* denotes crossed-out words.
** denotes underlined words.
*** denotes either bolded words or words in red color.

Youth Advisory Group (YAG) Feedback (DRAFT)

Revised 06/09/2017
ADA Compliant

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
1 - Introduction	1	•Delete first paragraph. Move this to an historical/background in Appendix or connect to Funding Section 10 •2nd Paragraph Change last sentence: delete "along with considerations for services" and add Institute of Medicine and Model after Care. The YSPM sets the minimum standards for delivery of services *~~along with considerations for services~~* across the ***Institute of Medicine Continuum of Care Model (COC).*** •Third paragraph: delete Comment: Generally, the document is too long; I would not include intentions throughout the document.
	1	Comment: Would this also be the place to discuss how EPSDT funding for youth with SUDs fits into the overall funding picture?
	1	Highlighted "treatment for adolescents". Comment: If the title of this document is “Youth Services Policy Manual,” then the introduction should cover that topic, but it focuses on Tx.
	1	Highlighted adolescents in second paragraph. Comment: The title of the document is “Youth Services Policy Manual.” However, the entire document refers to adolescents, not youth. Be consistent. In fact, I do not see youth referenced anywhere in this document, but the title.
	1	Highlighted "Considerations". Comment: What is meant by “considerations?” If this document sets “standards,” but the title states “guidelines.” Are they requirements, or just considerations? If you are writing about both, the document needs to be clear what is a requirement, what is a guideline, and what is a consideration. And you should define what is meant by all three in the introduction. If this is going to be a part of the State/County Contract, then all of it is requirements. If not, then this document is a recommendation. But this definition states minimum standards. A standard is merely a level of quality considered acceptable or desirable. A standard is not a requirement. And the title of the document refers to a “policy” manual. Be clear.
	1	Highlighted "Continuum of Care (COC)" http://www.ncbi.nlm.nih.gov/pubmed/10293297

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
		Highlighted "educational resource" in 3rd paragraph. Comment: First it is a document of policies, now an educational resource. I do not believe this document serves as an educational resource. There are not even definitions in the narrative or a mention of best practices.
	1	Highlighted "guide for juvenile and family court judges for choosing and placing adolescents" in 3rd paragraph. Comment: This guide is not and should not be a program placement guidance for juvenile offenders. The guide does not speak to the topic enough to take this on. This guidance is for service providers under DHCS SUD. Now, the author is saying that it is going to tell other public service systems what they should do. Be cautious. It is okay to say that the document supports SUD health care providers that work with other systems of care for placement services. But, I wouldn't put that in the introduction. You have a section for "Placement."
	1	Highlighted "Continuum of Care Model" in Figure 1 title. Comment: Is COC a requirement? http://www.ncbi.nlm.nih.gov/pubmed/8694389 http://www.himss.org/definition-continuum-care
	1	Comment: Who is the primary audience for this manual - Counties and service providers...?
2 - Target Population	2	Population highlghted with comment: Include concept of Population Management.
	2	Highlighted "target population". OWYPS has a document available entitled "Co-occuring Disorders (COS) Tx and Improved SUD Services for Youth. This document states that youth refers to minors and young adults up to age 26. Make sure that the public documents that exist match with what this policy manual intends. If you do use this definition, then TAY would adequately be included.
	2.1	Highlighted "adolescents between the ages of 12 and 18". Comment: Adolescents? Not youth? This is the target population for this manual that supposed to be across the continuum.

Youth Advisory Group (YAG) Feedback (DRAFT)

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	2.1	Highlighted "determined eligible". There are no eligibility criteria for most universal/selective intervention under Pv.
	2.1	Highlighted "validated". Is there a system/process in place that validates screening tools? Who does this? And if there are already “validated” screening tools, this document should provide a list of what screening tools can be used.
	2.1	Inserted: EPSDT mandates services up to age 21 - DMC services for adolescents will use EPSDT. Comment: A very good reason to rethink the description of the target population, etc.
	2.1 & 2.1.1	Comment: Would recommend using one term consistently throughout the manual for this population, i.e. either ''youth" (as per the title of the manual) or "adolescent." SAPC uses "youth" for 12-18 year olds and "young adult" for 18-25 year olds. Comment: Since the focus of this manual is on services for youth (under 18), it's a little confusing to include a whole section on TAY/young adults (although it is useful to call them out as a special population in need of developmentally appropriate services). It seems a separate manual targeting services for young adults would be more appropriate. Comment: The target population for this manual is adolescents between the ages of 12 and 18.The manual then goes on to define TAY as 18-24. It is recommended that age of adolescents follow national survey category guidelines of 12-17 (i.e., MTF and NSDUH). Comment: The manual indicates (under target population) that eligibility needs to be determined by ''validated screening tools." It is recommended that guidance be given by the State on specific validated tools to use.
	2.1.1	Highlighted "Transitional Age Youth (TAY)". If you address TAY in this document, then the first sentence under 2.1 is false because the manual doesn’t only cover the stated ages, it also covers TAY.
	2.1.2	Inserted after 2.1.2: Introduce concept of risk stratification and severity - not a homogenous group.

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	2.1.2	Comment: The manual specifies that admission priority shall be based on program design, client assessment, and clinical judgment. Clinical judgement is critical with youth. It is recommended that the State develop staffing/workforce guidelines, including how DHCS plans to determine clinical judgement standards for LPHA's who conduct the assessment.
	2.1.2	Highlighted "Admission". Admission to what? This makes sense if you are speaking about indicated interventions, Tx, and recovery. Put it under the appropriate heading.
	2.1.2	Comment: Our admission priority is established by our P&P and the ASAM level of care.
3 - Outcomes	3	***Add "mental" to sentence:*** This includes addressing family and community influences, home environment, and integrating physical, ***mental,*** and behavioral health into the SUD services.
	3	Adolescents are a *~~sensitive~~* ***diverse*** population ***with multi-dimensional developmental and cognitive needs. System will*** *~~that~~* require a comprehensive ***assessment of needs, strengths, and deficits in order to establish the interventions*** *~~level of care~~* to obtain the best possible outcome. *~~for themselves and , their families, and their community.~~* ***Best outcomes will be influenced by a whole person approach.*** *~~A comprehensive level of care means that the system must serve the adolescent as a whole.~~*
	3	Highlighted "OUTCOMES". Comment: This is not a strategic plan. It is a Policy Manual. Are you saying that if an agency meets all of the requirements, they will achieve these outcomes? I am not sure that the two are a connection. Outcomes are successful by assessment- driven objectives (planning) and implementation (program).
	3	Highlighted "sensitive population". Comment: Why? Explain if you are going to label a population. Why not resilient?

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	3	Highlighted "the best possible outcome for themselves, their families, and their community". Sounds like the target population is more than just adolescents: themselves, their families, and their community.
	3	Highlighted "comprehensive level of care means that the system must serve the adolescent as a whole". This is an approach.
	3	Highlighted "behavioral health into the SUD services". Behavioral health includes SUD and MH. You cannot integrate behavioral health into SUD because SUD is a component of behavioral health.
	3.1	Changed subtitle: System-Level Outcomes
	3.1.1	Changed to read: The need for increased adolescent-specific programs/treatment capacity;
	3.1.1	re. Increased adolescent-specific programs/treatment capacity: Comment: How is Increased "adolescent-specific programs/treatment capacity" operationalized? Does treatment capacity mean access to a developmentally responsive full continuum of care (early intervention, outpatient, intensive outpatient, detox, residential, medically assisted treatment)? Do adolescent-specific programs mean developmentally appropriate evidence-based programs (EBPs) and inclusion of family services, case management empowerment models and youth-centric aftercare -OR does this mean staffing/workforce capacity (knowledge, competency in adolescent specific programs/skills)?
	3.1.2	Specify whose awareness, i.e., teens, parents, teachers, etc.
	3.1.2	Increased awareness of and access to adolescent specific services; Comment: How is increased "awareness of and access to adolescent specific services" defined? Does this mean outreach efforts to community (parents, schools, juvenile justice, etc.) or wellness promotion?
	3.1.3	How is "increased quality of services" defined?

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	3.1.3	Comment: How is increased quality of services operationalized? This is a performance metric. Will this include performance quality indices of access (reduced wait-time, appropriate placement, engagement, retention, client satisfaction/perceptions, care coordination, and fidelity of EBPs)?
	3.1.4	Achievement and maintenance of a COC for adolescents: Comment: What is meant by "Achievement and maintenance of a COC for adolescents?" Does this mean successful transfers/referrals within the clinical COC? Does this mean successful linkages with primary prevention-early intervention to clinical treatment COC coordination? Does this mean successful transfers from clinical COC to aftercare? What about wellness promotion?
	3.1.5	Comment: How is "Promote safe and healthy behaviors and environments for adolescents, their families, and their communities" measured? Does this include movement along SUD behavioral spectrum, number of successful treatment episodes, number of successful care coordination efforts with health care, number of successful care coordination efforts with school health centers?
	3.2	Comment: This manual introduces Wellness and Prevention but does not include the outcomes of those interventions in outcomes.
	3.2	Highlighted "Adolescent Outcomes". Above you state “the best possible outcomes for themselves, their families, and their community. So you should have outcomes for all three.
	3.2.1	Edited to read: Remission of a SUD or reduced symptoms; Comment: (not all youth seeking services want to completely stop use.)
	3.2.1	Comment: What is remission of a SUD? Is this a movement along SUD behavioral spectrum or relapse? Comment: How is this defined? Important if outcome to be measureable. Similarly how to we define . recovery for youth, and is this strictly abstinence based?

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	3.2.1	Highlighted "remission of SUD". This is not a positive outcome. Maybe “decrease Tx admissions for adolescents,” “decrease relapse occurrences for adolescents in recover”, “increase participation of Pv services among adolescents”
	3.2.2	Comment: How will improved level of functioning in major life domains be measured? Will SUD recovery measures include adherence to and participation in recovery behaviors (aftercare, recreational, goal attainment)? Will education measures include absenteeism, truancies, attachment to school, grades/performance vs. in school? Does employment include a grit/vocational aptitude? Does family relationships include measures on conflict/communication? Does social connectedness include measures of volunteerism? Does physical well-being include measures of disability, impairment in functions, health care perceptions?
	3.2.2	Highlighted "level". Individual level? What is meant by this? How do you measure the level of functioning? Maybe improve level of wellness and use the 8 domains stated on pg. 4. The document needs to match.
	3.2.2	Highlighted "SUD recovery". SUD recovery is not a life domain, it is a service.
	3.2.3	Highlighted "least restrictive settings". What does this indicate? Some youth may need restrictive settings dependent upon their Tx plan. A policy manual cannot tell a provider what is needed for every patient.
	3.2.3	Comment: Clarify that this is treatment placement and not housing placement.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
4 - The Continuum of Care	4	Comment: The continuum of care should clearly describe the approach that the counties and providers should follow. Based on this section, the Recovery Oriented System of Care (ROSOC) approach and guiding principles should be the framework for the Youth Service Manual. Comment: ROSC for adolescents emphasizes the importance of: adolescent-guided care; family- centered care (employs a broad definition of family); age, culturally, 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. Comment: If this is required, recommend detailing as a footnote what standards/expectations will be for Counties and by extension providers. Also need to confirm that this approach is appropriate for all youth populations.
	4	Highlighted "Continuum of Care". Comment: http://nationalacademies.org/hmd/activities/children/childrenshealthforum/2015-nov-19.aspx

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4	A fundamental principle *~~in working with adolescents~~* is that SUD services are provided to youth *~~within a holistic~~* **throughout the** COC. The COC begins with **primary Pv** 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: Comments: Highlighted "holistic" above. This term can have different connotations and you have not defined what is meant by this for this manual. Highlighted "promote wellness" above. The entire COC promotes wellness. Highlighted "the following major strategies" above. These are not strategies. Promotion includes strategies. The others are referred to as services, according to SAMHSA.
	4	4.1 Wellness promotion 4.2 Primary prevention 4.3 Early intervention 4.4 Treatment 4.5 Recovery services Comment: These numbers do not align with the narrative.
	4	2nd paragraph: Each *~~aspect~~* **service type** of the COC plays an important role in the prevention, treatment, and recovery of adolescents with SUDs. Comment: This sentence does not make sense for Pv. Pv of adolescents does not include an adolescent with an SUD.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4	3rd paragraph: 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. Highlighted "within the different SUD services" above. Comment: Not Pv. Once u have diagnosis, you are not eligible for Pv. Highlighted "adolescents will utilize the services on the COC multiple times at different points in their recovery" above. Comment: Again… not Pv. Not just through recovery, but from secondary Pv and on.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4	4th paragraph: 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. “A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.” The central focus of a ROSC is to create an infrastructure or ‚system of care‘ with the resources to effectively address the full range of substance use problems within communities. Highlighted first sentence. Comment: Where does it state that this is a requirement for youth? Because if a requirement already exists, it should be explained more. If the ROSC is so crucial, why is this the only place that it is mentioned in this entire manual? Highlighted "at every level of substance abuse and SUDs". Comment: The doc has not discussed “levels of substance abuse” nor has it defined or stated what the difference is between substance abuse and SUDs. If there is a difference. Highlighted 'full spectrum' Comment: What spectrum? Highlighted and crossed out: 'from harmful use to chronic conditions' Comment:This assumes that “harmful use” is not chronic. I don’t think this is good terminology when discussing Tx. If you need Tx, you need help for an SUD. Is there a medical process that terms/categorizes the severity of an SUD? Comment on inserted sentence "A ROSC is a coordinated..." The ROSC would be like a “collective impact” for SUD services. 5th paragraph: 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.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4	Highlighted 'ROSC' Comment: Is this manual enforcing ROSC as a requirement? If so, how will an analyst monitor to this? If the manual introduces ROSC as the approach for this document, then services should tie into the ROSC approach. Since it is discussed here, it appears to be the set-up. Highlighted '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' Comment: It sounds like there is a definition/process for "adolescent-guided" and "self-directed" approaches that are not discussed. If these are approaches specific to youth in Tx, maybe it can be discussed in youth development under Tx. Highlighted 'adolescent-guided and family-centered' Comment: Adolescent-guided, family-centered, and self-directed. How do all three of these approaches combine to do what? Highlighted 'young adulthood' Comment: Are we also talking about young adulthood? Because that's not what was identified in the target population. 6th paragraph: When delivering implementing 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. Highlighted 'youth' Comment: Using youth, not adolescents? Highlighted 'must coordinate the relationships between promotion, prevention, treatment, and recovery' Comment: This manual could do this. The word relationship is the direct object here. These entities need to coordinate services through collaboration (referrals). Highlighted 'These relationships are frequently overlooked, opportunities for collaboration are missed, and outcomes are compromised.
	4	4th paragraph edited as: 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 the full spectrum of substance use problems, from harmful use to chronic conditions.

