescents will identify strengths and goals for life skills development. Opportunities for the development of life skills better equip the adolescent to identify triggers and resolve problems that create risks for returning to substance use. Providers that offer life skills development programs must meet the following requirements:

4.11.1   The life skills program shall provide educational groups as clinically appropriate and as identified in the treatment and recovery plan and shall:

(a)   Be age-appropriate;

(b)   Be culturally appropriate;

(c)   Be therapeutic;

(d)   Provide goal-oriented opportunities for adolescents to develop social skills and independent living skills;

(e)   Cultivate decision making abilities; and

(f)   Provide an opportunity to learn the values of vocational and employment skills necessary for adulthood.

4.11.2   Life skills development shall include assisting adolescents in learning how to self-manage triggers for substance use and self-monitor symptoms, including the recognition of relapse triggers and assist in building natural supports to prevent relapse.

4.11.3   The provider shall offer interpersonal skill development including, but not limited to, support in problem solving, conflict resolution, self-esteem improvement, anger management, and impulse control.

4.11.4   If a provider is unable to provide life skills development services, providers shall develop relationships through interagency agreements with other agencies that serve adolescents and refer the adolescent for him/her to receive life skills development including, but not limited to, interpersonal skills, social/societal skills, and self-care.

(a)   If the adolescent is referred to an agency (that the provider has an interagency agreement with), a qualified health professional, or a trained professional within the program, must follow up to ensure that the services were obtained. Furthermore, this process must be documented in the adolescent's file.

4.12   Education and Vocational Services

Adolescents facing SUDs have a variety of educational and vocational needs. Education is one of the most important factors in an adolescent's developmental path and in his/her recovery. In addition, adolescents who have been employed, and remain employed, during treatment tend to remain in treatment longer and experience more successful outcomes.

4.12.1   Programs must fully integrate the adolescent's individualized educational program into the adolescent's treatment and recovery programs by adhering to the following:

(a)   Providing adolescents access to educational instruction while in treatment, in accordance with state law.[11]

(b)   Allowing and encouraging time for homework and tutoring in residential programs.

(c)   Working with the educational system to address the adolescent's school related problems, including gathering information from Individualized Education Programs (IEPs) and school staff to incorporate educational goals into the adolescent's treatment and long term recovery plan.

(d)   Developing a plan to assist the adolescent to successfully transition back into the community educational system, if appropriate.

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[11] 22 CA ADC § 84072: Personal Rights

4.12.2   Programs shall link the adolescent to groups that support the adolescent's educational and vocational needs, as clinically appropriate, and as identified in the treatment and recovery plan.

4.12.3   Treatment and recovery programs shall link adolescents to additional educational sessions and culturally appropriate materials that address other health matters, including but not limited to, the following:

  (a)   HIV/AIDS;

  (b)   Sexually Transmitted Diseases;

  (c)   Tuberculosis;

  (d)   Hepatitis;

  (e)   Nutrition;

  (f)   Sexuality;

  (g)   Family planning/Reproductive health;

  (h)   Violence prevention;

  (i)   Anger management; and

  (j)   Smoking cessation.

4.12.4   Programs shall provide research-based education on addiction, treatment, recovery, and health risks associated with SUD.

4.12.5   Programs shall provide/arrange for vocational and employment support, including strategies and training that assist the adolescent in preparing to enter and succeed in the workforce with the long-term goal of self-sufficiency, and an improved quality of life. Programs shall provide/arrange for independent living skills, academic and work readiness skills, career planning, and job training for adolescents, as needed.

  (a)   If any of these support services are not provided by the program, a qualified health professional, or a trained professional who works for the program, must follow up to ensure that contact was made. Furthermore, this process must be documented in the adolescent's file.

4.13   Discharge Planning

Discharge planning ensures that an adolescent will seamlessly move from a more acute level of care to one that is less intensive, with the goal to eventually return to his/her community. The development of an effective discharge plan is a critical element of recovery support and helps prevent relapse. Programs are required to adhere to the following criteria when engaging in discharge planning:

4.13.1   Programs shall use the adolescent patient discharge criteria contained in ASAM's *Patient Placement Criteria for the Treatment of Substance Abuse Related Disorders*[12] in order to help determine length of stay and discharge readiness.

4.13.2   Adolescents shall be stabilized prior to being moved to a different level of treatment. However, additional lengths of stay may be authorized for withdrawal and residential services for criminal justice offenders, if identified as a need during the assessment.

4.13.3   With the exception of early intervention programs, a written discharge and/or aftercare plan shall be developed for each adolescent. The department reserves the right to review discharge plans.

4.13.4   The discharge plan shall be completed in cooperation with the adolescent and must contain the following elements to sustain gains made in treatment:

(a)   A process to prepare the adolescent for referral into another level of care.

(b)   The steps for post treatment return or re-entry into the community that includes, but is not limited to, a relapse prevention plan.

(c)   The linkage of the adolescent to essential education, community treatment, housing, and human services.

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[12] Mee-Lee D., Shulman G.D., Fisherman M.J., Gastfriend D.R., Miller M.M., eds. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.* 3rd ed. Carson City, NV: The Change Companies; 2013.

4.13.5   Programs must include a written summary in the discharge plan that contains relevant standardized data. The summary shall document progress towards goals and measurable outcomes during treatment, and characterize the adolescent's long-term success or need for further assessment and/or referral.

4.14   Continuing Care and Recovery Support Services

To prevent relapse and support the adolescent's transition into recovery, programs shall provide/arrange for recovery support and other continuing care services after the completion of formal treatment. These recovery support services must be clearly outlined in the adolescent's recovery plan prior to discharge from treatment.

4.14.1   If the recovery support services are not provided by the program, a qualified health professional, or a trained professional who works for the program must follow up to ensure that contact was made. Furthermore, this process must be documented in the adolescent's file.

4.14.2   Continuing care services may include, but are not limited to, the following:

(a)   Home or community-based meetings with a clinician or therapist to set and work towards goals.

(b)   Assistance in identifying signs of relapse and developing a plan to respond to such signs.

(c)   Family involvement.

(d)   Linkages to other services as necessary.

(e)   Aftercare and recovery support sessions.

(f)   Transition and emancipation options.

(g)   Self-help and peer support groups.

(h)   Telehealth, as appropriate.

4.14.3   Recovery support services are non-clinical services that are used concurrently with treatment to support individuals in their recovery goals. These services may be provided by peers, or others who are

already in recovery. Recovery support services are essential to assisting adolescents and families affected by SUD to attain and maintain long term recovery. Recovery support services may include, but are not limited to:

(a)   Transportation to and from treatment and recovery-oriented activities;

(b)   Employment or educational supports;

(c)   Specialized living situations;

(d)   Peer-to-peer services, mentoring, coaching;

(e)   Spiritual and faith-based support;

(f)   Parenting education;

(g)   Self-help and mutual aid groups;

(h)   Outreach and engagement;

(i)   Staffing drop in centers, clubhouses, respite/crisis services, or warm lines staffed by people in recovery themselves; and

(j)   Education about strategies to promote wellness and recovery.

4.14.4   Peer recovery coaches engage, educate, and support a person in recovery as they set goals and successfully make behavior changes necessary to maintain long term recovery from substance use and mental health disorders.[13,14]

4.14.5   Peer recovery coaching is often used in conjunction with appropriate clinical interventions. Programs that choose to use peer recovery coaching techniques are required to include the following activities in their coaching:

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[13] *"What are Peer Recovery Coaching Services?"* SAMHSA: https://store.samhsa.gov/shin/content/SMA09-4454/SMA09-4454.pdf

[14] *"Understanding the Role of Peer Recovery Coaches in the Addiction Profession."* NAADAC: *http://www.naadac.org/understandingtheroleofpeerrecoverycoachesintheaddictionprofession*

(a)   Assistance in developing self-management techniques.

(b)   One-on-one support sessions.

(c)   Developing goals and wellness plans.

