



CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

ADOLESCENT SUBSTANCE USE DISORDER BEST PRACTICES GUIDE

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Contents

- 1. Overview..... 5**
 - 1.1 Introduction..... 5
- 2. Overarching Principles of Care..... 6**
 - 2.1 Developmentally Appropriate Care.....6
 - 2.2 Cultural and Gender Competencies.....7
 - 2.3 Systems Collaboration Among Adolescent-Serving Agencies..... 9
 - 2.4 Integrated Care.....10
 - 2.5 Trauma Informed Care..... 11
 - 2.6 Recovery-Oriented Care..... 13
 - 2.7 Evidence Based Practices (EBPs)..... 14
- 3. Service Elements..... 15**
 - 3.1 Screening, Assessment, and Planning.....15
 - 3.1.1 Outreach, Engagement, and Retention.....15
 - 3.1.2 Screening.....17
 - 3.1.3 Assessment.....18
 - 3.1.4 Treatment and Recovery Planning.....19
 - 3.1.5 Physical Health: Education, Screening, and Referral..... 20
 - 3.1.6 Case Management and Care Coordination..... 21
 - 3.2 Treatment Services..... 22
 - 3.2.1 Levels of Care..... 22
 - 3.2.2 Substance Use Disorder Counseling..... 23
 - 3.2.2.1 Individual Counseling..... 23
 - 3.2.2.2 Family Counseling..... 24
 - 3.2.2.3 Group Therapies..... 26
 - 3.4 Co-Occurring Substance Use and Mental Health Disorders..... 26
- 4. Recovery Services..... 27**
 - 4.1 Continuing Care and Support..... 27
 - 4.2 Education..... 28
 - 4.3 Recreational Services or Prosocial Activities..... 29
 - 4.4 Positive Adolescent Development..... 30
 - 4.5 Employment/Vocational Services..... 31



4.6 Transportation..... 32

4.7 Life Skills..... 33

4.8 Referral to Mutual Aid Groups..... 34

4.9 Peer-to-Peer Recovery Coaching/Peer Mentoring..... 35

5. Administration Considerations..... 36

5.1 Designation Authority..... 36

5.2 Governance..... 36

5.3 Rights, Responsibilities, and Grievances..... 36

5.4 Workforce Competencies/Standards.....37

5.5 Safety and Facilities.....39

5.6 Technology.....39

Appendix A. Definitions..... 41

Appendix B. References..... 45



1. Overview

Substance Use Disorders (SUDs) among adolescents pose particular challenges for counties and providers responsible for managing SUD treatment and recovery programs. 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 on how SUD treatment and recovery programs can best serve adolescents. In response, the California Department of Health Care Services (DHCS), Youth Services Section (YSS) developed these guidelines incorporating scientific research and clinical practice from both the SUD treatment files and children’s service systems. The guidance is based on the American Society of Addiction Medicine (ASAM) Criteria for determining the appropriate intensity and length of treatment for adolescents with SUDs.

The guide is divided into four broad sections:

- Overarching Principles of Care
- Service Elements
- Recovery Services
- Administrative Considerations

These sections are defined in greater detail within this document and contain best practices as a resource to counties and providers in their continuous efforts to improve SUD intervention, treatment, and recovery services for adolescents funded by federal and state funds.

1.1 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, adolescents are individuals 12 through 17 years of age, inclusive.

Fundamentally, a best practice can be defined as “an intervention that has shown evidence of effectiveness in a particular setting and is likely to be replicable to other situations” (Ng & de Colombani, 2015). For the most positive outcomes among adolescents experiencing SUD-related problems, they must have access to age-appropriate intervention, treatment, recovery, practical support such as life skills training and employment, and meaningful opportunities for involvement and leadership. Adolescents need programs that address their developmental issues, provide comprehensive and integrated services, involve families, and allow adolescents to remain in the most appropriate, but least restrictive setting. As result,

Adolescents have psychological, developmental, and emotional strengths and needs that are distinct from those of adults.

adolescents can be serviced within the context of their families, classroom and community. Historically, the SUD intervention and treatment service system has not serviced adolescents well because it was designed and intended for adults.

For the purpose of this document, adolescents are individuals 12 through 17 years of age, inclusive.

Numerous studies periodically document the substantial prevalence of SUD among adolescents. Marijuana is the most widely used illicit substance among adolescents, with its usage rate increasing significantly since 1991. The most commonly abused substances besides alcohol and marijuana were amphetamines, prescription painkillers, cough medicine, and sedatives. Recent trends indicate that the onset of SUD is occurring at younger ages, and there are alarming increases in the use of e-cigarettes and the practice of “vaping” is becoming more popular than regular tobacco products.

The Adolescent SUD Best Practices Guide replaces the previously published Youth Treatment Guidelines revised August 2002. The guide is developed and intended to be used in place of and, not to conflict with or duplicate, other applicable laws, regulations or standards that govern programs serving adolescents.

2. 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 DHCS as the foundational principles of care for addressing the needs of adolescents with SUDs. This guide contains a brief description that introduces each of the nine principles, which pertain to all service elements described in the next section of this document. 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, County and provider systems of care/programs for adolescents).

