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The National Association of State Alcohol and Drug Abuse Directors, Inc.

State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide

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NASADAD

National Association of State Alcohol and Drug Abuse Directors

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Overview

Substance use disorders (SUDs) among adolescents pose particular challenges for the single State agencies (SSAs) responsible for managing substance abuse treatment and recovery systems. Given the differences in developmental and emotional growth between adolescents and adults, the complex needs of this population are remarkably different from those of the traditional adult treatment population, requiring different expertise and guidance to States on how their treatment and recovery systems can best serve adolescents. In response, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and its Federal and State partners collaborated to create this guidance document. NASADAD, along with its State Youth Substance Abuse Coordinators Committee, gathered information about existing State guidance for adolescent treatment and recovery services, identified essential elements of treatment and recovery systems for adolescents with SUDs, and developed the guidance that follows. The guidance is divided into three broad sections:

- Overarching principles of care
- Service elements, including screening, assessment, and treatment and recovery services
- Administrative considerations for States

These sections are defined in greater detail within the document, but in broad terms, each section contains draft guidance language that could be used in State regulations, contracts, and guidelines. However, the purpose of the document is not to dictate a specific set of services or practices to States but rather to provide a menu of options for States to consider as part of the management of their substance abuse treatment and recovery systems. The guidance contained herein will serve as a resource for States in their continuous efforts to improve substance abuse treatment and recovery systems for those in need of treatment, particularly for adolescents.

Introduction

Adolescents have psychological, developmental, and emotional strengths and needs that are distinct from those of the adults who comprise the majority of the SUD treatment and recovery population. For the purposes of this document, youth aged 12–18 will be the age group categorized as adolescence and will be recognized as distinct from earlier childhood and young adulthood in terms of specific cognitive, emotional, social, and neurodevelopmental processes. References to “youth” or “adolescents” throughout the document will refer to those aged 12–18. Research indicates most mental health and SUDs emerge during adolescence, partially due to the brain’s rapid development throughout this time period (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). Recent functional magnetic resonance imaging studies of adolescent brain development illustrate this neurological basis for adolescents’ susceptibility. These studies of adolescent brain development indicate “the brain systems providing for impulse control are still maturing during adolescence. The part of the brain that develops most during adolescence is the prefrontal cortex, the area involved in complicated decision making, thinking ahead, planning, and comparing risk and rewards” (Jainchill, 2012). These neurological and developmental differences between adolescents and adults require tailored treatment and recovery approaches for adolescents with SUDs.

Data from the National Survey on Drug Use and Health (NSDUH) reveal 1.7 million adolescents in the United States needed treatment in 2011, though only a small fraction received treatment at a specialty facility (SAMHSA, 2012b). Adolescents constitute 7.4 percent of total admissions to the public SUD treatment system (Center for Behavioral Health Statistics and Quality, 2012). As of 2011, a majority of

programs (59.6 percent) reported offering specific programs or groups for adolescents, and 34.7 percent of programs reported serving at least one client under the age of 18 (SAMHSA, 2012a).

This document is particularly needed given recent changes to the U.S. health care delivery system as a result of major health reform efforts. These policy changes will affect many aspects of health care delivery. For individuals and those in small group markets, health insurance plans are required to offer essential health benefits including mental health and SUD services. This will create greater opportunities for adolescents to receive SUD services. These provisions focus on the whole health of the adolescent and may begin to address the 1.6 million adolescents in need of specialty SUD treatment who are currently not receiving it. This likely increase in the demand for adolescent SUD treatment requires additional consideration for the provision of treatment and recovery services for this population. State agencies responsible for SUD prevention, treatment, and recovery services will play an instrumental role in the dissemination of new and improved evidenced-based treatment, continuing care, and recovery options for adolescents with SUDs by funding providers and their workforce, implementing quality initiatives, and licensing providers. Given these changes to the behavioral health delivery system, State agency staff members responsible for adolescent SUD services identified the need for the development of this guidance document.

The *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide* is a product of collaboration among NASADAD and Federal and State partners. The State Youth Substance Abuse Coordinators Committee (hereafter referred to as the Youth Coordinators) provided the direction and content expertise for this document. The process for its creation was based on that of a previous document, *Guidance to States: Treatment Standards for Women with Substance Use Disorders* (Mandell & Werner, 2008), as further detailed in the methodology section. Ultimately, the purpose of the *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide* is to serve as a resource for States, territories, and tribes.

More specifically, the goal of the document is to work with States to develop draft guidance language that could be used in regulations, contracts, and guidelines to enhance the treatment and recovery system for adolescents with SUDs. At least 24 States (Arizona, California, Colorado, Delaware, Georgia, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Minnesota, Mississippi, Missouri, Montana, New York, North Carolina, Oklahoma, Oregon, South Carolina, Texas, Utah, Washington, Wisconsin, Wyoming) have existing documentation on adolescent treatment standards and/or guidelines for the treatment of adolescents with SUDs. Ideally, States will select applicable language within this document and use it in policy and practice to develop and bolster their continuum of care for adolescents with SUDs. NASADAD understands all States are unique and have varying needs; as a result, the document is expected to be used in different ways by different States. The guide outlines suggestions based on States' documents and research, Youth Coordinators' and consultants' expertise, and recommendations from a prior SAMHSA-sponsored Technical Expert Panel draft report (SAMHSA, 2013). These guidelines do not constitute requirements or endorsements from NASADAD, the Federal Government, or States for any specific treatment or recovery services or approaches. Rather, the document provides information on services that may be provided. This document makes use of "will" and "should" statements so States may more easily borrow language for use in future contracts and regulations. This language is not meant to be prescriptive, as NASADAD acknowledges States will use the information in a variety of ways to improve their unique adolescent treatment and recovery systems.

Recognizing the importance of a public health approach that includes SUD prevention and early intervention, this guidance document focuses on the delivery of SUD treatment and recovery services for adolescents between the ages of 12 and 18. While some States and systems may define adolescence more broadly and extend up to age 25, the needs of young adults or transition-age youth (18–25) can be significantly different than those of younger youth and adolescents. The Youth Coordinators thought it important to focus on the specific requirements for adolescents aged 12–18.

It should be acknowledged there are several limitations to the scope of this document. For instance, the needs of transition-age youth or young adults are distinct from those of adolescents and cannot be adequately encompassed within this document. Likewise, defining "adolescents" as individuals aged 12–18 does not acknowledge the meaningful developmental and social differences in treating an adolescent who is 12 versus an adolescent who is 18. There are many subpopulations of adolescents with SUDs that may need more targeted attention. This document is intended to provide an overview that broadly addresses adolescents with SUDs and does not focus on specific populations that might need additional attention. Important issues of gender, sexual, and cultural identity are touched upon and need to be further explored to provide quality services.

Certain terminology in this document was standardized to achieve internal consistency. For instance, not all adolescents who use psychoactive substances may currently or ever meet the criteria for SUD. For this reason, labels and premature diagnoses should not be forced upon adolescents. For the purposes of this practice guide, the term "substance use disorder" is used to encompass patterns of problematic substance use that are diagnosable as an SUD according to criteria in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition. Likewise, certain important topics cannot be fully addressed because of the length and scope of this document. Two examples are school-based services and treatment staff competencies, both of which are critically important considerations. Conscious choices were also made as to the level of detail provided. For instance, in the discussion of evidence-based practices (EBPs), no specific EBPs are listed. This decision was made with the expectation that EBPs will continue to evolve after this document's publication and providers and States are better equipped to choose the EBPs that work best for their specific adolescent populations.

It should be noted this document is intended to serve as a guide for SSAs for oversight, management, and/or purchase of adolescent SUD services. Historically, direct procurement of services by SSAs comprised the majority of spending on substance abuse treatment and recovery services. However, national health reform efforts, particularly the inclusion of substance abuse services into the Essential Health Benefits package, have added additional payers and treatment structures that may result in increased reimbursement from Medicaid, the Children's Health Insurance Program, and private insurers. The degree to which this will occur will vary from State to State and over time. We acknowledge there are other systems that may provide services to adolescents with SUDs. While this guide was developed by SSA staff (the Youth Coordinators) to aid in their procurement and licensing of treatment and recovery support for adolescents with SUDs, the contents may also be helpful to States as they collaborate with public and private insurers and other funders.

The practice guide has three sections: Overarching Principles of Care, Service Elements, and Administration/Operations Considerations. The Overarching Principles of Care represent critical cross-cutting principles that underlie all components or elements of adolescent treatment and recovery (e.g., developmentally appropriate and trauma-informed care). Service Elements represent treatment, continuing care, and recovery services and supports. The Administration/Operations Considerations

address additional areas States may consider in the direct procurement of services or as they collaborate with other public and private funders of adolescent treatment and recovery support services.

Methodology

The State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide was developed in response to a need identified by and driven by the Youth Coordinators through an interactive process. Twenty-four Youth Coordinators volunteered to serve on the Adolescent Treatment and Recovery Practice Guide Workgroup, including team leaders of the three subworkgroups (Group A: Maria Morris-Groves, New York; Group B: Tina Burrell, Washington; and Group C: Katie Wells, Colorado). This methodology section provides a brief summary of the history of the development of this practice guide (see appendix A for a more detailed description of the development process).

The Youth Coordinators expressed interest in gathering information on States' existing regulations, contract language, treatment practice guidelines, and similar documents for adolescents with SUDs. A total of 40 States and 1 territory responded to the request for information (n = 41). NASADAD staff searched State Web pages to find additional documents from States that were unable to respond to the request for information. Twenty-four States (Arizona, California, Colorado, Delaware, Georgia, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Minnesota, Mississippi, Missouri, Montana, New York, North Carolina, Oklahoma, Oregon, South Carolina, Texas, Utah, Washington, Wisconsin, Wyoming) reported having some documentation on adolescent treatment standards and/or guidelines for the treatment of adolescents with SUDs. Seventeen States and one territory reported not having such documents.

In addition to the State-submitted documents, NASADAD staff reviewed and incorporated information from SAMHSA documents (e.g., *Designing a Recovery-Oriented Care Model for Adolescent and Transition Age Youth with Substance Use or Co-Occurring Mental Health Disorders*, *Good and Modern: Description of a Modern Addictions and Mental Health Service Systems*, *Treatment of Adolescents with Substance Use Disorders Treatment Improvement Protocol [TIP] Series 32)* and the work of recognized national experts (e.g., publications from national organizations or research-based documents: *Treating Teens: A Guide to Adolescent Drug Programs*, *Guidance to States: Treatment Standards for Women with Substance Use Disorders*). Content experts from SAMHSA and Georgetown University reviewed findings from the draft Technical Expert Panel document and provided additional information, drawing on *Selected Findings From SAMHSA-Sponsored Technical Expert Panel: What Does the Research Tell Us About Good and Modern Treatment and Recovery Services for Youth With Substance Use Disorders?*

Members of the Adolescent Treatment and Recovery Practice Guide Workgroup were divided into three subworkgroups (A, B, and C) to ease scheduling and encourage robust discussions throughout the review and content development processes. NASADAD staff distributed information packets for review and comment by the Youth Coordinator groups and their assigned NASADAD consultant. This feedback formed the basis for the development of initial central principles, which describe vital aspects of each element. These central principles, along with the revised descriptions, formed the basis for further review by the Adolescent Treatment and Recovery Practice Guide Workgroup.

Review and development of the sections were completed primarily through Web-facilitated meetings with the Youth Coordinators, consultants, content experts, and NASADAD staff. During these Web-facilitated meetings, the Youth Coordinators reviewed and provided feedback on content and edited the

information. The revised version of each topic reviewed during Web-facilitated meetings was sent back to the group for additional edits, comments, and suggestions. These edits, comments, and suggested revisions were used to create the draft Service Elements section.

The complete document was sent for review and comment to the Youth Coordinators; the NASADAD Board of Directors; the National Treatment Network (NTN) Executive Committee; JBS International, Inc.; and SAMHSA. The Youth Coordinators were asked to consult with other SSA staff members, including State directors, NTNs, providers, and other stakeholders. The comments and suggested revisions were incorporated into the *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide*.

A. Overarching Principles of Care

The Overarching Principles of Care express core values and principles that underlie the adolescent SUD treatment and recovery system. Nine principles were selected by the Youth Coordinators as the foundational principles of care for addressing the needs of adolescents with SUDs. The section contains a brief description followed by bulleted sample language that expresses each of the nine principles. These principles pertain to all service elements described in the next section of this document (Section B). For example, while certain aspects of developmentally appropriate care are specifically identified in this section, it is recommended the adolescent's development is a global consideration throughout all aspects of care (e.g., delivery of service elements, development of State systems for youth).

1. Developmentally Appropriate Care

Description

Adolescents are developmentally, physically, cognitively, emotionally, and socially different from younger children and adults. "[Adolescence] is a period of rapid developmental change involving major biological, behavioral and cognitive transitions. [Adolescents] are beginning to move away from family-based to peer-based identity on the way to defining who they are as individuals" (Drug Strategies, 2003). There is evidence that both psychotherapeutic and behavioral interventions, which explore the adolescents' cognitive processes and the learned behaviors, respectively (Center for Substance Abuse Treatment [CSAT], TIP 34, 1999), affect the neurobiology of SUDs in adolescence, and treatment approaches for adolescents with SUDs should be individualized to the adolescent's specific developmental stage. Staff should be informed about the cognitive and developmental level, growth, behavior, values/beliefs, and cultural differences among adolescents. Developmentally appropriate care also takes into account the distinct developmental stage of the adolescent and any cognitive, social, emotional, and/or developmental delays or disabilities he or she may have. Furthermore, developmentally appropriate care addresses the physical and emotional changes that occur during puberty, which vary by gender.

- Staff will understand the developmental stages, growth, behavior, values/beliefs, and cultural differences among adolescents.
- At every level of care, program services for adolescents will be designed and implemented in ways that are developmentally relevant (e.g., taking age, maturation, cognitive processing, decisionmaking skills, and special needs of the individual adolescents into consideration). Adolescents will be treated in the least restrictive environment possible.
- Programs will use effective strategies to engage adolescents, channel their energy, and hold their attention; these strategies are different from those for adults.