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4	Last paragraph highlighted "These relationships are frequently overlooked, opportunities for collaboration are missed, and outcomes are compromised." Question: Could this be phrased more positively so that it is strength-based?
	4.1	This term can have different connotations and you have not defined what is meant by this for this manual.
	4.1	Highlighted title 'Wellness Promotion'. Comment: This section is all definition. Not requirements. How does this relate to policy?
	4.1	1st Paragraph: Promotion *~~activities~~* strategies 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." Highlighted first sentence. Comment: Promotion is not the "first part" of the COC. It is throughout the COC. That's why it is on the bottom of the COC diagram. Comment regarding suggested deletion: This is personal commentary.
	4.1	Highlighted "has identified effective tools and interventions" in 3rd paragraph. Comment: How do these relate to policy and requirements? This document is intertwining definition of national/state initiatives and requirements. Very confusing if you do not link the two.
	4.1.1 and 4.4.4	These are not strategies. Promotion includes strategies. The others are referred to as services, according to SAMHSA.
	4.1.1	In my experience, prevention is currently not very well equipped to manage client records (although we need to be) and this would require HIPPA training - just a thought to keep in mind.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.2	Primary Prevention Comment: The title of this manual is Youth Services Policy Manual. Youth is the target population for Pv services, so I would expect Pv to receive a majority of this manual and there is only one page. It looks like Pv implements the least services to youth, when it is actually the opposite. Pv implements the most services to this population. This Youth Manual makes it look like Pv does nothing for youth in comparison to the other COC services.
	4.2	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. Comment: This is what's in the CFR. And there is a reference to high risk which would refer to indicated interventions.
	4.2.1	Comment in regards to sentence: The SPF is built on a community-based risk and protective factors approach to prevention. Is it possible to require that SPP plans have documented efforts to include adolescent SUD treatment providers &/or county adolescent treatment administrators in the SPP development? Perhaps include list of required or highly recommended stakeholders. Something that shows coordination and alignment between the treatment world and the primary prevention world.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	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 **that are engaged in a strategic Pv planning process**. *~~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~~* The five SPF steps are: Comment: Pv has a system to monitor against and the documents to support state requirements from counties. We do not need another document. Re. Strategic Prevention Plan (SPP) Comment: This is not in CFR, but it is under the CFR definition. This is a SAMHSA guidance and is in the State/County Contract. Re. culturally appropriate and sustainable Comment: Cultural competence and sustainability are guiding principles throughout SPF. Comment: The SPF is not built on a community-based risk and protective factors approach to Pv. The SPF is a framework to engage participants in strategic planning. Risk and protective factors is a model used to identify and prioritize factors to identify the best strategies to implement. Other models are the public health model, Youth Asset Development, and FNL's standards of practice. Risk and protective factors are referred to in this document and it belongs under Pv and can be used in other COC services. Yet, the document does not discuss what Risk and Protective Factor Theory is.
	4.2.2	Comment: The manual indicates that SAPT funded primary prevention programs must employ, at a minimum, one staff person that possess a prevention certificate. It is recommended that DHCS provide information about this certificate. Comment: Is this a future requirement and when will counties be notified of this requirement.
	4.2.2	SAPT funded primary prevention programs must employ, at a minimum, one staff person that possesses a prevention certificate. ***Why is this a must? Not sure what a prevention certificate is. This should be spelled out.***

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.2.2	Added: Effective -----, Comment: WHEN IS THIS IN EFFECT? WILL THERE BE ADEQUATE CAPACITY TO PROVIDE THIS CERTIFICATION? MUST THEY HAVE THE CERTIFICATE TO BE HIRED OR CAN STAFF OBTAIN IT AFTER THEY ARE HIRED?
	4.2.2	What type of certificate is required? Is there a grace period for agencies who apply for funding or is it required prior to grant application etc.
	4.2.2	Is this for county staff, community-based organizations, or both? Is this something that will be monitored by the state? The prevention coordinators were told that the certification was not a requirement, so this may be a shock for them and contradictory to the information previously provided. Perhaps the message could be that it is recommended that SAPT funded primary prevention programs consider prevention certification.
	4.2.2	Comment: It is too early to require this. I know we are moving in this direction, maybe? A lot of work internally needs to be done before Pv can monitor to this. We should look at college courses to see what other types of education could suffice. We have yet to build a Pv employment ladder. The certificate does not indicate a promotion or hiring. Pv has leads that have been doing Pv for 20 plus years and now they have to get a certificate that doesn't mean anything. No career path, no raise… Yet, the possessor has to pay to maintain the certificate. This requirement needs to be a win-win. We are not there yet.
	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~~* **<u>The</u> 45 CFR 96.125 <u>classifies six strategies</u>** for Pv activities: Comment: What is meant by this? The introduction to the manual already stated a target population. Comment: Pv monitors to this according to State County contract through data reviews and budget reviews.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.2.4	*~~In alignment with the county SPP, the selected~~* Prevention strategies shall target **<u>individuals, groups, and communities</u>** *~~populations with different~~* according to their level~~s~~ of risk. **<u>The Institute of Medicine classifies Pv interventions as follows</u>:** Comment: http://www.cars-rp.org/publications/Prevention%20Tactics/PT8.13.06.pdf (a) **<u>Universal:</u>** *~~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.~~* Comment re 'Universal, Selective, and Indicated prevention': This is part of the COC and I am surprised that there is not more information to explain this. Comment re 'targeted population': Use caution with this term because SAMSHA has already defined the target populations for Pv on their website. (b) <u>Selective:</u> *~~Selected prevention strategies shall assist in increasing protective factors and decreasing risk factors.~~* (c) <u>Indicated:</u> Comment re (b) and (c): There should be a component for Pv Theories and Frameworks Comment re (c): These interventions are critical to discuss in terms of discussing services across the COC. This is where youth who are at high-risk of developing an SUD receive services. These services may lead to a referral to Tx assessment.

Youth Advisory Group (YAG) Feedback (DRAFT)

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	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:~~* Comment: This is part of SPF, not a separate requirement. (a) Be Evidence-Based Programs (EBPs) and/or innovative programs that *~~best serve targeted populations*~~ **<u>address the needs identified in the Assessment of the SPP</u>.** (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." Comment for (a) and (b): Comment: Utilizing EBPs is a requirement that can be implemented across the COC, not just PV.
	4.2.5 a&b	Should this be either or? Otherwise it reads that programs implemented must be EBPs AND on NREPP. In the field there are programs that may be EBPs but on listed on NREPP.
	4.3	Pv monitors to this according to State County contract through data reviews and budget reviews. Pv monitors to this according to State County contract through data reviews and budget reviews.
	4.3	Comment: The level and specificity in the outreach and engagement is vague. It is recommended that evidence-based models be cited to support this section
	4.3	Is section 4.2 the only section that applies to SUD prevention? From here on in the document terminology used is more relevant to treatment. Do the requirements in section 5 also apply to prevention?
	4.3	Outreach and Engagement Comment: This is not identified on page 3, nor is it on the COC. Outreach and engagement is how you inform people of the services you provide. It is not "service delivery." Might be under "Promotion."

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	4.3.1	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: Highlighted "early intervention, treatment, and recovery management services". Comment: Pv too.
	4.3.1	Comment: Depending on where this fits in the continuum, may need to broaden "abusing" language to include "experimenting".
	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 . Comment re 'services offered across the COC': Not primary Pv
	4.3.1.a	Comment: HOW IS THIS FUNDED?
	4.3.1.a	Edited as: Outreach efforts should include 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. Comment: This is not about encouraging youth to participate. This is about systems of care providing equitable and accessible services to youth. Also, outreach efforts should educate to diminish the stigma around accessing these services to increase youth receiving services. This, however, is not a requirement either. But accessibility can be if it is worded correctly. Comment: Requirement or high priority (recommendation)? This should move to COC section. Comment: Resource. Is family centered Tx a requirement?
	4.3.3	Comment: HOW IS THIS FUNDED?

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.3.3	Programs shall *~~place high priority on~~* **<u>collaborate</u>** outreach *~~linking~~* activities 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. Comment: Requirement or recommendation? Highlight: (a) Outreach activities Comment: Define outreach activities in the first paragraph.
	4.3.3-3a	There is great concern about the funding for these efforts. Outreach and engagement is very important; however, where will the funds come from to provide this service? The use of the word "shall" throughout this document puts counties and providers in a difficult position when there is little to no funding for what is required.
	4.4	Addresses Screening. It is not clear who will accomplish "shall place priority on identifying all at-risk adolescents." There is a large adolescent population in San Mateo.
	4.4	Screening Comment: Does this screening refer to Problem ID and Referral in Pv or Tx screening.

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	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. Highlighted "Qualified adolescent health professionals". Comment: Is this an actual profession? Is this document going to provide the criteria for what makes a health professional qualified? If not, then this term should not be used. Does SUD have the authority to tell the medical department who is qualified or not? Even if you use "health professionals that specialize in adolescent care" – I am unaware that there is a doctor as such, but maybe. Highlighted "MH". Comment: Unless MH is involved with this product, we cannot speak to MH issues, processes, and especially requirements. Highlighted "validated screening tool". Comment: "validated" screening tool is mentioned again. Who has the validating authority? If it is us, then we should be able to provide criteria. Highlighted 'must' Comment: Here, "must" is used. So, this is a requirement. Now, we should be specific with the who. SUD Professionals? Medical professionals? This doc does not have the authority to tell medical professionals what to do unless they work under SUD.
	4.4.1	Comment after 1st sentence: THE ONLY ADOLESCENT TOOL THAT SCREENS BOTH MENTAL HEALTH AND SUBSTANCE USE, IS THE AC/OK, AND IT HAS MORE THAN TEN QUESTIONS. CLINICIANS CAN ALSO USE CLINICAL JUDGEMENT TO SCREEN; THERE MAY BE TIMES WHEN IT IS NOT PRUDENT TO USE A SCREENING TOOL.

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	4.4.1	Comment: All youth are at risk for substance use issues. The American Academy of Pediatrics recommends that all youth be screened using a validated screening tool. Comment: Recommend providing examples of screening tools. Comment: There are few tools that screen for both mental health ·and substance abuse for determining co-occurring disorders. The State should provide definition of "at risk." It is not clear on what is an "at risk" adolescent population.
	4.4.1.a	Deleted 'all'. Comment: It would be impossible to identify every at-risk youth.
	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: Comment: I am assuming that SUD has the authority to tell PCPs how to do their work. And is it feasible for a PCP to provide “health education and screenings” during an appointment. Maybe SUD requires that counties have an SUD Health Education Specialist who could collaborate with PCPs to provide this service. Comment: If a behavioral health issue is a concern, then the provider should have a network of other health providers to refer youth for specific services i.e. further assessment.
	4.4.2	This is good but we need to make certain A, B and C are also assessed at the SUD provider level.
	4.4.2	Most SUD programs do not have PCPs and visits would not be considered "medical care visits". Is this intended for FQHC services? Perhaps there should be a distinction made by saying something like: "In primary medical care clinics, as part of all medical care visits..." Without clarification, this will be confusing to non-primary care SUD providers.
	4.4.2	Comment: What about substance use?

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	4.4.2.a-c	Highlighted entire section. Comment: WE CANNOT ADVISE PHYSICIANS WHAT TO ASSESS FOR AND CANNOT BE ACCOUNTABLE FOR THIS. IS THE STATE MEDICAL BOARD GOING TO ENSURE THIS?
	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. Highlighted "adequately navigate". Comment: You are expecting youth to “adequately” navigate SUD services. Adults can’t even do this. There needs to be an identified health professional to support youth ACCESS services.
	4.4.4	Is this for initial screening or is this including more in depth assessment?
	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 Highlighted "validated, developmentally appropriate". Comment: Reference to validated screening tool again Highlighted "The screening tool must, at a minimum, have the following characteristics". Comment: Criteria for screening tool. This is a requirement?
	4.4.4.a	Edited to read: Different entities may have time or resources to do more extensive screenings. They may want to do more extensive screenings for better place otucomes.
	4.4.4.a	Reference to validated screening tool again

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	4.4.4.a	Not sure what is meant by flexibility. Our county has a very brief screeing instrument that is 11 questions. Because a tool "must" have the characteristics as follows, we need to eliminate an important question. I suggest not placing a number here and let counties determine what is appropriate. To get at both SUD and mental health, ten or fewer questions may be difficult. The CRAFFT all by itself is 9 questions.
	4.4.4.f	Identification *~~of the need~~* for further assessment or intervention for both mental health and substance use Highlighted "mental health".
	4.4.4.g	Highlighted "false positives". Comment: What is meant by this? Stick to the facts.
	4.4.4.h	*~~alcohol and other drugs~~* an SUD Comment: Not sure what is meant. Provide AOD education? Or identify SUD through screening/assessment.
	4.4.5	Adolescents identified with a possible SUDs, as identified through the screening, shall be referred to a qualified adolescent SUD treatment or recovery services provider for a more comprehensive assessment for possible SUD diagnosis. Comment: Again, is there such a job title or is this document requiring providers to employ an “adolescent SUD services provider” Comment: You do not send a person who is in the process of being screened for an SUD to a recovery provider. Comment: More assessment.
	4.4.5.a	What if these services do not exist?