The Overarching Principles of Care express core values and principles that underlie the adolescent SUD treatment and recovery system.

2.1 Developmentally Appropriate Care

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).

Adolescents are developmentally, physically, cognitively, emotionally, and socially different from younger children and adults.



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), Treatment Improvement Protocol (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.

- a) Staff should understand the developmental stages, growth, behavior, values/beliefs, and cultural differences among adolescents.
- b) At every level of care, program services for adolescents should be designed and implemented in ways that are developmentally relevant (e.g., taking age, maturation, cognitive processing, decision-making skills, and special needs of the individual adolescents into consideration). Adolescents should be treated in the least restrictive environment possible.
- c) Programs should use effective strategies to engage adolescents, channel their energy, and hold their attention; these strategies are different from those for adults.
- d) Staff should communicate and deliver services that are age appropriate in terms of the adolescent's developmental stage, cognitive ability, and relevant environmental and sociocultural factors.
- e) Treatment and recovery should 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.
- f) All screenings and assessment services should be developmentally appropriate, trauma informed, and responsive to gender identity, sexuality, and culture.
- g) Services, materials, and resources provided to adolescents should be accessible in that they will be developmentally appropriate and tailored to adolescents.

2.2 Cultural and Gender Competence

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 adolescents are disproportionately referred to more restrictive systems (e.g., juvenile justice and child welfare) than into specialty behavioral health or substance use treatment.

Culturally and gender-competent care is respectful of racial and ethnic identity, sexual orientation, gender, religion, age group, geographic location, and other shared

- a) Screening and assessments should be comprehensive, multifaceted, trauma-informed, culturally and developmentally appropriate, and provided in an empathetic, nonjudgmental manner.
- b) Providers should use culturally and gender-appropriate strategies for prevention, engagement, screening, assessment, treatment planning, intervention, treatment, and recovery supports for adolescents and their families.
- c) 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).
- d) 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.
- e) Providers should be sensitive to the cultural expectation’s adolescents have in their interactions with authority figures and adults and their expectations in interactions across genders and cultural/racial groups.
- f) Providers serving adolescents whose primary language is not English, including adolescents who use sign language, should provide skilled bilingual staff and/or interpreters as needed.
- g) Print and audiovisual materials should be both linguistically and literacy appropriate (e.g., at various reading and developmental levels) for adolescents and their families.
- h) Providers should 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.

- i) Providers should 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.
- j) Gender-responsive services should be available to ensure adolescents receive appropriate individualized care.
- k) A “safe” environment should be cultivated to talk about sensitive issues; this should include having gender-matched staff and gender-specific services and therapies, including same-gender groups and nonaggressive/nonconfrontational therapies, which will enhance therapeutic alliances.
- l) Programs should 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.
- m) Providers should take into account access to services, particularly in rural or frontier areas. When possible, telemedicine or e-therapy should be offered, to adolescents in rural or frontier areas (see “Technology” section for additional information).

2.3 Systems Collaboration Among Adolescent-Serving Agencies

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 (Substance Abuse and Mental Health Services Administration (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.

Adolescents’ interactions in other systems can afford an opportunity to link them to SUD services when appropriate.

- a) State, county, tribal, and provider levels should collaborate with other adolescent-serving systems or agencies to address the comprehensive needs of adolescents with SUDs and their families.
- b) State/County levels will educate other adolescent-serving systems or



agencies on services available to adolescents with SUDs.

- c) SUD providers will work with adolescents and their families to help them negotiate services across systems and coordinate referrals.
- d) 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.
- e) SUD providers will coordinate case management with other systems, adhering to state and federal laws pertaining to disclosure of confidential client information (see “Case Management and Care Coordination” section for additional information).
- f) 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.
- g) 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.

2.4 Integrated Care

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. It also includes 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) and National Association of State Alcohol and Drug Abuse Directors (NASADAD), 1999). Service coordination among the mental health, substance abuse, and primary health care systems should

Integrated adolescent SUD treatment should be comprehensive addressing co-occurring mental health disorders and primary care services as appropriate.

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. Counties and providers may formally collaborate to ensure both substance use and mental health issues are included in the treatment regimen. In cases of high severity, counties/providers 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).

- a) Providers should commit to the concept of one team with one plan for one person in whatever way this works for the treatment providers. Ideally, this would be accomplished within a single, integrated system or individualized treatment and recovery service plan that incorporates input from family and significant others in the adolescent's life and multiple adolescent-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 should include a continuum of services capable of addressing the full range of co-occurring mental health disorder severity.
- b) Individualized treatment and recovery service plans should be comprehensive and address each of the adolescents' and families' needs in the least restrictive setting that is safe and effective.
- c) 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.
- d) Treatment outcomes should be assessed over time, and individualized treatment and recovery service plans should be modified to ensure they meet the adolescent's changing needs and resources.
- e) Providers should receive ongoing education and training regarding the gender-specific prevalence, etiology, signs/symptoms, and treatment of co-occurring mental and/or physical health disorders.
- f) The provider should document services provided to individuals with co-occurring mental and/or physical health conditions (e.g., medication noncompliance or abuse, interactions of drug use and other medications).

