Youth Advisory Group (YAG) World Cafe Feedback on
Youth Substance Use Disorder (SUD) Commitments and Strategies

Commitment and Strategy	YAG Feedback	Action
C1 reads: Adolescents with a SUD shall receive treatment services that lead to obtaining a life of sustained health, wellness, and recovery.	Add "and supports" so it reads: Adolescents with a SUD shall receive treatment services and supports that lead to obtaining a life of sustained health, wellness, and recovery.	**Commitment 1 has been changed to read:** Adolescents with a SUD shall receive treatment services and supports that lead to obtaining a life of sustained health, wellness, and recovery.
	Expand funding to include community activities to increase protective factors.	
	Define sustained health, wellness, and recovery.	Sustained health, wellness, and recovery are defined in the Youth Services Policy Manual (YSPM).
	Don't invest in interventions that don't work.	
	Address key issues of the client during assessment - problem may be related to other things and not just SUD, e.g., Harm Reduction.	The YSPM addresses assessments and co-occurring disorders (COD).
	Define treatment - expand definition.	Treatment is defined in the YSPM.
S1 reads: Ensure youth treatment facilities maintain high quality, effective, and developmentally appropriate care for their clients.	Waiver needs more youth funding.	

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	Staff burnout, rotation, no consistency. Take into consideration the staff. Shouldn't have to be an expert in all areas. Find the strengths of everyone…meaning those providing services, i.e., those who work with adolescents.	
	Add settings to include schools and services not just "facilities".	**Strategy 1 has been revised to read:** Ensure youth treatment settings maintain high quality, effective, and developmentally appropriate care for their clients.
	Establish rates that ensure high quality - same rates as mental health Medi-Cal.	Rates are established by California Welfare and Institutions Codes §14021.9 and California Code of Regulations Section 50516.1, Title 22. Providers can consider using discretionary funds which will increase allowance.
	SB 238: Educate social workers, foster youth, probation & courts on substance abuse. Funding is needed to implement SB 238.	
	Educate mental health staff on substance abuse.	
	State departments need to do a better job streamlining, educating.	
	Holistic care. Need to learn appropriate coping skills to maintain abstinence.	
	After care.	
	Address co-occurring mental health and substance abuse.	COD is defined in the Appendix of the YSPM. Mental health and substance abuse COD is discussed in Section 5.11.
	How do you address a safe school environment?	

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	What is "effective, and developmentally appropriate"?	This is identified in the YSPM Chapter 5. It states: Developmentally appropriate care takes into consideration the "cognitive and developmental level, physical and emotional growth, behavior, values, beliefs, and cultural differences among adolescents." Effective treatment is based on evidence based practice and should consider: •Developmentally appropriate care •Cultural and language competence •Social determinants of health •Gender identity and sexuality •Gender specific environments •Adolescent-guided care (client-centered care approach) •Family-centered care •Adolescent development approaches to treatment •Transitional age youth development •Family intervention and support systems •Co-occurring disorders •Alcohol and drug testing with individual treatment plan •Information and communication technology
	Break down the line between prevention and SUD treatment.	
S2 reads: Communicate effectively and engage in partnerships with counties and other stakeholders.	Primary care needs to be stronger partner.	**Strategy 2 changed to read:** Communicate effectively and engage in partnerships with counties and other stakeholders (e.g., pediatricians or other primary care providers).
	Get the word out - chapter legislation.	
	Bridge the gap between agencies along the Continuum of Care.	

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	Communication - resources need to be available to everyone involved. How can we make data accessible to everyone (e.g., providers, schools, individuals, etc.)?	
	Engage partners through equitable funding	
	More coordination with student assistance programs so they don't get kicked out of school and are able to get the help they need. •Help build mental health assistance. •Get involved with activities, good alternatives (Friday Night Live).	
	Referral process, website, people don't know where to go for services.	
	Schools - important area and should be active partners. Need less stigmatizing. Allow student/youth to go to on-site school setting vs. drug treatment center.	
S3 reads: Encourage and support the submission of quality adolescent SUD treatment data to DHCS.	Improve TA with data.	
	More current data. Universities already have the programs for data analysis.	
	Need outcome data and relevant analysis.	
	Require all school districts to participate in Healthy Kids Survey. Due to funding cuts schools no longer participate.	