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.4.5.a	Adolescents *~~not referred for further assessment~~,* but who remain at risk, shall be referred to developmentally appropriate prevention or early intervention services. Highlighted "assessment". Comment: What is the criteria for a youth to not need further services? Comment: A&B discuss referral process. Referral should be a heading somewhere. Maybe “screening and referral.” Highlighted "developmentally". Comment: You have not defined “developmentally” appropriate Pv. Maybe use age-appropriate.
	4.4.5.b	We can make referrals, but youth may not follow up with them. The new provider may not be able to make contact- this is very common. We can follow up to see if they attempted contact, but we can’t ensure they can make contact. Furthermore, this process must be documented within the adolescent’s file.
	4.4.5.b	Highlighted "qualified health professional, or a professional within their office, is required". Comment: Requirement: how can you monitor to this? Can you tell the medical field what to do?
	4.4.5.b	Highlighted "…The referral was received and contact will…". Comment: THIS SEEMS INTRUSIVE- TO ASK A PROVIDER IF THEY WILL FOLLOW UP AND MAKE CONTACT. HOW CAN WE BE SURE THEY DO MAKE CONTACT?
	4.4.5.b	This type of service is most certainly ideal. Realistically, SUD services are very much underfunded in the state, so to require follow up would be burdonsome on providers. There are also confidentiality issues to figure out.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.4.5.b	Edited as: 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 the provider followed through with the referral. Furthermore, this process must be documented within the adolescent's file. Comment: We can make referrals, but youth may not follow up with them. The new provider may not be able to make contact- this is very common. We can follow up to see if they attempted contact, but we can't ensure they can make contact.
	4.5	Early Intervention Comment: Be sure to mention that this is not primary Pv. Also, should EI go under "Screening and Referral?" How is EI different from screening? I thought the purpose of EI was to reverse the problem behavior through assessment and education. Changed paragraphs to read: Early Intervention (EI) is assessment and brief education/counseling for adolescents whose risk factors contribute 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 for more information on ASAM criteria. EI addresses SUD related problems 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 written procedures to develop, implement, and maintain outreach, collaboration, and partnerships for coordination and referral with other agencies and organizations. Comment: "required to establish written procedures " requirement? Comment: This refers to outreach (collaboration) and referral, not specific to EI. (a) All collaborations/partnerships must be documented in writing (e.g., interagency agreements, memorandum of understanding, local statute, or local policy). Comment: Requirement - Move to Outreach and Engagement

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	4.5.1.a-4.5.2	Why is it required to have a formal agreement with every entity we work with? MOUs are very laborious and time consuming. what if entities want to collaborate, but are not willing to enter into an MOU? We are a very large county with many clinics, hospitals, schools, etc. This is unrealistic and really not doable to require formal agreements with every entity we collaborate with. This puts up barriers to services. I suggest leaving it up to providers to determine with whom formal agreements are necessary. This already occurs today. Also, better to state here that potential partners MAY include…
	4.5.2	Add SUD Treatment Provider (outpatient, residential, IOP to the list of partners, as EI is a pre-treatment service. Hlighlighted: Potential partners include, …
	4.5.2	Highlighted "Potential partners include, …". Comment: Just for EI, move to Outreach and Engagement
	4.5.2.a	Comment: We do not need an IA or MOU to send a youth to an emergency room.
	4.5.2.f	Comment: We can make a referral without an MOU or IA. Private practice counselor have no knowledge of IAs or MOUs.
	4.5.3	Comment: EARLY INTERVENTION DOES NOT NECESSARILY INCLUDE A FULL ASSESSMENT. IT MAY HAVE A NEGATIVE IMPACT ON THE EARLY INTERVENTION TREATMENT.
	4.5.3	Revised as: Adolescent SUD service providers shall establish and maintain written procedures for assessment and referrals that include: (a) Date and location assessments will occur; (b) Identifying the agency/provider administering the assessment; (c) Appropriate delivery of EI; and (d) Frequency and process for administering referra Comment re. (c): This section is EI

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	4.5.4	Eligible providers must provide or directly supervise all EI services delivered by qualified adolescent health professionals. Comment: Now you are using “eligible,” not qualified. Who determines who is eligible?
	4.5.4	Comment: This is unclear to me. Does this mean that eligible providers must refer to their own EI services and can’t refer to other providers?
	4.5.4.a	Comment: Is this the same for “qualified” providers?
	4.5.4.a	Edited: Eligible *~~providers~~* supervisors Comment: NURSE PRACTITIONERS AND PA’S WOULD NEED SPECIALIZATION IN ADOLESCENT SUBSTANCE USE TREATMENT IN ORDER TO PROVIDE COMPETENT SUPERVISION, JUST AS I WOULD NEED SOME NURSING TRAINING TO SUPERVISE LOWER-LEVEL NURSING ACTIVITIES.
	4.5.4.a	Comment: The term LPHA includes the listed practitioners as well as others (e.g. licensed social workers, etc.) Comment: It is recommended that physicians have specialty training and/or experience in "addiction medicine."
	4.5.4.b	Comment: "recommended" is too weak. Strongly recommended or required? If an MD with no training or experience in addiction medicine is operating out of scope for their knowledge base, it's unethical and potentially very harmful to client.
	4.5.4.b	Highlighted "recommended". Comment: Not a requirement.
	4.5.5	Comment: THIS SHOULD BE A SEPARATE SECTION. IT IS NOT EARLY INTERVENTION. YOU DO NOTE THAT THIS IS FOR TREATMENT SO IT SHOULD FALL UNDER TREATMENT.
	4.5.5	Comment: The narrative from here down in section 4 seems to have shifted from early intervention into treatment. Perhaps this should be a new section focusing on referral into.

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	4.5.5	Highlighted "requirements". Comment: requirement
	4.5.5.a & b	Revised to: a) Assessment is an ongoing process and shall be used in treatment planning for each individual admitted to treatment. Comment: This sentence speaks to Tx, not recovery. This is not a requirement. This is still under EI. b) Highlighted "providers are required". Comment: Requirement. How can you monitor to this? Providers do not complete the assessment; they administer it to patients. Patients complete the assessment.
	4.5.6	Edited: 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. Comment: THIS SHOULD ALIGN WITH ASAM REQUIREMENTS AND TITLE 22. GATHERING MORE INFORMATION THAN NECESSARY IS NOT CLIENT-CENTERED.
	4.5.6	Comment: Here, you are saying that DHCS will be approving assessment tools. What is the criteria for an assessment tool to be approved. Re. "major life domains" Comment: Has not been discussed. Should be placed in the introduction. Re. "inform" in second paragraph. Comment:This is confusing. Some of these are subject areas and some are behaviors. The assessment can survey (or evaluate) history (input from relative), cognitive development, current behaviors, relationships, assets, and vulnerabilities (which are really risk and protective factors in the areas of: substance abuse, MH, physical health, religion/spirituality, criminal justice, education, life skills, trauma, and personal safety.
	4.5.6	Comment: You are mandating several things in this document. You might want to mandate that providers move toward the ASAM assessment tool because it is the state-of-the- art tool. See 4.7.2.

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	4.5.6	Comment: This list should be split into minimum requirements (i.e. substance use patterns, mental health, evaluation of risk, etc). and recommended (i.e. spiritual history, independent living skills). Not all assessment tools will cover all these areas. Comment: Recommend DHCS allow County approve assessment tool, especially for its subcontracted agencies.
	4.5.6.m & n	m) An **<u>evaluation</u>** of risk to self and/or others. The program shall assess and identify safety issues, including risk of **<u>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</u>;** and Comment: The assessment is an evaluation. Comment: MH and trauma n) A medical history and a health screening for mental health, **<u>dental issues, and other physical health</u>** concerns Comment: This is physical health.
	4.5.7	Comment: If there are criteria for Assessments in chapter 5, why aren't they under the Assessment section?
	4.5.8	Added to end of sentence: if appropriate, and based on client consent.
	4.5.8	Comment: Assessment description is 4.5.6

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	4.5.9	In conjunction with acting on the health **<u>screening</u>** 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. If the assessment warrants further SUD services, refer the patient to the appropriate health care program/facility. Comment: Now, we call it screening… is this something different from the assessment we've been discussing? Comment: Recommendation. Requirement: Programs must have access to a medical director and/or PH professional for consultation for SUD services, just EI? re. If the health screening identifies an issue... Comment: Good transition to referral. Added last sentence..."If the assessment warrants..."
	4.5.10	Highlighted "…follow up with the service provider to ensure contact was made". Comment: THE YOUTH MAY NOT WANT TO FOLLOW THROUGH WITH THE REFERRAL. WE COULD FOLLOW UP AND SEE WHAT THE OUTCOME IS, BUT NOT TO ENSURE CONTACT WAS MADE. WILL THIS BE FUNDED?
	4.5.10	Comment: Already stated 4.5.5 (b)
	4.5.10	May run into confidentiality issues.
	4.5.10	Edited as: 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 that the provider followed through with the contact. Furthermore, this process must be documented within the adolescent's file.
	4.5.11	Comment: After assessment Delete: "do the following"

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	4.5.11	Comment: THIS LIST IS INCOMPLETE AND DOES NOT MATCH TITLE 22.
	4.5.11.a	Edited: Diagnose the severity of the SUD, if applicable.
	4.5.11.a	Edited: Determine if the youth qualifies for a *~~Diagnose the severity of the~~* substance use diagnosis. *~~condition.~~*
	4.5.11.b	Comment: YOU ARE THEN REQUIRING THE ASAM BE USED AS THE ASSESSMENT TOOL. THIS SHOULD BE STATED THEN IN 4.5.6.
	4.5.11.a& b	Comment: A validated ASAM tool for youth has not yet been developed. A work group should be convened by DHCS to develop such a tool for use by counties would be helpful. The reliability and validity of the assessment tool will not be obtained in short time frame. DHCS must take this into consideration before a formal, finalized assessment instrument is utilized by counties and providers.
	4.5.11.c	Added at end of sentence: if needed, and based on client interest.
	4.5.11.c	Comment: This is the EI section. How can it be based on a "response to Tx" if they are being referred to Tx. They have not received Tx services yet.
	4.5.11.d	Edited: Document the adolescent's unique abilities and strengths in the *~~treatment~~* plan assessment.
	4.5.12	This may not be possible if the child has not signed a consent to release PHI. The youth 12 and older is holder of privilege.
	4.5.12	Edited: If the assessment indicates that the patient is a harm to himself/herself and/or to 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. Comment: Still part of the provider's duties after EI assessment. Move to 4.5.11 or it should go under EI Referral.
	4.5.13	Add to sentence: At a minimum, these lists must include resources that offers ***preventive health care services and*** education on health behaviors and how to reduce the risk for certain health conditions including, but not limited to: ***Add Dental*** as a separate category.

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	4.5.13	Comment: Referral---specific to EI only? Edited: Programs shall 1) develop and sustain lists of local adolescent health providers and 2) assist adolescents with accessing health care services in accordance with the health assessment findings. At a minimum, these lists must include services that offer education on healthy behaviors including; but not limited to: Comment: How do you reduce the risk for health conditions? You can reduce the risk for unhealthy behaviors, disease…
	4.5.14	The initial assessment shall be completed as soon as possible, and no later than 30 days after admission. ***30-days is too long for an initial assessment. Ok for a full assessment, an initial assessment should happen within maybe 7-14 days after admission.***
	4.5.14	Edited 2nd sentence: Programs shall attempt to gather as much information as ***is relevant to the presenting problem*** *~~possible~~,* and update... Comment: IT IS NOT CLIENT-CENTERED TO GATHER AS MUCH INFORMATION AS POSSIBLE AND DOES NOT FURTHER THE THERAPEUTIC ALLIANCE. IT ALSO TAKES UP NEEDED TO TIME TO BEGIN TO INTERVENE WITH THE CLIENT'S PRESENTING PROBLEM.
	4.5.14	Comment: This timeline for completion of the initial assessment seems too long. Under the waiver, if the patient is placed in residential treatment, the maximum initial length of stay is 30 days. Comment: The term assessment should not be used in this section to help distinguish that providers engaging in EI are not conducting comprehensive assessments, but are more often screening for risk and conducting brief interventions based off those risk levels. Term assessment is used in sections 4.5.3 too. Section 4.5.5 however, seems to apply more to assessment under treatment.

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Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.5.14	Edited: The initial assessment shall be conducted as soon as within 30 days of admission. Programs shall gather more information to update the assessment. Building trust and rapport with the adolescent may take time, before he/she will reveal more detailed and honest information Comment: This is the initial assessment? The document has already discussed two other assessments/screenings. Confusing. Comment: We are still in EI. Admission of what? EI services? The EI assessment has to be completed within 30 days of applying to EI, receiving EI? Confusing. An EI assessment is re. last sentence: "Building trust and rapport..." Comment: This is a best practice. How to work with youth.
	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 ***RELEVANT*** 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. ***[It is intrusive and not client-centered to gather as much information as possible. Best practices indicate gathering information relevant to the presenting problems, not extraneous information.***
	4.6	Highlighted last sentence in paragraph "The following requirements must be adhered to when diagnosing an adolescent with a SUD". Comment: Can DHCS provide guidance or cite reference materials that explain rules for differentiating a primary from a secondary SUD diagnosis for clients with co-occurring MH and SUD?

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	4.6	Highlighted "process". Comment: Not to be confused with all the other process this document requires. This process should be stated because if I am a patient being diagnosed from someone's position or opinion, that is not good enough. How does the assessment tie in at this point? How does a provider link the assessment to the ASAM criteria to diagnose an SUD? re. first sentence Comment: You should source your definition. Highlighted "assessment" in second sentence. Comment: Another assessment?
	4.6.1	Edited: "Adolescents shall be assessed to determine if they meet the diagnostic criteria of a substance related disorder in the most current Diagnostic and Statistical Manual of Mental Disorders (DSM)." Deleted: As part of the comprehensive assessment described in Section 4.5, Comment: You did not title it a "comprehensive assessment." The assessment was under the EI section (4.5), so the reader can only assume that it was an EI assessment. Comment: We already discussed the assessment under EI. Is there another for Tx diagnosis? Deleted "most recently accepted by the state." Comment: This should be included when explaining what DSM is.
	4.6.2	Edited: Adolescents accepted for treatment 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). Comment: If you are accepted for Tx, you have already met DSM. Meeting DSM is pa

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	4.6.2-4.6.3	This admission criteria is contrary to the current DHCS Alcohol and/or Other Drug Program Certification Standards section 12010 (a), which states: "For each individual participant, including family members or significant others, involvement with alcohol and/or other drugs, or alcohol and/or other drug-related problems, shall be the primary criterion for participation." It doesn't say anything about medical necessity or a DSM diagnosis. This criteria may fit with the new DMC/ODS system, but not for SAPT funded services as per the certification standards.
	4.6.3	Edited: If the assessment is not adequate 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 substantiate admission to outpatient treatment. This documentation format may include, prior screening/assessment findings, and/or progress notes. See Table 1.
	4.6.3	Comment: It is not clear why Tble 1 is included under this bullet. Table 1 seems to be a list of all ASAM services for youth (not all of which are covered under the waiver). Comment: DHCS does not license youth residential facilities.
	TABLE 1	Comment: Is this extracted directly from ASAM? Is any of this self-created?
	4.7	Edited: 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 and a service delivery timeline. Appropriate youth placement identifies how SUD care settings must meet the findings from the EI assessment. Comment: If a person meets DSM criteria, they are diagnosed with an SUD? Comment: Placement is not on the COC graphic. If you are adding components, you should state this when discussing the COC in the introduction. Comment: You already stated that these were part of the assessment along with a list of other things.
	4.7	Edited: Placement of an adolescent who meets DSM criteria is the next phase in the ~~COC~~services. Comment: PLACEMENT IS NOT A LEVEL IN THE CONTINUUM OF CARE. IT IS A PHASE OF TREATMENT.

