NEW YORK STATE

Office of Addiction Services and Supports

Clinical Practice Standards for Adolescent Programs (CPS-AP)

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Introduction

This manual describes clinical practice standards for adolescent programs, which are guidelines intended to establish broad goals and practical benchmarks for delivering high-quality, evidence-based treatment services to adolescents with a substance use disorder. As providers who treat youth with substance use disorders know, adolescents and young adults have treatment needs that are distinct from adults in at least three main areas. First, generally speaking, adolescents present with a unique profile of substance use and related behaviors that are important to assess and address when generating a person-centered treatment plan. For example, research suggests adolescents and adults exhibit distinct physiological symptoms, such that adolescents are less likely than adults to report withdrawal symptoms and are more likely to report inability to control use and the continuation of substance use despite persistent physical or psychological problems.[1] Additionally, adolescents are less likely to recognize the need for treatment, in large part due to their shorter use histories, fewer perceived drug-related consequences, and normalization of use within their peer groups.[14]

Second, adolescence is a period of distinct developmental risk, during which substance use can create lifelong patterns of addiction. Teen users are much more likely to develop an addictive disorder compared to adults, and the earlier they began using, the higher their risk. In fact, nine out of 10 people who meet clinical criteria for substance use disorders began using drugs before they turned 18. Moreover, youth who begin using substances before age 15 are over six times more likely to develop a disorder than those who delay use until age 21 or older (28 percent vs. 4 percent).[15] This developmental risk is magnified by personal circumstances that further increase the likelihood of teens developing an addictive disorder, including genetic factors and family history of addiction, adverse childhood events (such as abuse, neglect, or other forms of trauma), the presence of a mental health disorder, having experienced extreme peer victimization or bullying, and poor academic performance.[15]

Third, adolescents experience exceptional vulnerabilities during brain maturation that create an additional urgency for providing effective treatment. The teen brain is a work in progress, making it more susceptible than the adult brain to the physical effects of drugs.[16] The regions of the brain that are critical to judgment, impulse control, and emotional regulation are not fully developed in adolescence, making teens more prone than adults to taking risks, including substance use. Also, because the teen brain is still under development, addictive substances can physically alter its structure and function faster and more intensely than in adults. For example, adolescents appear to be more sensitive to the perceived rewards of addictive substances and less sensitive to their negative properties than adults. As a result, addictive substances have a greater and longer-lasting impact on the adolescent brain, potentially causing weaknesses in attention, learning, memory, decision-making, and other fundamental cognitive abilities.[15]

Adolescent treatment needs are exacerbated by gaps in services, as demonstrated in Table 1:

Table 1. Substance Use Treatment Need and Receipt in 2019[58]

	# Needing SUD Treatment	# Needing and Receiving Any SUD Treatment	# Needing & Receiving SUD Treatment in a Specialty Facility
Ages 12-17	1,100,000	172,000 (15.6%)	68,000 (6.0%)
Ages 18-25	4,800,000	578,000 (12.0%)	357,000 (7.4%)
Ages 26+	15,600,000	3,400,000 (21.8%)	2,200,000 (14%)

Further still, of adolescents with an SUD but not receiving treatment at a specialty facility in 2019, 98.5% reported feeling they did not need treatment,[58] suggesting a low perception of harm.

In light of these unique service needs and gaps, OASAS, Partnership to End Addiction, and experienced clinicians from OASAS-certified programs developed Clinical Practice Standards for Adolescent Programs (CPS-AP) to support treatment providers of adolescents with a substance use and/or co-occurring mental health disorder – hereafter referred to as "provider" – who undertake the enormous and rewarding challenge of serving these vulnerable, complex young clients. From there, the CPS-AP became the basis for OASAS' Adolescent Services Endorsement and the guidance herein, which is intended to serve at least four purposes for New York State addiction treatment providers and other interested parties nationally:

1. Guide providers to aspire to the highest standards of quality care for substance-using adolescents, as determined by both empirical research and acknowledged best practices for this age group
2. Provide a basis for self-evaluating the degree to which the standards are met, using the companion Provider Self-Assessment Tool
3. Establish a foundation for defining and measuring implementation quality for the treatment of adolescent with a substance use disorder that can inform regulatory processes related to performance reviews and value-based contracting
4. Expand access to quality, evidence-based and developmentally appropriate SUD treatment services for adolescents

Finally, we want to emphasize that this manual—like the adolescent brain!—is a work in progress. Research, practice, and policy regarding treatment and recovery services for adolescent substance use disorder and/or co-occurring mental health disorders continue to evolve. As such, it is our intent to keep pace with the science and revise these standards as needed to reflect current research and best practices.

In the spirit of remaining up to date and responding to the needs and expertise of the provider community, we welcome comments and suggestions from all readers and users of this guidance document. Comments, inquiries, and suggestions can be submitted to AdolescentServices@oasas.ny.gov.

Contributors

The clinical standards and accompanying guidance in this document were created over many years with input from a diverse group of subject matter experts. What began as a presentation by Partnership to End Addiction Staff at an April 2016 meeting of the Adolescent Clinical Advisory Panel (ACAP) grew into a specialty endorsement for OASAS outpatient providers. We extend our deepest thanks to those listed below for their contributions to the addiction treatment field and this document:

Partnership to End Addiction
Aaron Hogue, PhD
Molly Bobek, LCSW
Tiffany John, LMSW
Carla Lisio, LCSW
Nicole Piazza, BA

National Experts
Marc Fishman, MD (Maryland)
Sharon Levy, MD, MPH (Massachusetts)

Adolescent Endorsement Pilot Programs
Crouse Health
Elmcor Youth and Adult Activities
Family and Children's Association
Finger Lakes Area Counseling and Recovery Agency
Huntington Youth Bureau
Lexington Center for Recovery – Page Park
The LGBT Community Center
Montefiore Medical Center
Outreach Development Corporation
St. Joseph's Addiction Treatment and Recovery
Villa of Hope

NYS OASAS
Steve Hanson, LMHC, Associate Commissioner
Patricia Lincourt, LCSW, Associate Commissioner
Maria L. Morris-Groves, MSEd.
Kimberly M. Benshoff, CRC
Belinda Greenfield, PhD
Samantha Kawola, LMSW
Janelle Riccio, MA
Margaret E. Taylor, PhD
Shyla Dauria, LMHC, NCC, CASAC
Kelly Ramsey, MD, MPH, MA, FACP
Marc Manseau, MD, MPH
Grace Hennessy, MD

ACAP Clinical Practice Standards Subgroup Members
Ellen Breslin
Carla Foster, MPH
Sonya Worthington
Celyon Moore, MSW, CARC, CASAC-T, CRPA
DJ Rhodes
John M. Venza, LCSW-R, LMHC
Jim Samenfield-Specht, MD
Mindy Nass, MSW
Saarah Waleed, CASAC, LMHC, NCC
David Wallace, LCSW-R

Clinical Practice Standards for Adolescent Programs (CPS-AP)

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Purpose

This document provides guidance to providers seeking designation pursuant to 14 NYCRR Part 830 as a provider of high-quality substance use treatment services for adolescents (ages 12-17). An Adolescent Services Endorsement (ASE) demonstrates an OASAS-certified, funded, or otherwise authorized program's efficacy and expertise in meeting the distinct treatment needs of adolescents with Substance Use Disorders (SUDs). This Endorsement provides an opportunity to increase visibility of and enhance access to adolescent SUD services at both the State and provider levels. Furthermore, programs with this designation on their operating certificate will join a public list of OASAS-recommended adolescent outpatient providers.

A program with an Adolescent Endorsement remains subject to any other regulations applicable to the program's certified modality, including (but not limited to) evaluations, admissions, treatment/recovery plan development and review, and discharge. In addition, providers seeking this specialty endorsement should closely follow the guidance set forth in this document.

It is important to note that all OASAS-certified programs may serve adolescents. This endorsement simply introduces the means for identifying providers with a specialty in adolescent services.