- Staff will communicate and deliver services that are age appropriate in terms of the adolescent's developmental stage, cognitive ability, and relevant environmental and sociocultural factors.
- Treatment and recovery will address the nuances of adolescent experience (including cognitive, emotional, physical, social, and moral development) and how these nuances interface with their alcohol and other drug use.
- All screenings and assessment services will be developmentally appropriate, trauma informed, and responsive to gender identity, sexuality, and culture.
- Services, materials, and resources provided to adolescents will be accessible in that they will be developmentally appropriate and tailored to adolescents.

2. Cultural and Gender Competence

Description

Cultural and gender competence stresses that adolescents and their families receive effective and respectful care provided in an understandable manner compatible with their cultural beliefs and practices, gender-specific needs, and preferred language. Further, culturally and gender-competent care is respectful of racial and ethnic identity, sexual orientation, gender, religion, age group, geographic location (e.g., rural/frontier, urban), and other shared affiliations. These principles require providers to be aware of the roles that culture, gender identity, and sexuality play in the development of SUDs and in the effectiveness of services and modalities. Culturally and gender-appropriate care is important given that cultural factors may affect how the adolescent responds to different interventions and treatment modalities. Programs that are culturally and gender competent have been found to increase engagement, access, utilization, retention, and positive outcomes for adolescents (Drug Strategies, 2003). Attention should also be given to addressing disparities in access to treatment and recovery supports across different ethnic and racial groups, recognizing many minority youth are disproportionately referred to more restrictive systems (e.g., juvenile justice and child welfare) than into specialty behavioral health or substance use treatment.

- Screening and assessments will be comprehensive, multifaceted, trauma informed, culturally and developmentally appropriate, and provided in an empathetic, nonjudgmental manner.
- Providers will use culturally and gender-appropriate strategies for prevention, engagement, screening, assessment, treatment planning, intervention, treatment, and recovery supports for adolescents and their families.
- Providers should also "be aware of the effects of socialization, stereotyping and unique life events on the development of girls…across diverse cultural groups" (American Psychological Association, 2007).
- The therapeutic alliance will be informed by the provider's understanding of the adolescent's cultural and sexual identity and connections, the adolescent's social supports, and the impact of cultural beliefs on social stigma.
- Providers will be sensitive to the cultural expectations adolescents have in their interactions with authority figures and adults and their expectations in interactions across genders and cultural/racial groups.
- Providers serving adolescents whose primary language is not English, including adolescents who use sign language, will provide skilled bilingual staff and/or interpreters as needed.

- Print and audiovisual materials will be both linguistically and literacy appropriate (e.g., at various reading and developmental levels) for adolescents and their families.
- Providers will train staff to address the needs of adolescents from various racial and ethnic groups, religions and spiritual affiliations, and cultural and indigenous beliefs with an emphasis on the populations in the provider's community. This includes ensuring cultural diversity in the staff and identifying and using engagement strategies that are culturally appropriate and effective in sustaining retention in services.
- Providers will assess staff attitudes and the program's informal procedures and institute formal policies to foster an environment of acceptance toward different sexual orientations. This will include an ability to address issues of sexuality, sexual identity, and gender identity, including those of lesbian, gay, bisexual, transgender, queer/questioning, and intersex (LGBTQI) adolescents.
- Gender-responsive services will be available to ensure adolescents receive appropriate individualized (youth-guided) care.
- A "safe" environment will be cultivated to talk about sensitive issues; this will include having gender-matched staff and gender-specific services and therapies, including same-gender groups and nonaggressive/nonconfrontational therapies, which will enhance therapeutic alliances.
- Programs will have an understanding of how culture, sexuality, and gender influence a young person's identity and substance involvement, which will in turn inform effective intervention strategies.
- Providers will take into account access to services, particularly in rural or frontier areas. Telemedicine or e-therapy will be offered, when possible, to adolescents in rural or frontier areas (see "Technology" section for additional information).

3. Systems Collaboration Among Youth-Serving Agencies

Description

SUDs affect multiple aspects of the adolescent's life, including family, community, school, and peers. To provide the best care for adolescents, it is important to acknowledge that adolescents are provided many services by other State systems such as Medicaid, mental health, physical health care, child welfare, juvenile justice, education, and others. Adolescents' interactions in other systems can afford an opportunity to link them to SUD services when appropriate (SAMHSA, 2011a). Joint goals or missions and interagency agreements or memoranda of understanding can help to facilitate cross-agency partnerships to better serve these adolescents.

- SSAs at the State/territory or tribal levels will collaborate with other adolescent-serving systems or agencies to address the comprehensive needs of adolescents with SUDs and their families.
- SSAs will educate other adolescent-serving systems or agencies on services available to adolescents with SUDs.
- SSAs will seek to identify and coordinate with resources provided to adolescents by other systems or agencies to develop a coordinated continuum of care through partnerships and strong linkages.

- SUD providers will work with adolescents and their families to help them negotiate services across systems and coordinate referrals.
- Collaboration with agencies serving family members with siblings, including child welfare agencies, will consider the needs of the individual adolescents and opportunities for family-centered recovery.
- SUD providers will coordinate case management with other systems, taking into account State and Federal laws pertaining to disclosure of confidential client information (see "Case Management and Care Coordination" section for additional information).
- For adolescents in residential treatment, a transition plan will be developed prior to their return to the community. This plan will include linkages to community-based agencies that will help address the adolescent's SUD needs through the provision of continuing care and recovery support services as needed.
- Providers will ensure adolescents returning to community educational settings meet with their treatment team and education officials to assist their transition back into school, in consideration of their continuing clinical monitoring and recovery needs. This will include teaching educators about SUDs.

4. Integrated Care

Description

Integrated SUD treatment for adolescents takes a comprehensive approach that addresses both the integration of treatment for substance use and co-occurring mental health disorders and the integration of adolescent SUD treatment and primary care services that may include primary pediatric care needs, reproductive health needs, or issues of abuse and neglect.

A comprehensive service system for adolescents with co-occurring substance use and mental health disorders must have support at the highest levels and be consumer-centered and culturally competent. These systems should take a "no wrong door" approach such that services are available and accessible no matter where and how an individual enters the system. To address adolescents' needs in a coordinated way, systems should use common data and assessment tools, train substance abuse and mental health staff in each other's disciplines, and use flexible funding mechanisms (National Association of State Mental Health Program Directors [NASMHPD] & NASADAD, 1999).

States may have more integrated treatment and recovery programs that are dual-diagnosis capable or enhanced, which streamlines the coordination of resources for adolescents with co-occurring substance use and mental health disorders. In the absence of integrated systems, service coordination among the mental health, substance abuse, and primary health care systems should correspond to the level of severity of the disorder. Coordination begins with consultation across systems, which ensures both mental health and substance use disorders are addressed. Systems may formally collaborate to ensure both substance use and mental health issues are included in the treatment regimen. In cases of high severity, systems may engage in services integration, which merges substance use and mental health disorder treatment efforts into a single treatment setting and treatment regimen (NASMHPD & NASADAD, 1999).

Adolescent SUD treatment providers work together with adolescents and their families to ensure access to primary care services, either directly or through coordinated referral and linkages to appropriate

service providers. Integrated care may also address other aspects of the adolescent's life, including culture; gender identity and sexuality issues of abuse and neglect; or social, education, vocational, and legal problems (see "Delivery of Services for Co-Occurring Substance Use and Mental Health Disorders" section for additional information).

- Providers will "commit to the concept of one team with one plan for one person" in whatever way this works for the treatment providers (California Department of Alcohol and Drug Programs & California Department of Mental Health, 2004). Ideally, this will be accomplished within a single, integrated system or individualized treatment and recovery service plans that incorporate input from family and significant others in the adolescent's life and multiple youth-serving agencies with which the adolescent may be involved (e.g., primary care, schools, child welfare, juvenile justice). *Addressing co-occurring mental health disorders in adolescents with SUDs is of utmost importance to achieving successful and lasting client outcomes. Provider networks will include a continuum of services capable of addressing the full range of co-occurring mental health disorder severity.*
- Individualized treatment and recovery service plans will be comprehensive and address each of the adolescents' and families' needs in the least restrictive setting that is safe and effective.
- Matching treatment settings, interventions, and services with the strengths, needs, and preferences of the individual adolescent and his or her family is imperative, given that a one-treatment approach will not adequately address the complex needs of all adolescents.
- Treatment outcomes will be assessed over time, and individualized treatment and recovery service plans will be modified to ensure they meet the adolescent's changing needs and resources.
- Providers will receive ongoing education and training regarding the gender-specific prevalence, etiology, signs/symptoms, and treatment of co-occurring mental and/or physical health disorders.
- The provider will document services provided to individuals with co-occurring mental and/or physical health conditions (e.g., medication noncompliance or abuse, interactions between potential drug use and other medications).

5. Trauma-Informed Care

Description

There is growing awareness that trauma plays a central role in SUDs. When an adolescent experiences trauma, especially repetitive trauma, it significantly increases the likelihood he or she may develop a SUD. At the same time, adolescents with SUDs are also more likely to experience trauma than other adolescents. Given the complex linkages among violence, victimization, trauma, and SUDs, it is important to acknowledge the role trauma plays in the lives of adolescents and their families. It is also important to acknowledge that gender identity plays a key role in the ways adolescents respond to trauma. A trauma-informed approach and trauma-specific services acknowledge and address the trauma and victimization common among adolescents who enter alcohol and drug treatment services. Trauma-informed care can be described as an "approach to organizing treatment that integrates an understanding of the impact and consequences of trauma into all clinical interventions as well as all aspects of organizational function" (Delaware Division of Prevention and Behavioral Health Services, 2011). A trauma-informed approach seeks to avoid retraumatization by taking a "safety first" and "do no harm" approach

(SAMHSA, 2012c). Trauma-specific interventions are used by trained practitioners to address different age groups, settings, and types of trauma (SAMHSA, 2012c).

- The impact and consequences of trauma will be considered in all clinical interventions, recovery support services, and organization operations.
- Screenings and assessments will be trauma informed, and trauma-specific interventions will be used when appropriate.
- Trauma-specific services will include evidence-based and promising practices that directly address the effect of trauma and facilitate recovery and healing.
- Because substance use can be a coping mechanism for adolescents who have experienced traumatic events, providers will work with adolescents to build other alternative, less harmful coping skills.
- Providers will not require that adolescents retell the details of their traumatic experience(s).
- Providers will assess and identify safety issues such as current risk for suicide or history of suicidal ideation and/or behaviors, physical or sexual abuse, or perpetration of physical or sexual abuse on others. When appropriate, referral will be made immediately. This assessment will include mental health (see "Safety and Facilities" section for additional information).
- Providers will make efforts to prevent the use of seclusion and restraint, recognizing these coercive practices are not therapeutic and can be retraumatizing. Seclusion and restraint should be used only as a last resort if the safety of the adolescent or staff is at risk.
- Providers' staff will be trained on the provision of a trauma-informed and trauma-responsive environment, trauma-specific services, and issues of retraumatization. This includes frontline and nonclinical staff members (Mandell & Werner, 2008).
- Providers will recognize physical, emotional, and psychological safety are critical for recovery.

6. Youth-Guided Care

Description

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

- Youth-guided care will be based on the unique circumstances and events that contributed to the adolescent's SUD that may influence his or her treatment and recovery.
- Treatment will not simply address the adolescent's SUD but will also be a comprehensive, strengths-based process that addresses medical, social, familial, vocational, and legal issues while providing recovery support.
- The entire treatment process will involve the adolescent as a full partner and will focus on measurable goals and resiliency building, with specific timeframes identified by the adolescent, his or her family, and the provider.

- Treatment plans will be developed in conjunction with the adolescent and his or her family and involve the adolescent in recognizing and appreciating his or her unique strengths and assets and clarifying needs.
- Skill development based on the different needs the adolescent has expressed, such as developing his or her identity, handling academic issues, and addressing peer and familial relationships, will be included for further capacity building.
- Adolescents will have a developmentally appropriate level of responsibility in their own care that encourages them to make decisions in coordination with their families, take on new roles, and enhance their self-confidence to encourage ownership of their treatment and recovery process.
- Providers will integrate a positive youth development approach into SUD treatment. This includes supporting the adolescents to develop their competence, character, connections, confidence, and contributions in positive ways (Pittman, Irby, Tolman, Yohalem, & Ferber, 2002).

7. Family-Centered Care

Description

Family plays an important part in adolescent treatment and recovery. It is important to include family members as a part of the "team" and consider their needs as a part of adolescent SUD services. Involvement from the family "is necessary to improve the quality of care provided and to insure that all adolescents in need of substance use disorder treatment receive high-quality care that incorporates their family members and promotes holistic recovery for everyone involved" (SAMHSA, 2010). 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. Youth may need assistance in identifying healthy, responsible individuals for a family of choice and setting boundaries and coping with less healthy family members (including those with SUDs themselves). A positive family structure helps reinforce the skills and behaviors established in treatment. Family engagement can improve treatment outcomes for the adolescent, prevent or reduce SUDs across generations by increasing parenting skills, and help facilitate environmental change (CSAT, TIP 32, 1999). Treatment gains, recovery, and ongoing personal development can be reinforced by family members.

- Providers will adopt a broad definition of family that includes family of origin or of choice.
- Providers will work with the adolescent to identify family members available to engage in the adolescent's recovery efforts.
- Programs will create a family-friendly environment that encourages adolescents and families to engage in recovery efforts. To the maximum extent possible, services will be adolescent and family driven or directed and will treat family members as shared decisionmakers in assessment, treatment planning, recovery support services, and clinical activities (e.g., family therapy and other services as identified by the goals and needs of the adolescent and family).
- While family-centered care will be supported, programs focused on adolescents with SUDs will respect and support adolescents who choose not to disclose their circumstances or involve particular family members in their treatment services.