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	4.7.2	Inserted "care settings": Place adolescents in appropriate treatment care settings, 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. Comment: Is the ASAM the same as DSM? You already mentioned it and you are barely referencing the document now?
	4.7.3	Comment: This assumes a routine assessment will determine placement in least restrictive environment. Policies should be developed that defines a routine assessment for placement in a least restrictive environment rather than through traditional approaches, such as admission and discharge. Comment: Appropriate placement and treatment and recovery planning should take into account the unique characteristics of youth. It is recommended that the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care be included in these two sections.
	4.7.3	Make every effort to assign an adolescent to an environment conducive to the needs identified in the assessment. Comment: This was already stated. 3.2.3
	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.-->Highlighted "unable to admit".
	4.7.5	Comment: Field based services may help resolve the capacity issue or at least provide interim services.
	4.7.5.a	If adolescent isn't a patient, need clarification on where to document this.
	4.8	Highlighted "services" with comment: This is certainly a best practice, but an actual service plan this extensive may not be feasible with the funding and staffing currently available at the county level. Currently youth are referred and linked to adjunctive services as needed by the assessment, but to expect counties to address other life needs via a service plan may not currently be realistic.

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Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.8	Highlighted "plans" in title. Comment: The requirement is “the plan,” not planning for it. Edited: Comprehensive treatment and recovery plans are required to be strength-based, client-led, and based on the findings in the adolescent’s individual assessment, including stage of change. The plans must integrate other services the adolescent is receiving including, but not limited to juvenile justice, education, child welfare, and mental health.
	4.8.1	Edited: Comprehensive treatment and recovery plans are required to be strength-based, client-led, and based on the findings in the adolescent’s individual assessment, including stage of change. The plans must integrate other services the adolescent is receiving including, but not limited to juvenile justice, education, child welfare, and mental health. Comment: Finally, a mention of state monitoring. Comment: This should go under the 4.8 paragraph. The rest are requirements of the plan.
	4.8.1	Added to end of 1st sentence: if the youth continues treatment. Reads as: 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 ***if the youth continues treatment. ***
	4.8.3	Replaced "these" with "the identified" problems.
	4.8.3	Edited: 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. Comment: IN ACCORDANCE WITH 4.8 AND 4.8.2 THE YOUTH MAY ONLY BE READY TO ADDRESS ONE PROBLEM AT THIS TIME.
	4.8.3	I suggest changing the wording to say: "The treatment and recovery plans shall address multiple problems experienced by the adolescent SUCH AS (instead of "including"), but not limited to..." Or change to say “may include the following…” The way it is currently written, each of the areas listed need to be addressed whether or not there is a problem. Is that the intention?

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Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.8.3	The treatment and recovery plans shall address [Generally three goals or fewer are selected so that the youth doesn't become overwhelmed. Goals are prioritized and then addressed in future plans. Not everything is addressed in the first plan]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:
	4.8.3.b	Comment: Goals with ****measurable objectives**** that address each problem
	4.8.3.c	Deleted: "which will be"
	4.8.3.d	Edited: Timelines to accomplishment action steps and goals;
	4.8.3.e	Edited: A detailed description, including thefrequency and duration, of the services to be provided.
	4.8.3 e	Edited: A *~~detailed~~* description of the services to be provided, ***including the type of counseling,*** along with the frequency and duration of those services. Comment: (I SUGGEST YOU USE TITLE 22 LANGUAGE TO MINIMIZE CONFUSION)
	4.8.4	Edited: A detailed description, including the frequency and duration, of the services to be provided
	4.8.4.a	Comment: this was stated in 4.8.3
	4.8.4.a	Comment: Already mentions 4.8.3.e
	4.8.4.b	Edited last sentence: 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.). Comment: A LCSW IS A LPHA.
	4.8.4.b	Comment: 4.8.4 is about quantifiable goal/treatment objectives, not timeframes. Unless, you state… Timeframes for the completion of goals and objectives must be stated in the Tx plan. Again, 4.8
	4.8.4.c	Comment: Again, 4.8.4 if about quantifiable goal/Tx objectives

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.8.4.d	Edited: The *~~components listed above~~* ***treatment plan*** must be mutually agreed upon by the clinician, the adolescent, and, if appropriate, the adolescent's family or caregiver.
	4.8.5	Highlighted "A self-administrered physical health questionnaire,…". Comment: Must the physical health questionnaire be self-administered? The State's current physical health questionnaire is not age appropriate for youth. (We are under the impression that we have to use the State's physical health questionnaire.) Would be helpful to see a good example of a self-administered physical health questionnaire for teens.
	4.8.5	Comment: Does the questionnaire occur before Tx starts, mid-term, or at the end? Or all. The answer to this question should impact the order of all the plan requirements.
	4.8.5.a	Comment: THIS IS NOT CLIENT-CENTERED AND IS NOT REQUIRED ON EVERY PLAN.THIS IS NOT IN ACCORDANCE WITH 4.8 AND 4.8.2
	4.8.5.a	Comment: This should go under 4.8.4 since it is referring to goals
	4.8.6	Highlighted "be completed within 30 days of admission". Comment: This is confusing. Is a Tx plan the same as the Patient's file? Usually, a plan is alongside the progress notes in the patient's file. Anything that happens with the patient MUST be entered into the notes AS IT OCCURS.
	4.8.6	Comment: Is there a different timeline for treatment plans to be completed for residential treatment for youth, since the maximum initial stay under the waiver is 30 days?
	4.8.6.a	Highlighted "is a change". Comment: Plan changes
	4.8.6 b	Comment: This timeline seems long and would not apply to residential treatment which is limited to no more than 60 days per year for youth under the waiver.
	4.9	Edited last sentence: A comprehensive treatment plan must be developed and, at a minimum, ~~is required~~may ~~to~~ consider the following:
	4.9	Comment: Under the waiver providers are required to be trained in evidence-based practices including cognitive behavioral therapy and motivational interviewing.

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.9	Comment: Tx should come before the discussion of Tx plans since the plans are a requirement for Tx Edited last two sentences: "Treatment services for adolescents depend on the particular substance an adolescent is using. A Tx services include the following:" Comment: We already discussed the Tx plan and it's requirement in 4.8
	4.9	Last paragraph (embedded comments): A person accessing treatment may not need to utilize all of these strategies (the strategies above or below?) ; however, each strategy plays an important role. (If this is referring to the three items above this is a very strong statement about medication for youth.)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.
	4.9.1	Comment: Are there guidelines around selecting innovative programs for treating youth?
	4.9.1	Edited: Cognitive behavioral therapies: Selected cognitive behavioral therapy interventions must be Evidence-Based Programs (EBPs) and/or innovative programs that best serve the adolescent. Cognitive-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.
	4.9.1	Changed "therapies" to "therapy".
	4.9.2	Highlighted "Psycho-education: Education about substances and the impact of…". Comment: Suggest weaving in here some of the new neuroscience/brain development research about the effect of drugs and alcohol that's unique to adolescent brains. Eg. cite Dr. Frances Jensen, Professor & Chair of Neurology Department, University of Pennsylvania. Author of The Teenage Brain: a Neuroscientist's guide to raising adolescents and young adults.
	4.9.2	Edited 1st sentence: Education about substances and the impact of these substances on the mind and body ***may*** help an adolescent better understand the addiction process.
	4.9.2	Deleted "These approaches and therapies are" and "set of" in last sentence. Comment: Not a good idea to refer to "tools" if you have not stated what they are.

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.9.3	Comment: MAT IS CONSIDERED ONLY FOR OPIOIDS FOR ADOLESCENTS AND ONLY OVER AGE 16. IT SHOULD NOT BE "REQUIRED" AS STATED IN 4.9 TO BE CONSIDERED EXCEPT FOR YOUTH OVER 16 WITH OPIOID ADDICTION. Embedded comment: These systems ***WHAT SYSTEMS? THIS SENTENCE IS NOT CONNECTED TO PREVIOUS SENTENCE*** 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.
	4.9.3	Comment: Discussion of health issues would seem to be broader than MAT. Include information on other health issues that might be a focus of treatment. Comment: Recommend saying that MAT is available only on a case-by-case basis for youth and leaving the rest of the description of this service under the MAT section. (See Section 5.13 for more information).
	4.9.3	Highlighted "Medications". Comment: This paragraph is about medications, not health issues
	4.9.3	Highlighted "These systems". Comment: What systems? Comment: How are they embedded. We are speaking of Tx and Tx is a service for the individual, not the community. Again, this is a policy manual, not a research paper. Comment: This section is under Tx, not recovery.
	4.9.3	Comment: This makes a strong statement about considering MAT for youth, which is still controversial and there is some, but not a lot of research yet.
	4.9.4	Highlighted "requirements": 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: Comment: THIS IMPLIES THAT EACH YOUTH IS REQUIRED TO HAVE INDIVIDUAL AND GROUP COUNSELING. GROUP TREATMENT IS CONTRAINDICATED FOR YOUTH WITH SOCIAL ANXIETY AND OTHER ISSUES, AS IS STATED BELOW

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.9.4	Edited: 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. Counselors and adolescents work collaboratively to identify challenges and develop solutions 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: Comment: Is this the same as psycho-education 4.9.2 Comment: This is not counseling: sustaining abstinence, relapse, improving personal health, social functioning.
	4.9.4	Embedded comments: 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 (some models focus on harm reduction which may be the goal for some non-Probation youth. Can we provide services for voluntary clients whose goal is harm reduction?), preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care:
	4.9.4.a	Comment: Already stated in the above paragraph
	4.9.4.b	Deleted: "via"
	4.9.4.c	Group counseling ***shall be provided as appropriate and*** 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.
	4.9.4.c	Changed "contacts" to "contact"

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.9.4.d	Edited: 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 plan. Comment: Already stated.
	4.9.5	Comment: THE YOUTH MAY HAVE A PARENT OR GUARDIAN PRESENT DEPENDING ON THE AGE AND DEVELOPMENTAL LEVEL. THIS LIMITS CLINICAL ABILITY TO INVOLVE THE FAMILY AS APPROPRIATE AND LIMITS BEST PRACTICE.
	4.9.5	Comment: 4.9.4 is about Counseling. 4.9.5 is still speaking to counseling – integrate them. 4.9.4 (b) discusses individual counseling
	4.9.5.b	Deleted: "and recovery plans;"
	4.9.5.C	Highlighted: As needed for adolescents who are uncomfortable with the group process or unready to discuss specific issues in a group setting; Comment: Good! Important to state this!
	4.9.5.e	Comment: YOU MAY WANT A PARENT PRESENT IF APPROPRIATE.
	4.9.5.a-e	Comment: Under the waiver, treatment should be tailored to the needs of the individual client. Some youth may benefit from more individual counseling.
	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. Comment: THIS IS VAGUE. WILL FUNDING COVER MENTAL HEALTH TREATMENT?
	4.9.6	Addresses the delivery of co-occurring treatment. Our experience is that the majority of adolescents who require SUD treatment (not just Early Intervention) have co-occurring disorders (including trauma issues) and that therefore program staff will most certanly need to be qualified to provide both mental health and SUD treatment.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.10	Comment: Suggest including description of ASAM approach to withdrawal management for adolescents. Withdrawal management is not an ASAM level of care for adolescents. If needed, it is integrated with services in other settings. ***Table I: ASAM Criteria Withdrawal Services Detoxification (Withdrawal Management)*** See comment above: ASAM approach to withdrawal management for adolescents. Not sure this table should be included in this document.
	4.10	Edited: Adolescents in need of withdrawal management services shall be placed in the most appropriate level of care, based on the Level of Withdrawal Management identified by ASAM Criteria for Withdrawal Services in Table 2. Withdrawal management services must adhere to the following: Comment: Put under 4.9.4.c where group counseling is discussed. Comment: define "withdrawal management services"
	4.10.1	Edited: Appropriately trained staff with specific knowledge and experience in the management of substance withdrawal shall monitor the withdrawal process under the direction of a physician or other health care professional.
	4.10.2	Edited: Programs shall create, maintain, and adhere to **written procedures** consistent with ASAM's Level of Withdrawal Management. The procedures of withdrawal management services include: Comment: Requirement
	4.10.2.a	Replaced "treatment program" with "withdrawal management program". Comment: Intake to Tx or intake to withdrawal management. This section is withdrawal management.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.10.2.b	Edited: Observation: Monitoring the adolescent's course of withdrawal will be conducted as required by the level of care identified in the Tx plan. This may include, but is not limited to, observation and review of the adolescent's health status. Comment: What does this process entail? Comment re. "This may include, but is not limited to, observation" - Already stated Comment re. last sentence: This was already determined in the assessment.
	4.10.2.c	Edited: Administering Medication Services: The administration of prescribed medication related to SUD treatment services, or the assessment of the side effects or results of that medication. Medication services will be conducted by a licensed prescriber or OTP for opioids. Comment: There is no such thing as "medication services" in table 2. However, procedures for prescribing and dispensing medication should be discussed. Specifically; dispensing is huge. When I worked in a foster home, I was allowed to dispense medication to the youth and there was a process. This section might be it's own section. There is a lot more about this. Comment: What is included in the "administration" of medication? Comment: Use the existing language in Table 2. I am unsure what OTP stands for.
	4.10.2.d	Edited: Discharge Services: The process of preparing the adolescent for referral into another level of care, and/or coordinating resources for the individual outside of the Tx setting i.e. SUD services, housing, and human services. Comment: A patient can be discharged for more than one reason: 1. successful completion of Tx program: discharged to recovery and to reside at home, if they were receiving residential Tx, 2. Refer to another Tx program because the patient was not successful. 3. The patient has to go to a different care system for many reasons: hospital, juvenile hall/criminal detention facility, mental health, etc. 4. Transition from residential Tx to non-residential Tx.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.10.3	Highlighted "written protocol". Comment: For what? Highlighted: "under the influence of alcohol or other drugs". Comment: Up to this point, there has not been a requirement to create a “substance use policy” or “no tolerance” policy. Comment: This is unclear. It sounds as if the agency will have to refer a patient out if they appear under the influence. We are still under the “withdrawal management” section. I would assume that the patient is under the influence until withdrawal services are complete. This is a disorder. If you are saying that youth need to be referred out if they are under the influence, that would not be beneficial for the patient. If a youth appears to be under the influence while in Tx, that identifies a
	4.11	Hightlighted last sentence.
	4.11	Comment: Life skills isn’t always a program. It is often part of treatment. I am concerned that the requirements below are too prescribed which makes it difficult to be client-centered and client-specific. It is more client friendly to provide life skills as part of treatment. Generally when we look at life skills we look at the current needs of our clients and offer what they need, not everything listed below, Otherwise we are not being client-centered as described.
	4.11	This statement leads one to believe that life skills development is not a requirement. If that is the case, why so specifically prescribe what life skills development program must include in the following section? If it isn't required, let providers have the flexibility to modify life skills development as they see fit. Don't make it an either/or option. 4.11.4 says to refer, but it is better to have services in-house. Transportation to other locations may be difficult.
	4.11	Comment: The life skills development activities are not clearly defined in this section. It is recommended that this section include examples of models and links to resources for life skills.