Adolescent Services Endorsement Standards

In order to receive the Adolescent Services Endorsement (ASE), a provider must demonstrate adherence to a set of standards that have been vetted by state and national subject matter experts. These standards are condensed into twelve (12) categories:

1. *Use of Developmentally Informed Treatment Using Evidence-Based Practice(s)/Program(s) Reflective of Adolescent Development*
    a. Evidence-based programs (EBP) include but are not limited to The Seven Challenges, MET/CBT, Adolescent Community Reinforcement Approach (A-CRA), and/or Motivational Interviewing. EBPs must be appropriate to adolescent development and record(s) of staff training must be kept on file.
    b. Youth clients are educated on addiction, biological factors, and life skill deficits that contribute to youth issues as it relates to substance use and/or problem gambling.
    c. Youth are treated with age appropriate clients, building on youth's strengths and protective factors to promote resiliency.
    d. Developmental maturity dictates how information is presented and services are conducted.

2. *Effective Assessment Procedures that are Culturally Sensitive, Gender-Specific, Trauma-Informed, and Identify Strength and Resilience Factors*
    a. Assessment of substance use and gambling-related problems should evaluate key domains of developmental functioning, as well as relationships and other social factors that affect youth behavior, using standardized adolescent specific instruments and interviews.
    b. Treatment eligibility and level of care determined with a valid tool (i.e. LOCADTR-A) and appropriate interventions are offered for presenting problems of varying severity.
    c. Trauma-informed screening from a valid tool must be administered at intake and whenever otherwise appropriate (e.g., CATS).
    d. Information gathered from assessment must be used to develop adolescent clients' Treatment/Recovery Plans in a person-centered manner, which emphasizes input and involvement from the youth/family throughout both the treatment plan development process and the course of treatment.

3. *Youth-Specific Outreach, Engagement, and Retention Strategies*
    a. Policies and procedures exist to outreach, engage, and retain the adolescent population into treatment.
    b. Youth Treatment/Recovery Plan includes ongoing identification of potential barriers to recovery, such as current difficulties in participating in treatment (e.g. transportation, childcare), beginning at intake and continuing throughout treatment. There is evidence of efforts made to strategize around and overcome barriers, as well as timely and appropriate follow-up on missed appointments.
    c. Providers will have at least one Certified Recovery Peer Advocate (CRPA), preferably a CRPA-Y, on staff who can establish rapport with youth and family members and/or maintain connection with youth in continuing care.
    d. Outreach efforts include connecting with other systems in which the youth may be accessing services (e.g. school, child welfare, juvenile justice, pediatricians).
    e. Program has in place and on file a HIPAA-compliant messaging policy for contacting clients (via encrypted text messages, email, etc), which includes a procedure to report a security breach within 60 days of the breach event.

4. *Family Involvement in Treatment*
    a. Formal services and supports are offered and provided on site or by referral to families of children/youth experiencing social, emotional, developmental, medical, substance use, problem gambling, and/or behavioral challenges in their home, school, or community [e.g. Significant Other services, including the use of Community Reinforcement and Family Training (CRAFT), family counseling, family therapy, Peer services)].
    b. Informal services and supports are offered and provided on site or by referral to families of children/youth experiencing social, emotional, developmental, medical, substance use, and/or behavioral challenges in their home, school, or community [e.g. psychoeducational groups for families/caregivers, family support and/or peer-led groups, including (but not limited to) Al-Anon, Alateen, and SMART Recovery Families and Friends].
    c. Attempts to engage family members in youth treatment sessions are made. If families are not involved or have limited involvement in treatment, attempts to engage families and/or reason(s) for lack of family involvement are documented.
    d. Program provides or links to appropriate child-care services for adolescent clients with children.

5. *Community Involvement in Treatment*
    a. Youth are provided with links, referrals, and/or are otherwise engaged in programs and activities in their home community.
    b. Youth are provided with opportunities to engage in recreational activities in their local communities at the cost of the provider in order to promote prosocial fun without substances or gambling.
    c. Youth are made aware of resources in their communities that may include, but are not limited to volunteer opportunities, employment opportunities, vocational programs, sexual health services, and resources for daily living (e.g. food pantries, shelters).

6. *Integrated Substance Use and Mental Health Treatment*
    a. Use of standardized mental health tools to assess common co-occurring disorders for all admissions [i.e., Pediatric Symptom Checklist 17-Youth (PSC-17), Strengths and Difficulties Questionnaire].

b. Policies and procedures are in place to ensure continuation of mental health treatment on site or by referral.
c. Maintain linkages with youth-serving medical professionals for medication consultations as needed.

7. *Significant Events like Injuries, Mandated Reporting, and Client and/or Family Complaints*
    a. Policies and procedures exist to ensure appropriate steps are taken in the event of an emergency and/or injury including having an emergency contact on file for each youth.
    b. Policies and procedures exist in the result that a client or family files a complaint with documentation of outcomes.
    c. Reports are made regarding any situation in which a person who is receiving supports or services is experiencing abuse, neglect, sexual, financial, or emotional exploitation, or is at risk of experiencing any of these incidents in a setting over which the Justice Center has jurisdiction.

8. *Comprehensive Coordinated Treatment and Continuing Care*
    a. Focus on multi-systemic collaboration to promote a continuum of coordinated services for youth within their community, including coordination with other state systems when indicated and having documented relationships with local pediatric primary care physicians.
    b. Addresses physical and sexual health education and needs of youth on site or by an outside provider (i.e. Planned Parenthood) that is documented by an MOU or another form of contract.
    c. Provides the option for supporting the maintenance of long-term recovery by offering continuing care and maintaining connections with prosocial, recovery-oriented community organizations, mentors, activities, and alternative peer groups during and after treatment.
    d. Offers recurrence prevention services, including education for youth and families about continuing care and recovery supports.
    e. Youth will receive education on life skills and will be linked to services relevant to increasing life skills, when appropriate.
    f. Provide a comprehensive continuing care/aftercare plan, including check-ins and re-engagement when indicated.

9. *Culturally Responsive Care*
    a. Maintain policies that ensure the emotional and physical safety of youth, including promoting respect for differences and preventing and/or addressing bullying, victimization, and boundary violations from other clients and staff.
    b. Maintain connections to community groups and other services that align with the clients' and families' culture (to include race, ethnicity, gender, sexual orientation, and other identity factors).
    c. Provide regular training to staff that expands cultural knowledge, deepens awareness of intersectionality, pervasive social biases, and issues affecting marginalized communities (e.g., communities of color, the LGBTQ community, people with disabilities), and staff's own cultural identities, and develop skills that enable effective and respectful cross-cultural communication.

10. *Trauma-Informed Care*
    a. Integrates knowledge about trauma into policies, procedures, and practices.
    b. Recognizes the signs and symptoms of trauma in youth and their families through documented ongoing assessment.
    c. Seeks to actively resist re-traumatization of youth through established policies and practices.

11. *Staff Qualifications and Training*
    a. Clinical staff are trained in adolescent development, case management, culturally informed treatment, and additional foundational skills for youth treatment. All training is documented and kept on file.
    b. Staff has ongoing training on the principles of emerging best practices relevant to trauma-informed care, medication-assisted treatment, and other topics relevant to youth treatment and recovery
    c. Have on staff at least one master's level clinician trained in family therapy or a licensed clinician with experience working with families, one Certified Recovery Peer Advocate (CRPA), and at least one master's level clinician trained in co-occurring mental health disorders and problem gambling.
    d. A provider such as a psychologist, psychiatrist, or nurse practitioner with knowledge of the youth population is on-site on at least a part-time basis for medication management services.
    e. Staff receive ongoing supervision, feedback, and evaluation regarding clinical skills as outlined in the OASAS Administrative & Clinical Supervision Definitions and Minimum Requirements.

12. *Medication-Assisted Treatment/Recovery*
    a. Youth have access to medication-assisted treatment, either on-site or by referral. Provider maintains and documents regular coordinated treatment with prescriber.
    b. Medication choices are determined through informed, shared decision-making between the youth, their family, and their clinical team while providing a space for confidential treatment.
    c. Staff know, understand, and can assess (formally or informally) for the signs and symptoms of substance withdrawal (including withdrawal from alcohol, opioids, and nicotine) and use best practices to avoid withdrawal complications.
    d. Youth and families are educated on overdose prevention and are provided with Naloxone, as needed.