2.5 Trauma-Informed Care

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 way 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” (SAMHSA, 2011). A trauma-informed approach seeks to avoid re-traumatization 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).

Trauma significantly increases the likelihood adolescents may develop a SUD. At the same time, adolescents with SUDs are more likely to experience trauma.

- a) The impact and consequences of trauma should be considered in all clinical interventions, recovery support services, and organization operations.
- b) Screenings and assessments should be trauma-informed, and trauma-specific interventions should be used when appropriate.
- c) Trauma-specific services should include evidence-based and promising practices that directly address the effect of trauma and facilitate recovery and healing.
- d) Because substance use can be a coping mechanism for adolescents who have experienced traumatic events, providers should work with adolescents to build other alternative, less harmful coping skills.
- e) Providers should not require that adolescents retell the details of their traumatic experience(s).
- f) Providers should 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 should include mental health (see Safety and Facilities section for additional information).

- g) Providers should make efforts to prevent the use of seclusion and restraint, recognizing these coercive practices are not therapeutic and can be re-traumatizing. Seclusion and restraint should be used only as a last resort if the safety of the adolescent or staff is at risk.
- h) Providers' staff should be trained on the provision of a trauma-informed and trauma-responsive environment, trauma-specific services, and issues of re-traumatization. This includes frontline and nonclinical staff members (Mandell & Werner, 2008).
- i) Providers should recognize physical, emotional, and psychological safety are critical for recovery.

2.6 Recovery-Oriented Systems of Care (ROSC)

ROSC for adolescent support, adolescent-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 adolescent-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.

A ROSC for adolescents emphasizes the importance of adolescent-guided and family-centered care; is culturally, age, and gender appropriate; reflects the developmental stages of adolescence; is strengths based and proactive.

- a) Providers should 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.
- b) Providers should be guides rather than directors of services in treatment planning and service provision.
- c) Providers should assist the adolescent in defining what wellness in recovery means for them and supporting the attainment of wellness.
- d) A range of recovery services should 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.
- e) Providers should 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.

- f) Providers should promote a greater responsibility on the part of adolescents for their own treatment and encourage them to practice decision-making skills and roles, thereby enhancing self-confidence and self-efficacy.
- g) Treatment and recovery planning should be adolescent guided and adolescent centered to the extent that is developmentally appropriate, building on the adolescent’s priorities and interests. Providers should give adolescents choices to assist in their self-directed care.
- h) Peer recovery groups and mentors should be an option for adolescents to assist in supporting their recovery.
- i) Providers should give adolescents the ability to check in with peer mentors/recovery coaches and administrative staff to access support or additional care.
- j) Programs should address lapse and relapse as learning opportunities for adolescents in treatment and recovery services. To the extent possible, adolescents should not be dismissed from programs as a result of lapse or relapse, which is often a part of recovery.

2.7 Evidence-Based Practices (EBPs)

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 adolescents’ with substance use disorders is effective (e.g., reduces substance use for adolescents’ 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.

Implementing developmentally and age appropriate EBPs for adolescents with SUDs is recommended to maximize positive treatment outcomes.

Promising practices may also be considered, particularly because there is not an EBP for every population. For instance, many EBPs do not provide practitioner 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. 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.

- a) Providers should have an understanding of models and theories of SUDs and behavioral, psychological, physical, and social effects of psychoactive substances. They should also remain up to date on current research and evidence-based and best practices for adolescent treatment and recovery.
- b) To use EBPs effectively, providers should ensure staff members are adequately trained and qualified to implement the practices with fidelity and have the appropriate supervision.
- c) Provider personnel files should document training(s) and/or certification(s) in the evidence-based model(s) the staff member is using in the provision of adolescent services.
- d) Providers should be able to demonstrate which EBP is implemented, how trainings and supervision are conducted, and how fidelity is assured.
- e) Providers should 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).

3. Service Elements

The service elements are services found in state/county treatment and recovery systems. These services are delivered by counties and/or providers for which the state/county has oversight and/or funding responsibilities. 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. The purpose of this guidance is to increase the quality of services for adolescents with SUDs.

The purpose of this guidance is to increase the quality of services for adolescents with SUDs.

3.1 Screening, Assessment, and Planning

3.1.1 Outreach, Engagement, and Retention

Outreach, engagement, and retention efforts are made throughout the adolescent's treatment and recovery to 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 (DADP, 2002). Effective outreach can help engage adolescents to enter treatment. An adolescent that is engaged in services 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).

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.

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 SUD 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.

- a) Outreach efforts should 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 (DADP, 2002). Providers should also consult with experts on outreach efforts appropriate for students with a learning or physical disability.
- b) When appropriate, providers should make intensive outreach efforts to engage the family, caregivers, and/or identified positive peer and adult supports while the adolescent is in treatment.
- c) Outreach should 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.