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.11	Comment re. "Life Skills": This concept has not been defined and I would suggest it be part of Primary Pv or a section that consists of services that would fit across the COC. Edited: Life skills programs consist of activities that build capacity of participants to make constructive decisions and demonstrate healthy behaviors that positively impact their lives. 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: Highlighted: "constructive". Comment: Maybe productive re. first sentence Comment: That's a pretty high expectation for someone who participates with Tx and recovey. Comment: Pv also implements life skills programs.
	4.11.1	Highlighted "clinically". Comment: Not for Pv.
	4.11.1.d	Comment: THIS ISN'T CLIENT-CENTERED. A BRIEF LIFE SKILLS GROUP MAY FOCUS ONLY ON MANAGING ANXIOUS THOUGHTS.
	4.11.1.f	Comment: REQUIRING THIS MAY CAUSE SOME LIFE SKILLS PROGRAMS TO STOP PROVIDING SERVICES. THIS IS NOT ALWAYS APPROPRIATE, DEPENDING ON THE SETTING, NUMBER OF SESSIONS, AGE GROUP, (i.e., A THREE SESSION SKILLS GROUP FOCUSED ON SOCIAL SKILLS FOR SEVENTH GRADERS). HOW WILL THIS FUNDED?
	4.11.1.f	Comment: A 14 YEAR OLD CLIENT MAY NOT WANT THIS AS A GOAL. SEE SECTION 5.6 ADOLESCENT-GUIDED CARE.
	4.11.2	Highlighted section. Comment: Good! The clarity and definition around Life Skills Development is helpful.
	4.11.2	Comment: Tx and recovery

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.11.2	Life skills development *~~shall~~* ***may*** 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~~* ***may*** offer interpersonal skill development including, but not limited to, support in problem solving, conflict resolution, self-esteem improvement, anger management, and impulse control.
	4.11.3	Comment: This is all life skills. Should be incorporated in the intro paragraph.
	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. Comment: INTERAGENCY AGREEMENTS ARE NOT NECESSARY UNDER ALL CIRCUMSTANCES. IT MAY BE A REFERRAL TO AN AGENCY WITHIN THE COC.
	4.11.4.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. Comment: WE CANNOT BE HELD ACCOUNTABLE IF WE MAKE A REFERRAL AND THE YOUTH CHOOSES NOT TO ACCEPT THE REFERRAL. THIS WILL HAVE A NEGATIVE IMPACT ON CASE MANAGEMENT SERVICES AND IS NOT-CLIENT CENTERED. CLINICIANS WILL MAKE FEWER REFERRALS UNLESS THEY ARE 100% CERTAIN A YOUTH WILL FOLLOW THROUGH.
	4.11.4.a	Comment: THE CLIENT MAY CHANGE THEIR MIND AND NOT WANT TO ENTER THE LIFE SKILLS PROGRAM AFTER THEY ARE REFERRED TO IT. CLIENTS MUST HAVE A VOICE AND CHOOSE THE SERVICES AND GOALS THEY WANT TO WORK ON.

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.12	Edited: Education and vocational services include school/college attendance and employment training that assist the adolescent with academic and career readiness, workforce entry, and/or assessment/training for professional development. If an adolescent is identified as needing educational and/or vocational services , programs must be able to provide the services or refer the adolescent to another agency where services are available. 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. Comment: Again, this is not a research paper. Define what educational and vocational services are and move to the requirements. All of this stuff should have been stated in the introduction of the manual. As well, these services can be administered across the COC.
	4.12	Education and Vocational Services Comment: this section is confusing. It is mostly related to residential care.
	4.12.1.a-d	Highlighted section. Comment: This section mainly applies to residential treatment. Maybe say that explicitly or create a section on residential.
	4.12.5.a	Comment: I like this a lot. Glad it's in there! Important that follow up occurs and its documented!
	4.12.1	Comment: THIS IS NOT CLIENT-CENTERED. THIS IS WRITTEN AS IF IT APPLIES TO ALL PROGRAMS, BUT MAYBE IT IS INTENDED FOR RESIDENTIAL.
	4.12.1	With the consent of the youth. This seems more appropriate in a residential treatment setting as opposed to an outpatient treatment setting.
	4.12.1	This requirement seems appropriate for adolescent residential treatment, but is not realistic nor always appropriate in outpatient care. If a client comes voluntarily to outpatient care, there may not be a need to work with the school. In fact, the client may refuse to sign a consent to release PHI. Also, many clients do not have an IEP and are somehow functioning in school. A distinction should be made between what must be required in residential treatment versus outpatient treatment.
	4.12.1	Highlighted "adolescent's individualized educational program". Comment: What is meant by this?

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.12.1.a	Added: while in residential care.
	4.12.1.a	Comment: Tx residential
	4.12.1.b	Comment: Residential care
	4.12.1.c	Comment: DEPENDING ON CLIENT CONSENT
	4.12.1.c	It is actually called "Individualized Education Plan", not "Program".
	4.12.1.c	Comment: COC
	4.12.1.d	***Residential programs shall develop*** a plan to assist the adolescent to successfully transition back into the community educational system, if appropriate.
	4.12.1.d	Comment: If the youth is in residential care
	4.12.2	Deleted section.
	4.12.2	Programs shall link the adolescent to groups that support the adolescent's educational and vocational needs, ***if needed and*** as clinically appropriate, and as identified in the treatment and recovery plan.
	4.12.3	Edited: Education and vocational services shall include health education including but not limited to:
	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, ***as appropriate and based on individual needs and client readiness:***
	4.12.3	re. "shall link adolescents to additional educational sessions": I suggest modifying this to say "...shall link adolescents as appropriate or when clinically indicated, to additional..." re. "including but not limited to": Suggest changing this to "may include".

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.12.3	Edited as: Treatment and recovery programs shall link adolescents as clinically appropriate to additional educational sessions and culturally appropriate materials that address other health matters, including but not limited to, the following:
	4.12.4	Highlighted "research-based education". Programs shall provide research-based education on addiction, treatment, recovery, and health risks associated with SUD. Comment: THIS IS NOT RELATED TO EDUCATIONAL SERVICES.
	4.12.4	Comment: When speaking of “education and vocational” services, usually programs are referring to academics.
	4.12.5	Deleted entire paragraph. Comment: Life skills were already discussed
	4.12.5	***Based on client interest, 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. ***Based on client need and interest,*** programs shall provide/arrange for independent living skills, academic and work readiness skills, career planning, and job training for adolescents *~~as needed~~.*
	4.12.5	This is ideal, but perhaps not realistic given the current resources of most counties. In our county these kinds of services are provided through a FSP, but only those youth with a co-occurring disorder are able to qualify for this intervention based on restrictions placed on the MHSA funding for FSPs which do not fund substance use treatment per se. Youth in FSPs are also receiving services for a mental illness in addition to substance use.
	4.12.5	What if the adolsescent is 12, 13, or 14 years old? This requirement is not approprate. Yet, it states a program shall provide/arrange for this service.
	4.12.5	Edited as: 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 as needed by the individual client. Programs shall provide/arrange for independent living skills, academic and work readiness skills, career planning, and job training for adolescents, as needed.

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.12.5.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. Comment: YOUTH OFTEN DO NOT FOLLOW THROUGH EVEN WITH REFERRALS TO TREATMENT.
	4.12.5.a	Edited: The referring program , must follow up with the referred parties to verify program participation. Furthermore, this process must be documented in the adolescent's file. Comment: What process? (b) Document the referral and follow-up services in the adolescent's file.
	4.12.5.a	Edited as: 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 the provider followed through with the referral. Furthermore, this process must be documented in the adolescent's file.
	4.13	Comment: THIS SHOULD BE IN ACCORDANCE WITH TITLE 22 REGULATIONS ON WHAT MUST BE INCLUDED IN THE DISCHARGE PLAN. Additional comment: THIS STATEMENT DOES NOT INCLUDE WHEN THE CLIENT NEEDS A HIGHER LEVEL OF CARE

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.13	Highlighted "Discharge". Comment: Discharge should go under Tx. Already discusses 4.10.2.d Changed "Discharge Planning" to "Discharge Services". Edited: Discharge is the planning and coordination to transition a patient from the current service to wither a new residential setting or a different level of care. Effective discharge planning ensures that the adolescent will seamlessly move from one level of care to another. one that is less intensive, with the goal to eventually return to his/her community. . Discharge services must adhere to the following criteria: Comment re."one that is less intensive": This is not always the case. Comment re. "eventually return to his/her community": I thought discharging meant that they were done with the service. Discharge can occur for more reasons than that. See comment 4.10.2.d. Be sure that if this is the definition, that you go by this throughout the manual. Comment: Moving from Tx to recovery. Put under Tx. Comment: How does a discharge plan prevent relapse?
	4.13.1	Added new 4.13.1: A written discharge and/or aftercare plan shall be developed for each adolescent.
	4.13.2	Highlighted "…and residential services for criminal justice offenders…". Comment: Why only criminal justice offenders? Additional lengths of stay should be made available to any youth who is identified as needing it during assessment
	4.13.2	Comment: THEY ARE OFTEN MOVED TO A HIGHER LEVEL OF CARE BECAUSE THEY ARE NOT STABILIZED.
	4.13.2	Renumbered 4.13.1 and highlighted "Placement". Comment: If discharge is covered in this guide under Placement, maybe the manual should follow and put under placement.

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.13.2	Highlighted "shall be stabilized". Comment: What is meant by this? Highlighted "level of treatment". Comment: Is it always discharge to another level of Tx Highlighted: "criminal justice offenders". Comment: What about patients in a MH facility
	4.13.3	Edited: With the exception of early intervention programs, The department reserves the right to review discharge plans. Highlighted last sentence. Comment: This is monitoring. We need to find a place for this.
	4.13.3	Strike out: and/or aftercare Added to end of sentence: ***that is assessed and enters services.***
	4.13.3	Comment: Include definition of peers.
	4.13.4	The discharge plan shall be completed in cooperation with the adolescent, ***if possible,*** and must contain the following elements to sustain gains made in treatment: Comment: THIS SHOULD BE TITLE 22 REQUIREMENTS
	4.13.4	Deleted: "to sustain gains made in treatment"
	4.13.4.a	A process to prepare the adolescent for referral into another level of care ***if the youth is being referred to another level of care.***
	4.13.4.b	***If appropriate,*** the steps for post treatment return or re-entry into the community that includes, but is not limited to, a relapse prevention plan. Comment: THE YOUTH MAY BE REFERRED TO RESIDENTIAL AND THEN THIS DISCHARGE PLAN WILL NOT INCLUDE COMMUNITY RE-ENTRY AT THIS TIME.

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Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.13.4.b	Important to keep in mind that the adolescent is already living in the community when in outpatient treatment. There are very few adolescent residential programs in the state, yet it seems much of this document is geared toward those in residential treatment.
	4.13.4.b	Edited: The goals and resources for post treatment return or re-entry into the community that includes, but is not limited to, a relapse prevention plan.
	4.13.4.c	***Add to sentence:*** The linkage of the adolescent to essential education, ***primary, medical care, dental health,*** community treatment, housing and human services. Original: The linkage of the adolescent to essential education, community treatment, housing, and human services.
	4.13.4.c	Comment: THIS IS NOT INDIVIDUALIZED TREATMENT.
	4.13.4.c	Edited: Programs must include a written summary that contains relevant standardized data. The summary shall document progress towards Tx goals and objectives and provide new goals for the adolescent's long-term success or need for further assessment and/or referral.
	4.14	Comment: Since continuing care and recovery support services are very different, I would separate them. Cover Recovery Support Services first, since they are provided concurrently with Tx services according to your definition below. Edited: To prevent relapse and support the adolescent's transition from Tx into recovery, programs shall provide/arrange for recovery support and other continuing care services. These Recovery support services must be clearly outlined in the adolescent's recovery plan prior to discharge from treatment. Comment: Now we are talking about another plan.
	4.14	Edited and embedded comments: To prevent relapse and support the adolescent's transition into recovery, programs shall provide/arrange for client-centered recovery support and other continuing care services if needed 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 if the client agrees to these services. (The way this is written it sounds like every youth must receive recovery services. We cannot and should not force youth into Recovery Services. It isn't ethical.)