Implementation Guidance

The remainder of this document provides guidance for meeting the standards laid out above and in the Self-Assessment tool. This may be particularly useful for treatment providers looking to establish or enhance their adolescent program, but can act as a reference for all adolescent-serving SUD treatment providers, as there are always opportunities for growth.

Developmentally Informed Treatment

Elements:

1. In group settings, youth are treated with clients of the same general age.
2. Youth maturity influences how information is presented and therapy is conducted.
3. Disruptive behavior is assessed in a developmental context.
4. Developmental tasks of adolescence are addressed, and youth have input in treatment.

There are various kinds of risk and protective factors for substance use during adolescence. Many social factors – peer relations, parenting and family relationship characteristics, neighborhood effects, and the like – and individual factors – perceived norms and harm of use, impulsivity, anxiety and depression problems, and so forth – are well-known and identified as targets for intervention. More recently, research on adolescent brain development has identified additional risk factors. In teenagers, cognitive systems associated with self-control are not yet fully developed[4] and their motivation to pursue pleasure and rewards without properly weighing risks is heightened.[1]

As a result, they are more "developmentally-primed" than adults to engage in risky behavior and adolescent substance use can interfere with normal brain maturation, creating the potential for lifelong consequences.[1,18] In order to tailor treatment to address these developmental risks, providers should account for risk and protective factors in each youth's profile of social, individual, and cognitive functioning.[19]

Elements of Effective Developmentally Informed Treatment:

1. ***In group settings, youth are treated with clients of the same general age.***
   Adolescents (age 11-15), transition-age youth (age 16-25), and adults should be judiciously grouped to honor developmental needs, maturity, and safety concerns.[20] **Adolescents should NOT be grouped with adults**.
   - To the degree possible, youth should be grouped by age and substance use severity.[17]
   - Within the above age divisions, youth should, to the degree possible, be further grouped according to individual maturity, case history, and/or treatment progress and goals.

2. ***Youth age and maturity influence how information is presented, skills are taught, and therapy is conducted.***
   - Providers should emphasize use of role plays, share concrete and relatable content, and avoid jargon.
   - Providers should be nonjudgmentally curious about youths' own ways of understanding their problems and treatment goals.
   - Where possible, providers should use evidence-based programs (EBPs) with proven efficacy for adolescents. (e.g., programs with a rating of 1-3 with the California Evidence-Based Clearinghouse)

   Staff should be trained to assess:
   - Cognitive functioning
   - Developmental maturity
   - Developmental context of disruptive behaviors
   - Achievement of developmental tasks

   For more information, see Staff Qualifications and Training.

3. ***Youth disruptive behavior is assessed in a developmental context when determining how to address the behavior and help youth learn from mistakes.***
   Youth with substance use disorders are four times more likely than non-using teens to have a disruptive behavior disorder that can interfere with treatment success.[2,21]

- Certain behavior characteristics that are normal in teens — such as limit testing, moodiness, rebelliousness, and impulsivity—can be mistaken for clinical symptoms and/or intensify clinically-concerning behaviors.
- Providers should take an empowerment-based, rather than controlling, approach that does not create problematic power dynamics.[3]
- Providers should recognize that youth may have experienced few negative consequences of substance use and may not perceive a need for treatment.[1]
- Providers should have a high tolerance, and favor moderate consequences, for disruptive and noncompliant behavior. Natural consequences, delivered immediately, are viewed as the key to behavioral change.
- Providers should address recurrence primarily as a learning opportunity for youth and, to the extent possible, not discharge youth solely due to recurrence.[3]

4. Developmental tasks of adolescence are addressed, and youth are encouraged to have input in their treatment plans.

Prime developmental considerations:
- Movement toward independence
- Peer group influences
- Identify formation
- Future interests
- Cognitive development
- Gender identity
- Sexuality and sexual orientation
- Family relationships and influences
- Physical changes and maturity

Providers should take into account the various developmental challenges of adolescence and, to the degree possible, assist youth in becoming more socially, emotionally, and cognitively competent.[3,22]

- Providers should assess availability of drugs within community, school, and social contexts and offer skill-building to resist peer influences.[1]
- Providers should involve youth in all aspects of care, such as treatment planning and goal development, feedback on program policies, and taking leadership roles to develop self-sufficiency.[3]
- Providers should offer education and skill development in problem solving, conflict resolution, self-esteem improvement, anger management, communication, and peer and romantic relationships.[3]
- Providers should facilitate skill-building to resist and refuse substances, as well as cope with triggers and cravings[1] as well as programming focused on life skills to promote self-sufficiency and independence.[3]
- Providers should offer peer services.[23]
- Providers should incorporate developmentally appropriate self-help support groups into treatment planning.
- Providers should attempt to strengthen motivation to change by helping youth recognize incentives for reducing and/or abstaining from drug use.
- Adolescents may have different gender-related developmental and social issues that call for differentiated treatment strategies. For example, substance-using girls are more likely to have mood and anxiety disorders and to have experienced physical or sexual abuse, whereas substance-using boys are more likely to have conduct, behavioral, and learning problems.[1]

Additional Resources:
- For guidance regarding peer services and Certified Recovery Peer Advocates (CRPAs), visit oasas.ny.gov/providers/peer-integration
- For a more complete description of the developmental stages and challenges of adolescence, please visit actforyouth.net/resources/rf/rf_stages_0504.pdf

Assessment

Elements:

1. Use standardized adolescent substance use assessment instruments and interviews.
2. Determine treatment eligibility and level of care with a valid tool (i.e.: LOCADTR-A) and offer appropriate interventions for presenting problems of varying severity.
3. Conduct comprehensive assessment of co-occurring problems as well as developmental resources.
4. Re-assess youth throughout the course of treatment to monitor progress.

Assessment, which includes both screening and clinical evaluation, is a critical process in clinical management that is used to identify problems needing treatment, measure the severity and range of such problems, aid in determining an appropriate level of care, help define needed services for each individual, and help determine appropriate referrals. Information gathered during assessment should form the basis for treatment and recovery plans.

Screening refers to typically brief assessment procedures aimed at identifying the presence or absence of a given problem or problems. Clinical evaluation refers to detailed procedures meant to identify the length and severity of problems, usually covering multiple domains of functioning and conducted via interview.

Effective assessments are evidence-based, culturally informed, gender-specific, trauma-informed, and identify strengths and resilience factors.[7] Moreover, assessment of substance use and related problems should evaluate key domains of developmental functioning, as well as relationships and other social factors that affect youth behavior. A comprehensive assessment will include, but is not limited to, the domains listed in the box below.

Elements of Effective Assessment:

1. Use standardized adolescent substance use instruments and interviews.

- Standardized, evidence-based assessments use reliable (i.e., consistent) and valid (i.e., clinically relevant) instruments and should be administered with fidelity.
- Assessment should cover major life domains such as family, school, and peer functioning.[17]
- In choosing a standardized assessment tool, providers should note differences among options, including the specific age range of the tool. For information on valid screening measures and clinical interviews, the Alcohol and Drug Abuse Institute database is updated regularly.[24]

Comprehensive assessment domains include[3,7]:

- History of abuse or other trauma
- Social and emotional development
- Cognitive abilities and strengths
- Independent living skills
- Identification of natural supports, skills, talents, strengths, and resiliencies
- Motivation and readiness for treatment
- Co-occurring mental health disorders
- Physical health
- Family, peer, and romantic relationships
- Suicidality and safety
- Evaluation of family systems and members
- Other addictive behaviors (e.g., gambling, sex, pornography, gaming)
- Tobacco/Nicotine use, including vaping and e-cigarettes

2. Determine treatment eligibility and level of care with a valid tool (LOCADTR-A) and offer appropriate interventions for presenting problems of varying severity.