(d)   Providing links to resources and natural supports in the adolescent's environment.

4.14.6   Adolescents shall be matched with gender, age, and developmentally appropriate peer recovery coaches who are stable in their own recovery.

4.14.7   Peer recovery coaches shall be appropriately trained and supervised by providers.

4.14.8   Due to the non-clinical nature of peer recovery coaching, supervision must include:

(a)   Administrative supervision to assist in the management of record-keeping etc.

(b)   Regular supervision by a qualified adolescent SUD service professional to ensure critical competencies and assist with problem solving.

4.15.1   The development and/or re-engagement in safe and healthy structured recreational activities are necessary for adolescents in early recovery and are critical for long-term recovery. Engagement in recreational and leisure activities promote pro-social behaviors, competence, and confidence through positive interactions and socialization with other adolescents. In addition, engagement in these activities plays an important role in building a healthy and satisfying life. In order to facilitate recovery-related recreational activities, the programs must ensure the following:

(a)   Counselors and other staff will work in conjunction with adolescents to help them discover their interests and strengths while developing the treatment and recovery plans.

(b)   Intensive outpatient and residential programs shall provide/make referrals to both therapeutic and diversionary pro-social recreation and activities that align with the adolescent's interests, strengths, skills, and needs.

4.15.2   Participation in mutual aid groups can be beneficial to enhance and sustain recovery gains for adolescents.[15] Mutual aid groups provide additional social, emotional, and informational support for adolescents and their families; however, the mutual aid groups must be compatible with the personal philosophy and beliefs of the adolescent in recovery. In order to offer appropriate mutual aid services and resources to clients, providers shall adhere to the following requirements:

(a)   Providers must be aware of the multiple types of mutual aid groups for adolescents within their community and obtain information on the focus and format of groups in order to give a thorough referral to their client.

(b)   If adolescents want to participate in a mutual aid group, the providers shall refer them to adolescent-specific mutual aid groups. The adolescent is required to be accompanied to their first meeting by someone they know or are comfortable with, such as a peer, friend, or family member, if possible.

5.   SERVICE DELIVERY REQUIREMENTS

The following service delivery requirements reflect the overarching principles of SUD services that characterize the most effective approaches and interventions, and the philosophy of care for youth that recognizes their unique needs, involves families, and ensures safety of the adolescents in treatment. The sections below must be adhered to when delivering SUD services for adolescents in any part of the COC:

5.1   Developmentally Appropriate Care

Adolescents and young adults are developmentally, physically, cognitively, emotionally, and socially different from younger children and older adults. Staff who work with adolescents must receive regular and ongoing training and professional development on the cognitive and developmental level, physical and emotional growth, behavior, values, beliefs, and cultural differences among adolescents. Programs shall have protocol to address these factors as well as any cognitive, social, emotional, and/or developmental delays or disabilities the individual may have.

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[15] Kelly, J. F., Dow, S. J., Yeterian, J. D., & Kahler, C. W. (2010). Can 12-step group participation strengthen and extend the benefits of adolescent addiction treatment? A prospective analysis. *Drug and Alcohol Dependence, 110*, 117–125.

5.2   Cultural and Language Competence

Culturally and linguistically competent care is care that is responsive to and respectful of racial and ethnic identity, religion, language spoken, age, geographic location, and other shared affiliations. The requirements of cultural and language competence also address disparities in access to treatment and recovery services across different ethnic and racial groups.

Cultural and linguistic competence will ensure that young people and their families receive effective and respectful care. Culturally responsive services can improve client engagement, strengthen therapeutic relationships between clients and providers, and enhance treatment retention and outcomes. This care must be provided in an understandable manner and is compatible with their cultural beliefs and practices, gender-specific needs, and preferred language.

5.2.1   To be most effective in serving adolescents, all programs shall adhere to the *National CLAS standards.*[16]

5.2.2   Additionally, programs shall ensure the following measures:

(a)   All services, from initial screening and assessments through treatment and after care, shall be conducted in a culturally and linguistically appropriate manner for adolescents and their families.

(b)   Programs that serve adolescents whose primary language is not English, including sign language, shall have skilled bilingual staff and/or interpreters, provided as needed.

(c)   Staff shall receive ongoing training and professional development in cultural competency, specific cultural issues, traditions, and beliefs in order to provide the most appropriate treatment for adolescents within the community.

(d)   All print and audio-visual materials used for educational purposes shall be culturally, linguistically, and literacy appropriate for the adolescent and families being served.

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[16] "*The National CLAS Standard.*" U.S. Department of Health and Human Services:
http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

5.3   Social Determinants of Health

Social determinants of health are the conditions that impact a person's health, functioning, quality-of-life, outcomes, and risks. These conditions include where an individual is born, lives, learns, works, plays, and his/her age.[17] Resources that enhance quality of life can have a significant influence on health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, access to healthy foods, access to parks and recreational activities, quality health care services, and toxin free environments. According to the Healthy People 2020[18] initiative, there are five key areas that define social determinants of health:

5.3.1   Economic stability

5.3.2   Education

5.3.3   Social and community context

5.3.4   Health and health care

5.3.5   Neighborhood and built environment

To ensure success in treatment and/or recovery services, programs must adhere to the following when providing adolescent SUD services:

5.3.6   Programs shall continuously assess adolescents for health and wellness risk factors.

(a)   Programs shall refer adolescents to additional services that address the social determinants of health. Programs must follow up to ensure that the services were obtained. Furthermore, this process must be documented in the adolescent's file.

For more information on social determinants of health, see the Appendix and References.

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[17] World Health Organization, Commission on Social Determinants of Health. Closing the Gap in a Generation: Health equity through action on the social determinants of health. Available from: http://www.who.int/social_determinants/en

[18] Secretary's Advisory Committee on Health Promotion and Disease Prevention Objectives for 2020. Healthy People 2020: An Opportunity to Address the Societal Determinants of Health in the United States. July 26, 2010. Available from: http://www.healthypeople.gov/2010/hp2020/advisory/SocietalDeterminantsHealth.htm

5.4 Gender Identity and Sexuality

Adolescents identifying as lesbian, gay, bisexual, transgender, asexual, intersexed, or two spirited are at a higher risk of becoming substance abusers than are heterosexual youth.[19] In order to appropriately serve adolescents who identify within these groups, counties and providers must adhere to the following requirements:

5.4.1   Staff shall foster an environment of acceptance of different sexual orientations and gender identities and shall be trained and prepared to address issues of sexuality, sexual identity, and gender identity, including those of gay, lesbian, transgender, asexual, bisexual, intersexed, and two spirited adolescents.

For further information about individuals who do not identify as heterosexual, particularly the special health needs of these individuals, refer to References: SAMHSA's "Top Health Issues for LGBT Populations: Information and Resource Kit."

5.5 Gender Specific Environments

With the exception of prevention and early intervention programs, all programs must provide or arrange for a gender-specific environment with substance abuse services and other therapeutic interventions. Exceptions to this standard require the following provisions:

5.5.1   The program addresses gender-specific issues in determining individual treatment needs and therapeutic approaches.

5.5.2   The program provides regular opportunities for separate gender group activities and counseling sessions.

5.5.3   In order for counties and providers to expand their capacity to meet the needs of adolescent girls, they must develop and implement policies and procedures that ensure the following:

(a)   Gender-specific and gender responsive service environments.

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[19] *"Drug Abuse among LGBT Youth,"* Council on Drug Abuse: http://www.drugabuse.ca/drug-abuse-amoung-lgbt-youth

      (b)   Person-centered services.

      (c)   Cultural-competence in accordance with National *CLAS standards*, recovery-oriented systems of care that uses research on gender-specific differences to support positive outcomes for clients.

A program meeting the conditions set forth in Sections 5.4 and 5.5 may add other appropriate gender-based measures to specialize in working with transgender or intersex adolescents.