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.14.1	We can't be responsible for whether or not the patient made contact with another provider, we can encourage and reinforce the need for the patient to do so.
	4.14.1	Comment: THE NEW AGENCY MAY NOT BE ABLE TO MAKE CONTACT.
	4.14.1	Comment: Does not make sense. If the Tx facility attended by the patient does not offer recovery support services, then the Tx provider must refer the patient to appropriate recovery support services according to the discharge plan. Comment: Tx is responsible for creating the recovery plan? I am unsure how this works.
	4.14.1	Edited as: 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 through to ensure that the agency followed through with the referral. Furthermore, this process must be documented in the adolescent's file.
	4.14.2	This is how many of the above sections should be written rather than stating various services "…must be provided, including and not limited to…"
	4.14.2.a	Home or community-based ***or telehealth*** meetings with a clinician or therapist to set and work towards goals.
	4.14.3	Highlighted "Recovery support services are non-clinical services that are used concurrently with". Comment: Definition of recovery support services
	4.14.3	Comment: IN THE WAIVER CLINICAL OUTPATIENT COUNSELING SERVICES ARE COVERED.
	4.14.3.a	Comment: HOW IS THIS GOING TO BE FUNDED?
	4.14.3.I	Comment: HOW IS THIS GOING TO BE FUNDED?
	4.14.4	Comment: Not a requirement. This is a definition.
	4.14.5	Why must all of these activities be required? I suggest that programs that have peer services be allowed flexibility within the provider's financial means. In most cases, some peer services are better than no peer services, especially if peer services are optional to begin with. I recommend that this not be all or nothing.

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.14.5	Comment: Peer recovery coaching should be defined first before you define what a coach does.
	4.14.6	Question: FOURTEEN YEAR OLDS WITH FOURTEEN YEAR OLDS?
	4.14.6	Comment: How is this defined, e.g., as xx number of years in recovery …? Comment: The section on recovery support needs clarification. There are EBPs that have been shown to work for recovery support for youth. Recommend approaches that go beyond self-help and peer support group programs. A peer coach should be more clearly defined. Is this a credentialed staff position? Comment: Recovery support definitions are from the adult model and an old version of recovery. See SAMHSA's new definition and recovery guiding principles which are more congruent with the way aftercare is defined by the American Society of Addiction Medicine -as "the provision of a recovery plan and organizational structure that will ensure that a patient receives whatever kind of care he or she needs at the time." Comment: Individualized recovery models are developmentally appropriate as services are tailored to address to the unique issues of individuals. (i.e., different patterns of use (severity), antecedents, and consequences as well as the voice/experience of the individuals undergoing the process themselves). Research among substance abusing youth support such individualized recovery models. Youth in SUD treatment tend to endorse recovery as a process of lifestyle change, asserting personal control to improve one's lifestyle using wellness-based approaches to getting healthy/healing, and having confidence in oneself to change. Comment: Recommend consistent language as the DMC-ODS waiver, especially with erms such as linkages
	4.14.6	Comment: DOES THIS MEAN 14-YEAR OLDS MUST BE MATCHED WITH 14 YEAR OLDS?
	4.14.6-8	Comment: Peer recovery
	4.14.8.a	Edited: Administrative supervision to assist in the management of record-keeping, etc.
	4.14.8.b	Added "licensed": Regular supervision by a licensed-qualified adolescent SUD service professional to ensure critical competencies and assist with problem solving.
	4.15.1	Comment: Recreational/Social Re-engagement: is this part of Recovery Support or Continuing Care? Highlighted "recovery and are critical for long-term recovery". Comment: Specific to recovery.

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Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	4.15.1.a	Highlighted "developing the treatment". Comment: At this time, they should be done with Tx plans. They are now in recovery according to the definition.
	4.15.2	Highlighted "mutual aid groups". Comment: Define what this is. Is it under Continuing Care ore Recovery Support?
	4.15.2	Suggest changing the wording to self-help groups or community support groups. The definitions page states that mutual aid groups are “sometimes” called self-help groups. In fact, they are mostly called self-help groups. I’ve never heard of them referred to as mutual aid groups.
	4.15.2.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. WHAT IF THE YOUTH DOESN’T WANT SOMEONE TO ACCOMPANY THEM? AN 18 YEAR OLD MAY NOT WANT SOMEONE TO GO WITH THEM. THIS IS NOT CLIENT-CENTERED TREATMENT.
	4.15.2.b	This sentence contradicts itself. “…, if possible…” contradicts “…is required…”
5 - Service Delivery Requirements		Addresses Service Deliver Requirements. A central challenge in providing adolescent SUD services is engagement (or a lack thereof). Challenges include AWOLs, clients leaving treatment AMA, appointment no shows, and uncooperative or resistant family members. The draft might further stress the need to develop creative/uniquely tailored treatment engagement and retention strategies for adolescents and families, and what to do when clients/families do not engage.
		Highlighted "Service Delivery Requirements". Comment: The entire manual discusses requirements. The structure of the manual needs to be re-vamped. Maybe call it: Service Deliveries Across the COC Highlighted "overarching principles". Comment: Decided if overarching principles should be discussed before COC services. My recommendation is yes.

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	5.1	Highlighted "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". Comment: Staff Development and Training This is not a requirement for Developmentally Appropriate Care
	5.2	Highlighted "Cultural and Language Competence". Comment: The title of this should be CLAS. Reference the CLAS training we attended. Use the appropriate language. No need to make up our own
	5.2	Highlighted the word treatment with comment: Prevention as well?
	5.2	Edited last sentence: This care must be provided in an understandable manner and is compatible with client and family cultural beliefs and practices, gender-specific needs, and preferred language.
	5.2.1	Is this a requirement for prevention?
	5.2.2	Comment: All of the info under “additionally” are stated in CLAS.
	5.3	Highlighted "Social Determinants of Health". Comment: SDOH is already included when doing Assessment. The jargon is different, but the practice is using SDOH to assess the patient. This could be discussed as part of the introduction when you are explaining the need for the manual and why this Target Population is different.
	5.3.6	Highlighted "assess". Comment: Assessment
	5.3.6.a	We can't ensure services were obtained. Without resources to support this type of important followup. ***Add:*** **Furthermore,** this process must be documented in the adolescent's file.

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	5.3.6.a	Highlighted "Programs must follow up to ensure that the services were obtained". Followed by comment: NOT CLIENT CENTERED - YOUTH CHOOSE THE SERVICES THAT THEY WILL ENGAGE IN.
	5.3.6.a	Add: “When assessed to be in need, programs shall refer…”
	5.3.6.a	Highlighted "refer". Comment: 5.3.6 discusses assessment and 5.3.6.a discusses referral. Doesn’t align. We have already provided requirements for both assessment and referral.
	5.3.6.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. YOUTH AND FAMILIES CANNOT BE FORCED INTO TREATMENT OR SERVICES. WE CAN REFER CLIENTS TO SERVICES IF THEY AGREE THEY WOULD LIKE A REFERRAL, BUT WE CANNOT FORCE THEM TO ENTER THOSE SERVICES. SERVICES ARE BASED ON CLIENT OR FAMILY VOICE AND CHOICE. Furthermore, this process must be documented in the adolescent’s file.
	5.4	Comment: The SAMHSA toolkit is helpful, but is not adequate enough to fully describe gender identity and sexuality issues. It is recommended that additional information be included on the special needs of minorities, transgender youth (male and female), and some evidence-based models.
	5.4	Highlighted "Gender Identity and Sexuality". Comment: This is part of CLAS. It is a good ideas to put 5.4.1 under the CLAS section.
	5.4.1	Correction: and two spirit*~~ed~~* adolescents.
	5.5	***As a best practice, when possible, with*** the exception of prevention and early intervention programs, all programs *~~must~~* ***will*** provide or arrange for a gender-specific environment with substance abuse services and other therapeutic interventions. Exceptions to this standard require the following provisions:

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	5.5.	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. Comment: BECAUSE YOUTH SERVICES ARE OFTEN DELIVERED IN MULTIPLE SATELLITE SITES IT IS OFTEN NOT POSSIBLE TO DO THIS AT EVERY SITE BECAUSE OF THE SMALL NUMBER OF CLIENTS AT SOME SITES. THIS WOULD REQUIRE THAT WE NOT PROVIDE SERVICES AT SMALLER SITES IN ORDER TO BE IN COMPLIANCE. FOR EXAMPLE, AT SMALL SCHOOL SITES IT IS SOMETIMES NECESSARY TO OFFER MIXED-GENDER GROUPS OR WE WOULD NOT BE ABLE TO OFFER SERVICES AT THOSE SCHOOLS AND THEN COULD NOT SERVE THOSE YOUTH IN NEED.
	5.5	re. "Exceptions to this standard" Not sure what is meant by this.
	5.5	Comment: Shouldn't all programs serving youth be culturally competent in serving transgender_ or intersex youth even if it is not their area of specialization? Comment: It may be helpful to include standards for serving transgender and intersex youth, especially in residential settings.
	5.5	Prevention is mentioned here as exempt however prevention is not clearly referred to in the other items in section 5
	5.5	With the exception of prevention and early intervention programs, all programs shall provide or arrange for a gender-specific environment with substance abuse services and other therapeutic interventions.
	5.5.3	Highlighted "adolescent girls". Comment: This is culturally incompetent in itself. Just for girls?
	5.6	Highlighted "Adolescent-Guided Care". Comment: Approach: Adolescent Guided Care Defined. No requirement. Across COC.
	5.6	Adolescent-Guided Care THIS SHOULD BE THE BEDROCK OF THE GUIDELINES.

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	5.7	Highlighted "Family-Centered Care". Comment: Approach: Family Centered Care Defined. No requirement. Across COC. Highlighted "treatment and recovery". Comment: And Pv.
	5.7	Comment: WHEN THE YOUTH CONSENT TO FAMILY INVOLVEMENT THEY SHOULDN'T BE INCLUDED AS MEMBERS OF THE "TEAM"- THEY ARE ALSO CLIENTS.
	5.7	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. Highlighted "When an adolescent has a potentially beneficial relationship with his or her family, providers must consider the needs of the family as part of adolescent SUD services". Comment: This sentence seems problematic to me. Is this a condition for family engagement? How is provider really to know of this potential if it hasn't engaged the family? This section needs re-working to emphasize the importance of family involvement in the youth's recovery. The default needs to be family involvement.
	5.7	Comment: MINOR CONSENT LAW SHOULD GUIDE THIS SECTION.
	5.8	Edited: Adolescent **Developtal** Approaches to Treatment Added same edit to first sentence: An adolescent **developmental** 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.

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	5.8	Highlighted "Adolescent Development Approaches to Treatment". Comment: Is this an actual service? Why can't it be used across COC instead of being specific for Tx (title)? Youth Development Approaches cross the COC. You can also refer to FNL youth development for this section. A lot of this has already been prescribed in services.
	5.8.2	Comment: SECTIONS B, C, D, AND E SHOULD NOT BE REQUIRED FOR EACH CLIENT AND PROGRAM AS THIS DOES NOT ALLOW FOR INDIVIDUALIZED TREATMENT, AND THESE ITEMS ARE OUTSIDE THE SCOPE OF A DMC PROGRAM. HOW WOULD THESE BE FUNDED? THEY ARE ALSO NOT REQUIREMENTS OF A THERAPEUTIC OUTPATIENT PROGRAM. THIS REMOVES THE FOCUS FROM EVIDENCE-BASED THERAPY. Highlighted section c, d, e
	5.8.2	Again this is a best practice, but in reality when we are working with youth one day at a time to maintain sobriety, much of their effort is put into maintaining sobriety and meeting their responsibilities related to school and family. B, C, D do not seem realistic from a boots on the ground perspective.
	5.8.2	I am concerned about sections such as this. I don't disagree that these things are important and ideal for any teenager. However, our first goal is to help one with a SUD to stop using drugs and the accompanying consequences. Sections like this are concerned with things that may be years down the road. I am less interested in developing a model citizen than I am about helping the adolescent fix a broken life due to drug use. Let's start there and help the adolescent put their life back together. This in itself may take many months and then some. Many adolescents don't even want to be in treatment and are there only because the judge sent them into treatment or their parents sent them.
	5.8.2	Comment: THESE ITEMS BELOW ARE NOT NECESSARILY RELATED TO BEING INVOLVED IN THE YOUTH'S INDIVIDUALIZED TREATMENT. THIS SECTION IS WRITTEN AS IF EVERY YOUTH MUST PARTICIPATE IN THESE ITEMS.
	5.8.2.b	Learning values and marketable skills for adulthood IF THE CLIENT SELECTS THIS AS A TREATMENT GOAL;
	5.8.3	Comment: I would say "if services described in section 5.8.2 are not provided," there should be no adolescent SUD program that doesn't use the "adolescent development approaches to treatment" outlined in 5.8.1.

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	5.8.3	Highlighted "…must follow up to ensure that the services were obtained". Comment: WE CANNOT ENSURE THAT A YOUTH CHOOSES TO FOLLOW THROUGH A GIVEN REFERRAL.
	5.8.3	Please see previous comment.
	5.9	Highlighted "Transitional Age Youth". Comment: Adolescents includes TAY? I recommend the Target Population changing to ages 12 to 25 to include TAY since TAY is a "transitional age." Then, I would move 5.9 to the introduction where you identify the target population.
	5.9	Edited and comment embedded: Transitional Age Youth (TAY) are defined as individuals between the ages of 18 and 25 years of age. These transition years span the WE SHOULD BE MODELLING STRENGTH-BASED LANGUAGE. developmental years of growing out of adolescence and into adulthood, when individuals may need assistance in developing . life skills needed to secure or maintain employment, housing, and other necessities for success in adulthood.
	5.9.2	Highlighted "TAY services should include, but are not limited to: ". and b) with comment: HOW WILL PROVIDING CELL PHONES BE FUNDED? And d) I THINK YOU MEAN THAT YOUTH SHOULD BE LINKED TO MANY OF THE FOLLOWING SERVICES: g) OUT OF SCOPE OF PRACTICE l) OUT OF SCOPE OF PRACTICE AND WILL NOT BE PAID FOR BY DMC m) OUT OF SCOPE OF PRACTICE.
	5.9.2	I just don't know how realistic it is to provide all these services in this section with limited funding. Our primary focus is to help them to be drug-free and deal with the issues listed here as they impact sobriety. It should be stated in a way that allows for treatment in these areas as applicable rather than including every one of these.
	5.9.3	Comment: HOW WILL MENTAL HEALTH TREATMENT BE FUNDED BY DMC?
	5.9.3	Highlighted "treatment needs". Comment: Move to Tx.