- d) Providers should 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.
- e) Providers should offer gender-specific services and matched-gender treatment staff to aid in the adolescent’s connection with treatment staff and build therapeutic alliances.
- f) Treatment options should be presented in a nonthreatening, strengths-based, trauma-informed manner.
- g) Providers should 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).
- h) Providers should 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.
- i) Engagement and retention efforts for adolescents should include technology (e.g., cell phones, social media), recovery coaching, and peer mentoring. Providers should also help adolescents develop their own technology safety plan to help them make good decisions that reduce their vulnerability to harassment, over-disclosure, and predators.
- j) High priority should 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.

3.1.2 Screening

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 intervention. 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.

The purpose of screening is not to diagnose; rather, screening determines whether adolescents should be recommended for an assessment and/or intervention.

- a) 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.



- b) The screening will be developmentally appropriate, short, simple, and easy to administer and interpret to enable a wide variety of professionals to screen adolescents.
- c) The screening process should last no more than 30 minutes—ideally, 10–15 minutes—and the instrument should be simple enough that a wide range of health professionals can administer it. It should 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).
- d) Professionals and individuals who work with adolescents should also be able to screen and detect possible substance use and refer adolescents to further assessment. Many health and judicial professionals will have screening expertise, including school counselors, street adolescent workers, probation officers, and pediatricians (CSAT, TIP 31, 1999).
- e) While many screening tools provide specific numbers or cutoff scores for referral to assessment, the individual screener should use his or her judgment to decide whether identified problem/high- risk behaviors or red flags warrant a referral to assessment.
- f) Providers should have culturally specific screening tool(s) available for a variety of individuals from diverse backgrounds.
- g) Screening should not be used as a diagnostic tool.
- h) There should be a protocol and referral criteria to triage adolescents who need immediate assistance and to identify adolescents who need a more comprehensive evaluation.
- i) If screening is done through another service setting (e.g., probation), the provider should receive and take into consideration the screening information provided.

3.1.3 Assessment

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 considers the broader aspects of the adolescent’s life, including psychosocial functioning and environmental factors. Effective assessments are culturally sensitive, gender

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.



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 regards 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).

- a) Providers should 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.
- b) Assessment is an ongoing process that should be trauma informed, comprehensive, multifaceted, and culturally and developmentally appropriate for each adolescent admitted to treatment.
- c) The assessment should 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.
- d) The adolescent's developmental and cognitive levels; social, emotional, and communication abilities and strengths; and independent living skills should be assessed.
- e) The goals of assessment should 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.
- f) The provider should 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 displays 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.
- g) Providers should also assess for signs of emotional or physical (including sexual) abuse in adolescent relationships, including same-sex relationships.
- h) Assessment should 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.

- i) The standardized, evidence-based assessment should use established, reliable, and valid protocols and measures and will be implemented with fidelity. It should be designed specifically for capturing information related to the major life domains of the adolescents in treatment for SUDs.
- j) The assessment should be administered by providers trained in the administration and interpretation of SUD assessments for adolescents (e.g., SUD counselor, psychologist, social worker).
- k) The assessment should 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).

3.1.4 Treatment and Recovery Planning

A treatment and recovery plan serves as a roadmap for treatment and recovery support service delivery. Treatment and recovery plans are strengths based, adolescent 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 plans are assessed and modified continuously and reflects changes in needs and preferences of the adolescent.

A treatment and recovery plan serves as a roadmap for treatment and recovery support service delivery.

- a) The treatment and recovery plan should 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.
- b) The plan should reflect the adolescent's developmental stage; gender identity; culture; sexuality; and chronological, emotional, and psychological age.
- c) During the treatment and recovery planning process, the adolescent and his or her family should 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, and improvement of family relationships).
- d) The adolescent's individual treatment and recovery plan should be assessed and reviewed by the adolescent and provider on a scheduled basis, and, additionally, as requested by the adolescent or family. The plan should 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.

- e) Treatment and recovery plans should include goals for family functioning, or the program should develop a family services plan that identifies the ongoing family support and improvement goals.
- f) Family members should 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.
- g) The strategies and services specified in the plan should include identification of the individuals providing treatment, an expected timetable for achieving adolescent-guided goals and objectives, where treatment is to take place, and when the plan will be reviewed.
- h) Recovery support services should be defined in the plan and should reflect progress toward adolescent-identified goals, desired improvements in functioning, and improvements in quality of life. Transition planning should be regularly discussed throughout the treatment and recovery process.
- i) Treatment and recovery plans should consider adolescent development goals including building competencies, identity/character development, contributions to community, and relationships.
- j) Transition planning should begin at the time of treatment and recovery planning to prepare for upcoming changes.

3.1.5 Physical Health, Education, Screening, and Referral

SUDs often co-occur with physical health conditions which is why 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, and sleep disorders) that could be ameliorated by physical interventions (SAMHSA, 2013). With this in mind, all SUD 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).

Because SUDs often co-occur with physical health conditions, it is important to identify such needs and provide access to appropriate medical care for adolescents entering treatment.

