Monterey County Behavioral Health
Policies and Procedures

Policy Number	707
Policy Title	**Youth Services Policy**
References	California Department of Health Care Services: Adolescent Substance Use Disorder Best Practice Guide October 2020
Effective	**11/21/2023**

Policy

The purpose of this policy is to establish best practice standards for SUD treatment for youth within Monterey County Behavioral Health. Because adolescents have a complex set of needs that are remarkably different from those of the traditional adult treatment population, they require different expertise and guidance on how SUD treatment and recovery programs can best serve them. Monterey County Behavioral Health utilizes the Adolescent Substance Use Disorder Best Practices (October 2020) to support adolescents receiving treatment and SUD services within its system. This policy is applicable to all contracted providers that serve youth in their substance use disorder programs.

The Adolescent Best Practice Guide, along with this Policy are comprised of certain sections:

I. Overarching Principles of Care
II. Service Elements
III. Recovery Services
IV. Administrative Considerations

I. Overarching Principles of Care

The following principles were selected by DHCS underlie the adolescent SUD treatment and recovery system, which build a foundation of care to address the service needs of adolescents with SUDs. These are:

1. ***Developmentally Appropriate Care*** – Developmentally appropriate care takes into account the distinct developmental stage of the adolescent and any cognitive, social, emotional, and/or developmental delays or disabilities the individual may have. Furthermore, developmentally age appropriate care addresses the physical and emotional changes that occur during puberty.
2. ***Cultural and Gender Competence*** – This principle 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. Attention should be given to addressing disparities in access to treatment and recovery supports across different ethnic and racial groups, recognizing many minority adolescents are disproportionally referred to more restrictive systems (e.g., juvenile justice and child welfare) than into specialty behavioral health or substance use treatment.

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, 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, and to coordinate care across these multiple dimensions.
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. Service coordination among the mental health, substance use, and primary health care systems correspond to the level of severity of the disorder. Coordination begins with consultation across systems, which ensures mental health and substance use disorders are addressed. Adolescent SUD treatment providers work together with adolescents and their families to ensure access to primary care services 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 or neglect; or social, education, vocational, and legal problems.
5. ***Trauma-Informed Care*** - 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-specific interventions are used by trained practitioners to address different age groups, settings, and types of trauma.
6. ***Recovery-Oriented Systems of Care (ROSC)*** – Recovery Oriented Systems of Care for adolescents emphasize the importance of adolescent-guided and family-centered care; employ a broad definition of family; is culturally, age, and gender appropriate; reflect the developmental stages of adolescence; acknowledge the nonlinear nature of recovery; promote resilience; are strengths based and proactive; and identify recovery capital (SAMHSA, 2011b).
7. ***Evidence-Based Practices*** – Implementing developmentally and age appropriate EBPs for adolescents with SUDs is recommended to maximize

positive treatment outcomes. EBPs are used most effectively when providers' staff are trained and qualified to implement interventions with fidelity and have appropriate supervision. Promising practices may also be considered, particularly because there is not an EBP for every population. It is important the practices used by providers are implemented with the adolescent's and family's cultural background in mind.

For comprehensive details on each of the Principles in the above-mentioned, refer to pages 5-14 of the Adolescent Best Practice Guidelines (October 2020) for more.

II. Service Elements

Service elements found in treatment and recovery systems and delivered by contracted providers include:

1. *Screening, Assessment, & Planning*
    a. ***Outreach, Engagement, & 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. 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 part of recovery. Providers should increase engagement and retention by reducing barriers to care such as by providing transportation and childcare.
    b. ***Screening*** - Providers within Monterey County shall use the SUD Screening Tool (see QI Memo: SUD Screening Tool). MCBH programs shall use the Youth Screening Tool (affirmative on question 17). For additional information, see QI Memo 007: Standardized Screening and Transition Tools on the QI website.
    c. ***Assessment*** – SUD Providers: If a level of care is indicated by the initial SUD screening process, Providers complete the Youth SUD Assessment to support medical necessity of SUD services. MCBH Programs: If indicated by the initial screening process, a person in care is referred for a CalAIM assessment. The purpose of both assessments 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.
    d. ***Treatment & Recovery Planning (NTP LOC Only)*** - A treatment and recovery plan serves as a roadmap for treatment and recovery support service delivery and is assessed and modified continuously. Treatment and recovery plans are strengths based, adolescent guided, and based on an individual assessment, with involvement from the adolescent, their family, and other involved entities (e.g., juvenile justice, child welfare, schools) as appropriate.