5.6   Adolescent-Guided Care

"Adolescent-Guided Care" is a client-centered care approach, in which, adolescents are involved in all aspects of their care. In adolescent-guided care, the young person is at the center of the team, and service delivery is individualized to meet the adolescent's needs, taking into account his or her developmental stage, life experience, sexuality, gender/gender identity, and culture. Adolescent-guided care builds on the natural supports, strengths, resiliencies, and perspectives of the adolescent and his/her family, and focuses on the needs and goals of the young client and family.

5.7   Family-Centered Care

Family plays an important part in adolescent treatment and recovery. When an adolescent has a potentially beneficial relationship with his or her family, providers must consider the needs of the family as a part of adolescent SUD services. Family members shall be included as a part of the "team" whenever possible. Effective treatment and recovery supports for adolescents include family connections and roles. Family may be defined as the adolescent's family of origin, blended family, or family of choice.

5.8   Adolescent Development Approaches to Treatment

An adolescent development approach is a framework that guides counties and providers in the way they organize services, opportunities, and supports so the adolescents receiving services can develop to their full potential.[20] Programs/providers must adhere to the following when delivering adolescent SUD services:

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[20] "Principles of Youth Development." ACT for Youth Center of Excellence
http://www.actforyouth.net/youth_development/development/

5.8.1   Programs shall integrate an adolescent development philosophy as the foundation of treatment for adolescents. Adolescent development approaches must, at minimum, include:

(a)   Strength-based assessment, treatment, and recovery planning processes.

(b)   Discovery of the adolescent's unique strengths and building on his/her individual abilities and strengths.

(c)   Frequent expressions of support and clear, consistent, and appropriate messages about what is expected of the adolescent.

(d)   Encouragement and assistance in developing multiple supportive relationships with responsible, caring adults.

5.8.2   Programs must provide or arrange for opportunities for encouraging adolescents to actively participate in treatment. Adolescents shall be involved in treatment through means that, at a minimum, include:

(a)   Developing social skills and decision-making abilities;

(b)   Learning values and marketable skills for adulthood;

(c)   Contributing to their community and serve others;

(d)   Planning, organizing, and leading program activities and projects; and

(e)   Advising and making decisions related to program policies/ procedures that affect them.

5.8.3   If the services described in Section 5.8 above are not provided by the program, a qualified health professional, or a trained professional who works for the program, must follow up to ensure that the services were obtained. Furthermore, this process must be documented in the adolescent's file.

5.9   Transitional Age Youth

Transitional Age Youth (TAY) are defined as individuals between the ages of 18 and 25 years of age. These transition years span the potentially dangerous

developmental years of growing out of childhood and into adulthood, when individuals have often not yet mastered the maturity of adulthood. TAY have unique service challenges because they often lack the basic life skills needed to secure or maintain employment, housing, and other necessities for success in adulthood.

5.9.1 To serve youth ages 18 through 25, or individuals younger than age 12, the program shall:

(a) Document clinical appropriateness individually for each client.

(b) Have a written protocol that addresses developmentally appropriate services for that age group. The department reserves the right to review and approve each written protocol.

5.9.2 TAY services must be directed at meeting specific issues faced by this age group. These services address a variety of age-specific issues as well as other challenges that may or may not apply to adolescents or older adults. TAY services should include, but are not limited to:

(a) Transportation;

(b) Communication (such as lack of cell phone);

(c) Family estrangement;

(d) Gender and sexuality;

(e) Legal issues;

(f) Educational issues, including access to GED and higher education;

(g) Job search skills and training and employment skills;

(h) Undiagnosed and/or untreated mental health issues;

(i) Assistance with access to primary health and dental care;

(j) Homelessness or unstable housing;

(k) Access to public assistance services;

(l)   Nutritional education;

(m)   Money management, budgeting, and other basic financial literacy skills;

(n)   Pro-social skills, including anger management, limit setting (especially in relationships), and communications; and

(o)   Information on public resources, such as recreational, emotional support, and educational resources.

5.9.3   Programs shall ensure that staff is adequately prepared to meet the treatment needs of TAY with mental health, substance use, or co-occurring disorders. At a minimum, staff must be prepared to address:

(a)   The unique needs of TAY that differentiate them from adolescents or older adults; and

(b)   The cultural differences among the TAY being served.

5.9.4   Programs shall ensure that TAY services include information on accessing community resources that TAY may require, including, but not limited to, the following:

(a)   County department of health services and/or local clinics;

(b)   Social services (foster care and child welfare);

(c)   Mental health;

(d)   Juvenile justice (e.g., courts and probation);

(e)   State agencies such as the Employment Development Department (e.g., workforce development and training); and

(f)   Other community-based organizations providing services to adolescents, such as housing, transportation, education, and crisis services.

5.9.5   Since the age span of TAY can cover different developmental stages and each youth will have a different rate of development, staff shall be able to provide TAY with services that are appropriate to each individual's current stage of development.

5.10   Family Interventions and Support Systems

Troubled family systems and disrupted living patterns often accompany SUDs. Successful treatment programs for adolescents shall include a family component. This family component can range from family support for the adolescent as they near the end of treatment and prepare for the path of long term recovery, to family therapy to develop healthy communication and parenting skills.

Family-centered treatment often reduces relapse risk in adolescents. This type of treatment has been proven to mitigate both individual and family risk factors, in addition to building protective factors.[21] Whenever appropriate, parents or caregivers shall participate in all phases of the adolescent's services; however, the provider should not insist on parental involvement in SUD services if they are estranged from the adolescent.

In the case of family or parental estrangement, the program shall create new opportunities for these adolescents to develop supportive relationships with appropriate adults who will remain involved in their lives during treatment, recovery, and beyond.

5.10.1   When family therapy and services are clinically appropriate, programs shall:

(a)   Ensure all family services are culturally relevant and appropriate;

(b)   Ensure services are offered in a language and environment conducive to family engagement;

(c)   Identify family dynamics and include the family in the adolescent's treatment as early as possible, if clinically appropriate and specified in the treatment and recovery plan;

(d)   Provide or arrange for family services, such as individual family counseling, family problem solving, family anger management, multi-family groups, and parental education sessions, as clinically appropriate and specified in the treatment and recovery plan; and

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[21] Substance Abuse and Mental Health Services Administration. (2007) *Family-Centered Treatment for Women With Substance Use Disorders - History, Key Elements, and Challenges.* Available from: http://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf

(e) Focus family-related services on enhancing family relationships, communication, and functioning to promote long-term recovery from substance use disorders and encourage healthy, culturally and developmentally appropriate behavior.

5.10.2 The program shall assist the adolescent in developing a support system to help reinforce behavioral gains made during treatment, and provide ongoing support to prevent relapse.

5.11 Co-Occurring Disorders

Increasingly, the field is acknowledging that mental health (MH) issues frequently co-occur with SUD in adolescents.[22] Due to the challenges of treatment and relapse for adolescents with co-occurring disorders (COD), treatment for COD must be integrated.[23]

Integration occurs when treatment for all SUD and MH conditions are conducted within the same program and/or facility, by the same staff and/or by staff supervised by one person who is in charge of and closely coordinating the adolescent's treatment. Assessment of all adolescent SUD and MH clients is a best practice for identifying those experiencing COD.

5.11.1 When an integrated treatment approach is not feasible, providers shall use a case manager for COD treatment.

(a) A case manager must be used for integration of MH and SUD treatment, so all COD treatment providers are aware of, and appropriately responsive to, the treatment being provided by the others as well as the adolescent's progress in that treatment.

5.12 Trauma-Informed Care

There is growing awareness that trauma plays an important role in SUDs. Numerous studies have shown a correlation between trauma and both

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[22] ASAM criteria, p. 28.

[23] "Co-Occurring Disorders." SAMHSA web page: http://www.samhsa.gov/co-occurring.

adolescent substance abuse and adolescent mental health issues.[24],[25] Given the complex linkages among violence, victimization, trauma, and SUDs, it is important to acknowledge the role trauma plays in the lives of adolescents, especially many of those receiving SUD services, and their families.