- When involvement by the adolescent's family of origin is not appropriate, the reason will be documented. Referrals to services may be offered for any family member not included in the adolescent's family services. If the parent(s) are not available, program staff will assist in developing alternate social and family support systems for the adolescent.
- Regardless of the parents' or caregivers' capacity, providers will give them the opportunity to build skills to support the adolescent; in some cases, this may require a substance use intervention for the parents or caregivers.
- Providers will offer family members support services in accordance with the goals determined by the family unit.

8. Recovery-Oriented Systems of Care

Description

Recovery-oriented systems of care (ROSC) for youth support youth-guided and self-directed approaches to care that build on the strengths and resilience of adolescents, their families, and communities to take responsibility for their sustained health, wellness, and recovery from SUDs (SAMHSA, 2009). A ROSC for adolescents emphasizes the importance of youth-guided and family-centered care; employs a broad definition of family; is culturally, age, and gender appropriate; reflects the developmental stages of adolescence; acknowledges the nonlinear nature of recovery; promotes resilience; is strengths based and proactive; and identifies recovery capital (SAMHSA, 2011b). Among the most important elements of treatment is provision for supporting or building relationships that promote recovery.

- Providers will offer developmentally, culturally, and gender-appropriate care and a choice of services that can be used in recovery efforts and in supporting or building relationships that promote recovery.
- Providers will be guides rather than directors of services in treatment planning and service provision.
- Providers will assist the adolescent in defining what wellness in recovery means for them and supporting the attainment of wellness.
- A range of recovery services will be available that allows the adolescent to choose support services that can be adjusted and combined based on his or her needs and stage of recovery.
- Providers will encourage the use of peer recovery groups and mentors/coaches, which enhance development of skills and reasoning abilities and assist in establishing new drug refusal skills, relapse prevention techniques, and anger management skills.
- Providers will promote a greater responsibility on the part of adolescents for their own treatment and encourage them to practice decisionmaking skills and roles, thereby enhancing self-confidence and self-efficacy.
- Treatment and recovery planning will be youth guided and youth centered to the extent that is developmentally appropriate, building on the adolescent's priorities and interests. Providers will give adolescents choices to assist in their self-directed care.
- Peer recovery groups and mentors will be an option for adolescents to assist in supporting their recovery.

- Providers will give adolescents the ability to check in with peer mentors/recovery coaches and administrative staff to access support or additional care.
- Programs will address lapse and relapse as learning opportunities for adolescents in treatment and recovery services. To the extent possible, adolescents will not be dismissed from programs as a result of lapse or relapse, which is often a part of recovery.

9. Evidence-Based Practices

Description

Implementing developmentally and age-appropriate EBPs for adolescents with SUDs is recommended to maximize positive treatment outcomes. Indeed, "the body of controlled studies clearly shows that evidence-based psychosocial treatment for youth with substance use disorders is effective (e.g., reduces substance use for youth with clinical levels of abuse/dependence)" (SAMHSA, 2013). Use of EBPs has been shown to improve family functioning and reduce the risk of progression to more severe behavioral and substance use problems in adolescents. EBPs are used most effectively when providers' staff are trained and qualified to implement interventions with fidelity and have appropriate supervision. "Promising practices" may also be considered, particularly because there is not an EBP for every population. For instance, many EBPs do not provide practitioners with differential application for specific stages of development, but these modifications may need to be made to accommodate the adolescent's developmental stage. Likewise, providers should examine which specific populations' programs and practices the EBPs have been tested in before implementing them. It is important the practices used by providers are implemented with the adolescent's and family's cultural background in mind.

Examples of EBPs include screening tools, assessment tools, counseling, family counseling, group counseling practices, and use of medications in treatment. EBPs are one component of the continuum of care provided to youth in SUD treatment. In acknowledgement of the ever-evolving field of SUD treatment, specific EBPs are not listed in this document, but providers are encouraged to seek out and use developmentally appropriate EBPs.

- Providers will have an understanding of models and theories of SUDs and behavioral, psychological, physical, and social effects of psychoactive substances. They will also remain up to date on current research and evidence-based and best practices for adolescent treatment and recovery.
- To use EBPs effectively, providers will ensure staff members are adequately trained and qualified to implement the practices with fidelity and have the appropriate supervision.
- Provider personnel files will document training(s) and/or certification(s) in the evidence-based model(s) the staff member is using in the provision of adolescent services.
- Providers will be able to demonstrate which EBP is implemented, how trainings and supervision are conducted, and how fidelity is assured.
- Providers will use EBPs that are age, gender, developmentally, and culturally appropriate as identified by national or State-level EBP clearinghouses (e.g., EBPs listed in SAMHSA's National Registry of Evidence-Based Programs and Practices).

B. Service Elements

The service elements are services found in State treatment and recovery systems. These are the services often delivered by providers in States for which the States may have oversight and/or funding responsibilities. States have varying structures for the delivery of these services. For example, State agencies may contract with counties, regions, or directly with providers. Increasingly, States may be reimbursing for services through insurance mechanisms and other financing arrangements (e.g., managed care organizations, health homes). These guidelines may be applied to SSA direct State purchasing and to the SSA's role as regulator and collaborator with other public and private purchasers of services for adolescents with SUDs. For the purposes of this section, "provider" is the standard term used to denote a SUD treatment/recovery services provider, but it could be adapted to accommodate any State structure. As with other sections of the document, the language is directive, using the term "will" or "should" to enable States to directly take language from the document and use it to develop contracts, regulations, or guidance documents or in other ways that increase the quality of services for adolescents with SUDs.

1. Screening, Assessment, and Planning

a. Outreach, Engagement, and Retention

Description

Outreach, engagement, and retention efforts are made throughout the adolescent's treatment and recovery to create access to the continuum of care, complete an appropriate course of treatment, and support recovery. Outreach efforts identify adolescents who could benefit from services and provide them with access to care. Methods of outreach may include linkages to and the education of other public systems (e.g., schools, child welfare, and juvenile justice) and community-based organizations (California Department of Alcohol and Drug Programs, 2002). Effective outreach can help engage adolescents to enter treatment. When an adolescent is engaged in services, he or she is more likely to attend, participate in, be retained in, and complete treatment. Good engagement methods reach adolescents through their preferred channels to build a positive rapport. Strategies for engagement and retention include orientation; reminder calls; multiple ways to connect adolescents, their family, and members of their treatment team; building trust and dialogue; using mentoring organizations; assistance from faith-based organizations; and the acknowledgement of relapse as a part of recovery (CSAT, TIP 31, 1999). Providers build the adolescents' motivation and commitment to change by connecting with them, which can aid in engagement and retention. Creative, individualized, and culturally appropriate program content can also increase retention of adolescents in treatment and recovery support services.

By understanding gender differences in disease etiology (both SUDs and co-occurring mental health disorders), and treatment preference and effectiveness, providers can increase engagement and retention. For instance, "female adolescents in substance abuse treatment may require a more comprehensive approach to treatment. They also may require a longer duration of care and more careful follow-up" (Kloos, Weller, Chan, & Weller, 2009). Gender-specific treatment may provide an environment where girls—particularly those with a history of trauma perpetrated by males—feel safer discussing issues related to their SUD, potentially increasing engagement and retention. Providers should increase engagement and retention by reducing barriers to care such as by providing transportation and childcare.

- Outreach efforts will include linkages to partner agencies where adolescents may already be accessing services (e.g., schools, child welfare, employment services) as a source for

identification of adolescents with SUDs and as a locus for referral to treatment (California Department of Alcohol and Drug Programs, 2002). Providers will also consult with experts on outreach efforts appropriate for students with a learning or physical disability.

- When appropriate, providers will make intensive outreach efforts to engage the family, caregivers, and/or identified positive peer and adult supports while the adolescent is in treatment.
- Outreach will be used as a primary intervention strategy for homeless adolescents, recognizing and addressing the unique barriers homeless adolescents confront in their path to treatment and recovery (CSAT, TIP 32, 1999). Outreach efforts should also be directed toward adolescents in public housing communities.
- Providers will be culturally aware and sensitive toward adolescents and families and provide staff training on differing cultural beliefs and values to increase the likelihood of adolescents engaging and staying in treatment.
- Providers will offer gender-specific services and matched-gender treatment staff to aid in the adolescent's connection with treatment staff and build therapeutic alliances.
- Treatment options will be presented in a nonthreatening, strengths-based, trauma-informed manner.
- Providers will be knowledgeable about the adolescent's developmental stage, language, culture, and unique issues he or she faces and approach adolescents in ways that are relevant to them (CSAT, TIP 31, 1999).
- Providers will identify priorities and appropriate services throughout the engagement process that speak to the adolescent's individual needs in consideration of his or her readiness to change.
- Engagement and retention efforts for adolescents will include technology (e.g., cell phones, social media), recovery coaching, and peer mentoring. Providers will also help adolescents develop their own technology safety plan to help them make good decisions that reduce their vulnerability to harassment, overdisclosure, and predators.
- High priority will be placed on connecting with other public adolescent-serving service systems (e.g., schools, child protective services, mental health, juvenile justice) to identify adolescents with SUDs.

Screening

Description

"Screening is the first step to finding the appropriate kind of help for [adolescents] with substance abuse and other problems. Treatment experts recommend that programs use standard screening instruments which have been rigorously evaluated for reliability and validity" (Drug Strategies, 2003). The purpose of screening is not to diagnose; rather, screening determines whether adolescents should be recommended for an assessment and/or interventions. In some cases, there may be a need for immediate assistance, services, or a full biopsychosocial assessment. This requires action by the interviewer to assist the adolescent in accessing care.

- Adolescents identified to be at high risk for SUDs will be screened with a trauma-sensitive tool designed for adolescents to uncover indicators of substance use and related problems. Adolescents with possible SUDs as identified through the screening will be referred for a more comprehensive assessment for SUDs.
- The screening will be developmentally appropriate, short, simple, and easy to administer and interpret to enable a wide variety of professionals to screen adolescents.
- "The screening process [will] last no more than 30 minutes—ideally, 10–15 minutes—and the instrument [will] be simple enough that a wide range of health professionals can administer it. It [will] focus on the adolescent's substance use severity (primarily consumption patterns) and a core group of associated factors such as legal problems, physical and mental health status, educational functioning, and living situation" (CSAT, TIP 31, 1999).
- Professionals and individuals who work with adolescents "[will] also be able to screen and detect possible substance use and refer youth to further assessment. Many health and judicial professionals [will] have screening expertise, including school counselors, street youth workers, probation officers, and pediatricians" (CSAT, TIP 31, 1999).
- While many screening tools provide specific numbers or cutoff scores for referral to assessment, the individual screener will use his or her judgment to decide whether identified problem/high-risk behaviors or "red flags" warrant a referral to assessment.
- Providers will have culturally specific screening tool(s) available for a variety of individuals from diverse backgrounds.
- Screening will not be used as a diagnostic tool.
- There will be a protocol and referral criteria to triage adolescents who need immediate assistance and to identify adolescents who need a more comprehensive evaluation.
- If screening is done through another service setting (e.g., probation), the provider will receive and take into consideration the screening information provided.

b. Assessment

Description

If indicated by the initial screening process, a client is referred to assessment. The purpose of the assessment is to identify the level of severity and appropriate level of care, to help define services the individual adolescent needs, and to provide appropriate referrals as needed. The information gathered from an assessment is used to create the treatment and recovery plan. Assessment is a comprehensive, ongoing process that takes into account the broader aspects of the adolescent's life, including psychosocial functioning and environmental factors (Arizona Department of Health Services, 2009). Effective assessments are culturally sensitive, gender specific, and trauma informed. They capture information on substance use, developmental status, educational experiences, sexual orientation, trauma history, mental health and physical health status, legal involvement, and family and relationships. During the assessment process, it is important for providers to allow adolescents to self-identify with regard to gender identity and sexual orientation. Providers should also be aware that for some adolescents it can be traumatizing to discuss sexuality. Effective assessments identify the adolescent's strengths and resilience factors (Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 2011).

- Providers will use a comprehensive and multidimensional assessment to determine the adolescent's level of care, needs, and treatment approach. The adolescent's geographic location, school, cultural identity, family, developmental level, priorities, and gender and sexual identity may also be taken into account as they relate to engagement, retention, and recovery supports.
- Assessment is an ongoing process that will be trauma informed, comprehensive, multifaceted, and culturally and developmentally appropriate for each adolescent admitted to treatment.
- The assessment will include questions that identify the strengths, resiliencies, natural supports, and interests of the adolescent to accurately assess the adolescent's unique abilities that will assist in his or her recovery.
- The adolescent's developmental and cognitive levels; social, emotional, and communication abilities and strengths; and independent living skills will be assessed.
- The goals of assessment will include the identification of natural supports, strengths, and resilience along with motivation and readiness for treatment, cultural/linguistic barriers to treatment and recovery, and areas of functional impairment or skills deficit.
- The provider will assess for substance use (including tobacco/nicotine use); co-occurring mental health disorders; physical health; cognitive, social, and affective development; family, peer, and romantic relationships; trauma; current or past emotional, physical, or sexual abuse; suicidality; and safety. If an adolescent evidences a high risk of danger to self or others, the program will address the issue immediately if capable or make a referral to an appropriate source and appropriate family members and/or guardians will be notified.
- Providers will also assess for signs of emotional or physical (including sexual) abuse in adolescent relationships, including same-sex relationships.
- Assessment will include evaluation of family systems, identification of family priorities and concerns, assessment of family members (e.g., parents/caregivers, siblings) for family-centered services, and consideration of individual family members' referral needs.
- The standardized, evidence-based assessment will use established, reliable, and valid protocols and measures and will be implemented with fidelity. It will be designed specifically for capturing information related to the major life domains of the adolescents in treatment for SUDs.
- The assessment will be administered by providers trained in the administration and interpretation of SUD assessments for adolescents (e.g., SUD counselor, psychologist, social worker).
- The assessment will be used to inform treatment and recovery planning including determining the services and levels of care best suited to the adolescent (e.g., medication-assisted treatment, counseling, co-occurring mental health treatment).

c. Treatment and Recovery Planning

Description

A treatment and recovery plan serves as a roadmap for treatment and recovery support service delivery. Treatment and recovery plans are strengths based, youth guided, and based on an individual assessment, with involvement from the adolescent, his or her family, and other involved entities (e.g.,

juvenile justice, child welfare, schools) as appropriate. The treatment and recovery plan is assessed and modified continuously and reflects changes in needs and preferences of the adolescent.