e. ***Problem List*** – All persons in care shall have a problem list. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. This may include:
    i. Mental health diagnosis
    ii. Substance use diagnosis
    iii. Social determinants of health (Z55-Z65)
    iv. Other Z codes
    v. Physical health conditions

    The providers responsible for the person's care create and maintain the problem list. The problem list includes clinician-identified diagnoses, identified concerns of the person in care, and issues identified by other service providers, including those by Mental Health Rehabilitation Specialists, Peer Support Specialists, and other treatment team members acting within their scope. The problem list helps facilitate continuity of care by providing a comprehensive and accessible list of problems to quickly identify the person's care needs, including current diagnoses and key health and social issues.
f. ***Physical Health, Education, Screening, & Referral*** - SUDs often co-occur with physical health conditions. It is recommended part of the adolescent's assessment include identification of physical health issues and subsequent referral to relevant providers, services, and supports.
g. ***Case Management & Care Coordination*** - Adolescents are often involved in multiple systems while in or on their path to treatment and throughout their recovery. 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). Case managers/coordinators provide continuous support to the adolescent throughout this process and facilitate linkage and effective communication across various systems.

2. *Treatment Services*

a. *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), and/or other validated sets of criteria; providers should use clinical judgment in consideration of culturally appropriate, gender-specific, and trauma-informed services.
b. SUD Counseling
    i. Individual Counseling
    ii. Family Counseling
    iii. Group Therapies

3. *Co-Occurring Substance Use & Mental Health Disorders* - 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 shall 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).

For comprehensive details on each of the above-mentioned Service Elements, refer to pages 15-26 of the Adolescent Best Practice Guidelines (October 2020).

III. Recovery Services

Recovery support services are ideally incorporated at the beginning of services 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 their family.

1. ***Continuing Care & Support*** - Continuing care and support services can bridge the gap between completing a treatment program and returning to the home environment, 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.
2. ***Education*** – 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).
3. ***Recreational Services or Prosocial Activities*** – 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.
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. 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).

5. ***Employment/Vocational Services*** – 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.
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.
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.
8. ***Referral to Mutual Aid Groups*** – 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.
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.

Providers shall ensure that they follow the recommendations outlined in the Guide for each of the above-mentioned recovery services offered. For comprehensive details on each of these elements of Recovery Services, refer to pages 27-35 of the Adolescent Best Practice Guidelines (October 2020).

IV. Administrative Considerations

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.
2. ***Governance Requirements*** – DHCS oversees the provision of services and sets requirements for general governance, of adolescent SUD treatment programs. Please refer to the most current DHCS AOD Program Certification Standards on DHCS' website.
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.

4. ***Workforce Competencies/Standards*** – Provider competencies help to ensure providers have the appropriate skills to serve adolescents effectively. 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.
5. ***Safety & Facilities*** - Licensure requirements for State-funded SUD treatment providers are established through the DHCS Licensing and Certification Division. For additional information, please refer to the Licensing and Certification Division on the DHCS' webpage.
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).

For comprehensive details on each of the above-mentioned Administrative Considerations, refer to pages 36-29 of the Adolescent Best Practice Guidelines (October 2020).

Definitions

I. *Adolescence*: The period of life between puberty and maturity, generally accepted as age 12 through 17.
II. *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.
III. *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.
IV. *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.
V. *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.
VI. *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.

VII. *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.

VIII. *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.

IX. *Intake:* The process of determining that a person in care 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.

X. *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.

XI. *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.

XII. *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.

XIII. *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.

XIV. *Recovery Navigation:* See Case Management.

XV. *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.

XVI. *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.

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

XVIII. *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.

XIX. *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.

XX. *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 persons in care, 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.