Trauma-Informed Care and a trauma-informed approach apply certain general principles.

5.12.1   Rather than following a specific set of practices or procedures, service providers shall use a trauma-informed approach that adheres to the six key principles identified by SAMHSA.

5.12.2   Providers shall apply these principles across multiple types of settings. The terminology and the application must be suited to the particular setting, sector, or care level.

5.12.3   SAMHSA's Six Key Trauma-Informed Principles:

(a)   Safety

(b)   Trustworthiness and transparency

(c)   Peer support

(d)   Collaboration and mutuality

(e)   Empowerment, voice, and choice

(f)   Cultural, historical, and gender issues[26]

For more information, see the Appendix and References. The references include information on well-known trauma-specific interventions based on psychosocial educational empowerment principles.

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[24] Adolescent Trauma and Substance Abuse Committee of the National Child Traumatic Stress Network (NCTSN), *Understanding the Links Between Adolescent Trauma and Substance Abuse*: A Toolkit for Providers. June 2008. pp. 5-6. For further resources and information on the connections between these, see "Adolescence and Substance Abuse", NCTSN web page: http://www.nctsn.org/resources/topics/adolescence-and-substance-abuse.

[25] Mackenzie Whitesell, Annette Bachand, Jennifer Peel, and Mark Brown, "Familial, Social, and Individual Factors Contributing to Risk for Adolescent Substance Use." Journal of Addiction, vol. 2013, Article ID 579310, 9 pages, 2013. doi:10.1155/2013/579310. Sections 3.2, 3.3, and 3.4.

[26] "Trauma-Informed Approach and Trauma-Specific Interventions." SAMHSA web page: http://www.samhsa.gov/nctic/trauma-interventions. For additional SAMHSA information on trauma and TIC, also see http://www.integration.samhsa.gov/clinical-practice/trauma.

5.13   Medication Assisted Treatment (MAT)

Medication Assisted Treatment (MAT) includes the ordering, rendering, and prescribing of all medications for SUDs. Opioid and alcohol dependence, in particular, have well established medication options.

MAT medications lack sufficient evidence for effectiveness and safety; therefore, the use of MAT is not recommended for adolescents. In addition, any use of these medications has not been approved by the FDA to be used on adolescents. The National Institute on Drug Abuse (NIDA) stated that, the neurobiological effects on the developing brain of these medications have not been established.[27]

Consequently, any use of MAT for adolescents may carry risks. While the use of medication in adolescent SUD treatment can be used in addition to other therapeutic treatment and recovery support services, determining if MAT is appropriate for an adolescent and monitoring that form of treatment involves many considerations. Factors in the determination must include, but are not limited to, the following:

5.13.1   The decision to start MAT shall be made in conjunction with the medical professional, adolescent, and his/her family, as appropriate. In addition, the decision shall involve a discussion of the benefits, drawbacks, potential side effects of the medication, and the possible challenges related to discontinuing use of them. This discussion shall also include the costs of the medication, administration requirements, and regulations governing their use.[28]

5.13.2   Qualified medical professionals (e.g., physician) are required to closely monitor both, the adolescent's response to the medication for possible negative reactions, and the adolescent's use of the medications to ensure they are being used as directed and not abused.

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[27] *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide.* National Institute on Drug Abuse. "Addiction Medications"(2014): http://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/evidence-based-approaches-to-treating-adolescent-substance-use-disorders/addiction-medications.

[28] Substance Abuse and Mental Health Services Administration. (2013). *What does the research tell us* about good and modern treatment and recovery services for youth with substance use disorders? Report of the SAMHSA Technical Expert Panel, December 5–6, 2011. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Table 3: Availability of MAT Inside and Outside of Drug Medi-Cal Programs

Medication	TAR*	Availability
Methadone*	No	Only in NTP/OTP**
Buprenorphine*	Yes, unless provided in an NTP/OTP	Pharmacy Benefit NTP/OTP
Naltrexone* tablets	No	Pharmacy Benefit MediCal Benefit DMC Benefit
Naltrexone* long-acting injection	Yes	Pharmacy Benefit, MediCal Benefit
Disulfiram***	No	Pharmacy Benefit NTP/OTP
Acamprosate***	Yes	Pharmacy Benefit
Naloxone	No	Pharmacy Benefit

*TAR (Treatment Authorization Request)

**Narcotic Treatment Program/Outpatient Treatment Program

Note: Per both ASAM criteria and NIDA,[29] to be admitted into opioid maintenance treatment, a person under age 18 must have the written consent of a parent, legal guardian, or other appropriately designated responsible adult. Other special requirements apply for those under age 18, as provided in the ASAM criteria [30] and under State law. Also see the National Association of State Alcohol and Drug Abuse Directors *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide*, pp. 24-25.

***Per NIDA, "Medication-assisted therapies are rarely used to treat adolescent alcohol use disorders.[31]

5.14   Alcohol and Drug Testing

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[29] *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide*. National Institute on Drug Abuse. Specifically quoted from the "Addiction Medications" web page (2014): http://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/evidence-based-approaches-to-treating-adolescent-substance-use-disorders/addiction-medications.

[30] p. 296, The ASAM criteria

[31] *loc. cit.*, *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide*. National Institute on Drug Abuse.

Alcohol and drug test results are meant to assist in diagnosis, confirm clinical impressions, help modify the adolescent's treatment and recovery plan, and determine the extent of the adolescent's reduction in substance use. Clinical decisions shall not be based solely on these results. Programs must also adhere to the following requirements:

5.14.1   With the exception of early intervention programs, programs shall provide/arrange for alcohol and drug testing for all adolescents.

5.14.2   The frequency of alcohol and drug testing shall be determined individually for each adolescent, based on clinical appropriateness, and shall allow for rapid response to the possibility of relapse.

5.14.3   The individual treatment plan shall provide options for constructively addressing possible relapse.

5.15   Information and Communication Technology

Information and communication technology, also known as telehealth (e.g., web-based, telephone, and social media), can be a valuable tool in establishing and maintaining relationships with adolescent clients when used effectively. Adolescent clients may encounter geographic, transportation, and/or socio-economic barriers to receiving critical SUD services. Telehealth allows adolescents to access cost-effective, high quality SUD services at a time and in a location convenient to them. Use of the following media[32] may increase adolescent involvement:

5.15.1   Social media/social networking sites

5.15.2   Text messaging

5.15.3   E-mail

5.15.4   Live video or "real time" video conferencing

5.15.5   Streaming media

These tools can be used to facilitate communication, and to serve as reminders about events, therapeutic sessions, and recovery goals. When utilizing media and technology, programs must adhere to the following requirements:

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[32] "Telemedicine: Opportunities and Developments in Member States," World Health Organization (2010): http://www.who.int/goe/publications/goe_telemedicine_2010.pdf

5.15.6   Providers and all staff who utilize communications media and technology within their programs shall be trained on state and federal privacy laws, including but not limited to, HIPPA and 42 CFR, Part 2, that apply to the use of technology for adolescent treatment and recovery support services.

5.15.7   Providers shall have policies and procedures in place. The policies/procedures must include direction for how to use these mediums, and they must identify the benefits and risks of utilizing appropriate communications media and technology in the treatment and recovery support services they offer to adolescents.

5.15.8   Providers shall ensure that services are conducted in a confidential location.

6.   SYSTEMS COLLABORATION AMONG AGENCIES

SUDs affect multiple aspects of an adolescent's life, including family, community, school, and peer relationships. To provide the best care for adolescents, it is important to acknowledge that they may receive many services from other State systems (e.g., Medi-Cal, behavioral health, primary care, child welfare, juvenile justice, and education). When collaborating with other agencies, adolescent SUD service providers are required to establish, maintain, and implement written procedures to develop outreach, collaboration, and partnerships for coordination and referral with other agencies and organizations. All collaborations/partnerships must be documented in writing (e.g., interagency agreements, memorandum of understanding, local statute, or local policy).
These options help facilitate cross-collaboration efforts to better serve these adolescents.