- a) Comprehensive assessments should include a screening of the adolescent's medical status, including medical history.
- b) Appropriately trained and educated providers should 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 should 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], and tuberculosis).

- c) Providers should 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.
- d) Providers should 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).
- e) Adolescents should receive health education that includes information on family planning, tobacco cessation, and other health behaviors.

3.1.6 Case Management and Care Coordination

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, and juvenile justice).

Effective case management/care coordination includes interfacing with the services and systems the adolescent and family are involved with.

Involvement of these professionals, as identified by the team, assists in developing and executing a comprehensive treatment plan. 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).

- a) Each adolescent and his or her family should receive case management and/or care coordination services from the SUD treatment provider.
- b) Providers should 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).
- c) 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.
- d) Case managers and/or care coordinators should be familiar with adolescent-serving agencies/systems and other community resources, both formal and



informal, to effectively facilitate access to other systems. Providers should 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.

3.2 Treatment Services

3.2.1 Levels of Care

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 ASAM Criteria (Mee-Lee, Shulman, Fishman, Gastfriend, & Griffith, 2013), or another validated set of criteria. In concert with these tools and criteria, providers should 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.

Through assessment, using developmentally appropriate tools or a validated set of criteria, such as the ASAM Criteria, in concert with clinical judgement, providers should determine the appropriate level of care and identify the service type and frequency of delivery.

- a) Providers should 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.
- b) Providers should actively coordinate with relevant adolescent-serving agencies (e.g., schools) to provide needed services to promote recovery and resiliency.
- c) There should 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.
- d) Providers should be able to provide or refer adolescents to the appropriate continuum of services as indicated in the adolescent's assessment.
- e) Continuing care support services should be made available to adolescents as appropriate with the levels of care and the adolescents' goals.

- f) Recovery support services should be used in alignment with the level of care and goals of the adolescents.

3.2.2 SUD Counseling

3.2.2.1 Individual Counseling

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 help 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 (NASADAD, 2014).

Sensitivity to gender and cultural differences helps develop a successful therapeutic alliance between the adolescent and the counselor and is key to facilitating behavior change.

- a) Each adolescent should be assigned a primary counselor who is part of the adolescent's treatment team. The counselor should 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.
- b) Providers who are capable should 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.
- c) Individual counseling sessions should 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 should be met to the extent possible.
- d) SUD counselors should provide SUD treatment services for adolescents in coordination with the case managers or care coordinators.
- e) SUD counselors should be trained and qualified based on state standards for licensure and credentialing (see Staff Competencies section for additional information).

- f) Counseling and recovery support services should be provided for the adolescent’s family to aid them in supporting his or her recovery (see Family Counseling section for additional information).
- g) Individual counseling sessions should 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).

3.2.2.2 Family Counseling

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 a SUD and for the family as a whole. (NASADAD, 2014). 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).

Adolescents may be from complex, blended, or troubled families, therefore, identification of family member (of origin or of choice) is an important element of family counseling.

- a) 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).
- b) Providers should work with each adolescent to identify family relationships (of origin or choice) and what family members to involve in services.
- c) Providers should 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).
- d) Family counseling sessions should include activities focused on enhancing



family relationships, communication, and functioning to promote the resiliency of the family unit (NASADAD, 2014).

- e) 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).
- f) Family services should 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).
- g) Family services should focus on recovery and wellness for the adolescent and his or her family.
- h) When applicable, family-based services should take into account the broader social and community groups that shape adolescents' behavior, beliefs, and attitudes.
- i) Providers should implement evidence-based and promising practices for family counseling or therapy models with attention to cultural, racial, ethnic, gender, and sexual minority factors.
- j) In consideration of the intergenerational nature of SUDs, providers should create access to assessments and referrals to individual treatment and support services for family members (e.g., parents or caregivers, grandparents, or siblings).
- k) Providers should be familiar with issues related to family violence. This may include knowledge of family reunification and collaboration with the child welfare system.
- l) Providers should be familiar with child and elder abuse reporting laws and will inform families of their status as mandatory reporters.
- m) As appropriate, adolescent's siblings should be involved in family counseling or other educational programs.
- n) In addition to these services, providers should create a family-friendly environment and encourage family members' healthy engagement in adolescents' treatment/recovery.

3.2.2.3 Group Therapies

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

For adolescents, group therapy can be a way to build healthy relationships, experience positive peer reinforcement, and bond within a culture of recovery.



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.

- a) Group counseling sessions should be provided when deemed clinically appropriate and in accordance with the adolescent's treatment and recovery plan.
- b) Group counseling sessions should 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).
- c) When possible and appropriate, providers should offer separate groups for girls, boys, and LGBTQI adolescents. All groups should be trauma-informed and sensitive to issues of gender, cultural norms, and sexual orientation.
- d) Providers should 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.
- e) Prior to placing adolescents in specific group therapy sessions (e.g., prevention based or educational), the provider (e.g., case manager or counselor) should properly screen participants for SUDs and match the participants to appropriate group(s) (CSAT, TIP 41, 2009).
- f) Group therapists/facilitators should have an understanding of group processes, group dynamics, and the stages of group development (CSAT, TIP 41, 2009).