- The treatment and recovery plan will be developed in collaboration with the adolescent and his or her family or other supportive adults based on his or her unique strengths, assets, and needs.
- The plan will reflect the adolescent's developmental stage; gender identity; culture; sexuality; and chronological, emotional, and psychological age.
- During the treatment and recovery planning process, the adolescent and his or her family will identify recovery goals (desired outcomes) that reflect how they define progress and support needs (e.g., the adolescent developing positive relationships, reduced substance use and abuse symptoms, school retention, improvement of family relationships).
- The adolescent's individual treatment and recovery plan will be assessed and reviewed by the adolescent and provider on a scheduled basis, and, additionally, as requested by the adolescent or family. The plan will be open to changes by either the provider or adolescent based on the adolescent's preference or if the desired outcomes are not being achieved.
- Treatment and recovery plans will include goals for family functioning, or the program will develop a family services plan that identifies the ongoing family support and improvement goals.
- Family members will be involved and/or updated about changes in the treatment and recovery plan as appropriate, including being provided information on recovery support services and continuing care options.
- The strategies and services specified in the plan will include identification of the individuals providing treatment, an expected timetable for achieving youth-guided goals and objectives, where treatment is to take place, and when the plan will be reviewed.
- Recovery support services will be defined in the plan and will reflect progress toward adolescent-identified goals, desired improvements in functioning, and improvements in quality of life. Transition planning will be regularly discussed throughout the treatment and recovery process (see "Monitoring and Quality Improvement" and "Continued Care and Support" sections for additional information).
- Treatment and recovery plans will consider adolescent development goals including building competencies, identity/character development, contributions to community, and relationships.
- Transition planning will begin at the time of treatment and recovery planning to take into account upcoming changes.

d. Physical Health: Education, Screening, and Referral

Description

Because SUDs often co-occur with physical health conditions, it is important to provide access to appropriate medical care for adolescents entering treatment. It is recommended part of the adolescent's assessment include identification of physical health issues and subsequent referral to relevant providers, services, and supports. Physical interventions may lessen the likelihood of depression and support abstinence and recovery. Additionally, adolescents being treated for SUDs have a significantly higher prevalence of several medical conditions (e.g., asthma, pain conditions, sleep disorders) that could be

ameliorated by physical interventions (SAMHSA, 2013). With this in mind, "all substance use disorder treatment providers should screen for health conditions, be familiar with the process for making health care referrals, and make appropriate referrals to health care providers as needed" (SAMHSA, 2013).

- Comprehensive assessments will include a screening of the adolescent's medical status, including medical history.
- Appropriately trained and educated providers will screen or refer adolescents for screening of existing physical health conditions and assess for behaviors that may place the adolescent's physical health at risk. The screening will pay particular attention to the identification of conditions that co-occur more commonly in individuals with SUDs (e.g., fetal alcohol spectrum disorders, HIV, hepatitis, liver/kidney disease, chronic pain, sexually transmitted infections [STIs], tuberculosis).
- Providers will establish partnerships with medical organizations or practitioners equipped to address the physical health needs of adolescents (e.g., primary care physicians, dentists, optometrists, gynecologists, obstetricians) to facilitate any necessary referrals.
- Providers will ensure that health education will be used to provide information about healthy behaviors and how to reduce risks for certain health conditions (e.g., HIV, STIs, hepatitis).
- Adolescents will receive health education that includes information on family planning, tobacco cessation, and other health behaviors.

e. Case Management and Care Coordination

Description

Adolescents are often involved in multiple systems while in or on their path to treatment and throughout their recovery (see "Systems Collaboration" section for additional information). Effective adolescent services coordinate with the adolescent's family and with professionals from the various systems with which he or she interacts (e.g., mental health, physical health care, education, social services, child welfare, juvenile justice). Involvement of these professionals, as identified by the team, assists in developing and executing a comprehensive treatment plan (Minnesota Department of Human Services, 2009). Case managers (e.g., care coordinators) provide continuous support for the adolescents, ensuring there are linkages to services including those provided by other systems (CSAT, TIP 27, 2008). Effective case management is youth guided and family centered and takes a goal-oriented approach to accessing and coordinating services across multiple systems (SAMHSA, 2009). Coordinated care facilitates cross-agency collaboration by establishing linkages and maximizing resources, thereby increasing access to services.

- Each adolescent and his or her family will receive case management and/or care coordination services from the SUD treatment system.
- Providers will be trained in adolescents' alcohol and other drug use and recovery, safety issues (e.g., physical and sexual abuse), and legal issues in working with minors (e.g., informed consent).
- Case management/care coordination may also include interfacing with the services and systems the adolescent's parent or other family members are involved with such as parenting programs, child welfare agencies, and probation.

- Case managers and/or care coordinators will be familiar with adolescent-serving agencies/systems and other community resources, both formal and informal, to effectively facilitate access to other systems. Providers will help ensure the adolescent and his or her family are educated on health care options in the community. This may include assisting with the coordination of transportation and scheduling medical appointments.

2. Medication-Assisted Withdrawal

Description

Some adolescents may need medication-assisted withdrawal prior to initiating treatment, for example, in the situation of relapsive addictive disorders. Medication-assisted withdrawal, also referred to as "detoxification," is the process of ridding the body of a substance on which a person is physically dependent and addresses the attenuation of the physiological and psychological features of withdrawal syndromes. Substances that produce physical dependence and may require medication-assisted withdrawal currently include opioids, alcohol, and benzodiazepines. Medication-assisted withdrawal interrupts the momentum of habitual compulsive use in individuals diagnosed with a severe SUD and sets the stage for treatment engagement and patient role induction.

Medication-assisted withdrawal may be delivered in either inpatient settings (e.g., hospitals, 24-hour residential facilities) or through community-based programs (i.e., ambulatory detoxification). It is important to note, however, ambulatory detoxification should be reserved for those with uncomplicated SUDs who can be safely withdrawn from the substance on which they are physiologically dependent. Most adolescents with SUDs of a severity to require detoxification treatment will have co-occurring disorders including polysubstance abuse, mental disorders, and substantial social needs. Ambulatory detoxification should be carefully considered and used sparingly in adolescent patients who generally require an inpatient level of care for this treatment and to address other clinical needs.

- Medication-assisted withdrawal will be considered as appropriate for adolescents using substances that produce physical dependence.
- SUD treatment providers who are not capable of delivering medication-assisted withdrawal will refer to a capable provider.
- SUD treatment providers will consult with the medication-assisted withdrawal providers and facilitate the adolescent's continued treatment after withdrawal.

3. Treatment Services

a. Levels of Care

Description

The appropriate level of care, as determined by the assessment, should inform treatment planning and identify the service type and frequency of service delivery. This is accomplished by using developmentally appropriate tools or criteria such as State-specific placement criteria, the American Society of Addiction Medicine (ASAM) Adolescent Patient Placement Criteria (Mee-Lee, Shulman, Fishman, Gastfriend, & Griffith, 2013), or another validated set of criteria. In concert with these tools and criteria, providers use clinical judgment in consideration of culturally appropriate, gender-specific, and trauma-informed services. Adolescents may need to move back and forth along the continuum of treatment services, using different intensities of service and recovery support services as their symptom severity changes (Whitmore, Sakai, & Riggs, 2010). Levels of care may include outpatient, intensive outpatient, partial hospitalization, residential, inpatient, continuing care, and recovery support services. There are mixed findings on which treatment modalities work best for which adolescents with SUDs. It is important to

have a range of treatment models and a comprehensive continuum of care for adolescents with SUDs (SAMHSA, 2013).

- Providers will use the current edition of the ASAM criteria (Mee-Lee, Shulman, Fishman, Gastfriend, & Griffith, 2013), State-specific placement criteria, or another validated set of criteria to determine the level of care for adolescents. These criteria will be used for admission, determination of continued care, and discharge.
- Providers will actively coordinate with relevant adolescent-serving agencies (e.g., schools) to provide needed services along the continuum of care and to promote recovery and resiliency.
- There will be an ongoing review process that takes into account the adolescent's progress and changes in his or her environment that affect determination of best level of care. The adolescent will be able to move back and forth along the continuum of care based on these reviews.
- Providers will be able to provide or refer adolescents to the appropriate continuum of services as indicated in the adolescent's assessment.
- Continuing care support services will be made available to adolescents as appropriate with the levels of care and the adolescents' goals.
- Recovery support services will be used in alignment with the level of care and goals of the adolescents.

b. Substance Use Disorder Counseling

I. Individual Counseling

Description

SUD counseling takes a collaborative approach that is culturally relevant, trauma informed, and gender specific (e.g., encompassing the unique developmental needs of girls and boys and of LGBTQI individuals). Sensitivity to gender and cultural differences helps develop a successful therapeutic alliance between the adolescents and the counselor and is key to facilitating behavior change. SUD counseling is also respectful of the adolescent's ability to guide how he or she addresses issues of alcohol and drug use (e.g., illicit drug use, use of prescription drugs); motivation; skills needed to resist drug use; replacement of drug-using activities with constructive and rewarding non-drug-using activities; and improvement of problem-solving abilities, self-esteem, and identity (Oregon Legislative Counsel Committee, 2011).

- Each adolescent will be assigned a primary counselor who is part of the youth's treatment team. The counselor will use a developmentally and culturally appropriate, gender-specific, strengths-based, and evidence-based approach to working with the adolescent and be responsible for gaining his or her emotional trust and assisting the adolescent in the development of goals for his or her recovery.
- Providers who are capable will also address co-occurring mental health disorders. Providers who are not co-occurring capable will consult with mental health providers when an adolescent has co-occurring mental health and SUDs, particularly as it pertains to medications for mental health disorders.
- Individual counseling sessions will be provided for adolescents upon admission to treatment, on a scheduled ongoing basis to be outlined in the adolescent's treatment and recovery plan, in situations of crisis intervention and during recovery/discharge planning. When an adolescent

requests additional individual counseling sessions, these requests will be met to the extent possible.

- SUD counselors will provide SUD treatment services for adolescents in coordination with the case managers or care coordinators.
- SUD counselors will be trained and qualified based on State standards for licensure and credentialing (see "Staff Competencies" section for additional information).
- Counseling and recovery support services will be provided for the adolescent's family to aid them in supporting his or her recovery (see "Family-Centered Care" and "Family Counseling" sections for additional information).
- Individual counseling sessions will meet State regulations or requirements for SUD counseling and the recommendations of the developer or purveyor of the counseling type (e.g., standards of discipline).

II. Family Counseling

Description

Family counseling is an important aspect of adolescents' SUD treatment. For many adolescents, family factors may play an important role in the development of their SUD. Gender may play an important role in considering family factors, given adolescent girls with SUDs are more likely to have family issues (Drug Strategies, 2003). Adolescents may be from complex, blended, or troubled families; therefore, identification of family members (of origin or of choice) is an important element of family counseling. Likewise, identification of the ways in which these family members can participate in the adolescent's treatment and recovery is crucial in establishing family supports for adolescents. Family counseling helps address strained familial relationships, improves communication, boosts parents' or caregivers' skills and confidence, and develops a support system for the adolescent with an SUD and for the family as a whole (Georgia Department of Behavioral Health and Developmental Disabilities, 2011). Family therapy models have consistently been shown to be more effective across diverse samples of adolescents with SUDs when compared to other treatment models. This model may be especially relevant for adolescents and parents whose differences in acculturation have historically affected their communication (SAMHSA, 2013).

- Family services include family counseling, family education, family problem solving, and family therapy. Family therapy is administered by professionals with training in family dynamics and family therapy and takes into account differences in parenting styles and attitudes toward therapy across cultures (CSAT, TIP 32, 1999).
- Providers will work with each adolescent to identify family relationships (of origin or choice) and what family members to involve in services.
- Providers will offer engagement services to help the adolescent's family members connect and participate in services. When necessary, individual outreach, telemedicine, home visiting, or childcare may be provided to engage family members (see "Outreach, Engagement, and Retention" section for additional information).
- Family counseling sessions will include activities focused on enhancing family relationships, communication, and functioning to promote the resiliency of the family unit (Georgia Department of Behavioral Health and Developmental Disabilities, 2011).

- Family counseling addresses family dynamics and may focus on skill building, encouraging awareness of the parents' needs, changing communication styles, facilitating changes to the household environment, and encouraging steps to build resiliency in their child(ren) (CSAT, TIP 32, 1999).
- Family services will encompass both education on the nature of the adolescent's SUD (e.g., its effect on development, the process of recovery) and the impact on family (e.g., dysfunction, stress).
- Family services will focus on recovery and wellness for the adolescent and his or her family.
- When applicable, family-based services will take into account the broader social and community groups that shape adolescents' behavior, beliefs, and attitudes.
- Providers will implement evidence-based and promising practices for family counseling or therapy models with attention to cultural, racial, ethnic, gender, and sexual minority factors.
- In consideration of the intergenerational nature of SUDs, providers will create access to assessments and referrals to individual treatment and support services for family members (e.g., parents or caregivers, grandparents, siblings).
- Providers will be familiar with issues related to family violence. This may include knowledge of family reunification and collaboration with the child welfare system.
- Providers will be familiar with child and elder abuse reporting laws and will inform families of their status as mandatory reporters.
- As appropriate, youth siblings will be involved in family counseling or other educational programs.
- In addition to these services, providers will create a family-friendly environment and encourage family members' healthy engagement in adolescents' treatment/recovery.