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	5.9.5	Providers should already provide individualized treatment regardless of age, and take into account development stage of the individual.
	5.9.4	(d) (See highlighted revision) ***__Criminal justice__*** (e.g., courts and probation);
	5.9.5	Edited as: 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 client-centered TAY with services that are appropriate to each individual's current stage of development and needs.
	5.10	(See highlighted revision) Troubled family systems and disrupted living patterns often accompany SUDs. Successful treatment programs for adolescents shall include a family component ***__when appropriate__.*** 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. 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. Comment: Provider should not insist on parental involvement if it is not deemed to be in the youth's best interest (e.g. due to safety concern).
	5.10	Highlighted "Family-centered treatment". Comment: If this is what we are talking about, then title 5.10 the same. This is an approach.
	5.10	Second paragraph: 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. 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. NOR CAN WE INSIST ON PARENTAL INVOLVEMENT UNDER ANY CIRCUMSTANCES- THIS IS A VIOLATION OF MINOR CONSENT LAWS.
	5.10.1.c	Identify family dynamics and include the family in the adolescent's treatment as early as possible, based on client consent and if clinically appropriate and specified in the treatment and recovery plan;

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	5.10.1.d	Based on client consent, 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
	5.10.1.e	Based on the family's and adolescent's input, 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.
	5.10.1	Highlighted section d.
	5.11	Highlighted "must be integrated and whole 2nd paragraph". Comment: SAMHSA HAS DIFFERENT MODELS AND STAGES OF INTEGRATION. DMC WILL NOT FUND A PRIMARY MENTAL HEALTH DIAGNOSIS WITH A SECONDARY SUBSTANCE USE DIAGNOSIS
	5.11	Comment: This section should more clearly describe integration models for adolescents with co- occurring disorders.
	5.11	Highlighted "Co-Occurring Disorders". Comment: COD should be placed under Tx.
	5.11.1	***Add:*** When an integrated treatment approach is not feasible, providers shall use a case manager ***or counselor*** for COD ***(remove treatment), referral, or coordination of care.*** Original: When an integrated treatment approach is not feasible, providers shall use a case manager for COD treatment.
	5.11.1	Comment: OUR THERAPISTS PROVIDE CASE MANAGEMENT AND WE FIND IT TO BE EFFECTIVE.
	5.11.1.a	***Add (?) at end of paragraph: This can and should be the role of the counselor under the supervision of the clinical supervisor.*** Original: 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.

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	5.11.1.a	Highlighted first phrase. Comment: HOW WILL THIS STAND-ALONE CASE MANAGER BE FUNDED? THIS MINIMIZES FLEXIBILITY FOR COUNTIES. THIS WILL BE VERY DIFFICULT FOR SMALLER COUNTIES WHERE THERE IS NOT A LARGER ENOUGH POPULATION TO WARRANT THIS STAND-ALONE POSITION.
	5.12	Deleted first sentence. Highlighted "and" in second sentence. Comment: Trauma informed care is a trauma-informed approach. Across COC.
	5.12	Comment: Would be helpful to be more explicit about the correlation between trauma and SUD/mental health issues, and the impact that addressing trauma in the course of treatment may have,
	5.12.2	Edited: Providers shall apply these **Trauma-Informed Care key** 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.c	e.g. on preventing relapse by addressing the underlying issues related to why the youth may be using substances to begin with.
	5.13	Table 2: Availability of MAT Inside and Outside of Drug Medi-Cal Programs Comment: This table describes availability of MAT for adults and, as such, probably should not be included in this document. Only methadone and buprenorphine may be prescribed of youth and this is only on a case-by-case basis.
	5.13	Highlighted "Medication Assisted Treatment (MAT)". Comment: We covered administering medication under the Tx section. This should move under Tx and include any requirements. Highlighted "the use of MAT is not recommended for adolescents." in second paragraph. Comment: Are you sure you want to put it in this manual. Remember, this manual covers requirements and policy.
	5.13	Comment: THE HIGHLIGHTED AREAS IN THIS SECTION ARE NOT CONSISTENT IN THEIR MESSAGE.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	5.13.2	Table 3: Comment: NOT ALL OF THESE ARE APPROPRIATE FOR YOUTH.
	5.13.2	Table 3: Comment: . NOT ALL OF THESE ARE APPROVED FOR ADOLESCENTS AS NOTED ABOVE.
	5.14	Commented: IS THIS THEN MANDATED?
	5.14.1	Comment: Need to make considerations for appropriate ways of testing, e.g. observed UAs are not really possible in school bathrooms for school-based SUD programs.
	5.14.1	Comment: WE DO NOT DO DRUG TESTING. REQUIRING IT IS NOT CLIENT CENTERED. MANY STAFF ARE FEMALE AND MANY CLIENTS ARE MALE. MOST OF OUR SERVICES ARE DELIVERED AT SCHOOL SITES. WE THEN COULD NOT DO SCHOOL-BASED TREATMENT. THIS SHOULD NOT BE A MANDATE TO RECEIVE TREATMENT. THIS IS ALSO NOT A TRAUMA-CENTERED PRACTICE.
	5.14.1	Highlighted "With the exception of early intervention programs". Comment: What about Pv?
	5.14.1	Highlighted: "shall provide/arrange for alcohol and drug testing for all adolescents." Comment: THIS IS NOT INDIVIDUALIZED TREATMENT NOR IS IT CLIENT- CENTERED TREATMENT. YOUTH CAN CONSENT TO THEIR OWN TREATMENT AND WE WILL NOT TURN THEM AWAY IF THEY DO NOT CONSENT TO DRUG TESTING. ONLY THE COURTS CAN ENFORCE DRUG TESTING.
	5.14.3	Comment: Requirement for Tx Plan. Also discussed in 4.10.3. Relapse procedures is missing in this document.
	5.15.7	Highlighted "treatment and recovery". Comment: This piece is specific to Tx and recovery. Move to a different section.
	5.15.8	Comment: It would be helpful to describe how to collaborate while at the same time protecting the youth's confidentiality.
6 - Systems Collaboration Among Agencies		It feels like this has been said over and over but good to keep saying.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	6	Highlighted "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)". Comment: Excellent!
	6	In our county we have a long history of collaboration with our agency and community partners. Requiring formal agreements, MOEs etc seems more like a barrier to referral and linkage rather than a help.
	6	This is absolutely unnecessary and unrealistic to have MOUs or similar written agreements with all entities with which we work. As I wrote above in section 4.5.1(a): MOUs are very laborious and time consuming. What if entities want to collaborate, but are not willing to enter into an MOU? We are a very large county with many clinics, hospitals, schools, etc. This is unrealistic and really not doable to require formal agreements with every entity we collaborate with. This puts up barriers to services. I suggest leaving it up to providers to determine with whom formal agreements are necessary. This already occurs today.
	6	Comment: It would be helpful to describe how to collaborate while at the same time protecting the youth's confidentiality
	6	Highlighted "Systems Collaboration Among Agencies". Comment: This is the COC and should be placed there.
	6	Edited as: SUDs may 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	Define: Interim Services

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	6.1.1	Comment: If the youth needs immediate access to services, it seems like he/she should be referred to another program right away if one is available. The rest of this section would then only apply if the youth must wait for access to treatment because there is not another program available.
	6.1.1	Comment: This should go under admission or placement.
	6.1.1.a	Not sure how a provider can ensure this, a provider should make every attempt to link. Original: The program site must be accessible to the adolescent, based on his or her transportation needs.
	6.1.2.a	Concerned that somehow this makes the provider the responsible party for something that may be out of their control. Also, what records does the provider keep for folks not being admitted? Original: Interim services are supportive services that are provided until an adolescent is admitted into an appropriate SUD treatment program.
	6.1.2.b	Highlighted "...within 48 hours of the diagnosis". Comment: IF WE HAVE NOT CONDUCTED AN INTAKE, WE HAVE NOT ASSESSED AND DETERMINED A DIAGNOSIS. THIS WOULD REQUIRE PROVIDING SOME TREATMENT EVEN IF THEY DO NOT HAVE A QUALIFYING DIAGNOSIS.
	6.1.3	Edited: At a minimum, ***based on individual need,*** interim services for adolescents ***may*** include referrals ***as appropriate*** for:
	6.1.3	These things may not be needed, so instead of saying “At a minimum…” better to say something like “Interim services MAY include referrals for:”
	6.1.3	Edited as: At a minimum, interim services for adolescents may include, if needed, referrals for:
	6.1.3.c	~~*Psychical*~~* ***Physical*** and behavioral health education services; and Comment: WHAT ARE BEHAVIORAL HEALTH EDUCATION SERVICES?
	6.1.3.c	Psychical?

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	6.2	Highlighted "Case Management and Complementary Services". Comment: Case management is across the COC. Deleted first 3 paragraphs. Begins with "Case management services are defined…"
	6.2	Edited as: 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	Highlighted "must" and b). Comment: PRIMARY CARE SERVICES ARE NOT PROVIDED WITHOUT PARENTAL CONSENT. THIS WOULD ABOLISH THE MINOR CONSENT LAW. C) Comment: THE YOUTH MAY NOT PROVIDE CONSENT FOR THIS COMMUNICATION.
	6.2.1	Highlighted "every adolescent". Comment: Any adolescent, based on the definition provided, can have case management. Many Pv programs provide case management to selective and indicated individuals. Highlighted "treatment". Comment: Not just Tx. Across the COC.
	6.2.2	What do they mean by complementary? Original: Case management and complementary services must include, but are not limited to, the following:
	6.2.2	Comment: this seems redundant with 6.2.6 below.
	6.2.2.a	Embedded comment: Coordination of behavioral health care (we are part of behavioral health. Is this referring to mental health services?), if needed;
	6.2.2.c	Remove "if needed" Original: Interaction with other social services systems, as needed (e.g., juvenile justice).

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	6.2.4	Case management can be accomplished by trained county staff. Requiring a LPHA or certified eligible counselor to perform these services will be a barrier.
	6.2.4 and a	Comment: You do not need credentials to "assist adolescents to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services." Really, what a case manager does is coordinates services, verifies services and participation, and makes referrals. Case managers also advocate for the youth/family in different systems of care; specifically, in court and at school. The case manager does not administer specific services i.e. counseling, therapy, Tx, medication, etc.
	6.2.5	Add "or counselor" after Case managers. Original: 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.
	6.2.5	Highlighted "must follow up with other professionals". Comment: THIS VIOLATES MINOR CONSENT AND THE CLIENT'S RIGHT TO DETERMINE WHO INFORMATION IS SHARED WITH. SECTION 5.6 REFERS TO ADOLESCENT- GUIDED CARE.
	6.2.5	Comment: with whom the youth provides consent and a signed release of information,
	6.2.5	With consent of the client to release PHI
	6.2.6	re. "include": Should state "may include".
	6.2.6.a	Comment: A case manager should not be administering assessment because an assessment needs to be assessed by someone that could prescribe diagnosis.
	6.2.6.c	Deleted "Development and"
	6.2.6.g	Highlighted "Monitoring". Comment: Verifies
	6.2.6.h	Highlighted "Monitoring the adolescent's progress". Comment: A case manager would not monitor or administer specific services such as Tx.

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	6.2.8	Comment after If phrase: UNSURE WHAT THE PRECEDING PART OF THIS SENTENCE MEANS
	6.2.8	Highlighted "Note" paragraph. Comment: Good!
	6.2.8	Because of this note, all words “shall” and “must” need to be removed.
	6.2.8.a	Edited as: Based on the client’s consent, Aarrange for, ensure access to, and coordinate complementary services identified in the adolescent’s treatment and recovery plan;
	6.2.8.a	Tough to ensure depending on geographic location. Again, what is meant by complementary, need to define.
	6.2.8.b	Edited as: Based on client consent, Ccommunicate 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;
	6.2.8.c	Comment: THE YOUTH MAY CHOOSE A CLINCIAN OR OTHER PERSON TO BE THEIR ADVOCATE
	6.2.8.c	Edited as: Based on client consent and interest, Bbe the adolescent’s advocate and liaison with other systems;
	6.2.8.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) ***as the client agrees to;*** and
	6.2.8.d	Edited as: As appropriate, Ccoordinate 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) if the youth provides consent to share information; and
	6.2.8.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, ***based on client consent and individual need.***

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	6.2.8.e	Highlighted "group". Comment: A case manager does not meet with other youth in a “group” session. That’s what it sounds like here.
	6.2.8.e	Edited as: Based on individualized need and as appropriate, Tthe case manager shall coordinate with the other agencies/ systems, referenced in Section 6, including possible group case management meetings, if the client consents, and to the extent possible.
	6.2.8 Note	Edited and embedded comment: In addition to the client providing consent to sharing information, Tthis role may require careful limit setting on collaboration and sharing of information when working with some systems (e.g., juvenile justice) I WOULD CHANGE THIS LANGUAGE, PARTICULARLY IF THIS DOCUMENT IS SHARED WITH OUR PARTNERS AND STAKEHOLDERS. 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	Add: Integrated substance use treatment for adolescents is a comprehensive approach that ***analyzes and*** treats substance use and co-occurring mental health disorders simultaneously. In addition, integrated care analyzes ***and treats dental and*** primary care ***prevention and*** services 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 ***and dental care*** services by coordinating referrals and linkages to the appropriate service providers.
	6.3	Effective adolescent SUD service providers work with young clients and their families to *~~ensure~~* ***assist with*** access to primary care services by coordinating referrals and linkages to the appropriate service providers.
	6.3	Highlighted "Integrated Care". Comment: Definition of “comprehensive approach.” In the beginning, the manual mentions a “comprehensive approach” which is never defined until now and we are on page 51.