3.4 Co-Occurring Substance Use and Mental Health Disorders

Of those adolescents who are in treatment for SUDs, more than half may 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 (CSAT, TIP 42, 2008).

Of those adolescents who are in treatment for SUDs, more than half may have co-occurring mental health disorders.



- a) SUD treatment settings should include screening of co-occurring mental health disorders at the time of intake and provide referrals for assessments for adolescents who screen positive.
- b) As a result of the prevalence of co-occurring mental health disorders in adolescents with SUDs, the providers should conduct ongoing assessments for mental health disorders.
- c) Comprehensive co-occurring treatment should 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.
- d) Providers should 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.

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. 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).

Recovery support services are ideally incorporated at the inception of services and continue after the adolescent’s discharge.

4.1 Continuing Care and Support

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, emphasize the importance of the continuity of the relationship between the adolescent 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 adolescent and his or her family that are identified through an ongoing process of clinical monitoring and reassessment (Mandell & Werner, 2008).

- a) Providers should focus on strategies to help support the maintenance of the



adolescent's long-term wellness and recovery through the provision of continuing care and ongoing support in the adolescent's community.

- b) Continuing care services may be provided in a variety of settings, and adolescents should be given the opportunity to identify which services are best for them (SAMHSA, 2013).
- c) The provider should work with the adolescent and his or her family to determine services that will assist in the maintenance of the adolescent's recovery.
- d) Clinical monitoring and care should encompass efforts to develop skills for the adolescent to cope with his or her substance use such as recognition and management of triggers that may interfere with the adolescent's recovery (relapse prevention) and to intervene after a lapse or setback to prevent a full relapse (relapse management).
- e) When possible and as appropriate, recovery management checkups (e.g., a discussion with the adolescent on his or her recovery) should be ongoing and target continued skill building, relapse prevention, problem solving, and the therapeutic alliance between counselor and adolescent.
- f) Providers should be aware that adolescent's 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.
- g) Continuing care should 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).

4.2 Education

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).

Education is one of the most important factors in adolescents' developmental paths and in their recovery from SUDs.



- a) Treatment and recovery plans should reflect the adolescent’s educational goals and objectives.
- b) With consent, providers should 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.
- c) Providers should have a referral source with information on state high school equivalency test requirements.

Additional education considerations for residential treatment providers —

- d) Residential treatment staff should coordinate education services while the adolescent is in residential treatment in accordance with state laws for education and/or special education.
- e) Adolescents in residential treatment should be given time and support to keep up with schoolwork.
- f) Providers should 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 should begin with treatment and recovery planning.

4.3 Recreational Services or Prosocial Activities

Development of, or re-engagement in, safe and healthy recreational activities is critical for adolescents’ ongoing recovery support. These prosocial activities “influence adolescent engagement in continuing care and . . . identify ways to engage adolescents 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.

Development of, or re-engagement in, safe and healthy recreational activities is critical for adolescents’ ongoing recovery support.

- a) Providers should work with adolescents to help them discover their interests (e.g., hobbies, games, sports, creative ventures) and strengths through the treatment and recovery plan.
- b) Recreational and leisure activities should 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.

- c) Given that prosocial activities are important to the development of adolescents’ resiliency and positive relationships, providers should ensure recreational and prosocial activities incorporate nonsubstance using peers and engaged adult involvement and monitoring.
- d) Adolescents should be encouraged to participate in civic and community activities to contribute to the community.
- e) Providers should 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.
- f) Providers should 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.
- g) Engagement in prosocial activities should be promoted as an essential component of adolescent treatment and recovery.

4.4 Positive Adolescent Development

Positive adolescent development incorporates an understanding and appreciation of adolescent development and empowerment as the foundation of adolescents’ 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 (DADP, 2002). Adolescent 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).

Positive adolescent development incorporates an understanding and appreciation of adolescent development and empowerment as the foundation of adolescent treatment and recovery.

- a) Providers should be trained on adolescent development (e.g., stages of development, brain development, puberty; see “Developmentally Appropriate Care” section for additional information).
- b) Adolescent development should 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 (DADP, 2002).



- c) Providers should emphasize resilience and the unique developmental aspects of the recovery process for adolescents (SAMHSA, 2009).
- d) All services should be adolescent 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.
- e) Providers should 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.
- f) Providers should offer adolescents decision-making skills training and opportunities to actively participate in their own treatment planning and develop goals and personal objectives.
- g) Providers should 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 (DADP, 2002).
- h) Adolescents should be connected with local adolescent groups and advocacy groups to aid in the cultivation of leadership and to empower the adolescents through working with other adolescents.
- i) Providers should take an empowerment-based, rather than controlling, approach that does not provoke or reinforce problematic power dynamics.

4.5 Employment/Vocational Services

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 (NASDAD, 2014). 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).

Adolescents who have been employed before and remain employed during treatment tend to remain in treatment longer and experience more successful outcomes once discharged.