III. Group Therapies

Description

Adolescent identity formation is influenced by interactions with peers. Positive interaction with peers in facilitated, supportive group sessions can help the adolescent build meaningful interactions and/or relationships with his or her peers. Group therapies can be psychoeducational, cognitive-behavioral, therapeutic, or focused on relapse prevention. All group therapies should reflect the adolescent's treatment and recovery goals and objectives (CSAT, TIP 41, 2009). For adolescents, group therapy can be a way to build healthy relationships, experience positive peer reinforcement, and bond within a culture of recovery. In contrast to mutual aid or self-help groups (which may also be a part of SUD recovery), group therapy is facilitated by trained providers.

- Group counseling sessions will be provided when deemed clinically appropriate and in accordance with the adolescent's treatment and recovery plan.
- Group counseling sessions will meet the client-to-staff ratio as designated by State regulation or requirement and the recommendations of the developer or purveyor of the group counseling type (e.g., group size).
- When possible and appropriate, providers will offer separate groups for girls, boys, and LGBTQI

youth. All groups will be trauma informed and sensitive to issues of gender, cultural norms, and sexual orientation.

- Providers will ensure proper training and supervision of staff members leading group therapy sessions. Training will include practicing group therapy techniques under the supervision of an experienced clinician and obtaining proper licensure or certification as required by the State.
- Prior to placing adolescents in specific group therapy sessions (e.g., prevention based or educational), the provider (e.g., case manager or counselor) will properly screen participants for SUDs and match the participants to appropriate group(s) (CSAT, TIP 41, 2009).
- Group therapists/facilitators will have an understanding of group processes, group dynamics, and the stages of group development (CSAT, TIP 41, 2009).

c. Delivery of Services for Co-Occurring Substance Use and Mental Health Disorders

Description

Of the adolescents who are in treatment for SUDs, more than half have co-occurring mental health disorders (e.g., depression, anxiety, conduct disorder, posttraumatic stress disorder). Given the high prevalence of co-occurring substance use and mental health disorders, programs need to be equipped to screen adolescents' mental health issues and demonstrate an understanding of how identified mental illnesses interact with SUDs (Drug Strategies, 2003). Programs provide developmentally appropriate and trauma-informed co-occurring substance use and mental health services on site or address them through collaboration with nearby qualified adolescent-serving agencies with which linkages have been established. States should be aware of the continuum of care (e.g., dual diagnosis capable or enhanced) and strive to improve the services available in their State (CSAT, TIP 42, 2008).

- SUD treatment settings will include screening of co-occurring mental health disorders at the time of intake and provide referrals for assessments for adolescents who screen positive.
- As a result of the prevalence of co-occurring mental health disorders in adolescents with SUDs, the providers will conduct ongoing assessments for mental health disorders.
- Comprehensive co-occurring treatment will address other contributing factors that may be implicated in the etiology of, treatment of, and recovery from co-occurring disorders. These factors include gender; sexual orientation; abuse, neglect, and domestic violence; familial substance and mental health issues; neighborhood, community, and peer factors; and legal, school, and vocational issues.
- Providers will support and encourage participation in integrated treatment and coordinated care for co-occurring disorders and work collaboratively among systems and services and family or other supportive adults as much as possible.

d. Use of Medications in Treatment

Description

"Pharmacotherapy is promising for treating youth with substance use disorders; however, the neurobiology of youth requires unique approaches to pharmacotherapy for this population" (SAMHSA, 2013). Physicians (or other appropriate prescribers as identified by State regulations) with knowledge of SUD and addiction medications can assess adolescents and, when clinically indicated, educate

adolescents and their families on the role of medication-assisted treatment as a complement to other therapeutic services (e.g., counseling, case management). This process includes careful consideration of each adolescent's unique developmental needs. Decisions about starting medication-assisted treatment should be made jointly with the adolescent and the family whenever appropriate. If medication is prescribed or dispensed, close monitoring of adherence and side effects is needed, particularly if the adolescent is also taking medications for a co-occurring physical or mental disorder(s). Medications can be used for short-term and longer term maintenance treatment, depending on the severity of the adolescent's SUD and needs as identified during the assessment process.

Although rarely used for adolescents, there are medications available to treat alcohol use disorders, including naltrexone, acamprosate, and disulfiram. There are currently three medications available to treat opioid addiction: buprenorphine, naltrexone, and methadone. The effectiveness of buprenorphine products for adolescents under the age of 16 has not been established. However, medication-assisted treatment with buprenorphine should be considered part of the menu of treatment options for adolescents over 16. Naltrexone may be used for the prevention of relapse during and after treatment for an opioid use disorder. Methadone has been the standard medication used in adult opioid treatment programs, but regulations restricting the terms of its use for people under 18 (Office of the Federal Register, 2002) mean it is rarely used in the treatment of adolescents. State regulations for youth opioid medication treatment vary by State. In some States approval for these prescriptions is needed for youth under 18 years of age and in others for youth under 16 years of age. Additional documentation on past SUD treatment and outcomes may be required. Unlike methadone, buprenorphine may be dispensed by trained physicians in an office-based setting, generally making it a more accessible treatment option for adolescents either as short-term or longer term maintenance or during medical withdrawal. Buprenorphine may also be preferred because of its easier withdrawal process as compared to methadone (CSAT, TIP 40, 2004).

When indicated, using medications in adolescent SUD treatment is an important component of a comprehensive set of treatment and recovery services. As a recent review article by leading experts points out, "[t]he implementation of medication assisted treatment as standard practice is feasible in specialty care settings, easily integrated with counseling or psychotherapy, and has the potential to greatly improve the outcomes of psychosocial treatment. Certainly concerns about safety and efficacy need to be addressed with more research, and more work needs to be done on articulating and testing youth-specific models of care" (Pecoraro, Fisherman, Ma, Piralishvili, & Woody, 2013).

- Case management and counseling will be provided to adolescents who are receiving medication-assisted treatment (SAMHSA, 2013).
- Research on medication-assisted treatment for adolescents is a newer field of inquiry than for adults. Therefore, the informed consent process will include a detailed rationale and full disclosure of risks and benefits for treating adolescents with medication (e.g., potential side effects, potential adverse reactions, expected outcomes). These considerations will be discussed with the adolescents and their families when contemplating use of medications in treatment. Treatment agreements are suggested for all buprenorphine-treated patients, including adolescents.
- Close monitoring of adherence and side effects will be conducted, particularly if the adolescent is also taking medications for a co-occurring physical or mental health disorder(s). The provider

will monitor for side effects and will work with the prescribing physician or pharmacist to review possible side effects.

- Providers will monitor the use of medication using toxicology tests or other means to ensure it is being used as directed and is not being diverted or abused.
- The provider will work with the adolescent and family or supportive adults to designate a "trial period" to closely monitor the adolescent's use of the medication and determine if the medication is aiding the adolescent's recovery.

4. Recovery Services

Recovery support services are ideally incorporated at the inception of services (e.g., during engagement, assessment, treatment, and recovery planning) and continue after the adolescent's discharge from or completion of a primary treatment episode. Given the particular needs and concerns of adolescents, recovery support services should be developmentally appropriate and tailored to each adolescent and his or her family. Support services should also be provided in a variety of settings and formats, using new technologies to communicate and engage with adolescents in innovative ways (SAMHSA, 2013).

a. Continuing Care and Support

Description

The transition period between completing a treatment program and returning to the home environment can be challenging for adolescents, often putting them at greater risk for relapse (CSAT, TIP 32, 1999). Continuing care and support services can bridge that gap and emphasize the importance of the continuity of the relationship between the youth and the treatment provider and reflect the multiple pathways to recovery based on the individual's unique strengths, needs, preferences, experiences, and developmental stage. Participation in continuing care is based on the needs of the youth and his or her family that are identified through an ongoing process of clinical monitoring and reassessment (Mandell & Werner, 2008). Continuing care is linked to better treatment outcomes for youth with SUDs, particularly for youth exiting residential treatment (SAMHSA, 2013).

- Providers will focus on strategies to help support the maintenance of the youth's long-term wellness and recovery through the provision of continuing care and ongoing support in the youth's community.
- Continuing care services may be provided in a variety of settings, and youth should be given the opportunity to identify which services are best for them (SAMHSA, 2013).
- The provider will work with the youth and his or her family to determine services that will aid in the understanding of the continuum of care and provide services that assist in the maintenance of the youth's recovery.
- Clinical monitoring and care will encompass efforts to develop skills for the youth to cope with his or her substance use such as recognition and management of triggers that may interfere with the youth's recovery (relapse prevention) and to intervene after a lapse or setback to prevent a full relapse (relapse management).
- When possible and as appropriate, recovery management checkups (e.g., a discussion with the youth on his or her recovery) will be ongoing and will target continued skill building, relapse prevention, problem solving, and the therapeutic alliance between counselor and youth.

- Providers will be aware that youth with co-occurring disorders may be discharged from SUD services while still receiving services for mental health disorders and should continue with SUD-related activities and recovery support services (see "Delivery of Services for Co-Occurring Substance Use and Mental Health Disorders" section for additional information).
- Continuing care will also be supported through the use of technology when available (e.g., telephone, Web-based applications, email, text messages (see "Technology" section for additional information). Telephone continuing care is one promising service that can reduce patient burden and costs (SAMHSA, 2013).

b. Education

Description

Adolescents with SUDs have an array of educational needs: some were top students whose performance recently declined due to substance use; others have a history of school failure, have attended multiple schools, or have dropped out of school; and many have learning disabilities. Schools are also a social environment for adolescents in which they build peer relationships and affiliations, express themselves, and engage in extracurricular activities. Education is one of the most important factors in adolescents' developmental paths and in their recovery from SUDs. Whether schooling is provided on or off site, education is fully integrated into adolescents' treatment, and teaching staff can be considered part of the treatment team (CSAT, TIP 32, 1999). In some States, recovery high schools and colleges are an option for providing additional support to adolescents in recovery from an SUD. These school-based recovery models can provide useful and effective support for adolescents, but fully addressing these initiatives is beyond the scope of this document.

- Treatment and recovery plans will reflect the adolescent's educational goals and objectives.
- With consent, providers will reach out to schools to gather information (e.g., special needs, Individualized Education Plans) and input from school staff (e.g., teachers, guidance counselors) to incorporate these goals into the adolescent's treatment and recovery plan.
- Providers will be aware of or have a referral source with information on State high school equivalency test requirements.

Additional education considerations for residential treatment providers—

- Residential treatment staff will coordinate education services while the adolescent is in residential treatment in accordance with State laws for education and/or special education.
- Adolescents in residential treatment will be given time and support to do homework to keep up with school work.
- Providers will work with the adolescent and family to reintegrate the adolescent into school or into educational or vocational training services appropriate for his or her needs. This process will begin with treatment and recovery planning.

c. Recreational Services or Prosocial Activities

Description

Development of, or reengagement in, safe and healthy recreational activities is critical for adolescents' ongoing recovery support. These prosocial activities "[influence] youth engagement in continuing care and . . . identify ways to engage youth with substance use disorders [SUDs] in positive activities during

treatment, continuing care, and recovery"(SAMHSA, 2013). Assistance is given to adolescents to develop interests and participate in recreational and social activities that do not involve and may serve as alternatives to substance use. Development of and reengagement in hobbies, family activities, games, sports, creative ventures, community activities, and other recreational and leisure activities, both structured and unstructured, are important components of recovery that are put into place during the treatment and recovery planning and remain through continuing care and recovery support.

- Providers will work with adolescents to help them discover their interests (e.g., hobbies, games, sports, creative ventures) and strengths through the treatment and recovery plan.
- Recreational and leisure activities will be used to promote prosocial behaviors, competence, and confidence in interacting and socializing with others and foster a positive attitude toward physical activities as an important component of a healthy and satisfying life or wellness.
- Given that prosocial activities are important to the development of adolescents' resiliency and positive relationships, providers will ensure recreational and prosocial activities incorporate nonsubstance using peers and engaged adult involvement and monitoring.
- Adolescents will be encouraged to participate in civic and community activities to contribute to the community.
- Providers will work with parents/caregivers to encourage the adolescents to discover their own recreational and prosocial activities; once adolescents are discharged from treatment, the parents/caregivers should be encouraged to promote continued engagement in recreational and prosocial activities.
- Providers will offer or make referrals to recreational services and/or prosocial activities that align with the adolescent's strengths, needs, and capabilities. These services will be modified as needed based on changes in the adolescent's treatment and recovery process.
- Engagement in prosocial activities will be promoted as an essential component of adolescent treatment and recovery.

d. Positive Youth Development

Description

Positive youth development incorporates an understanding and appreciation of youth development and empowerment as the foundation of youths' treatment and recovery. The SUD treatment and recovery system provides or arranges for opportunities for adolescents to advocate for their own personal involvement and recovery to ensure their voice is heard (California Department of Alcohol and Drug Programs, 2002). Youth development includes opportunities that prepare adolescents to meet the challenges of adolescence and adulthood through a coordinated and progressive series of activities and experiences that assist them in becoming more socially, emotionally, physically, and cognitively competent (SAMHSA, 2009).

- Providers will be trained on youth development (e.g., stages of development, brain development, puberty; see "Developmentally Appropriate Care" section for additional information).
- Youth development will include a strengths-based assessment and treatment planning process that allows the adolescent to discover his or her individual abilities and strengths, includes

frequent expressions of support, and assists in developing multiple supportive relationships with responsible, caring adults (California Department of Alcohol and Drug Programs, 2002).