- The appropriate level of care, as determined by the LOCADTR-A (see box on next page), should inform treatment planning and identify type and frequency of service delivery. Because youth require different intensities of treatment and recovery supports as symptom severity changes, and often transition along a continuum of treatment services,

assessment should be a continuous process that can inform a full continuum of services for youth.[3,22]

3. ***Conduct comprehensive assessment of co-occurring behavioral problems as well as developmental functioning and resources.***
    - Histories of physical, emotional, and/or sexual abuse and other trauma are common among adolescents who use substances. Providers should also assess for signs of emotional, physical, and/or sexual abuse in all types of current relationships. **If abuse is suspected, reports should be made to appropriate protective services according to local regulations and reporting requirements[1].**
    - Assessment should include evaluation of family structure and functioning, as well as take into consideration the referral needs of individual family members.[3]
    - Virtually all clinical evaluation tools assess risk and protective factors in multiple areas of youth development such as school achievement, peer relations, physical health and sexuality, and involvement in various sectors of care (e.g., juvenile justice, child welfare).
    - When a broad assessment indicates need for further information to make a diagnosis or treatment planning decision, providers can administer domain-specific assessments.

LOCADTR-3.0:
The LOCADTR-3.0 is the Level of Care for Alcohol and Drug Treatment Referral. **An adolescent-specific version (LOCADTR-A) will automatically activate when a birthdate under 18 years of age is entered.** LOCADTR provides NYS-specific placement criteria that will be used for admission, determination of continued care, and discharge.[3] Many LOCADTR resources are available to guide proper completion.[12] When completing LOCADTR providers should use data drawn from a comprehensive clinical interview, preferably including a standardized diagnostic assessment.[13]

4. ***Re-assess youth throughout course of treatment to monitor progress.***
    - Providers should continuously monitor each youth's developmental progress. Gains and/or successes in important areas (including substance use treatment) should be discussed with the youth and used as the basis for decreasing level of care or discontinuing services. Conversely, when a youth encounters difficulties or experiences increased desire to use substances, increasing level of care and/or adding new supports and services should be considered.

Additional Resources:

- To view OASAS approved screening tools for adolescents, visit oasas.ny.gov/system/files/documents/2020/09/adolescent_resource_list.pdf or oasas.ny.gov/providers/screening-brief-intervention-and-referral-treatment-sbirt
- For an extended list of screening tools and clinical evaluation interviews that are valid for substance-using youth populations, visit lib.adai.washington.edu/instruments/.
- For a detailed guide on screening tools and clinical evaluation for juvenile justice system involved youth, visit ncjrs.gov/pdffiles1/ojjdp/204956.pdf.

Engage and Retain Youth in Treatment

Elements:

1. Maintain procedures to reduce barriers to treatment for youth and families.
2. Emphasize therapeutic alliance between youth and staff.
3. Use motivational enhancement techniques to support treatment attendance.
4. Use outreach and re-engagement procedures for missed treatment and poor attendance.

Strategies for engaging and retaining youth in treatment and throughout recovery differ from those for adults.[3] Attending treatment individually and on time can be challenging for youth for a variety of reasons and missed appointments and dropouts are commonplace, making the adoption of youth-specific outreach, engagement, and retention strategies is vital for treatment success. Effective strategies of these kinds expand access to care, ensure treatment completion, and support recovery.[3]

Engagement predictors and strategies[10,11]:

- Interpersonal connection
- Match between youth and counselor
- Counselor experience and training
- Perceived relevance of treatment
- Treatment readiness
- Youth empowerment
- Social and familial supports
- Family involvement
- Availability of childcare
- Coordination of transportation
- Reminder phone calls
- Reduced waitlist time

<u>Elements of Effective Engagement and Retention in Treatment:</u>

1. ***Maintain procedures to reduce barriers to attendance for youth and families.***
    - Providers should assist with the coordination of transportation and, if possible, offer child care as needed.[3]
    - Some adolescents and their families may be unable and/or resistant to accessing services within the four walls of a clinic or program. Thus, providers should consider alternate treatment methods, including telemedicine, home visiting, text messaging, and social media platforms.[3]
    - Providers can utilize OASAS-supported in-community services (e.g., Children and Family Treatment and Support Services; see box on next page) and peer services to establish rapport with high-risk youth and difficult-to-reach families and/or to maintain connection with youth in continuing care.
    - Providers should consider using treatment motivation and readiness measures at intake to identify youth at higher risk for engagement failure and client-specific barriers to treatment.

Peer services:

- Certified Recovery Peer Advocates (CRPA)
    a. CRPA-Youth
    b. CRPA-Family
- Other youth peer advocates
- Recovery coaches
- Adolescent 12-step programs

2. ***Emphasize therapeutic alliance between youth and staff.***
    - When possible and desired by youth, providers should offer matched-gender staff to aid in alliance building.[3]
    - Providers should utilize their knowledge about the development, language, and culture of each youth to approach youth and family in an informed and productive manner.[3,25]
    - Providers should help youth and families understand the potential benefits of treatment services and instill hope for meeting treatment goals.[26]

- Counselor should be fluent in evidence-based strategies for initiating and maintaining therapeutic alliances with youth and families and be skillful in using them to support a productive relationship.[3]

3. Use motivational enhancement techniques that include contingent positive reinforcement and other incentives to support treatment attendance and participation.

- Motivation is a strong predictor of youth engagement in treatment. Research suggests youth may be less motivated than adults to seek treatment due to fewer negative consequences related to their drug use.[17]
- Providers should consider using the motivational enhancement techniques and incentives detailed in the box.
- Providers should assist youth in achieving goals beyond drug use reduction (e.g., graduating on time, joining a team) to promote treatment buy-in and increase attendance.[10]

Motivational enhancement techniques[1,10]:

- Contingent positive reinforcement
- Incentives for attendance, reduced substance use, and goal achievement
- Intrinsic motivation versus threat of punishment (e.g., probation violation)

Potential incentives:

- Leadership roles
- Special recognition
- Low-cost items and gift/movie vouchers
- Privileges

4. Use outreach and re-engagement procedures for missed treatment sessions and/or poor attendance.

- Providers should make intensive outreach efforts with families throughout treatment to aid long-term retention of youth.[3]
- Providers should be assertive in identifying youth who are reluctant to attend treatment or who have unexpectedly stopped attending and consider providing flexible or alternative treatment delivery methods or treatment services.[10] In Community Services and Peer Services may be appropriate.
- Outreach efforts should include connecting with other systems in which youth may be accessing services (e.g., school, child welfare, juvenile justice).[3]

OASAS In-Community Services

There are a few options available for OASAS-certified programs seeking to serve youth and their families in the community:

- Part 822 Outpatient Services Guidance: health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/learning_symposiums/docs/sept2016_presentations/support_oasaspart822.pdf
- Part 823 Children and Family Treatment and Support Services (CFTSS) Overview: oasas.ny.gov/child-and-family-treatment-and-support-services-part-823

Additional Resources:

- For additional guidance on OASAS Part 822, visit oasas.ny.gov/providers/outpatient-services
- For more information on the Children and Family Treatment Support Services, visit health.ny.gov/health_care/medicaid/redesign/behavioral_health/children/proposed_spa.htm
- For effective strategies to engage individuals and families, learn about the Community Reinforcement and Family Training (CRAFT) program at motivationandchange.com/outpatient-treatment/for-families/craft-

Integrated Substance Use & Mental Health Treatment

Elements:

1. Use standardized mental health tools to assess common co-occurring disorders for all admissions.
2. Provide continuing mental health treatment (on-site or by referral).
3. Maintain linkages with adolescent-serving medical professionals for medication consultations.

As much as 75% of youth presenting with a substance use disorder have a co-occurring mental health (MH) disorder, yet less than one third receive needed treatment.[1] Failure to address co-occurring MH disorders increases the likelihood of escalating behavior problems and treatment failure.[5] The first step in ensuring integrated treatment is screening for MH problems.[17]

Common co-occurring disorders:

- Conduct Disorder
- Oppositional Defiance Disorder
- Attention Deficit Hyperactivity Disorder
- Depression
- Anxiety
- Post-Traumatic Stress Disorder (PTSD)
- Bipolar Disorder
- Eating Disorders

OASAS program regulations require that clients be screened for co-occurring mental health conditions in, at minimum, the following domains: suicide, depression, trauma, and anxiety. Many general mental health screening instruments will cover these domains. Note that if a general mental health screening does not include a question about suicide, the program must administer a separate suicide screening instrument as well.