- a) The treatment and recovery plans should be adolescent centered and



adolescent driven. The adolescent's individual strengths, abilities, interests, and priorities will set the direction for vocational skills development (as developmentally and age appropriate).

- b) The provider (through case manager or referral) should 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 should include exploring the importance of time management, acting responsibly, working within the goal of an organization, and offering tips for retaining a job.
- c) Appropriate vocational training interventions should include prevocational training, career planning, and job-finding skills training (CSAT, TIP 32, 1999).
- d) The provider (through case manager or referral) should 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.
- e) Providers should develop and maintain relationships with vocational programs (e.g., partnerships with school districts and local workforce services).
- f) For adolescents who require long-term treatment or recovery support services (particularly those who are at or above the age of 17), treatment programs should provide linkages to education or post-primary education, adult SUD and mental health treatment services, employment opportunities, and other transitional approaches to adulthood.
- g) Adolescents involved in the juvenile justice system should receive education and assistance on managing their records needed to attain employment and other vocational opportunities.

4.6 Transportation

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, such as provision of public transportation passes; and identification of and access to other community transportation resources (NASADAD, 2014).

Access to safe, affordable transportation for adolescents with SUDs can increase their engagement and retention in treatment...

- a) Treatment programs should have policies and procedures for how adolescents will be provided transportation and by whom.
- b) Residential programs should have written procedures for signing adolescents in and out of program sites.
- c) Providers should adhere to the requirements for licensure and operation of vehicles as set by relevant states and localities.
- d) Vehicles should not be labeled in a way that calls attention to the facility or the vehicle’s occupants.
- e) Providers should 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).
- f) When applicable, adolescents should be given training on how to access public transportation (e.g., how to read bus schedules, where to wait).

4.7 Life Skills

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).

Life skills are interpersonal, daily living, and societal skills instrumental in attaining autonomy and in sustaining healthy living in the community.

- a) Providers should connect with other adolescent-serving agencies that offer opportunities for life skills development.
- b) Providers should foster age-appropriate, culturally appropriate, therapeutic, and goal-oriented opportunities for adolescents to develop social skills, cultivate decision-making abilities, and learn the values of employment and vocational skills necessary for adulthood.
- c) Life skills development should 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 (NASADAD, 2014).
- d) The provider should offer interpersonal skill development including support in problem solving, conflict resolution, self-esteem improvement, anger



management, and impulse control (NASADAD, 2014).

- e) The provider should 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.
- f) As part of ongoing recovery supports, providers should 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.
- g) 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 (NASADAD, 2014).
- h) Providers should offer education on developing healthy sexuality and building healthy peer and romantic relationships for adolescents of any sexual orientation or gender identity.

4.8 Referral to Mutual Aid Groups

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 (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.

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 (SUDs)”.



- a) When possible, providers should refer adolescents to a mutual aid group with adolescents in it or to an adolescent-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).
- b) If the adolescent would like to participate in a mutual aid group, the provider should help him or her access a developmentally and age-appropriate group.
- c) The provider should give the adolescent multiple mutual aid group options when possible.
- d) Providers should 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 should also be made for adolescents whose primary language is not English and for the primary substance used.
- e) Adolescents should 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.
- f) Families or others affected by the adolescent's use of alcohol or other drugs should 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.
- g) 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).

4.9 Peer-to-Peer Recovery Coaching/Peer Mentoring

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

Peer mentoring may provide a set of activities that engage, educate, and support an adolescent to successfully make behavioral changes necessary to recover from SUDs and mental health disorder conditions.

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.

- a) Providers should 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.
- b) Peer mentors should assist in guiding the adolescent through treatment, recovery support services, and the transition to a life of recovery in the community.
- c) Providers should 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).
- d) Providers should 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).
- e) Providers should partner with the educational system to develop, expand, and refer adolescents to peer recovery networks in schools and colleges when possible.
- f) Peer mentors should have the appropriate training and supervision as determined by the county.

5 Administration Considerations

5.1 Designation of Authority

Programs will be licensed, certified, or accredited per state laws and regulations prior to the state/county referring adolescents to the provider and before the provision of reimbursement with federal/state funding.

5.2 Governance Requirements

DHCS oversees the provision of services and sets requirements for general governance, of adolescent SUD treatment programs such as maintenance of records and documentation requirements for the providers, counties, or regions the use 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. Please refer to the DHCS AOD Program Certification Standards at <https://www.dhcs.ca.gov/Documents/DHCS-AOD-Certification-Standards-2.7.2020.pdf>

5.3 Rights, Responsibilities, and Grievances

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.

- a) All information pertaining to the adolescent's rights, responsibilities, and grievance procedures should be delivered in a culturally, linguistically, developmentally, age, and literacy-appropriate manner, with interpretation assistance provided as needed.
- b) The program's rules and rights should be posted visibly at the program site, and a copy will be given to adolescents and their families.
- c) Any rules, consequences, or disciplinary actions should be clearly stated, developmentally appropriate, nonviolent, non-aversive, and free from practices of seclusion and restraint.
- d) All adolescents and families provided services should 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.
- e) The provider's staff should 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.
- f) Relationships between adolescents and providers' staff should 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.
- g) Providers should have a written code of ethics statement that will be signed by each staff member and kept in their personnel files.
- h) Adolescents have the right to be treated ethically, professionally, and with respect by all staff members.
- i) Adolescents and their families will be informed by the provider about how to register complaints or grievances.