- Providers will emphasize resilience and the unique developmental aspects of the recovery process for adolescents (SAMHSA, 2009).
- All services will be youth guided to the extent possible. Adolescents will be supported to make decisions, build their competencies and skills, establish connections, develop their identities, and make contributions.
- Providers will offer activities that tie into adolescents' desire for social connectedness and service by including community service activities and other leadership training and activities for adolescents.
- Providers will offer adolescents decisionmaking skills training and opportunities to actively participate in their own treatment planning and develop goals and personal objectives.
- Providers will arrange opportunities for adolescent leadership and self-sufficiency by encouraging adolescents to provide feedback on the program policies that affect them and to take leadership in planning and executing activities and projects within their treatment and recovery community (California Department of Alcohol and Drug Programs, 2002).
- When possible and appropriate, adolescents will be connected with local youth groups and advocacy groups to aid in the cultivation of leadership and to empower the adolescents through working with other adolescents.
- Providers will take an empowerment-based, rather than controlling, approach that does not provoke or reinforce problematic power dynamics.

e. Employment/Vocational Services

Description

Adolescents who have been employed before and remain employed during treatment tend to remain in treatment longer and experience more successful outcomes once discharged (CSAT, TIP 38, 2000). Employment/vocational support consists of strategies to assist adolescents, as developmentally and age appropriate, in becoming ready to enter and function in the workforce, and in achieving resilience, self-sufficiency, and improved quality of life. As appropriate, prevocational or vocational systems training, work-readiness skills, career planning, and job training for adolescents are provided in conjunction with their educational goals (California Department of Alcohol and Drug Programs, 2002). Quality employment and/or vocational training can provide adolescents with greater self-esteem, progress towards economic security, and social skills development that will provide adolescents opportunities to meet new sober friends, all of which contribute to sustained recovery (Oregon Health Authority, n.d.; CSAT, TIP 32, 1999; CSAT, TIP 38, 2000).

- The treatment and recovery plans will be youth centered and youth driven. The adolescent's individual strengths, abilities, interests, and priorities will set the direction for vocational skills development (as developmentally and age appropriate).
- The provider (through case manager or referral) will facilitate access to vocational skills development services (e.g., job shadowing or internships, résumé writing, interviewing skills) that are designed to prepare the adolescent for work. This will include exploring the importance

of time management, acting responsibly, and working within the goal of an organization and offering tips for retaining a job.

- Appropriate vocational training interventions will include prevocational training, career planning, and job-finding skills training (CSAT, TIP 32, 1999).
- The provider (through case manager or referral) will facilitate access to services and supports such as job coaching, career exploration or placement, and part-time and supportive employment (when available). These services and supports may assist the adolescent in developing skills for attaining, improving, or maintaining employment currently and in adulthood. The provider may also offer strategies for maintaining motivation and coping with stress at work.
- Providers will develop and maintain relationships with vocational programs (e.g., partnerships with school districts and local workforce services).
- For adolescents who require long-term treatment or recovery support services (particularly those who are at or above the age of 17), treatment programs will provide linkages to education or postprimary education, adult SUD and mental health treatment services, employment opportunities, and other transitional approaches to adulthood.
- Youth involved in the juvenile justice system will receive education and assistance on managing their records needed to attain employment and other vocational opportunities.

f. Transportation

Description

Access to safe, affordable transportation for adolescents with SUDs can increase their engagement and retention in treatment, aid in accessing other treatment-related services, and assist in achieving treatment and recovery plan goals. Transportation assistance may be accomplished in a variety of ways, including use of the provider's vehicle(s) or the vehicle(s) of a person with appropriate licensure and insurance who is affiliated with the eligible provider; provision of public transportation passes; and identification of and access to other community transportation resources (New York Office of Alcoholism and Substance Abuse Services, 2010). States and localities have different requirements for licensure and operation of vehicles that need to be reviewed prior to the development of procedures related to transporting adolescents to and from treatment and recovery support services.

- Treatment programs will have policies and procedures for how adolescents will be provided transportation and by whom.
- Residential programs will have written procedures for signing adolescents in and out of program sites.
- Providers will adhere to the requirements for licensure and operation of vehicles as set by relevant States and localities.
- Vehicles will not be labeled in a way that calls attention to the facility or the vehicle's occupants.
- Providers will take into account the unique challenges frontier, rural, suburban, and urban locations face with respect to transportation, taking a "place-based" approach that focuses on how the strengths of each community can be used to facilitate care for the adolescent. When

transportation is not practical, services may be delivered through e-therapy, telemedicine, or electronic means (SAMHSA, 2011a; see "Technology" section for additional information).

- When applicable, adolescents will be given training on how to access public transportation (e.g., how to read bus schedules, where to wait).

g. Housing Assistance

Description

Access to safe, affordable, and substance-free housing is a critical component of treatment and ongoing recovery support for adolescents and their families. Creating a viable plan for obtaining such housing for adolescents and their families is a part of early treatment planning and should be in place before discharge from residential programs. Every effort is made to mitigate environmental stressors that could contribute to an adolescent's relapse, including addressing substance use in the home by other family members and addressing substance use by the adolescent's peers. Housing support and assistance may include, but is not limited to, helping adolescents and their families access transitional and/or permanent housing, develop adequate independent living skills, and maintain their housing and substance-free lifestyles (Mandell & Werner, 2008).

- Providers will partner with relevant agencies and be knowledgeable about community resources that assist adolescents and their families in accessing housing to support their recovery.
- Given that a disproportionate number of homeless adolescents struggling with SUDs identify as LGBTQI, providers will facilitate access to supports for LGBTQI adolescents and their families and education on healthy sexuality in an effort to promote acceptance in the home.
- Adolescents who are not able to live with families or other adult guardians will be assisted to identify alternative family-like environments such as transitional living programs within the community.
- The treatment and recovery plan will include information on viable, developmentally appropriate, and age-appropriate housing for the adolescents and their families or other supportive adults, as appropriate.

h. Life Skills

Description

Life skills development is a process through which adolescents are provided with and encouraged to participate in services designed to nurture a range of skills needed for performance of everyday tasks and entry back into the community. Life skills are interpersonal, daily living, and societal skills instrumental in attaining autonomy and in sustaining healthy living in the community (Mandell & Werner, 2008). Through the treatment and recovery planning process, the adolescent identifies strengths and goals for life skills development. Opportunities for the development of life skills better equip adolescents to identify triggers and resolve problems that create risks for returning to alcohol and other drug use (Georgia Department of Behavioral Health and Developmental Disabilities, 2011). Because social pressure and peer networks are often associated with substance use, SUD treatment for adolescents should emphasize the skills needed to form and maintain appropriate, safe peer relationships and networks. The provider will offer social and interpersonal skill development designed to help the adolescent develop and maintain these appropriate relationships (Mississippi Department of Mental Health, 2011).

- Providers will connect with other adolescent-serving agencies that offer opportunities for life skills development.
- Providers will foster age-appropriate, culturally appropriate, therapeutic, and goal-oriented opportunities for adolescents to develop social skills, cultivate decisionmaking abilities, and learn the values of employment and vocational skills necessary for adulthood.
- Life skills development will assist adolescents in learning how to self-manage triggers for substance use and self-monitor symptoms. This will involve the recognition of relapse triggers and supporting the adolescent in building natural supports to prevent relapse (Georgia Department of Behavioral Health and Developmental Disabilities, 2011).
- The provider will offer interpersonal skill development including support in problem solving, conflict resolution, self-esteem improvement, anger management, and impulse control (Mississippi Department of Mental Health, 2011).
- The provider will offer social and interpersonal skills development designed to help the adolescent develop and maintain appropriate friendships and romantic relationships (if desired) and communicate and interact appropriately with peers and adults.
- As part of ongoing recovery supports, providers will educate, train, and motivate adolescents to perform routine activities of daily living (e.g., organizational skills, time management, money management, food preparation, establishing structure and routine, personal hygiene, literacy) to promote self-esteem, self-sufficiency, and independence. These services may be delivered on site or through recovery coaches/mentors, by referral, and/or with family support throughout treatment and recovery planning.
- Societal skill building will assist adolescents and their families in learning how to gain access to and navigate any necessary rehabilitative, medical, social, legal, transportation-related, and financial supports and services (Georgia Department of Behavioral Health and Developmental Disabilities, 2011).
- Providers will offer education on developing healthy sexuality and building healthy peer and romantic relationships for adolescents of any sexual orientation or gender identity.

i. Pregnant and Parenting Adolescents

Description

Pregnant and parenting adolescents are one priority population identified in the Substance Abuse Prevention and Treatment Block Grant and present unique health and other treatment considerations. Parenting adolescents (female or male) have additional responsibilities and service needs that can serve as barriers or enhancements to substance use services. They may need support in parenting, overcoming economic/educational barriers, accessing childcare, addressing intimate partner violence, and building a support peer network (Arizona Department of Health Services, 2009). Treatment for adolescents who are pregnant or have children is optimized when their roles as mothers or fathers are acknowledged and incorporated throughout treatment.

- All female adolescents will be screened for pregnancy at time of admission. Screening will be delivered in a manner that is trauma informed and sensitive to the diverse sexual experiences of adolescents. Screening will not assume all female adolescents are sexually active heterosexuals.

- Children of adolescents in general, and especially adolescents with a history of SUDs, are at risk for physical, mental, and developmental problems; therefore, providers will offer (directly or through referrals) screening or assessments and appropriate therapeutic services, educational services, and child development services for the children to support their healthy growth and development (Mandell & Werner, 2008).
- Providers will offer (directly or through partnerships) enhanced services such as childcare, medical screening, transportation, family counseling, and parenting support classes for pregnant and parenting adolescents (including fathers). Such services may be needed for pregnant or parenting clients to stay in treatment (Arizona Department of Health Services, 2009).
- Pregnant adolescents will receive health education that includes information pertaining to family planning to help the adolescent in exploring options (e.g., abortion, adoption, raising child herself, family supports). Pregnant adolescents will be connected with ongoing prenatal care from a medical professional.
- In addition to their unique responsibilities, young parents have the same developmental needs as other adolescents. Programs will seek to support young pregnant and parenting adolescents to develop social connections, access recreation, and grow personally while also caring for their young children.
- Providers will address (directly or through collaborations) the unique parenting and support needs of pregnant and parenting adolescents in treatment.
- Young mothers are at high risk of trauma, intimate partner violence, and behavioral health problems. Providers will ensure a comprehensive assessment and support services for the mother, working with other agencies involved in her life as necessary.
- Screening for intimate partner violence and the parenting adolescent's safety and priorities will occur prior to including the partner of a pregnant or parenting adolescent in family services.
- Parenting adolescents will be educated about child development, parenting, childcare, and parenting skills using models that build on their strengths and resiliencies.
- The provider will collaborate with child welfare agencies when needed or required to support the pregnant or parenting adolescent.

j. Referral to Mutual Aid Groups

Description

Mutual aid can be defined as "the process of giving and receiving non-clinical and non-professional help to achieve long-term recovery from addiction [substance use disorders (SUDs)]" (Faces and Voices of Recovery, n.d.). Mutual aid groups are available for adolescents and their families to receive social, emotional, and informational support. The personal philosophy of the adolescent should be compatible with the philosophy of the mutual aid group to which he or she is referred. For example, providers should take into account the adolescent's spiritual practices and religious beliefs when referring to a mutual aid group with spiritual or religious elements. While research has shown many adolescents do not attend mutual aid groups without encouragement, some studies show an increased likelihood of better outcomes for adolescents who attend mutual aid group meetings to enhance and sustain treatment gains (Kelly, Dow, Yeterian, & Kahler, 2010). Adolescents with SUDs who become involved in 12-step programs after treatment can experience increased positive outcomes, and emerging research indicates adolescents with co-occurring substance use and mental health disorders may benefit from peer-based

mutual support groups as well (SAMHSA, 2013). Providers can offer referrals to established mutual aid groups whose philosophies and methods are consistent with the treatment being provided to support the adolescent's recovery.

- When possible, providers will refer adolescents to a mutual aid group with adolescents in it or to a youth-specific mutual aid group, keeping in mind adult mutual aid groups may have developmentally related barriers for the adolescents such as differences in addiction severity, greater levels of distress and dysfunction, and different life stage issues; and age similarity in groups positively influences attendance rates and perceived importance of attendance (Kelly, 2013; Kelly, Myers, & Brown, 2005).
- If the adolescent would like to participate in a mutual aid group, the provider will help him or her access a developmentally and age-appropriate group.
- When possible, the provider will give the adolescent multiple mutual aid group options.
- Providers will be familiar with different types of mutual aid groups, encompassing the unique needs of different age groups, genders, and LGBTQI individuals. Considerations for mutual aid group recommendations will also be made for adolescents whose primary language is not English and for the primary substance used. When available, alumni associations will be considered in the referral to the mutual aid group.
- When possible, adolescents will be accompanied to their first mutual aid group by someone they know or someone with whom they are comfortable, such as a peer mentor, friend, or family member/caregiver.
- Families or others affected by the adolescent's use of alcohol or other drugs will be referred by the provider to mutual aid groups that provide support consistent with the issues pertinent to the adolescent and are not in conflict with the treatment approach being used.
- The use of Web-based technology and mobile applications to provide mutual aid recovery support (e.g., social networking Web sites, private messengers, chat rooms) should be offered for adolescents, particularly in rural areas, when available (see "Technology" section for additional information).

k. Peer-to-Peer Recovery Coaching/Peer Mentoring

Description

Peer mentoring may provide a set of activities that engage, educate, and support an adolescent to successfully make behavioral changes necessary to recover from disabling substance use/mental health disorder conditions. This service is often used in conjunction with and in support of clinical interventions. Service activities include assisting the individual in developing self-management strategies, conducting one-on-one support sessions, organizing structured prosocial activities, developing goals and recovery/wellness plans, and providing crisis support and linkage to natural supports in the workplace and other environments (SAMHSA Financing Center for Excellence, 2011). The services they provide can include a set of nonclinical, peer-based activities that engage, educate, and support adolescents in making life changes necessary to recovery from SUDs. When appropriate, peer mentors highlight personal, lived experience of recovery to build rapport, efficacy, and meaningful interactions with the adolescent receiving services. Adolescents should be matched to age-and developmentally appropriate peer mentors who are stable in their recovery. States may have specific certifications or protocols for the

provision of peer mentoring services for adolescents, with the safety of the adolescent remaining the primary priority throughout.