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	6.3	Edited and embedded comment: 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. THESE ISSUES ARE ADDRESSED EVEN IF MENTAL HEALTH ISSUES ARE NOT ADDRESSED. Effective adolescent SUD service providers work with young clients and their families to ensureassist with access to primary care services by coordinating referrals and linkages to the appropriate service providers.
	6.4	Highlighted "Critical Linkages". Comment: Place under COC .
	6.4.1	Highlighted entire section. Comment: THIS IS DIFFICULT BECAUSE THERE ARE 33 SCHOOL DISTRICTS IN THE COUNTY, WE DO EFFECTIVELY LINK WITH THESE SYSTEMS, BUT IT IS NOT NECESSARY TO HAVE A PRIOR WORKING RELATIONSHIOP.
	6.4.1	Should say “may” include… All of these won’t be necessary for each adolescent while in treatment.
	6.4.2	Additionally, programs shall link with the juvenile justice and *~~SUD~~* ***other*** services systems, which provide opportunities for identification and referral of adolescents with SUDs. These include, but are not limited to, the following programs:
	6.4 Note	Edited and embedded comment: 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. I WOULD SAY SOMETHING MORE STRENGTH-BASED LIKE, “Only that information which is relevant and necessary for other systems shall be shared, and only with signed client consent to share information. Programs shall exercise careful limit setting in case management conferences.
7 - Health and Safety Issues	7.1	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. Comment: DMC PAYS FOR THE DESCRIPTION IN THE FIRST SENTENCE AT THIS TIME. WILL DMC EXPAND ITS REIMBURSABLE DEFINITION OF CRISIS SERVICES TO COVER THE ITEMS IN THE SECOND SENTENCE?

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	7.1	Edited: 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. Comment re. "actual relapse": Relapse is specific to someone who is diagnosed with an SUD. Relapse services needs to be included under Tx. Comment re. "of relapse": It doesn't always have to be a threat of using drugs. It can be a threat of injuring yourself and/or others.
	7.1.2	Comment: Create a relapse section and move this there.
	7.2	Highlighted "suicide prevention". Comment: If you are going to take this stand, then Pv funding should cover suicide Pv.
	7.2.1	(See highlighted revisions) Program staff shall be trained to recognize ***__and address__*** risk of suicide in clients ***__and to call 911 in a crisis situation or make a referral into mental health treatment as appropriate__.***
	7.2.1	Highlighted "Program staff". Comment: Which program staff? Across the COC? Highlighted "clients". Comment: First time using "clients"
	7.2.3	Not sure what is meant by this or what the intention is. Our county has 78 public high schools and many private high schools. Any provider cannot possibly monitor each of these for suicides nor all social networking sites.
	7.2.3	Highlighted "programs should monitor the situation and attitudes". Comment: Programs cannot monitor an actual "suicide" and the attitudes around it. They can
	7.2.3 & a	Highlighted last sentence "This monitoring…" and all of a. Comment: THIS IS AN INVASION OF PRIVACY WITHOUT OBTAINING WRITTEN CONSENT AND IT IS NOT WITHIN OUR SCOPE OF PRACTICE TO MONITOR SITES. WE ALSO CANNOT BE "CLIENT SHOPPING."

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	7.2.3.a	Highlighted first sentence. Comment: Programs cannot monitor an actual "suicide" and the attitudes around it. They can
	7.2.3.a	Comment: THIS IS OUTSIDE OUR SCOPE OF PRACTICE AND A VIOLATION OF PRIVACY WITHOUT CLIENT CONSENT.
	7.2.3.b	If the treatment program has a social networking site.
	7.2.3.b	Comment: Part of CLAS. Recommend adding a para on LGBTQ and suicide.
	7.3	Edited Title: *~~Care~~* Health and Safety *~~and Supervision~~* Edited: 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~~* ***Residential programs*** 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
	7.3.1	Edited as: *~~The~~* Residential programs 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:
	7.3.1.d	If applicable. Most outpatient sites would not have anything to do with storing and distributing medications.
	7.3.2	Comments: Programs should also have a policy for addressing situations in which a youth is being bullied by another youth in the program as this is also a safety issue.
	7.3.2	Comment: Move to intro

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	7.3.4	Add to sentence: Program staff shall ensure the availability of secure, safe, and reliable transportation for adolescents to and from the program site and to supportive services ***by directly providing or use of public transportation; if provided by family member or significant other, the responsibility needs to rest with them.*** How can all providers provide this for all patients, to include supportive services? So if a patient has a bus pass and is going to use public bus to return home, does the provider have to walk them to the bus stop and wait with them? Would not be possible.
	7.3.4	Programs shall have written procedures for signing in and out of program sites. Comment: THIS IS NOT PART OF TITLE 22. IS THAT FIRST SENTENCE REFERRING TO RESIDENTIAL? 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. Comment: HOW WILL THIS BE FUNDED? WE SUPPORT THIS IDEAL OF PROVIDING TRANSPORTATION BUT IT IS NOT FUNDED.
	7.3.4	re. signing in and out of program sites: Seems appropriate for a residential program but not an outpatient clinic based program.
	7.3.5	Programs shall establish a protocol for the submission of program incident reports TO WHO? in consultation with their county agencies, including
	7.3.7	Embedded comment: To ensure the welfare of the adolescent, all programs shall develop training to increase staff awareness and skills in the detection of injury, disease, THIS IS OUTSIDE OUR SCOPE OF PRACTICE emotional, physical, or sexual abuse, and neglect.
	7.3.7	(See highlighted revision) 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 ***as well as knowledge of child abuse reporting requirements.***

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	7.4	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[1]). THIS IS OUT OF OUTPATIENT SCOPE OF PRACTICE. *~~Residential~~* 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	This is applicable to residential treatment, not outpatient treatment
	7.4	(See highlighted revision) Medication Management in ***__Residential Treatment Settings__***
	7.4	Highlighted "Medication Management". Comment: Medication management has been mentioned twice. It should go under one section.
	7.4	Edited: Medication Management in Residential Care
	7.5	Comment: Need to define "emergency situation."
	7.5	Highlighted "treatment and recovery". Comment: This can be an issue for Pv as well.
	7.5.2	Seems appropriate for residential treatment, but not for outpatient clinic based care.
	7.5.3.a	Comment: THERE IS A MULTITUDE OF AMBULANCE COMPANIES AND WE GENERALLY WOULD CALL 911.
	7.6	Deleted "treatment and recovery".
	7.6.1	Comment: Include a description of licensing requirements

Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
8 - Legal and Ethical Issues	8.1	Edited title: Voluntary Participation Comment: Not just specific to Tx. Highlighted first sentence. Comment: Is this a research finding? If this is not a requirement, take it out. You are just saying it is most effective – which is a best practice.
	8.1	Edited as: 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~~* other 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.
	8.1.1	Edited as: If an adolescent appears to be mismatched to court-ordered SUD services, the program shall ensure that the youth receives or is referred to the appropriate level of care based on a clinical assessment.
	8.1.1	Medications used in MAT require particular attention to legal requirements.[2]
	8.1.1	(See highlighted revision) If an adolescent appears to be mismatched to court-ordered SUD services ***__on the basis of medical necessity__,*** 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.
	8.2	Highlighted first sentence. Comment: What areas? Comment: Does not make sense.
	8.2.4	Comment: Here you provide a description, but not for the others. Not sure what Short Doyle is.
9 - Admin		Comment: I do not think this is the correct word for this section.
	9.2.1.b&c	There are small providers that may only have LPHAs or only certified addiction counselors. Doesn't seem reasonable to require a certified addiction counselor when there are LPHAs.

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Youth Advisory Group (YAG) Feedback (DRAFT)

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	9.2.1.b	Currently our county run outpatient SU treatment programs use licensed MFTs and LCSWs with training in substance use treatment to provide services. Our programs emphasize "co-occurring" capability so we have moved away from "SUD counselors."
	9.2.1.b	Comment: WE HAVE ALL MFT OR SOCIAL WORKER CLINICIANS WHICH IS A HIGHER STANDARD THAN HAVE A CERTIFIED COUNSELOR. THIS REQUIREMENT WOULD REDUCE THE LEVEL OF COMPETENCE FOR OUR PROGRAM.
	9.2.1.c	Comment: ALL OF OUR CLINICIANS ARE TRAINED AND COMPETENT IN PROVIDING FAMILY THERAPY. I WOULD CHANGE THIS TO SAY, "Each program shall have certified, licensed or licensed-waivered clinicians to provide treatment. Each program must have at least one staff or contracted licensed or licensed-waivered clinician who can provide family therapy.
	9.2.1.c	***Changes to sentence:*** The family therapist may be a ***direct employee or independent*** contracted employee ***of the provider.***
	9.2.1.c	Residential 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:
	9.2.1.c	WILL DMC PAY FOR A DESIGNATED FAMILY THERAPIST? THE THERAPIST PROVIDES THE FAMILY THERAPY. You could say, "Each program must have a BBS or Board of Psychology-registered staff who can provide family therapy."
	9.2.2.c	THIS COMPLETE ASSESSMENT IS NOT WITHIN THE SCOPE OF 9.2.1b NOTED ABOVE.
	9.2.2.c	Comment: ; THIS IS OUT OF THE SCOPE FOR SUD COUNSELORS.
	9.2.2.d	THIS IS NOT WITHIN THE SCOPE OF AOD COUNSELORS
	9.2.2.f	Comment: THIS IS OUT OF THE SCOPE OF BBS CLINICIANS.
	9.2.2.g	NOT WIHTIN SCOPE
	9.2.2.h	NOT WITHIN SCOPE TO DETECT DISEASE OR INJURY
	9.2.2.j	CLINICAL STAFF ARE NOT TRAINED IN ADA REQUIREMENTS. THIS IS A MANAGERIAL FUNCTION.

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Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	9.2.2.l	OUT OF SCOPE FOR THIS STAFF.
	9.2.2.l	Comment: THIS IS OUT OF THE SCOPE OF PRACTICE.
	9.2.4	Many providers leave this up to each individual therapist/counselor. Suggest changing this to say that programs shall support continuing education. This sentence really may not be necessary because licensing and certification require clinical staff to complete CEUs anyway.
10 - Funding		Comment: I would put Funding in the beginning of this document. That's why we are here: SAPT!
	10.1.1	May not want to write the funding amount because it is fluid from year to year unless it is planned to update this document each year.
	10.1.2	The Federal Medicaid program funds routine youth screenings for SUDs utilizing the *~~Car, Relax, Alone, Forget, Friends, Trouble~~* (CRAFFT) screening tool. IS THIS THE ONLY TOOL THEY FUND?
	10.2.1	SAPT discretionary funds may be used to support ***__SOC__*** SUD early intervention services.
	10.2.1 & 10.2.2	Comment: Need clarification on accessing EPSDT funding for youth at risk of SUDs.
	10.3.2.a	For counties that opt in.
	10.3.3	Currently in California the EPSDT will not pay for substance use treatment when the SU diagnosis is the primary diagnosis. It will only fund services when the SU diagnosis is secondary to an included mental health diagnosis and only when the treatment provided for the SU disorder is documented in the note that the intervention for the SU disorder will ameliorate the primary mental health diagnosis. In other words the treatment of the substance use disorder must contribute to the improvement of the mental health disorder.
	10.3.3	This is not currently allowable in California. There is no billing mechanism for SUD as a primary diagnosis.
	10.3.3	Comment: Describe how providers may be reimbursed under EPSDT for SUD services for youth who have not been diagnosed with COD.

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
	10.3.4	This is not exactly true. In the new DMC ODS, residential will be covered, but not now. Also, this will only be available to counties that opt-in to the DMC ODS.
General Comments regarding the YSPM		[1] 42 C.F.R. § 59.11; HSC §§ 123110(a), 123115(a)(1); Reisner v. Regents of the University of California.
		[2] FAM § 6929(e).
		There are challenges for Youth Tx such as network capacity or staff to provide for adolescent Tx. Need to face the challenges that do not incentivize providers to have programs/resources. Need to provide incentive for networking. The biggest barrier for families and services is there is no place to send them.
		Rates that make other provisions feasible will make access to services possible, but, there are workforce issues. Parnerships with professional schools so that those coming out of those schools will bill at reasonable rates. A problem is that there is not equal time in the curriculum on substance use Tx. There may be an opportunity for DHCS to approach schools to revise curriculum.
		Early intervention and Tx programs need more flexibility so that Tx programs support EI.
		Currently, and with the new MediCal ODS requirements, treatment services can only be offered at provider sites. This may be an additional barrier to engaging adolescents. Programs and services embedded in schools and CBOs may make engagement and retention more likely. Currently, only Case Management may be provided off-site of a program's facility.
		Given this is a California state manual, and that marijuana legalization may pass in November of this year and be implemented in 2017, specific prevention activities may need to be included to focus on problems associated with marijuana use in youth and the increased prevalence of the drug in California culture. Marijuana and alcohol are already the most frequently used substances among adolescents in San Mateo County (and perhaps the state). The increased accessibility and acceptance of marijuana statewide (if the law is passed) may create additional challenges).

Section	Sub Section	Feedback on Youth Services Policy Manual (YSPM)
		I thought that the document was very well written, generally clear to the reader and covered both fundamental and emerging issues well. I had a couple of specific questions that may just be an issue of clarity...
		As a representative of the prevention field, I noticed that in general the document is somewhat difficult to follow as it relates to requirements for prevention vs. treatment. Would it be possible to include some sort of mechanism to clarify when the requirements are different?
		It is a beautiful document and clearly has been put together to reflect the most recent literature related to effective substance use treatment and programs. I made a few comments on the attached document, but in general my concern is that this now appears to be a regulatory document (instead of a "guideline") that if not followed could affect substance use treatment funding. It is really a best practice document, but I fear that there are not nearly enough resources currently for substance use treatment for counties to even begin to meet the very detailed requirements. Although it did not specify it, the document appeared to be written for residential treatment programs and certain aspects of it did not appear to be realistic in clinic based outpatient programs. There are very few residential treatment programs for adolescents across the state. Orange County is fortunate to have one of them. Our SU services are primarily outpatient services and are clinic based and co-located with our mental health programs. In fact Orange County has moved to a co-occurring model where all of our clinicians are trained to provide services in a co-occurring manner. Having said that we do have located in each clinic a licensed clinician who focuses primarily on youth who have been identified to have a primary diagnosis of a substance use disorder.
		This is an amazing document into which much energy and effort went into, including significant research. I have made many comments throughout the document from the perspective of being a provider as we do have county-operated SUD services. There are things in the document that are really excellent, but not practical nor realistic on the ground level. In fact, I see some things, while idealistic, actually would create barriers to treatment.