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	Common function assessment. Common tool that we all use. Better indication of how we are all doing.	
C2 reads: Adolescents with a SUD shall receive individualized care that is developmentally appropriate to address cognitive, social, emotional, or developmental delays/differences.	Add: …in a family context, if appropriate, client-centered.	
S1 reads: Ensure youth treatment facilities maintain high quality, effective, and developmentally appropriate care for their clients.	Different steps at different age.	
	Provide templates - protocol for developing appropriate care, eg. best practices.	
	Amend 1115 to allow up to 90 days for residential.	
S2 reads: Support integrated systems of care that focus on a holistic approach to SUD treatment services.	Funding sources •Different requirements (too many) •Early intervention not covered by some (for example)	

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Commitment and Strategy	YAG Feedback	Action
	Different data systems may impede. Who is necessary to make this possible?	
	Add Strategy 3 Tailor intervention to family's needs when necessary, for example, treatment setting.	**Added as Strategy 3 to Commitment 2** which reads: Tailor intervention to family's needs when necessary, for example, treatment setting.
	Add Strategy 4 Create case management/counseling services with different levels of treatment.	**Added as Strategy 4 to Commitment 2** which reads: Create case management and/or counseling services within different levels of treatment.
	Add Strategy 5 Expand funding sources and regulations to enable individualized treatment based on youth needs, for example, EPSDT, SB 75. DHCS work with CDSS & CBHDA on implementation of CCR.	
C3 reads: Provide SUD services to underserved, underprivileged adolescents identified to be in need.	Define underserved, underprivileged. Who is defining?	
	CalOMS is currently not the best way to identify the data. It doesn't capture EPSDT (for MH, COD) treatment data.	
	Adequate screening is important to reach youth. Why have they dropped out of school? Tough to engage. Note: This was a strong emphasis.	
	Providers not always diligent with inputting data. It is better now; make sure all data is being collected (rather than missed).	
	Need for transportation.	

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	Drug Medi-Cal can address SUD for adolescents. How is it possible to do services other than group counseling (e.g., EPSDT) for SUD?	
	Need clarity on how to provide services to targeted population.	
	How are standards of performance measured? What are the objective measures that identify what good data looks like? What are the common standards that constitute "successful discharge"?	
	Use other objective measures of treatment outcomes: school attendance, graduation.	
	SB 75 will increase services, regardless of immigration status. (Prior fear of immigration authorities).	No action required.
S1 reads: Ensure youth treatment facilities maintain high quality, effective, and developmentally appropriate care for their clients.	Cost of site-specific certification process for DMC ($2,500). The "program" should be certified for each of 10 schools, with some site oversight.	
	Funding isn't adequate	
	Need staff that are appropriately trained. Staff burnout.	
	Best practices guidance to allow flexibility in choice and use of EBPs to address county training variety and how to make treatment client-centered rather than program-centered: more consideration for cultural and linguistic needs.	

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	Treatment settings, e.g., home-based, etc. One can provide treatment in the home as done in mental health. This was a strong emphasis. **S1 reads:** *Ensure youth treatment facilities maintain high quality, effective, and developmentally appropriate care for their clients.*	
S2 reads: Engage and communicate effectively with counties and other stakeholders.	Help social workers, other agencies, and counselors understand that a referral for treatment is to help the young person (a boundary issue); it's not a punishment or harm to the youth.	
	LA schools do mental health training for student leaders; something similar for SUD/Pv?	
	In light of Institute of Medicine framework on universal prevention, use social media and public media (TV, radio, papers) to reach a wider audience. Note: Many Latino families lack other items, but they have mobile phones. The use of an electronic device was a strong emphasis by other participants.	
S3 reads: Encourage and support the submission of quality adolescent SUD treatment data to DHCS.	Add "and outcomes".	**Strategy 3 has been changed to read:** Encourage and support the submission of quality adolescent SUD treatment data and outcomes to DHCS.

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C4 reads: Adolescent SUD treatment services shall be delivered with cultural and linguistic competency, and shall contain family-centered support, when appropriate.	CLAS standards training • Sac & Alameda are doing it • Have a youth "voice" in the standards • Sexual orientation - how does the state support this?	
	Evidenced-based practices should be included.	
S1 reads: Ensure youth treatment facilities maintain high quality, effective, and developmentally appropriate care for their clients.	If aiming at cultural/linguistic competency, do we do TA? • Add Celebrating Families.	
S2 reads: Enhance outreach and education to counties and other stakeholders.	Youth and family friendly settings • Home • Youth club • School • New environment/engage with peers • After school events, resources o Free meals	
	Need to clarify funding responsibilities and program boundaries first.	