Required client safety instruments:

- Columbia-Suicide Severity Rating Scale (C-SSRS) *OR* Ask Suicide – Screening Questions (asQ)

Recommended general mental health screening tools:

- Pediatric Symptom Checklist 17
  a. Youth self-report: PSC-17-Y
  b. Parent/Guardian report (PSC-17)
- Strengths and Difficulties Questionnaire (S17+)

Ideally, treatment for co-occurring MH disorders is directly provided by substance use programs.[2,9] Integrated treatment can also be achieved via collaboration between substance use disorder treatment programs and accessible youth-serving MH agencies.[27]

Elements of Effective Integrated Substance Use and Mental Health Treatment:

1. Use standardized mental health tools to screen for and assess common co-occurring disorders for all admissions.

Standardized instruments that assess both MH and substance use disorders provide the most complete diagnostic picture.

- Assessment staff should be competent in using MH assessment instruments with fidelity.[9]
- Providers should refer youth who screen positively for a co-occurring MH condition for a full MH clinical evaluation.[3]
- Providers are required to use an OASAS-approved screening instrument for co-occurring mental health conditions. Additional guidance on these screening instruments can be found here.

2. Provide continuing mental health treatment on-site or in coordination with youth-serving MH providers.

- Procedures should exist to ensure rapid referral for clinical evaluation and treatment for youth experiencing MH and/or trauma symptoms.[17]

- Providers unable to offer MH treatment on site should establish a memorandum of understanding (MOU) with a nearby, qualified youth-serving MH agency to promote concurrent MH services (see box).
- Abstinence from alcohol and/or other drug use should not be required prior to referring for MH services.[9,20]
- Providers should conduct ongoing assessment of MH disorders throughout treatment.[2,3]

Elements of effective inter-agency MH collaboration[8,9]:

- Treatment plan and goals
- Frequent and timely case updates
- Shared decision-making
- Treatment attendance/participation
- Changes in behavior
- Medication initiation/changes

3. ***Providers should maintain linkages with youth-serving medical professionals for medication consultations as needed.***
   - Providers should consider individual youth's need for MH medications if a co-existing MH problem is present, and when indicated, they should consult with experienced adolescent-serving medical staff.[3,28]
   - Treatment decisions should be proceeded by careful discussion with youth and families about risks and benefits of undertaking a medication regimen.[9]
   - Medication prescribers should educate youth, families, counselors, and other individuals involved in treatment planning about target effects and side effects, in addition to providing ongoing medication monitoring.[9]

Additional Resources:

- For more information on treating youth with co-occurring disorders, visit:
  - omh.ny.gov/omhweb/resources/publications/co_occurring/TaskForceOn_COD_YouthSubcommitteeReport.pdf
  - youth.gov/youth-topics/youth-mental-health/co-occurring

Comprehensive Coordinated Treatment

Elements:

1. Focus on multi-systemic collaboration to promote a continuum of coordinated services.
2. Address physical health needs of youth.
3. Address educational and vocational needs of youth.
4. Plan for recovery and facilitate connections with recovery-oriented community organizations.
5. Build on youth's strengths and protective factors to promote resiliency.

When youth enter treatment for a substance use disorder, they may already be receiving services from other systems such as Medicaid, physical health care, child welfare, juvenile justice, housing services, and education. To best support the adolescent in substance use disorder treatment, providers must consider all of the adolescent's needs. If a provider fails to address all needs, it could sabotage treatment success.[1] A comprehensive treatment approach addresses all needs of the adolescent and also engages the respective service systems.

Factors addressed in comprehensive care[1]:

- Gender identity and sexual orientation
- Abuse, neglect, and domestic violence
- Familial substance and MH issues
- Community and peer factors
- Legal, school, and vocational issues
- Mental and physical health
- Housing and transportation

Elements of Effective Comprehensive Coordinated Treatment:

1. Focus on multi-systemic collaboration to promote a continuum of coordinated services.

- Providers should work with youth and their families to help them navigate services across systems and coordinate referrals.[1] Providers should be knowledgeable about New York State Health Homes Serving Children, a NYS Medicaid program that may be accessible to some youth. Ideally, providers will support, and even take the lead in, essential service coordination activities when indicated.

Inter- and intra-agency coordination of care requires multiple agencies (or programs within agencies) and providers to work together, share resources, collaborate in service delivery with shared decision-making, and target common outcomes for youth and their families.

Structured collaboration of this kind involves regular and planned communication between providers, and is often marked by the existence of formal agreements or expectations regarding contact between providers.[5]

- When multiple systems are involved, providers should work to provide comprehensive coordinated care through effective communication and collaboration to ensure a shared understanding of goals and roles, frequent and timely case updates, and shared decision-making.[8] This can inlcude formal or informal partnerships among agencies or providers, MOUs, and regular use of multi-agency team meetings.[29]
- When an adolescent is enrolled in a Health Home Serving Children, the substance use disorder treatment provider should work with the Health Home care manager to facilitate case management and wraparound services when indicated. This may include developing and monitoring a comprehensive service plan, providing support services, and providing crisis intervention and advocacy services.[3]
- To advocate effectively for adolescents in treatment, providers should educate juvenile justice staff and child welfare workers about adolescent substance use, especially as it relates to positive urine screens and program attendance.
- Providers might invite juvenile justice staff to training opportunities within their agency, as well as offer case-specific information when advocating for youth's needs.

2. ***Address physical health needs of youth.***
    - This includes testing and counseling for infectious diseases and sexual health, through on-site medical services or by referral.
    - Providers should be aware of physical health conditions that commonly co-occur in substance-using youth (e.g., asthma, pain conditions, sleep disorders), educate youth and their families on healthcare options in the community, and assist with scheduling appointments.

3. ***Address educational and vocational needs of youth.***
    - Providers should coordinate care with school systems and provide educational and vocational services to youth, either on-side or by referral.
    - On-site academic and vocational staff should be considered part of the treatment team. Treatment and recovery plans should include educational goals and objectives.[30]

4. ***Plan for recovery and facilitate connections with prosocial, recovery-oriented community organizations, mentors, activities, and alternative peer groups during treatment.***
    - Providers should support the maintenance of long-term wellness and recovery by providing continuing care and ongoing support in the youth's community, beginning with admission
    - Programs should provide education about recovery to youth and their families, to include information about multiple pathways to recovery and where they can access recovery services and supports.

5. ***Interventions should use a strengths-based approach to promote resiliency.***
    - Through a strengths-based approach, providers should identify adolescents' strengths and protective factors. Providers can then match treatment settings, interventions, and services with the strengths, needs, and preferences of the individual youth and family,[3] as well as capitalize on available family and community supports.[4]

Additional Resources:

- For a more detailed account of coordinating care across systems, visit ncbi.nlm.nih.gov/books/NBK19833/
- To identify regional recovery resources, visit:
    - Friends of Recovery – NY at for-ny.org/recovery-support/
    - Youth Voices Matter (YVM) at youthvoicesmatterny.org/recovery-resources
    - OASAS' Regional Services at oasas.ny.gov/recovery/regional-services

Family Engagement

Elements:

1. Assess family functioning and relationships.
2. Work to engage families meaningfully in treatment.
3. Provide treatment education to families.
4. Provide structured family-based treatment.