6.1   Interim Services

Adolescents with a SUD diagnosis require rapid access to treatment and ongoing recovery supports. Untreated, adolescents may experience complex health issues, jeopardize their education, and further harm relationships with their families and community.

6.1.1   When a program is unable to admit an adolescent with a SUD due to insufficient capacity, the program must refer the adolescent to another adolescent appropriate program within 14 calendar days.

(a)   The program site must be accessible to the adolescent, based on his or her transportation needs.

6.1.2   While another program is being identified, the program must provide interim services to the adolescent.

     (a)   Interim services are supportive services that are provided until an adolescent is admitted into an appropriate SUD treatment program.

     (b)   Referral to interim services must occur within 48 hours of the diagnosis.

6.1.3   At a minimum, interim services for adolescents include referrals for:

     (a)   Counseling;

     (b)   Food and clothing;

     (c)   Psychical and behavioral health education services; and

     (d)   Temporary housing.

6.1.4   To assist programs in making appropriate referrals, each county must create and maintain a current directory of its community resources.

6.2   Case Management and Complementary Services

Adolescents often interact with multiple systems while on their path to treatment and through recovery. Adolescents and their families may have a challenging time interacting with the various systems at the same time. Effective assistance in recovery support service coordination is critical to help adolescents and their families successfully navigate the systems that they encounter. Case management services are defined as services that assist adolescents to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Programs must adhere to the following case management services requirements:

6.2.1   Except for early intervention programs, programs shall provide/arrange for case management services for every adolescent in treatment as needed and as appropriate.

6.2.2   Case management and complementary services must include, but are not limited to, the following:

     (a)   Coordination of behavioral health care, if needed;

(b)   Integration around primary care, especially for clients with a chronic SUD, if needed; and

(c)   Interaction with other social services systems, as needed (e.g., juvenile justice).

6.2.3   Case management services may be provided face-to-face, by telephone, or by telehealth with the adolescent, and may be provided in any confidential environment within the community.

6.2.4   Services must be provided by a LPHA or certified eligible counselor.

(a)   Licensing and certification must be through the State of California.

6.2.5   Case managers must follow up with other professionals who are treating or providing services to the same adolescents, and communicate the appropriate information on the adolescents' needs to ensure coordination of care.

6.2.6   Case management services include, but are not limited to, the following:

(a)   Comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services;

(b)   Assistance during a transition to a higher or lower level of SUD care;

(c)   Development and periodic revision of a treatment and recovery plan that includes service activities;

(d)   Communication;

(e)   Coordination;

(f)   Referrals and related activities;

(g)   Monitoring service delivery to ensure client has access to service and the service delivery system;

(h)   Monitoring the adolescent's progress; and

(i)   Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

6.2.7   If the case manager duties are provided directly by the treatment program, the case manager shall have training and skills in the following areas:

(a)   Substance use disorder treatment, an understanding of addiction, and the intergenerational nature of substance abuse;

(b)   Familiarity with community resources and other adolescent service systems (education, child welfare, juvenile justice, health care, mental health, etc.);

(c)   Physical, emotional, and sexual abuse and trauma;

(d)   Family dynamics and relationships; and

(e)   Legal issues (e.g., informed consent for minors, disclosure of confidential information, child abuse/neglect reporting requirements, and duty-to-warn issues, etc.).

6.2.8   If the case manager is provided directly by the treatment program, he/she shall do the following:

(a)   Arrange for, ensure access to, and coordinate complementary services identified in the adolescent's treatment and recovery plan;

(b)   Communicate regularly with the primary counselor to monitor the services and activities for the adolescent and his/her family identified in the adolescent's treatment and recovery plan;

(c)   Be the adolescent's advocate and liaison with other systems;

(d)   Coordinate referrals and communicate with other community agencies providing services to the adolescent in the program (e.g., schools, child welfare, juvenile justice, employment development, mental health, and primary medical care); and

(e)   The case manager shall coordinate with the other agencies/ systems, referenced in ==Section 6==, including possible group case management meetings, to the extent possible.

Note: This role may require careful limit setting on collaboration and sharing of information when working with some systems (e.g., juvenile justice) that may penalize adolescents when specific information is disclosed. Providers shall prioritize their efforts for the most beneficial outcomes for the adolescent and his/her family while adhering to HIPPA, 42 CFR, and other federal, state, and local privacy laws.

6.3   Integrated Care

Integrated substance use treatment for adolescents is a comprehensive approach that treats substance use and co-occurring mental health disorders simultaneously. In addition, integrated care analyzes primary care service needs, including primary pediatric care, reproductive health, and issues of trauma, abuse, and neglect. Effective adolescent SUD service providers work with young clients and their families to ensure access to primary care services by coordinating referrals and linkages to the appropriate service providers.

6.4   Critical Linkages

In order to provide the services and smooth transitions between systems that support good outcomes for adolescents, programs must identify and interact with agencies/organizations, outside of SUD services, to identify potential resources and develop strong relationships.

6.4.1   The program shall develop strong linkages with existing programs and systems that provide services to adolescents to ensure a coordinated approach to addressing the adolescent's needs. These include, but are not limited to, the following:

(a)   Physical health;

(b)   Mental health;

(c)   Social services;

(d)   Education;

(e)   Mentoring;

(f)   County departments of health services;

(g)	Employment and vocational development; and
(h)	Other community-based organizations providing appropriate beneficial services to adolescents, such as transportation and housing assistance.

6.4.2   Additionally, programs shall link with the juvenile justice and SUD services systems, which provide opportunities for identification and referral of adolescents with SUDs. These include, but are not limited to, the following programs:

(a)	Substance use prevention;
(b)	Perinatal treatment; and
(c)	Juvenile courts/probation.

6.4.3   To the extent possible, and in accordance with state and federal laws regarding disclosure of confidential information, case management conferences and treatment and recovery planning shall include representatives from relevant agencies. See Section 8.2 for information on disclosure and confidentiality requirements.

Note: Some systems (e.g., juvenile justice) may penalize adolescents if specific information is disclosed; therefore, programs shall take appropriate precautions to avoid disclosing information that could be potentially harmful. Programs shall exercise careful limit setting in case management conferences.

7.   HEALTH AND SAFETY ISSUES

7.1   Crisis Intervention Services

A crisis is an actual relapse or an unforeseen event/circumstance which presents an impending threat of relapse. Crisis intervention covers the medical, psychological, and sociological services used to assist an adolescent who is going through severe physical, emotional, mental, or behavioral distress.

These services are always short-term and are aimed at giving an adolescent the tools they need to immediately cope with problems they may be having. When providing these services, programs must adhere to the following requirements:

7.1.1   Providers shall make arrangements to allow for contact between a therapist/counselor and an adolescent in crisis. Such crisis services shall focus on alleviating crisis problems in ongoing treatment/ recovery.

7.1.2   Crisis intervention services, for responding to an actual relapse or other unforeseen relapse risk, shall be limited to the stabilization of the adolescent's situation.

7.2   Suicide Prevention in Adolescent Services

Research findings show that mental disorders and/or substance abuse have been found in 90 percent of people who have died by suicide.[33] Adolescents receiving services for substance abuse constitute a high-risk group for suicide; therefore, programs must adhere to the following to aid in suicide prevention:

7.2.1   Program staff shall be trained to recognize risk of suicide in clients.

7.2.2   Programs shall have brochures or other information on suicide prevention, including suicide prevention hotlines, available for adolescents, their families, and others supporting the adolescent.

7.2.3   In the event of a suicide in the school, program, or other community facilities serving adolescents, programs should monitor the situation and attitudes that may arise in response to the suicide. This monitoring includes, but is not limited to:

(a)   Social networking sites that may become memorials to the deceased. These sites should be monitored for any degrading comments and/or statements indicating that others are considering suicide, so the statements may be addressed appropriately.