- Providers will help adolescents gain the skills to build positive peer relationships with non-alcohol or non-drug users. This can be done through peer mentors who facilitate participation in adolescent-based mutual aid groups and/or connecting adolescents to prosocial activities.
- Peer mentors will assist in guiding the adolescent through treatment, recovery support services, and the transition to a life of recovery in the community.
- Providers will use services and supports that foster social connectedness, including peer mentors, and the use of specialized recovery supports such as electronic media and Internet-based tools (SAMHSA, 2009).
- Providers will create or connect adolescents to opportunities to become peer mentors as a way to give back to their community while bolstering their recovery and feelings of self-efficacy (SAMHSA, 2009).
- Providers will partner with the educational system to develop, expand, and refer adolescents to peer recovery networks in schools and colleges when possible.
- Peer mentors will have the appropriate training and supervision as determined by the provider, State agency, or credentialing body.

l. Therapeutic Mentoring/Recovery Coaches

Description

Therapeutic mentoring is "a one-to-one relationship that can be in-person or technologically facilitated that is intended to increase wellness behaviors, facilitate life skills, enhance social skills, and augment a youth's ability to function in the community" (SAMHSA, 2011a). Recovery coaches are one way to provide therapeutic mentoring services to adolescents with SUDs either during or after treatment. The services provided by recovery coaches support and extend the gains achieved during treatment and provide opportunities to address any issues that arise after treatment. Recovery coaches provide support to the youth and serve as a guide in his or her recovery. A therapeutic mentor or recovery coach may or may not be a person in recovery. Requirements and certifications for therapeutic mentors/recovery coaches differ from State to State.

- Providers will help adolescents gain the skills to build positive peer relationships with non-alcohol or non-drug users. Recovery coaches can aid this process in a number of ways, including training adolescents in psychosocial skills such as communication or problem solving, helping adolescents develop coping strategies, or facilitating participation in adolescent-based mutual aid groups and/or connecting youth to prosocial activities (SAMHSA, 2011a).
- Recovery coaches will assist in the provision of advocacy, access to services, systems navigation, outreach, and support to continue with treatment and/or recovery support services.
- Recovery coaches will assist in guiding the adolescent through treatment, recovery support services, and the transition to a life of recovery in the community.
- Providers will use services and supports that foster social connectedness, including recovery coaches, and the use of specialized recovery supports such as electronic media and Internet-based tools (SAMHSA, 2009).

- Providers will create or connect adolescents to opportunities to become recovery coaches as a way to give back to their community while bolstering their recovery and feelings of self-efficacy (SAMHSA, 2009).
- Recovery coaches will have the appropriate training and supervision as determined by the provider, State agency, or credentialing body.

C. Administration/Operations Considerations for the States

This section provides sample language for some of the considerations related to State procurement and oversight of service provisions the Youth Coordinators felt important to highlight. The operations vary by State, and the examples below are reflective of regulations, contract language, and/or guidelines in only some States. The information is not meant to be prescriptive; rather, it is meant to provide a list of potential considerations for States in either the direct procurement of SUD services for youth or in their role as content experts advising other purchasers (e.g., private insurance, managed care organizations).

1. Designation Authority

Description

The SSA for substance abuse services, other State or county agency, or other accreditation body ensures the designation authority develops adolescent SUD treatment regulations, licenses programs, and regulates programs. The designated State or county agency and/or accreditation body authority for these responsibilities varies by State. The SSA or other State or county agency has the ability to use authority through the following mechanisms when setting standards and guiding the provision of adolescent services in the State: legislation; administrative codes and regulations; requests for proposals for funding and contracts; licensing and certification; interdepartmental memoranda of understanding; and guidelines, protocols, or administration priorities (Mandell & Werner, 2008). This guide may aid SSAs in their role as a regulator, licensing body, purchaser of services, etc.

- The designated State agency and/or accreditation body will design, implement, and oversee the programs, policies, and initiatives created to address SUD issues among adolescents either directly or in collaboration with other public and private funders.
- The designated State agency and/or accreditation body will be committed to developing services that are developmentally appropriate and youth centered, are evidence-based or promising practices, involve family and caregivers as appropriate, and entail multiservice coordination with other State agencies and adolescent service providers to promote collaboration and integrated care.
- The designated State agency and/or accreditation body will develop a system requiring providers to establish a protocol for submitting program incident reports, including incidents such as injuries that require medical evaluation or treatment; suspected physical, sexual, or psychological abuse; transmissible diseases; and death (see “Safety and Facilities” section for additional information).
- The designated State agency and/or accreditation body will set guidelines that define minimum competencies for staff working with adolescents and set minimum or best practice standards for assessing, providing, and evaluating treatment services to adolescents (see “Staff Competencies” section for additional information).

- Programs will be licensed, certified, or accredited for the State agency to refer adolescents to the provider or receive reimbursement from the State.

2. Governance: Maintenance of Records and Documentation Requirements

Description

States that procure and oversee the provision of services often set standards or requirements for general governance, such as maintenance of records and documentation requirements for the providers, counties, or regions the State funds. General governance also includes a review of policies and procedures, recordkeeping, document billing in auditable form, and referrals to ensure providers are meeting standards and reducing barriers to treatment.

- Documentation will include admission, release, special occurrence, or incidence reports; medical and dental records; disciplinary records; education records; and staff and volunteer records.
- Documentation will be provided that indicates which qualified staff member(s) is responsible for specific clinical and administrative tasks such as case management, psychoeducation, coordination of treatment plan, oversight of emergencies, and supervision of professionals as applicable.
- Clinical records will contain progress notes that contain information on the adolescent's work toward his or her goals and objectives and responsiveness to treatment and recovery services.
- All adolescents and their families provided services will be given a written confidentiality notice with their signature to indicate receipt of the notice. The signed notification will be kept in the adolescent's records (see "Rights, Responsibilities, and Grievances" section for additional information).
- Information will be provided on discharge including the reason(s) for termination of treatment, referrals for alternative services, continued clinical monitoring, and the provision of recovery support services.
- Adolescent service agencies will have regular, family-friendly hours, including nights and weekends. Records will include treatment hours, daily schedules, and after-hours emergency procedures.
- Providers will comply with 42 CFR Part 2, the Health Insurance Portability and Accountability Act (HIPAA), and State privacy laws as applicable.

3. Monitoring and Quality Improvement

Description

Achieving high-quality treatment standards and demonstrating the results as measurable outcomes are important to States' monitoring and quality improvement efforts. States can promote adolescent SUD program standards in a variety of ways, including the development and use of common service definitions, standardized screening and assessment tools, utilization measurements/criteria, quality requirements, system performance expectations, and measures for adolescent/family/consumer outcomes (SAMHSA, 2011a).

- Providers will develop a process for evaluating treatment effectiveness and outcomes to ensure the quality of services provided.

- States will integrate specific outcome measures, benchmarks, and documentation requirements as part of adolescent treatment standards and/or contracting. States are encouraged to aggregate data, conduct comparative analysis, use data for quality assurance, and document the effectiveness of treatment services.
- Payers (e.g., State, county, Medicaid, insurance) are encouraged to link performance improvement with payment or contract renewal incentives. States and accreditation bodies will seek ways to reward providers for quality of services and outcomes and not just numbers served.
- Providers will focus on program improvements through the findings of outcome-based evaluations. This may include methods such as standardized screening and assessment tools at the beginning of treatment and at regular intervals during and after treatment.
- Providers will survey discharged adolescents, parents/caregivers or legal guardians, family members, and the referring agency regarding satisfaction with the services provided.
- Providers will be monitored by the SSA, region, or county authority through a State-specific program evaluation to ensure requirements are met.
- States will coordinate with licensing/credentialing agencies or bodies to monitor providers to ensure they maintain the standards for State certification or accreditation and national accreditation based on State requirements at all times.
- Providers will be evaluated on service outcomes using measures such as SAMHSA's National Outcome Measures, which include reduced morbidity, employment/education outcomes, crime and criminal justice involvement, stability in housing, social connectedness, access and capacity, retention, perception of care, cost effectiveness, and use of evidence-based practices.

4. Rights, Responsibilities, and Grievances

Description

Policies and procedures, adolescent and family rights and responsibilities, and grievance/complaint procedures are important to establishing and communicating adolescents' rights in treatment. These rights and responsibilities ensure adolescents receive services that are developmentally and age appropriate and free from corporal or unusual punishment, sexual exploitation, and seclusion and restraint. The adolescent has the right to treatment in the least restrictive setting.

- All information pertaining to the adolescent's rights, responsibilities, and grievance procedures will be delivered in a culturally, linguistically, developmentally, age-, and literacy-appropriate manner, with interpretation assistance provided as needed.
- The program's rules and rights will be posted visibly at the program site, and a copy will be given to adolescents and their families.
- Any rules, consequences, or disciplinary actions will be clearly stated, developmentally appropriate, nonviolent, nonaversive, and free from practices of seclusion and restraint.
- All adolescents and families provided services will be given a written confidentiality notice with their signature to indicate its receipt. The adolescent and family will also be notified about mandatory reporting of child or elder abuse and the procedures required.

- The provider's staff will be trained on program rules, policies, and procedures pertaining to rights, complaints, grievance procedures, and legal issues (e.g., juvenile justice, child welfare) and maintain documentation thereof.
- Relationships between adolescents and providers' staff will be free from corporal or unusual punishment, exploitation, prejudice, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, sexual harassment, mental abuse, or other actions of a punitive nature.
- Providers will have a written code of ethics statement that will be signed by each staff member and kept in their personnel files.
- Adolescents have the right to be treated ethically, professionally, and with respect by all staff members.
- Adolescents and their families will be informed by the provider about how to register complaints or grievances.

5. Workforce Competencies/Standards

Note: While the contributors to this document acknowledge the importance of provider competencies and standards, it should be noted that fully addressing them is beyond the scope of this document. This section is meant to provide some condensed information on this topic that was seen as important by the contributors to include, but it is not exhaustive or comprehensive in nature. For the purposes of this section, the term "provider" will be used to refer to all persons employed by an adolescent SUD service provider who provide services to adolescents, including screening and assessment, counseling services, and any other services provided in treatment and recovery programs.

Description

Provider competencies help to ensure providers have the appropriate skills to serve adolescents effectively. "Staff qualifications should be specified for each level of treatment for youth with substance use disorders [SUDs]" (SAMHSA, 2013). Competencies may include requirements pertaining to providers' licensure, certification, training, and areas of expertise according to the State licensing body, regulations, contract language or knowledge, skills, and attitudes that enable an individual to perform his or her job functions. The training and continuing education requirements for providers may include adolescent development (e.g., cognitive, neurological), culture and gender competence, behavior management, ethics, trauma-informed care, and legal issues related to adolescents. Provider competencies may also include the ability to detect abuse, neglect, and co-occurring disorders. More broadly, the "agency ensures that staff who come into contact with youth are those who evidently like and respect youth" (Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 2011).

- Providers completing assessments and providing services to adolescents will be adequately trained and clinically supervised.
- Providers in adolescent programs will have evidence of licensure and certification as defined by the State and practice within that scope, recognizing any potential limitations to their training.
- There will be a ratio of provider-to-adolescent maintained as determined by State standards.
- Providers, administrative staff, and volunteers will undergo criminal background checks and child welfare registry clearance in accordance with State and Federal laws pertaining to work with adolescents.

- Coaches, mentors, and all volunteers will receive training on developmentally and age-appropriate expectations, ethics, and program guidelines.
- Providers will be knowledgeable about adolescent health and safety, signs of child abuse, sexual orientation and gender identity, co-occurring mental health disorders, and youth development (including age-appropriate activities, sexuality, maturation and development, risk-taking, and identity development).
- Providers will be skilled at reaching and communicating with adolescents and their families, presenting information in ways youth can understand and benefit from.
- Providers will be trained and have knowledge of or access to information on community resources or partnerships (e.g., mental health, child welfare, juvenile justice, education, foster care).
- Providers will use nonjudgmental, nonconfrontational, respectful, strengths-based approaches in working with adolescents and their families.
- Continuing education will be available to all providers to maintain and further develop their skills in working with adolescents and their licensure or certification.
- Innovative and intensive continuing education, staff development, and outreach efforts during provider recruitment may be needed to improve cultural competence among providers.
- Providers will be trained on program rules, policies, and procedures (including staff and client rights) and complaint or grievance procedures. Providers will be able to discuss and explain these protocols with adolescents (see "Rights, Responsibilities, and Grievances" section for additional information).
- Providers will "model positive adult behavior within appropriate boundaries (rather than blurring the lines between themselves and their young clients)" (Drug Strategies, 2003).
- Disciplinary and termination processes for providers will be clearly communicated to them.

6. Safety and Facilities

Description

License requirements for State-funded SUD treatment providers are established through the SSA, another State agency, or a national accrediting body. These safety and facility requirements ensure providers maintain an environment supportive of adolescents' physical and emotional growth and development in a manner appropriate for their needs. For example, many States' regulations and contract language for residential treatment require there be separate quarters (e.g., bedrooms, bathrooms) for adults and adolescents and for boys and girls. Another example is that emergency safety interventions should be performed in a manner that is safe and proportionate and appropriate to the severity of the behavior; the client's age, size, and gender; the client's physical, medical, and psychiatric condition; and the client's personal history (Georgia Department of Behavioral Health and Developmental Disabilities, 2011).

The bullets below are examples of States' safety and facilities requirements. They are not meant to be prescriptive but to serve as a menu of options for States to decide the most appropriate standards to meet their unique needs.