Families play a critical role in adolescent treatment and recovery and benefit the treatment process in a variety of ways. Family members have information about the history and needs of their youth that is invaluable to the treatment planning process and can provide insight that may be otherwise unattainable. Further, healthy family engagement in youth SUD treatment strengthens the relationship between the parent/caregiver(s) and youth, increases adolescent self-disclosure, and results in greater reduction of substance use.[32]

Apart from providing moral and emotional support, family members can also play a crucial role in supporting the practical aspects of treatment. Parent(s)/caregiver(s) can assist with scheduling and making appointments, as well as providing structure and supervision through household monitoring.[1] Family counseling and involvement in treatment can help address strained familial relationships, improve communication, boost parents' or caregivers' skills and confidence, and develop a support system for the youth and the family as a whole.[31] Family therapy models have consistently been shown to be more effective across diverse samples of substance-using youth compared to other treatment models.[3,22]

In some cases, youth may have complex family origins and/or families who experience many stressors; therefore, a clinician must always assess family functioning in addition to identifying those family members who are willing to be engaged in the youth's treatment, those who are resistant, and those the youth would like to be involved in treatment.

Defining family:
It is vital to honor the group of people the adolescent defines as their family.

Providers should work with each adolescent client to identify needs and strengths in family relationships and determine which family members to involve in treatment services.[3]

<u>Elements of Effective Family Engagement in Treatment:</u>

1. ***Assess family functioning and relationships.***
   Family assessments should include past and/or present substance use of family members, mental health (MH) problems of family members, domestic violence issues, and referrals for parents/caregivers, family, and other household members to needed services.
   - Family assessments should explore the broader social and community groups that shape youths' and their family members' behavior, beliefs, and attitudes[3] (e.g. religious organizations, social clubs).
   - Providers should become knowledgeable about family violence issues for each family, including knowledge of family reunification and involvement in the child welfare system.[3]
   - Genograms can be a useful tool for identifying and exploring family structure, history, and current relationships.

2. ***Work to engage families meaningfully in treatment.***
   - Family engagement creates opportunities for family members to gain information about and have input in decisions regarding treatment, recovery, and resiliency plans for their youth.

- Engagement services help family members, including siblings, connect and participate in services. When necessary and possible, family outreach, family peer services, telemedicine, in-community services, and/or childcare should be provided to engage family members.[3]
- To create a family-friendly environment and enhance treatment, providers can offer recreational activities designed to increase family cohesion and identify areas for intervention and growth.
- Providers should give all parents/caregivers the opportunity to build skills to support the youth; in some cases, this may require substance use services for the caregivers.[1]

3. ***Provide treatment education to families.***
   - Procedures should be in place to maintain contact with families and provide educational support groups to keep families engaged and provide information about the nature and progress of treatment. Multi-family groups are a format that encourages families to educate and support one another.
   - Treatment education services should cover both the nature of the youth's substance use disorder (e.g., effects on development, typical recovery processes) and the impact of substance use on family (e.g., dysfunction, stress).[3]

4. ***Provide structured family therapy services.***
   - Several evidence-based practices for adolescent substance use disorders seek to strengthen family relationships by improving communication and family members' ability to support recovery.
   - Providers can help family members identify ways to support changes the youth achieves in treatment and to help them generalize changes outside of treatment.[1]
   - Providers should ensure that family-based services are offered by staff with specific family therapy training to ensure effective service delivery.

Family evidence-based practices (EBPs):
Structured EBPs that focus on family-based interventions include but are not limited to:

- Brief Strategic Family Therapy
- Functional Family Therapy
- Multidimensional Family Therapy
- Multisystemic Therapy

These models address a wide range of issues beyond drug use, including family communication and conflict and co-occurring behavioral, mental health, and learning disorders.[1]

Additional Resources:

- For a Retention Toolkit for family involvement, visit adai.uw.edu/retentiontoolkit/family.htm
- To read more about providing family and significant other services, visit oasas.ny.gov/system/files/documents/2020/02/family-treatment-services.pdf

Culturally Responsive Care

Elements:

1. Consider youths' culture and gender when implementing treatment plans.
2. Make connections to services that align with adolescents' culture, gender, and sexual orientation.
3. Become and remain educated on the unique challenges faced by LGBTQ youth.
4. Maintain and enforce policies and procedures that ensure the emotional and physical safety of youth.
5. Remain sensitive to cultural expectations youth have in their interactions with authority figures.
6. Provide staff opportunities to deepen knowledge of their cultural identities and of social biases.

Culturally-responsive treatment builds on the natural supports, strengths, resiliencies, and perspectives of youth and families[3] and emphasizes that youth and families should receive respectful care provided in a manner that is compatible with their cultural practices and preferred language. These principles require providers to be aware of the role that culture plays in the lives of youth. Programs that are culturally responsive have been found to increase engagement, utilization, retention, and positive outcomes for youth.[27]

Culturally responsive treatment includes (but is not limited to) awareness of:

- Race/Ethnicity
- Culture
- Gender identity
- Language
- Sexual Orientation
- Religion
- Geographic Location
- Social Class

Programs should be aware of and attend to disparities in access to treatment and recovery supports in marginalized groups. For example, youth of color are disproportionately referred to more restrictive systems and settings (e.g., juvenile justice, child welfare) rather than to specialty behavioral treatment.[3] Further, lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth face unique challenges that their heterosexual, cisgender counterparts do not.

With this in mind, programs must remain up to date on strategies to minimize health care disparities and provider bias(es) in substance use treatment for adolescents. This includes approaching one's work in the addiction field with an intersectional lens.

Intersectionality, a term coined by Kimberlé Crenshaw, a law professor, civil rights activist, and leading scholar of critical race theory, is a framework for understanding how aspects of an individual's many identities combine to create layers of privilege and/or discrimination. Examples of identity factors are race, ethnicity, gender identity, sexuality, class, disability, and religion.

One's overlapping and intersecting social identities may be both empowering and oppressing, and a youth client with intersecting oppressed identities may face more difficulties in accessing and engaging in treatment than a youth client with multiple privileged identities. For more information, please see the Additional Resources box at the end of this section.

Elements of Effective Culturally Responsive Care:

1. ***Consider the values and practices of youths' culture when developing and implementing treatment plans.***
    - Providers should assess and promote effective and respectful staff attitudes and skills in providing culturally responsive care, to include the provision of, at minimum, annual training. See #6 in this section for more information.

- Providers should make skilled bilingual staff and/or sign language interpreters available as needed.[3]
- Print and audiovisual materials should be easily accessible with respect to language and literacy.[3]

2. ***Make connections to community groups and other services that align with youths' and families' culture, gender, and sexual orientation.***
    - Cultural, gender, and sexual identities can be pivotal to the treatment process by affecting relationships among everyone involved in service delivery.[33] Providers who are connected with culturally-aligned community groups, and with services that cater to gender and sexual diversity, can boost treatment engagement and alliance with youth and families.

3. ***Become and remain educated on the unique challenges faced by LGBTQ youth.***
    - Lesbian, gay, bisexual, trans, queer, and questioning (LGBTQ) youth and young adults often face social, discriminatory, harassing, and/or violent challenges that are not encountered by heterosexual and/or cisgender individuals.
    - This population is more likely to develop a substance use disorder in their lifetime and often present to treatment with more severe substance use disorders than non-LGBTQ individuals.[40] As such, staff should remain aware of the additional risk factors faced by LGBTQ youth and become familiar with best practices associated with substance use treatment for this population.

4. ***Maintain and enforce policies procedures that ensure the emotional and physical safety of youth.***
    - Providers should not make assumptions about youth's race, ethnic heritage, gender, sexual orientation, or culture based on appearance, accents, behavior, or language. Instead, they should explore, in partnership with youth, their cultural identity, which can involve multiple identities.[33]
    - Staff should be trained in procedures to ensure emotional and physical safety. This includes promoting respect for differences, and preventing (and/or ameliorating the effects of) bullying, victimization, and boundary violations from other youth or staff.
    - Providers should actively work to create and maintain a treatment environment that reflects acceptance and celebration of diversity and differences in culture.