(b)   The program shall create and implement policies and procedures to address degrading comments and/or statements indicating others are considering suicide posted on the program's social networking sites.[34]

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[33] "Recommendations for Reporting on Suicide." SAMHSA and U.S. National Suicide Prevention Lifeline: http://store.samhsa.gov/shin/content/SMA11-4640/SMA11-4640.pdf.

[34] Ibid.

7.3   Care and Supervision

Adolescents are not yet adults and therefore continue to require care and supervision for their own safety. This care and supervision must be provided in an appropriate way to respect their sense of personal dignity.

7.3.1   The program shall provide a reasonable level of age-appropriate structure, care, and supervision to ensure the safety/security of adolescents and staff on the program site, at all times. Appropriate care and supervision includes, but is not limited to, the following:

(a)   The maintenance of rules for the protection of adolescents;

(b)   Supervision of adolescents' schedules and activities;

(c)   Monitoring of food intake/special diets (if meals or snacks are served); and

(d)   Storing, distribution, and assistance with taking medications. For more information, see Section 7.4 - Medication Management.

7.3.2   Adolescents must be treated with respect and dignity in their personal relationships with program staff and other persons. In addition, adolescents have a right to be free from corporal or unusual punishment, exploitation, prejudice, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, sexual harassment, mental abuse, or other actions of a punitive nature.[35]

7.3.3   Program consequences/discipline for an adolescent's inappropriate behavior during the program shall be non-violent, age and developmentally appropriate, non-aversive, and clearly stated in the program's rules and procedures.

7.3.4   Programs shall have written procedures for signing in and out of program sites. Program staff shall ensure the availability of secure, safe and reliable transportation for adolescents to and from the program site and to supportive services. The program shall never leave an adolescent alone to wait for his/her ride.

7.3.5   Programs shall establish a protocol for the submission of program incident reports in consultation with their county agencies, including:

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[35] 22 CA ADC § 84072: Personal Rights

(a)   The reporting of such incidents as injuries that require medical evaluation or treatment;

(b)   Suspected physical, sexual or psychological abuse;

(c)   Transmissible diseases (non-STDs); and

(d)   Deaths.

7.3.6   All programs shall conduct a criminal record review of staff who have supervisory responsibility for or frequent/routine contact with adolescents while they are at the program.[36]

(a)   If the review discloses that the individual has been convicted of, or is the subject of any criminal investigation relating to a felony or misdemeanor perpetrated against a child/minor, the program shall prohibit that individual from employment that results in any contact with adolescents while they are at the program.[37]

(b)   The program shall develop criteria in their policies and procedures regarding criminal record examinations and shall keep the results of the criminal record review in a confidential portion of the personnel file.

7.3.7   To ensure the welfare of the adolescent, all programs shall develop training to increase staff awareness and skills in the detection of injury, disease, emotional, physical, or sexual abuse, and neglect.

(a)   Programs shall have written policies and procedures concerning appropriate staff response to and preparation for such issues.

7.3.8   The state reserves the right to review all procedures required in Section 9.

7.4   Medication Management

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[36] 9 CCR § 10624 – Criminal Record Review

[37] 9 CCR § 10626 – Review of Criminal History Summaries

Programs shall manage adolescent's prescription medication in accordance with all applicable state and local laws (e.g., those governing school sites, residential SUD treatment programs, and group homes[38]). Medications used in MAT require particular attention to legal requirements.[39]

Programs that are not otherwise regulated in this area must develop and adhere to a written protocol for the self-administration and management of adolescent's prescription medications. The state reserves the right to review the written protocol.   The protocol must include, but is not limited to, the following:

7.4.1   Review and documentation of medications in the adolescent's chart, upon admission to the program, and periodically updating the medication records throughout the program.

7.4.2   Issuance of written instructions concerning an adolescent's medication regimen to staff members directly involved in individual client care.

7.4.3   Appropriate secure storage and self-management of an adolescent's medications to minimize risk of tampering, loss, or contamination.

7.5   Emergency Services

While providing onsite treatment and recovery support services for adolescents, a facility may encounter an emergency situation. The following requirements must be met in order to prepare for an emergency situation:

7.5.1   All staff involved in direct client care shall be trained in the emergency care procedures.

7.5.2   At least one staff member on all shifts shall be trained and certified in first aid and cardiopulmonary resuscitation to ensure adequate emergency services are available when adolescents are present.

7.5.3   All programs shall develop written protocols and procedures in case of a medical or psychological emergency.

(a)   The program protocol and procedures must include established referral relationships with emergency facilities.

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[38] 42 C.F.R. § 59.11; HSC §§ 123110(a), 123115(a)(1); Reisner v. Regents of the University of California.

[39] FAM § 6929(e).

7.6   Facilities and Grounds

The facility, in which adolescent substance use clients receive services, has a strong influence on the effectiveness of treatment and recovery support services. It is critical that providers create and maintain an environment supportive of an adolescent's physical, emotional, and developmental needs. The following are the requirements for facilities serving adolescents:

7.6.1   All residential facilities shall be licensed in accordance with applicable state licensing statutes and regulations. In addition, all facilities must remain in compliance with such requirements.

7.6.2   All facilities shall be clean, sanitary, and in good repair at all times for the health, safety, dignity, and well-being of adolescent, staff, and visitors.

7.6.3   The program and facility must comply with the Americans with Disabilities Act (ADA) requirements.

8.   LEGAL AND ETHICAL ISSUES

8.1   Voluntary Treatment

In order to be most effective, substance abuse prevention, intervention, treatment, and recovery services should be voluntary; however, the SUD system often serves adolescents who choose SUD services to avoid more severe consequences (e.g., school expulsion, juvenile detention or felony conviction, placement in a group home, or a parental consequence). Such SUD services can be successful if adolescents are assessed and matched with the appropriate level of care and the program works to motivate the adolescents to change.

To promote best outcomes for the adolescents involved, programs must adhere to the following provisions:

8.1.1   If an adolescent appears to be mismatched to court-ordered SUD services, the program has a right to refuse services based on a clinical assessment. However, the program is required to make a recommendation and referral for a more appropriate placement.

8.1.2   The program shall encourage participation by utilizing strategies with demonstrated effectiveness (e.g., evidence based practices, adolescent development strategies, family involvement, and motivational interviewing).

8.1.3   Adolescents must consent to be admitted to treatment.

8.2   Consent, Confidentiality, and Criminal Reporting

The laws and regulations in these areas can have interacting restrictions. Programs must comply with state and federal laws/regulations regarding these matters:

8.2.1   Informed consent for children and adolescents.[40]

8.2.2   Disclosure of confidential information, such as patient-identifying information (e.g., communication with parents, guardians, the courts, and others).[41]

8.2.3   Child abuse and neglect reporting requirements.

8.2.4   Duty-to-warn issues (e.g., threats of violence, HIV infection risk[42]): Each Short-Doyle contractor must develop a policy relevant to the protection of third parties which is consistent with State law. The policy must include recourse to legal counsel should questions arise as to whether State law creates a duty to warn and protect in a particular case.

8.3   Notice of Program Rules, Client Rights, and Grievance Procedures

Upon admission, all adolescents and their families shall be personally advised of, and given a copy of, the program rules, client rights, and the complaint and/or grievance procedures. These shall be culturally, linguistically, and literacy appropriate for the adolescents and families being served. The program shall post these items in a noticeable place in the facility.

9.   ADMINISTRATION

9.1   Program Rules and Procedures

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[40] 45 C.F.R. §§ 164.502(a)(1)(i) & (iv), (a)(2)(i), (g)(1); (g)(3)(i); FAM § 7002; FAM § 6929(b); FAM § 6929(e); FAM § 6929(f); FAM § 6929(g);FAM § 6924(b); HSC §§ 123110(a), 123115(a)(1), 123115(a)(2); 42 C.F.R. § 2.11; 42 C.F.R. § 2.12; 42 C.F.R. § 2.14; FAM § 6929(g); FAM § 6924(d).