5.4 Workforce Competencies/Standards

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 adolescents with 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.

Provider competencies help to ensure providers have the appropriate skills to serve adolescents effectively.

- a) Providers completing assessments and providing services to adolescents should be adequately trained and clinically supervised.
- b) Providers in adolescent programs should have evidence of licensure and certification as defined by the state and practice within that scope, recognizing any potential limitations to their training.
- c) There should be a ratio of provider-to-adolescent maintained as determined by state standards.
- d) Providers, administrative staff, and volunteers should undergo criminal background checks and child welfare registry clearance in accordance with state and federal laws pertaining to work with adolescents.
- e) Coaches, mentors, and all volunteers should receive training on developmentally and age-appropriate expectations, ethics, and program guidelines.
- f) Providers should be knowledgeable about adolescent health and safety, signs of child abuse, sexual orientation and gender identity, co-occurring mental health disorders, and adolescent development (including age-appropriate activities, sexuality, maturation and development, risk-taking, and identity development).
- g) Providers should be skilled at reaching and communicating with adolescents and their families, presenting information in ways adolescents can understand and benefit from.
- h) Providers should 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).

- i) Providers should use nonjudgmental, non-confrontational, respectful, strengths-based approaches in working with adolescents and their families.
- j) Continuing education should be available to all providers to maintain and further develop their skills in working with adolescents and their licensure or certification.
- k) Innovative and intensive continuing education, staff development, and outreach efforts during provider recruitment may be needed to improve cultural competence among providers.
- l) Providers should be trained on program rules, policies, and procedures (including staff and client rights) and complaint or grievance procedures. Providers should be able to discuss and explain these protocols with adolescents (see “Rights, Responsibilities, and Grievances” section for additional information).
- m) Providers should “model positive adult behavior within appropriate boundaries (rather than blurring the lines between themselves and their young clients)” (Drug Strategies, 2003).
- n) Disciplinary and termination processes for providers should be clearly communicated to them.

5.5 Safety and Facilities

Licensure requirements for State-funded SUD treatment providers are established through the DHCS Licensing and Certification Division. 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 additional information, please refer to the Licensing webpage at: https://www.dhcs.ca.gov/provgovpart/Pages/Licensing_and_Certification_Division.aspx

5.6 Technology

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

Technology is a useful tool in expanding the adolescent’s and his or her family’s access to care...

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 adolescent access to and availability of services.

Technology and telemedicine can serve as adjuncts to in-person SUD treatment for adolescents. The use of technology to deliver elements of treatment and recovery services may also result in resource (e.g., money, time) savings” (SAMHSA, 2013).

- a) Providers should 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.
- b) Providers should 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.
- c) Providers should 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 (NASADAD, 2014).
- d) 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.
- e) Telemedicine, web-based applications, personal digital assistants, electronic media, use of tablets, and internet-based tools, when available and developmentally appropriate, should be used to assist with treatment and recovery support.

Appendix A. Definitions

This section contains a list of terms and definitions used in this guide.

Adolescence: The period of life between puberty and maturity, generally accepted as age 12 through 17.

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

Adolescent In At-Risk Environments: Minors whose environment increases their chance of using alcohol and other drugs, dropping out of school, teen pregnancy, and involvement in criminal activity.

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

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

Best Practices: An intervention that has shown evidence of effectiveness in a particular setting and is likely to be replicable to other situations.

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

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

Co-occurring Capable Programs: Programs that address co-occurring mental and substance use disorders in their policies and procedures, assessments, treatment planning, program content, and discharge planning. Programs have arrangements in place for coordination and collaboration between addiction and mental health services. They can also provide medication monitoring and psychological assessments/ consultation on-site. Program staff are able to address the interaction between mental and substance use disorders and their effect on the patient's recovery dynamics.

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



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

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

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

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

Family Therapy: SUD treatment and intervention services that include family members. While family therapy may take on a variety of forms, based on the needs of the adolescent and his/her family, the purpose of family therapy is to take into account the psychosocial environments in which the adolescent lives and may return to once SUD services are complete.

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

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

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

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

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



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

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

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

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

Narcotic Treatment Program (NTP): NTPs provide narcotic replacement therapy using methadone, buprenorphine and other Federal Drug Administration approved medications for the treatment of opioid addiction.

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

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

Qualified Adolescent Health Professional: The areas and functions for which a staff person is qualified will depend on individual and program/facility state licensing, certification, and regulatory requirements. Examples of positions that are qualified for particular functions include Medical Doctor, Licensed Marriage and Family Therapy, Counselor or Psychotherapist, Licensed Clinical Social Worker, Licensed Practitioner of the Healing Arts, and a certified Alcohol and Other Drug Counselor.

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

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

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



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

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

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

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

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

Appendix B. References

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