5. ***Remain sensitive to cultural expectations that youth have in their interactions with authority figures and across genders and cultural groups.***
    - Providers should avoid assuming that youth have particular expectations or communication styles based solely on their cultural backgrounds. Providers should be knowledgeable and open to cultural differences in communication.[33]
    - Youth perceptions of provider influence vary across cultural contexts. In some contexts, providers can be seen as all-knowing professionals, but in others, they can be viewed as representatives of an unjust system. Providers should explore how these dynamics affect the treatment process.[33]

6. ***Provide training to all staff to deepen knowledge of their cultural identities and of pervasive social biases, which will strengthen their connections with clients and improve treatment.***
    - Staff who are aware of their own cultural backgrounds are more likely to acknowledge and explore how cultural identity affects all aspects of youth treatment[4] (see box).
    - Culturally skilled staff possess understanding of how racism, racial and economic discrimination, and stereotyping affect them personally and in their work. This allows for a better therapeutic connection with diverse youth and families.[4]

Cultural self of the therapist:
It is important for therapists to consider the dynamic nature of cultural identity in all exchanges with clients. Starting with personal reflection, staff should consider how their own cultural identities influence treatment planning, case presentations, supervision, and even interactions with other staff. Staff can also help youth and families understand how cultural identity impacts their interactions with all entities involved in the youth's treatment.[4]

Additional Resources:

- To learn more about culturally responsive care visit aci.health.nsw.gov.au/resources/primary-health/consumer-enablement/guide/how-to-support-enablement/culturally-responsive-practice
- To learn more about culturally responsive approaches to service provision visit nsvrc.org/sites/default/files/2017-06/cultural-competence-guide.pdf
- For more information on mental health and communities of color, visit genderjusticeandopportunity.georgetown.edu/wp-content/uploads/2020/06/Mental-Health-and-Communities-of-Color.pdf
- For more resources on improving cultural proficiency, visit samhsa.gov/section-223/cultural-competency/resources
- To learn more about intersectionality, read Kimberlé Crenshaw's 1989 article, Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics, and/or view her TED Talk, The Urgency of Intersectionality
- To learn more about Minority Stress Theory, visit ncbi.nlm.nih.gov/pmc/articles/PMC2072932/

Trauma-Informed Care

Elements:

1. Recognize the signs of trauma in youth and families.
2. Integrate knowledge about trauma into policies and practices.
3. Actively seek to resist youth re-traumatization.

National studies indicate that one in four youth experience at least one potentially traumatic event before age 16, and more than 13% of 17-year-olds have met diagnostic criteria for Posttraumatic Stress Disorder (PTSD) at some point in their lives. In surveys of youth receiving substance use treatment, up to 70% report a history of trauma exposure.[34] Young people with PTSD and/or trauma exposure often use substances to dull the effects of stress which, in turn, increases their risk of experiencing additional trauma, making it vital to provide trauma-informed care.

Evidence-based treatments for adolescent trauma include:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Seeking Safety
- Eye Movement Desensitization and Reprocessing (EMDR)

See the California Evidence-Based Clearinghouse for more.

Unaddressed trauma symptoms can lead to poor treatment engagement, premature termination, greater risk for recurrence, and worse substance use and behavioral outcomes. Screening for trauma issues throughout the treatment engagement period is important to ensure effective treatment of youth. Note that a trauma-informed service approach can be implemented in any service setting and is distinct from specific intervention models designed to treat trauma-related symptoms, some of which can be viewed in the box to the left.

Elements of Effective Trauma-Informed Care:

1. Recognize the signs and symptoms of trauma in youth and their families.

- Trauma-informed screening is an essential part of the intake and treatment planning process.
- A positive response to a screen does not necessarily indicate that a client has PTSD, but when a youth screens positive for trauma-related symptoms, providers should follow up with a validated clinical evaluation.[35]
- The following trauma and PTSD screening instruments are approved by OASAS for use with adolescent clients:
  - Child and Adolescent Trauma Screen (CATS)
  - Child PTSD Symptom Scale
- The National Center for PTSD[36] lists the following trauma and PTSD evaluations as effective for use with adolescents:
  - Trauma Exposure and Symptom Measure (*evaluation*)
    - UCLA Child/Adolescent PTSD Reaction Index for *DSM-5*
  - PTSD and General Symptom Measure (*evaluation*)
    - Child Posttraumatic Stress Reaction Index (CPTS-RI)
- Additional screening and evaluation instruments are as follows:
  - Adverse Childhood Experiences (ACEs) Questionnaire (*screening*)
  - Pediatric ACEs and Related Life-Events Screener (PEARLS) *(screening)*
  - Child and Adolescent Needs and Strengths (CANS) *(evaluations)*
    - CANS-Trauma Comprehensive
    - CANS-NY

2. ***Integrate knowledge about trauma into policies and practices.***
    - Providers should recruit trauma-informed staff.
    - Providers should train staff on the principles of emerging best practices relevant to trauma-informed care.

3. ***Actively seek to resist youth re-traumatization.***
    - Providers that anticipate the risk of re-traumatization and work to remain sensitive to the needs of trauma-exposed youth are likely to have more success in retaining such youth and achieving positive outcomes.[35]
    - Policies and practices that aim to avoid re-traumatization include:
        - Sensitivity to features of the treatment setting – such as lack of privacy, feeling pushed to take medications, or perceiving limited choices within the treatment process – that might trigger memories of trauma.
        - Development of individual coping plans in anticipation of triggers that the trauma-exposed youth may be likely to experience in treatment.
        - Training staff and youth to avoid shaming trauma-exposed youth for their behavior, such as teasing or joking about the situation.[35]

Additional Resources:

- For more trauma-related resources, visit:
    - ptsd.va.gov/professional/assessment/list_measures.asp
    - apa.org/pi/families/resources/task-force/child-trauma
- For more information on PTSD in children and adolescents, visit ptsd.va.gov/professional/treat/specific/ptsd_child_teens.asp.
- For more information on the ACE Study, visit cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html.
- For more information on CATS (including how to score the screening), visit depts.washington.edu/hcsats/PDF/TF-%20CBT/pages/assessment.html.
- For more information on trauma-informed care, visit the Institute on Trauma and Trauma-Informed Care (ITTIC) website.
    - To learn more about how your organization can implement a trauma-informed approach, request ITTIC's Trauma-Informed Organizational Change Manual here.

Continuing Care and Recovery Supports

Elements:

1. Offer recurrence prevention services including education of available supports.
2. Maintain linkages with community services and connect youth prior to discharge.
3. Provide a comprehensive continuing care and recovery support plan for an extended period.

Recovery from substance use disorder is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[37] Youth are at high risk for recurrence, especially those with co-occurring conditions; therefore, continued care and recovery support services are paramount in sustaining treatment gains.[17] Continuing care provides ongoing clinical monitoring to address situations and developmental factors that may impact recurrence and to promote a substance-free lifestyle that features positive relationships with family, peers, and the community.[1,17] The strongest form of continuing care includes (1) direct provider communication with youth and family (e.g., follow-up phone calls); (2) linkage to individuals and community organizations that support positive development; (3) life skills training and, (4) when applicable, case coordination across systems.[6]

Recurrence prevention & Recovery supports[1,6]:

- Assertive Continuing Care
- Adolescent 12-Step and other mutual aid meetings
- Peer recovery supports (CRPA, CRPA-Y, recovery coaches)
- Recovery high schools
- Support groups for families
- Youth Clubhouses, respite services, drop in centers
- Spiritual and faith-based support

<u>Elements of Effective Continuing Care and Recovery Supports:</u>

1. Offer recurrence prevention services, including education for youth and families about continuing care and recovery supports.

- Providers should educate youth and families about the chronic nature of substance use problems, the need for continued monitoring and support, and available recovery supports in their community.
- Recovery support services should be individually tailored to each youth's unique strengths, needs, experiences, and developmental stage, as well as those of the family.[3]

2. Maintain linkages with relevant community services and connect youth (and their families) prior to discharge.

- Providers should be familiar with and refer youth to different mutual aid groups that are available to meet their specific developmental, social, cultural, and emotional needs.
- Web-based technology and mobile applications that provide recovery support (e.g., social networking sites, chat rooms) should be offered to youth, especially in rural areas where other support services may not be accessible.[3] Youth can and should play a lead role in working with the provider to identify which web-based recovery supports are best suited for their needs and lifestyle.