[41] 45 C.F.R. §§ 164.502(a)(1)(i)&(iv); (a)(2)(i); (g)(1); (g)(3)(i); 45 C.F.R.§ 160, Subpart C; FAM § 6929(c); HSC § 123115(a)(2); 42 C.F.R. § 2.11; 42 C.F.R. § 2.12; 42 C.F.R. § 2.14; FAM § 6929(g).

[42] 42 C.F.R. § 59.11; HSC §§ 123110(a), 123115(a)(1).

The program shall have written program policies and procedures, client rules and rights, and complaint and/or grievance procedures.

9.1.1   All staff shall receive training on the program rules, policies, and procedures.

9.2   Program Staffing

9.2.1   Each adolescent treatment program shall have at least one of each of the following core staff:

(a)   A program or clinical supervisor, who must have management experience (e.g., staff supervision, fiscal operations, or business administration), and education and experience in alcohol and drug addiction counseling.

(b)   A SUD counselor, who must be certified by an alcohol and drug addiction counselor credentialing organization.

(c)   A family therapist, who must be licensed as either a Marriage and Family Therapist (MFT), Licensed Clinical Social Worker (LCSW), psychologist, or a registered intern under the supervision of a licensed therapist. The family therapist may be a contracted employee.

9.2.2   The core staff shall, at a minimum, have training and/or skills in the following areas:

(a)   SUD treatment, an understanding of addiction, the intergenerational nature of substance abuse, and the dynamics of adolescent recovery;

(b)   Effective and developmentally-appropriate interventions and approaches for treating substance-abusing adolescents;

(c)   Assessment of SUDs, mental health disorders (psychotic, mood, anxiety, behavioral and personality), and cognitive impairments;

(d)   Psychoactive medications prescribed to adolescents, their benefits, and their potential side effects and interactions with other medications or substances;

(e)   Child development and normal adolescent growth and development;

(f)   Therapeutic recreational therapy;

(g)   Family dynamics;

(h)   Detection of adolescent injury, disease, abuse, and neglect;

(i)   HIV/AIDS and other health issues (e.g., STDs, hepatitis, smoking, etc.);

(j)   Cultural competence, including ADA requirements;

(k)   Community resources and other adolescent treatment systems (schools, child welfare, mental health, juvenile justice system, etc.);

(l)   Methods of drug and alcohol testing, interpreting test results, and the benefits and limitations of the tests;

(m)   Legal issues (informed consent for minors, disclosure of confidential information, child abuse/neglect reporting requirements, and duty-to-warn issues);

(n)   Program rules and procedures; and

(o)   Client rights and grievance procedures.

9.2.3   Programs shall retain written documentation of the required staff licensure, skills, and training. The department reserves the right to review staffing files.

9.2.4   Programs shall provide or arrange for continuing education for all clinical staff to enhance their knowledge.

10.   FUNDING

Addressing adolescent substance use is a cost-effective, common-sense approach to preventing future challenges in other social service and public health related areas, including corrections, and education. The Federal and State governments support a variety of public funding sources for adolescent SUD along the continuum of care. Counties and providers are encouraged to consider these and other sources to develop robust adolescent SUD services.

See Table 4: Youth Services Funding Overview for more information on funding availability.

10.1   Prevention

10.1.1   The SAPT Block Grant provides a set aside of approximately $46 million per year for primary prevention activities including information dissemination, education, alternative activities, problem identification and referrals, community-based process, and environmental strategies. SAPT discretionary funds may also be used to support SUD prevention services.

10.1.2   The Federal Medicaid program funds routine youth screenings for SUDs utilizing the Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) screening tool.

10.2   Early Intervention

10.2.1   SAPT discretionary funds may be used to support some SUD early intervention services.

10.2.2   The Federal Medicaid program recently expanded its services to include early intervention. Once DHCS policies are implemented, early intervention services will be available for adolescents.

10.3   Treatment

10.3.1   Approximately $7 million in SAPT funding is dedicated annually to supporting to supporting comprehensive, age-appropriate, SUD treatment services for adolescents.[43] SAPT discretionary funds may also be used to support SUD treatment.

10.3.2   The Drug Medi-Cal (DMC) treatment program provides medically necessary SUD treatment services for eligible Medi-Cal beneficiaries.

(a)   The DMC Organized Delivery System (ODS) pilot, within the 1115 waiver, added new reimbursable services through DMC. Treatment services expanded through the DMC ODS pilot include residential care to beneficiaries previously not eligible, withdrawal management, case management, physician's consultation, and additional MAT.

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[43] For current year funding amount, see website at: http://www.dhcs.ca.gov/formsandpubs/Pages/MHSUDS-Information-Notices.aspx

10.3.3 The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. Treatment services available through the EPSDT benefit include:

(a) Individualized SUD treatment services;

(b) Intensive outpatient services;

(c) Medication management; and

(d) Counseling services.

10.3.4 Medicaid currently covers outpatient and residential SUD treatment services, outpatient drug-free, and narcotic treatment programs.

10.4 Recovery Support

10.4.1 Recovery support services covered by SAPT include self-directed care, shared decision making, peer-operated services, peer specialists, recovery coaches, wellness activities, supported and recovery housing, supported employment and education, warm lines, person centered planning, peer and family support, social inclusion activities, and rights protections. SAPT discretionary funds may also be used to support SUD recovery support services.

10.4.2 After the completion of treatment services, the DMC ODS Pilot authorizes recovery support services including:

(a) Counseling;

(b) Case management;

(c) Relapse prevention; and

(d) Recovery coaching.

Table 4: Youth Services Funding Overview

	Prevention	Early Intervention	Treatment	Recovery Support
SAPT	X	X	X	X
Drug Medi-Cal			X	
1115 Waiver			X	X
EPSDT			X	
Medicaid	X*	X**	X	

  * Funding only available for screening
 ** Policies still in development

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APPENDIX

ADA: The Federal Americans with Disabilities Act.

Adolescence: The period of life between puberty and maturity, generally accepted as age 12 until 18.

Assessment: An ongoing process by which the treatment team collaborates with the adolescent, family, and others to gather and interpret information necessary to determine their level of problem severity, match their clinical needs to the appropriate level of treatment, and evaluate progress in treatment.

ASAM: The American Society of Addiction Medicine. The ASAM criteria is a single, common standard for assessing patient needs, optimizing placement, and determining medical necessity. ASAM criteria uses five basic levels of care, numbered Level 0.5 (early intervention) through Level 4 (medically managed intensive inpatient services).

Biomedically Enhanced Programs: Programs providing specialized services to address biological and physiological aspects of a patient's condition that require physical health assessment and services.

CalOMS Pv: California Outcomes Measurement Service for Prevention; the data collection and data base system that records information and outcomes related to SUD primary prevention activities at the county level.

CalOMS Tx: California Outcomes Measurement Service for Treatment; the data collection and data base system that records information and outcomes related to SUD treatment activities.

Case Management: An ongoing process by which the program establishes linkages with other service systems and its providers, acts as liaison between the adolescent and those other systems, and coordinates referrals to ensure access to necessary services to assist adolescents and their families to address their special needs. Also called Recovery Navigation.

Clinically Managed Residential Treatment: The level of care equivalent to Adolescent Level III in the ASAM criteria. This level of care is provided in either a facility licensed by the Department of Social Services or in a Department-licensed adult alcoholism or drug abuse recovery or treatment facility with an approved waiver to serve adolescents.

Clinically Managed Services: Services directed at non-physician addiction specialists rather than medical and nursing personnel; appropriate for individuals whose primary problems involve emotional, behavioral, or cognitive concerns, readiness to change, or recovery environment.