- Providers will comply with State licensing statutes and regulations, address the special needs of adolescents, and comply with all protocols and standards to protect their rights.
- If a provider plans to admit an adolescent aged 17 or younger, policies or approved processes will be established regarding how to determine the appropriateness of admitting this client and addressing the different safety and supervision needs of younger clients. While this practice should be discouraged, this may include State approval for admittance of an adolescent client to an adult program when necessary.
- All facilities will be sanitary and in good repair for the safety, well-being, and dignity of adolescents, staff, and visitors.
- Providers will ensure food services, storage, housekeeping, laundry, and maintenance are operated on a consistent basis and in keeping with health standards.
- If a provider offers educational services on site, the classrooms will provide an atmosphere conducive to learning and that meets the adolescent's special physical, sensory, and emotional needs.
- Providers will accommodate individuals with disabilities and meet Americans with Disabilities Act standards.
- Equipment, furnishings, and décor will be developmentally, culturally, and age appropriate for the adolescents served.
- Adolescents will be treated in the least restrictive environment possible.
- Providers and volunteers who work in adolescent facilities will be screened (e.g., thorough criminal background check, dependent on State laws) to ensure the safety of adolescents within the facility.
- The entrance to the provider's building will be controlled by staff who will not permit unauthorized persons on the premises.
- "Emergency safety interventions [will] be performed in a manner that is safe, proportionate and appropriate to the severity of the behavior, and the client's chronological and developmental age, size, gender [identity], physical, medical and psychiatric condition and personal history (including physical or sexual abuse)" (Georgia Department of Behavioral Health and Developmental Disabilities, 2011).
- Providers will not search or physically examine a transgender or intersex resident for the sole purpose of determining the resident's genital status (U.S. Department of Justice, Prison Rape Elimination Act).

7. Technology

Description

Technology is a useful tool in expanding the adolescent's and his or her family's access to care, coordinating care beyond a location-based service delivery system, and providing different avenues for treatment and recovery support services (SAMHSA, 2011a). When working with adolescents, it is important providers stay informed of established and new trends in technology and communication such as email, texting, Web-based applications and recovery groups, smartphone applications, and social media to foster effective communication and expand adolescents' access to care and recovery supports.

Use of e-therapy and telemedicine may have particular importance in rural and frontier communities because there may be a lack of specialized clinicians located in those areas. Overall, "the use of technology to deliver elements of treatment and recovery may increase youth access to and availability of services. Technology and telemedicine can serve as adjuncts to in-person substance use disorder (SUD) treatment for youth. The use of technology to deliver elements of treatment and recovery may also result in resource (e.g., money, time) savings" (SAMHSA, 2013).

- Providers will be trained to use technology and will be updated on emerging technologies in delivering services to adolescents to assist in the provision of quality, innovative care.
- Providers will train staff on how privacy laws at the State and Federal levels (e.g., HIPAA, 42 CFR Part 2, Health Information Technology for Economic and Clinical Health Act) interact with use of technology for adolescent treatment and recovery support services.
- Providers will discuss and implement policies regarding the potential risks and benefits of any electronic communications (e.g., texting, social media) used to engage adolescents in treatment and recovery supports (Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 2011).
- In communities in which it is difficult to access appropriate adolescent treatment, such as some rural or frontier areas, e-therapy, telemedicine, or telephone-based continuing care may be used to increase access to care.
- Telemedicine, Web-based applications, personal digital assistants, electronic media, use of tablets, and Internet-based tools, when available and developmentally appropriate, will be used to assist with treatment and recovery support.

Conclusion

Adolescents have differing strengths and needs in SUD treatment and recovery than those of adults. While adults make up the majority of the SUD treatment system, adolescents are an important and underserved population—only 8.4 percent of the adolescents who need treatment in the United States receive SUD services (SAMHSA, 2012b). Further, given the changing health care delivery environment in many States, the implementation of the Mental Health Parity and Addiction Equity Act, and the inclusion of mental health and substance abuse services in the Essential Health Benefits required by the Affordable Care Act, it is likely that a growing number of adolescents will be seeking services in the near future. When adolescents access treatment and recovery support services for SUDs, it is important they receive appropriate care. The three sections of this document outline considerations States can take into account when building and strengthening their adolescent SUD treatment and recovery systems. The Overarching Principles of Care outlines core components of service delivery to be considered throughout the adolescent's treatment and recovery, such as developmentally appropriate care and gender and cultural competence; the Service Elements identify treatment and recovery support services for adolescents, including screening and recovery support services; and the Administration/Operations Considerations for the States relate to the oversight and procurement of adolescent SUD services, such as designation authority and quality monitoring and oversight. This document is intended to serve as both a guide for all States in building their adolescent-serving SUD treatment and recovery systems and a reflection and recognition of States' work in this important area. NASADAD generated this document using the expertise of the Youth Coordinators with the expectation that it would provide States useful guidance.

The structure of this document and some of its processes were modeled after NASADAD's and the Women's Services Network's development of *Guidance to States: Treatment Standards for Women with Substance Use Disorders* (Mandell & Werner, 2008). Since its publication, *Guidance to States* has been used in a variety of ways by States. A presentation at the National Conference on Substance Abuse, Child Welfare, and the Courts in 2011 illustrated three innovative ways in which States used the document. In New Jersey, the Governor's Substance Abuse Workgroup, composed of individuals from different disciplines that interface with child welfare, implemented parts of the document in its guidance given to the Women's Treatment Providers. In Illinois, a State Gender Competency Endorsement was developed as part of an effort to train a gender-competent workforce (Illinois also has an Adolescent Treatment Endorsement). Moreover, in New York, a continuum of gender-responsive services was established based on *Guidance to States* and on CSAT's Treatment Improvement Protocol 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (2009) (Brooks, Morris-Groves, & Scalise, 2011). These examples illustrate the potential ways in which the *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide* may be used in the future. Additional ways this guide could be used include the development or enhancement of adolescent standards through regulations, contract language, guidelines, and service bulletins. This guide can also serve as a tool for strategic planning for adolescents with SUDs or in the development of provider evaluations and technical assistance. Overall, the information can be adapted to fit in the strengths and needs of State systems across the country.

States have many challenges in working to provide services to adolescents with SUDs, including funding and accessibility to services. To successfully implement standards or modifications to the adolescent-serving system, funding, training, monitoring, and technical assistance are needed to aid in the transition. NASADAD understands an adolescent SUD system requires continuous quality improvement and States' systems vary. Further, the adolescent SUD system requires an understanding and acknowledgement of adolescents' unique strengths and needs in providing its services. It is our hope the information contained in this document will provide useful suggestions for services, best practices, and approaches to adolescent SUD treatment and recovery and aid in the system's progression.

Appendix A: Detailed Methodology

The *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide* was developed in response to a need identified by the State Youth Substance Abuse Coordinators Committee (Youth Coordinators) through an interactive process. Twenty-four Youth Coordinators volunteered to serve on the Adolescent Treatment and Recovery Practice Guide Workgroup, including three team leaders (Group A: Maria Morris-Groves, New York; Group B: Tina Burrell, Washington; and Group C: Katie Wells, Colorado). This methodology section provides a summary of the history of the development of this practice guide.

The Youth Coordinators expressed interest in gathering information on States' existing regulations, contract language, treatment practice guidelines, and similar documents for adolescents with substance use disorders (SUDs). A total of 40 States and 1 territory responded to the request for information (n = 41). Staff from the National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), searched State Web pages to find additional documents from States unable to respond to the request for information. Twenty-four States (Arizona, California, Colorado, Delaware, Georgia, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Minnesota, Mississippi, Missouri, Montana, New York, North Carolina, Oklahoma, Oregon, South Carolina, Texas, Utah, Washington, Wisconsin, Wyoming) reported having some documentation on adolescent treatment standards and/or guidelines for the treatment of adolescents with SUDs. Seventeen States and one territory reported not having such documents.

The Youth Coordinators met during the Joint Meeting on Adolescent Treatment Effectiveness (JMATE) in April 2012. One of the issues selected by the Youth Coordinators for discussion was the States' adolescent treatment standards or guidelines. In preparation for the in-person meeting at JMATE, NASADAD staff completed an analysis of the topics (e.g., elements) found in different States' standards or guidelines for adolescent SUD treatment and the frequency of these topics and elements across States. This issue produced a robust dialogue that accounted for the majority of the Youth Coordinators' meetings at JMATE. As a result, the *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide* was further discussed at an in-person meeting at the NASADAD Annual Meeting in June 2012, through conference calls, and in response to email or Web-based inquiries. The collated information prepared for JMATE was expanded upon after the meetings and was used in conjunction with feedback from the Youth Coordinators to develop an outline for the document. The proposed outline was discussed with the Youth Coordinators on several teleconference calls. The Youth Coordinators were the drivers of this process, providing input and content expertise in the development of the document.

As a result of the 2 in-person meetings and subsequent conference calls, 24 Youth Coordinators volunteered to serve on the Adolescent Treatment and Recovery Practice Guide Workgroup. The workgroup decided the process would mirror the process used for NASADAD's *Guidance to States: Treatment Standards for Women with Substance Use Disorders*, which was developed using the expertise of the Women's Services Network (WSN) (Mandell & Werner, 2008). Some of the WSN members are also Youth Coordinators and worked on the development of both documents. A key difference between the two documents is that the *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide* was intended to be very concise (under 50 pages in length), providing an overview of important topics and major considerations.

NASADAD staff put together packets on each topic in the three sections of the document: Overarching Principles of Care, Service Elements, and Administration/Operations Considerations for the States. The packets consisted of draft descriptions of each element and language taken directly from State documents and other national publications. In addition to the State documents, NASADAD staff added information from national documents from the Substance Abuse and Mental Health Services Administration (SAMHSA) (e.g., *Designing a Recovery-Oriented Care Model for Adolescent and Transition Age Youth with Substance Use or Co-Occurring Mental Health Disorders*, *Good and Modern: Description of a Modern Addictions and Mental Health Service Systems*, *Treatment of Adolescents with Substance Use Disorders Treatment Improvement Protocol [TIP] Series 32*) and national experts (e.g., publications from national organizations or research-based documents: *Treating Teens: A Guide to Adolescent Drug Programs, Guidance to States: Treatment Standards for Women with Substance Use Disorders*). Larke Huang, Ph.D., and Twyla Adams, M.H.S. (SAMHSA), along with Doreen Cavanaugh, Ph.D. (Georgetown University), reviewed findings from the draft Technical Expert Panel document and provided additional information on *Selected Findings From SAMHSA-Sponsored Technical Expert Panel: What Does the Research Tell Us About Good and Modern Treatment and Recovery Services for Youth With Substance Use Disorders?* This information served to establish a base of expert input and information. Additional national documents were reviewed based on research and suggestions by the Youth Coordinators, the consultants, and SAMHSA staff. The list of works cited (see appendix C) indicates the specific documents cited herein. It is not an exhaustive list of all documents that were reviewed in the creation of this document.

Members of the Adolescent Treatment and Recovery Practice Guide Workgroup were divided into three groups (A, B, and C) to review the information and develop the content. NASADAD staff sent each group packets and asked members to highlight or comment on what they considered the most salient information provided on each topic. For each topic, NASADAD received feedback from three to five Youth Coordinators and from the NASADAD consultants (Kara Mandell, Randy Muck, and Deb Werner). This feedback formed the basis for the development of initial bullet points, which describe vital aspects of each element. These bullet points, along with the revised descriptions, formed the basis for further review by the Adolescent Treatment and Recovery Practice Guide Workgroup. The Service Elements section was reviewed through Web-based workgroup meetings, whereas the Overarching Principles of Care and the Administration/Operations Considerations sections were reviewed through an email communication feedback process. Because there were challenges with scheduling and a limited timeframe in which to complete this stage of the process, only one of the sections could be reviewed through the Web-facilitated meetings. The Service Elements were chosen for the Web-facilitated meeting process because they comprise the largest section of the document.

Although originally planned as an in-person meeting, the process for the Youth Coordinators' review was completed entirely through Web-facilitated meetings. A 1-hour kickoff meeting with the entire workgroup outlined the process and enabled the group to acclimate to the technology. Ten Web-facilitated meetings were convened; each of the three groups (A, B, C) met for a total of 3 to 4 hours. The meetings included a group of up to eight Youth Coordinators, a Youth Coordinator team leader and a consultant who worked with each group (Group A: Randy Muck; Group B: Deb Werner; Group C: Kara Mandell), and NASADAD staff. When available, Doreen Cavanaugh (Georgetown University) provided her expertise, and JBS staff (Roxsana Saenz, Amy Pinkney, Steve Cleiman) provided technical support. During these Web-facilitated meetings, the Youth Coordinators reviewed several Service Elements, provided feedback on content, and edited the information. The revised version of each topic reviewed during Web-facilitated meetings was sent back to the group for additional edits, comments, and

suggestions. These edits, comments, and suggested revisions were used to create the draft Service Elements section.

For the Overarching Principles of Care and Administration/Operations Considerations sections, the Adolescent Treatment and Recovery Practice Guide Workgroup was solicited for review, suggestions, and edits as outlined above. Each of the three workgroups (A, B, C) was given five or six of the Overarching Principles of Care or the Administration/Operations Considerations elements for review. Based on this review, 1-page draft documents with a description and central principles (written in bullet point format) were sent to the workgroups for additional revisions, suggestions, and edits. The email feedback from the multiple rounds of workgroup edits was incorporated into the drafts of these two sections.

The document was sent for review and comment to all Youth Coordinators, the NASADAD Board of Directors, the National Treatment Network (NTN) Executive Committee, JBS, and SAMHSA. The Youth Coordinators were asked to consult with other SSA staff members, including State directors, NTNs, providers, and other stakeholders. The comments and suggested revisions were incorporated into the *State Adolescent Substance Use Disorder Treatment and Recovery Practice Guide*.

Appendix B: State Documents

*We would like to acknowledge the 24 States (*Arizona, California, Colorado, Delaware, Georgia, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Minnesota, Mississippi, Missouri, Montana, New York, North Carolina, Oklahoma, Oregon, South Carolina, Texas, Utah, Washington, Wisconsin, Wyoming*) that contributed their guidelines and other documentation on youth treatment and recovery services within their State. These documents have been used throughout the course of the project and are listed below.*

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