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	Need "ethnic champions" • Some to represent all cultural categories • Include LGBTQI	
	Need more collaboration with student assistance programs with SUD piece.	
	Culturally specific may not be an EBP • Programs • Techniques • Approach *Same as above.*	
	How to encourage doctors and mental health professionals to expand their expertise.	
	Trauma informed services including treatment services (e.g., trauma-focused cognitive behavioral therapy).	
	Culture of trafficked youth (sexually or forced menial labor).	
S3 reads: Encourage and support the submission of quality adolescent SUD treatment data to DHCS.	Have DHCS share graphs (Denise's) with counties and the California Department of Education.	Shared for the April YAG meeting via email on 4/22/16 and at the Behavioral Health Forum on 7/22/16.
	Primary care and county behavioral data sets need to be merged - integration of data with standard format.	
	Data requirements are labor intensive.	
	Look at prevention program - marijuana.	

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	Prevention/substance education before the age of 12.	
C5 reads: Adolescent SUD treatment services will be delivered in compliance with DHCS policy and guidelines.	Certifying organization - will they be training to youth guidelines?	
	Clinician to be informed of the guidelines - disconnect between language and practice.	
	Mental health SUD guidelines/workbooks to be used during services. Felt that there should be some sort SUD guideline to use.	
	Licensing issues, funding/training (who)-->there needs to be consistency. More interconnection between DHCS & CDSS. Too many contradictions.	
	Policy title 22 does not match youth Tx guidelines	
S1 reads: Ensure youth treatment facilities maintain high quality, effective, and developmentally apropriate care for their clients.	Change wording: Ensure youth treatment settings maintain high quality, effective, and developmentally appropriate care for their clients. (Facilities needs to be broaden to schools, homes, etc. Many did not like "facilities".)	**Strategy 1 has been changed read:** Ensure youth treatment settings maintain high quality, effective, and developmentally appropriate care for their clients.
	Evidence-based funding.	
	Overall problem behaviors risk/projective factors need to be addressed early.	
	Break down steps of the continuum of care.	

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	In DHCS SUD services, costs for site certification are a barrier and forcing providers to consider program cuts.	
	• Best practices broken down by age, e.g., appropriate care for youth. • What is meant by facilities? Place/building?	
	Ensure that DHCS policies/requirements are youth friendly and collaboratively structured with CDSS.	
S2 reads: Ensure that the workforce is trained and informed to provide quality SUD treatment services to adolescents.	Adequate salaries/compensation	
	Overall drug education health class.	
	Partner with vocational schools to ensure training.	
	Train county on adolescents and adults.	
	Counselors - required (CEU related) Licensed Practitioner of the Healing Arts or license waiver.	
	Need of minimum certification by DHCS and California Department of Public Health new tele-tech-training services.	
	Rural areas	
	SUD - mental health training assumption.	
	Terms? Define age range for adolescents.	

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	PARKING LOT **Created during World Café at YAG meeting**	
#1	Add students to solve problems •They are part of solution •Assist with Interventions •Conversation starters •Peer counselors •Network with people inside the schools	
#2	Integration of existing program components	
#3	How do you get people in the community to have a discussion on what they need	
#4	Engagement	
#5	Parents should be educated.	
#6	Don't exclude financially privileged. We are missing the SUD youth from within upper-income community: reach out to PTA, gym club, etc. Use social media.	
#7	How do you engage the family under minor consent?	
#8	Services to youth are not provided in "facilities".	
#9	Expand SB 1101	
#10	SB 614 - peer support	
#11	Can't do treatment unless underlying issues are addressed.	
#12	There is a disconnect with responsibilities and defintions under EPSDT.	
#13	Lack of utilization of EPDST in SUD Tx.	
#14	When does the state plan to implement the guidelines; everything in general?	
#15	Need more early intervention programs.	
#16	Not enough services between Pv and psychiatrist.	
#17	Reduce burn out with excessive paperwork (Drug Medi-Cal/Medi-Cal) due to different funding requirements.	

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Added note from World Café	The following should be addressed in **all commitments:** •There are funding issues. •Treatment must be client-centered. •Funding should be in all commitments. •Transportation should be in all commitments. •Family-centered treatment.	
WHO should be included		
	CBHDA	
	CDSS	
	CPS	
	Cultural competency committee	
	Family members, organizations or associations	
	Legislators	
	Local hospitals	
	Mental Health, especially to encourage SUD screening and referrals	
	Pediatricians	
	Peer support specialist	
	Providers actually doing the work	
	PTA	
	School officials/educators	
	SUD community-based organizations	
	Youth receiving Tx and Pv	