Co-occurring Capable Programs: Programs that address co-occurring mental and substance use disorders in their policies and procedures, assessments, treatment planning, program content, and discharge planning. Programs have arrangements in

place for coordination and collaboration between addiction and mental health services, they can also provide medication monitoring and psychological assessments/ consultation on-site. Program staff are able to address the interaction between mental and substance use disorders and their effect on the patient's recovery dynamics.

Co-occurring Disorders (COD): The co-existence of both a diagnosis of one or more DSM 5-defined substance use disorders and a diagnosis of having a serious emotional disturbance (SED). This condition is also called Dual Diagnosis.

Co-occurring Enhanced Programs: Treatment programs that address co-occurring mental and substance use disorders in their policies and procedures, assessment, treatment planning, program content, and discharge planning. Programs accommodate patients who have both unstable co-occurring mental health and substance use disorders, providing mental health symptom management treatment and motivational enhancement therapies designed specifically for those with co-occurring disorders. There is a close collaboration between addiction and mental health services that provide crisis back-up. Programs place a primary focus on the integration of mental and substance use services.

Continuum of Care: The full range of substance use disorder services available to address the diverse needs of adolescents. The COC generally includes wellness promotion, prevention, early intervention, treatment, and after care or recovery maintenance with a variety of settings and services included within each category.

Department: The Department of Health Care Services (DHCS).

Diagnosis: A process of examination to determine the nature of a problem or set of problems, and the decision or opinion based on that examination.

DSM 5: The *Diagnostic and Statistical Manual of Mental Disorders 5*. DSM 5 is the 2013 update to the [American Psychiatric Association](#)'s (APA) classification and diagnostic tool. In the United States the DSM serves as a universal authority for psychiatric diagnosis. Treatment recommendations, as well as payment by health care providers, are often determined by DSM classifications. The prior DSM was DSM IV.

Early Intervention: The level of care equivalent to Adolescent Level .05 in the ASAM Criteria. This level of care is delivered in a variety of settings and usually consists of brief contact or a series of contacts designed to explore and address problems or risk factors that appear to be related to substance abuse. It is most appropriate for adolescents with low substance use problem severity (experimental and regular use) and those who do not meet the diagnosis for a substance related disorder. Also called Secondary Prevention.

Family: The nuclear family (e.g., parents, grandparents, siblings, step-parents, adoptive parents, foster parents, or legal guardians), extended family (e.g., aunts, uncles, cousins), significant others, mentors, or persons viewed as family members by the adolescent receiving services.

Family Therapy: SUD treatment and intervention services that include family members. While family therapy make take on a variety of forms, based on the needs of the adolescent and his/her family, the purpose of family therapy is to take into account the psychosocial environments in which the adolescent lives and may return to once SUD services are complete. By utilizing family therapy as a tool for adolescent SUD treatment and recovery, family members can provide social support to the adolescent, help motivate him/her to remain in treatment, and receive help and support for their own family recovery as well.

Group home: A facility licensed by the Department of Social Services, which provides 24-hour nonmedical care and supervision to adolescents.

Intake: The process of determining that a client meets the medical necessity criteria and is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders, the diagnosis of substance use disorders, and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.

Intensive Outpatient Treatment: The level of care equivalent to Adolescent Level II in the ASAM criteria. This level of care is usually provided in a school or community-based program that extends the school day to include a wide array of services. It is appropriate for adolescents with severe problems related to their substance use that have the potential to distract from recovery efforts.

Interim Substance Abuse Services: Supportive services such as counseling, food and clothing for individuals, often adolescents or other vulnerable populations, who are awaiting a space in an appropriate SUD treatment program, with the objective of helping them maintain a commitment to seeking SUD services.

Medical Necessity: Pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient.

Medically-Managed Residential Treatment: The level of care equivalent to Adolescent Level IV in the ASAM criteria, and is provided only in a hospital setting.

Medically-Managed Services: Services that involve daily medical care, where diagnostic and treatment services are directly provided and/or managed by a licensed physician. Services are generally provided in an acute care hospital, psychiatric hospital, or licensed treatment unit.

Medical Psychotherapy: Type of counseling services consisting of a face-to-face discussion conducted by the Medical Director of the NTP on a one-on-one basis with the patient**.**

Medication Assisted Treatment (MAT): The treatment of addictive disorders, especially opioid and alcohol dependence, assisted by the use of medications. This

procedure includes the ordering, prescribing, administering, and monitoring of all medications for SUD.

Mutual Aid Groups: Sometimes called self-help groups or support groups, are community-based groups where people recovering from drug and alcohol addiction meet to support each other. Mutual aid groups can serve to help people achieve sobriety, but most often they exist to help them maintain it over the long run. Most mutual aid groups meet face to face, but there are web-based groups as well.

OBOT: Office-based opioid treatment.

Outpatient Treatment: The level of care equivalent to Adolescent Level I in the ASAM criteria. This level of care may be provided in any age-appropriate setting and is appropriate for adolescents with low to medium problem severity.

Patient Education: Research based education on addiction, treatment, recovery and associated health risks provided to clients receiving substance use disorder services.

Placement: Both the settings in which services may take place and the level of care that patients may receive in particular settings. Appropriate placement identifies how care settings may be matched to patient unique needs and characteristics.

Pv: Prevention

Qualified Adolescent Health Professional: The areas and functions for which a staff person is qualified will depend on individual and program/facility State licensing, certification, and regulatory requirements. Examples of positions that are qualified for particular functions include MD, MFT, LCSW, LPHA, and a certified Alcohol and Other Drug Counselor.

Recovery Navigation: See Case Management; an ongoing process by which the program establishes linkages with other service systems and its providers, acts as liaison between the adolescent and those other systems, and coordinates referrals to ensure access to necessary services to assist adolescents and their families to address their special needs.

Recovery-Oriented Systems of Care (ROSC): An orientation to all stages in the COC that relates each stage after primary prevention to the maintenance and support of recovery. ROSC suggest a network of services and supports to address the full spectrum of substance use problems, from harmful use to chronic conditions.

Screening: The use of a brief and simple tool to identify adolescents who may need substance abuse treatment by uncovering indicators of substance abuse disorders.

Short-Doyle: A claims processing system that enables California county Mental Health Plans (MHPs) to obtain reimbursement of Federal funds for medically necessary specialty mental health services provided to Medi-Cal-eligible beneficiaries and to Healthy Families subscribers diagnosed as Seriously Emotionally Disturbed (SED).

Social Determinants of Health: The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

Substance Abuse: Alcohol and other drug abuse.

Substance Use Disorder (SUD): Either substance abuse or substance dependent as defined by DSM 5.

Telehealth: The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include, but are not limited to, videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Transitional Age Youth (TAY): Individuals between the ages of 18 and 25 years. They have unique service challenges because they are too old for child services but are often not ready or eligible for adult services.

Trauma: Event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Trauma Informed Care: A program, organization, or system, including an organizational structure and treatment framework, that involves understanding, recognizing, and responding to the effects of all types of trauma. It realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices. Additionally, it seeks to actively resist re-traumatization by emphasizing physical, psychological, and emotional safety for both consumers and providers and helping survivors rebuild a sense of control and empowerment.

Validated Screening Tool: a screening tool that is appropriate for the client, and his or her situation, as defined by SAMHSA'S Treatment Improvement Protocol (TIP) Series, No. 31.

Withdrawal Management: A process that systematically and safely withdraws people from drugs and alcohol, usually under the care of a physician or requiring medical monitoring and management; previously known as detoxification.

Youth: The period of life between childhood and maturity. For the purposes of this document, youth are identified as 12-18 years of age.

Youth Development Philosophy: A concept that promotes developmental asset building, social supports and services, and job skill and workforce opportunities to help reduce problem behaviors and produce positive long-term outcomes for adolescents.

Youth in At-Risk Environments: Adolescents whose environment increases their chance of substance use, dropping out of school, teen pregnancy, and involvement in criminal activity.