Continuing care plan[1,3]:

- Involves the entire treatment team
- Targets continued skill building
- Provides recurrence prevention and intervention
- Continues alliance building
- Incorporates educational goals
- Encourages prosocial and recreational activities
- Promotes healthy lifestyle

3. ***Provide a comprehensive continuing care and recovery support plan covering an extended period of time after treatment is completed.***
    - Recurrence should not be considered a sign of treatment failure, but rather a normal part of the recovery process that indicates the need to adjust the current recovery treatment plan to better meet the adolescent's needs.[1]
    - Comprehensive plans will include some or all of the following: maintaining an ongoing connection with youth and family, monitoring youth with periodic assessment checkups, and, when indicated by assessment, providing referral and re-engagement in treatment with the same or an alternative provider.

Additional Resources:

- For more information on recovery coaching, visit for-ny.org/recovery-coaching/
- For additional information regarding Certified Recovery Peer Advocates (CRPAs), visit oasas.ny.gov/recovery/become-certified-recovery-peer-advocate or www.asapnys.org/ny-certification-board/
- For web-based recovery support services, visit smartrecovery.org/smart-recovery-toolbox or smartrecovery.org/community/

Staff Qualifications and Training

Elements:

1. Staff has training in adolescent development, case management, and additional foundational skills needed to provide youth treatment.
2. Programs employ at least one master's level clinician trained in family therapy and at least one master's level clinician trained in co-occurring mental health disorders.
3. Staff receives ongoing supervision, feedback, and evaluation regarding youth clinical skills.
4. Staff receives ongoing training to remain up to date with current best practices for youth.
5. A medical professional is on-site on at least a part-time basis.

To achieve the best outcomes for youth, licensed/certified addiction treatment professionals must have proper experience and training in serving youth. Without that background, it's possible that a provider could have a negative impact on the youth's treatment and outcomes.[38,39] To ensure that staff is capable of serving youth effectively, provider agencies should adhere to a set of competencies for hiring and supervising staff who serve youth. This may include requirements pertaining to licensure, certification, training, and areas of expertise, as well as skills and attitudes that enable providers to deliver required services in diverse areas of need.

Elements of Effective Staff Qualifications and Training:

1. ***Staff has training in youth developmental stages and additional foundational skills needed to provide youth treatment:***
    - Staff should model positive adult behavior within appropriate boundaries and avoid blurring the lines between themselves and youth in treatment.[27]
    - Staff members have foundational knowledge in most or all of the areas indicated in the box (right).

Foundational knowledge for staff:

- Adolescent developmental stages, growth, and behavior
- Theories of adolescent substance use and behavioral, psychological, physical, and social effects of psychoactive substances
- Youth health and safety, signs of abuse and neglect, and reporting laws
- Youth values, beliefs, and culture
- Gender identity and sexual orientation
- Cultural competency
- Trauma
- Co-occurring MH and physical disorders

2. ***Programs employ at least one Master's level clinician trained in family therapy and co-occurring MH disorders.***
    - A provider can have one Master's level clinician trained in both family therapy and MH disorders or two Master's level clinicians, each trained in one specialty.
    - Programs should also employ a range of staff with training in various aspects of youth MH in order to address multiple needs of substance-using youth.
3. ***Staff receives ongoing supervision, feedback, and evaluation regarding youth clinical skills.***
    - Supervisors should have the proficiencies required to provide effective clinical supervision for staff working with youth populations.
    - Supervision and coaching should be used to improve the implementation of evidence-based adolescent interventions.[17]

4. ***Staff receives ongoing training to remain up to date with current best practices for youth.***
    - Providers should remain up to date on current research and best practices for youth treatment and recovery.
    - Staff should receive ongoing in-service training and/or reimbursement or paid leave for training outside the agency.
    - Staff training should be scheduled periodically throughout the year rather than in ad hoc situations to address crises or acute problems.

Suggested training topics[1]:

- Treatment approaches specific to adolescents and their families
- Family dynamics and family therapy
- Adolescent growth and development
- Gender identity issues
- Mental health and co-occurring disorders
- Culturally informed treatment
- Psychopharmacology
- Referral and community resources
- Neurodevelopmental disorders
- Legal matters

5. ***A medical professional (i.e., physician, registered nurse, nurse practitioner, or physician assistant) is on-site on at least a part-time basis.***
    - Medical staff should be able to provide medical care and consultation for co-occurring MH and physical health conditions as they relate to youth populations.
    - Medical staff should consider the use of medication assisted treatment as part of a comprehensive treatment program for youth opioid disorder.[1]

Additional Resources:

- For additional guidance for adolescent-serving staff, visit oasas.ny.gov/system/files/documents/2020/09/program-staff-guidance-adolescents.pdf
- For guidance on person-centered care, visit oasas.ny.gov/system/files/documents/2020/01/oasasperson-centeredcareguidance.pdf

Medication-Assisted Treatment/Recovery

Elements:

1. Youth have access to medication-assisted treatment (MAT), either on-site or by referral
2. Medication choices are determined through informed, shared decision-making between the youth, their family, and their clinical team.
3. Staff understand the signs and symptoms of substance withdrawal (including withdrawal from alcohol and other sedatives, opioids, and nicotine) and use best practices to avoid withdrawal complications.

Youth and families in NYS impacted by use of opioids, alcohol, and/or nicotine need access to a full continuum of developmentally appropriate addiction services including medication-assisted treatment (MAT). MAT is the use of medications to treat certain substance use disorders. Recommended treatment combines MAT with psychosocial treatment such as counseling and behavioral therapies to address withdrawal symptoms and craving and prevent unintentional overdose.[41] Though this combined approach is the recommendation, youth should not be denied MAT if unwilling to engage in psychosocial treatment. FDA-approved MAT options are available for the above stated disorders. Several "off-label" options are also available, though with less effectiveness and/or less evidence of effectiveness, for other substances.[42] MAT for OUD (or Medications for Opioid Use Disorder; MOUD) are especially effective, have been established as the clear standard of care for adults, have clear and increasing evidence of safety and effectiveness in adolescents and young adults, and are supported by treatment guidelines from key professional organizations (i.e., American Academy of Pediatrics; AAP and American Society of Addiction Medicine; ASAM)[57]. Despite this, MAT is underutilized and access to developmentally appropriate treatment has traditionally been limited for adolescents and young adults.[43,44]

Opioid Use Disorder (OUD)

Non-medical opioid use, or opioid misuse, refers to any use of opioids in a manner that was not prescribed by a healthcare professional. Opioid use disorder (OUD) refers to a maladaptive pattern of opioid use resulting in health risk and/or psychosocial problems as defined by Diagnostic and Statistical Manual, 5the Version (DSM-5).[45] All patients who use misuse opioids are at risk of potentially fatal overdose. Patients with OUD commonly experience behavioral, medical, and socioeconomic consequences, as well as co-occurring physical and mental health disorders.[46,47] Engaging patients in treatment and providing MAT can reduce the consequences of OUD, though evidence-based treatment is underutilized, especially among youth.[47]

MAT Options for Youth:

- Methadone (primarily accessible to youth over age 18)
- Buprenorphine (i.e. brand Suboxone)
- XR Naltrexone (i.e. brand Vivitrol)

Currently, there are three approved medications in the United States for the treatment of OUD: the opioid full agonist, methadone; the opioid partial agonist, buprenorphine; and the opioid antagonist, naltrexone. All three medications can be prescribed to youth, though methadone is only available through specially licensed opioid treatment programs (OTPs), which by law cannot accept patients under the age of 18 without an individual regulatory exception. Buprenorphine is indicated for the treatment of patients with OUD aged 16 and older, and extended release naltrexone injection for patients aged 18 and older, though both can be used off label for younger patients when needed. It is important to note that in general, MAT for OUD is much safer and leads to better outcomes than treatment without medication or no treatment at all and should be considered the community standard of care for all populations, including youth.[42,56]

Methadone treatment for OUD can only be provided in federal-and-state-licensed OTPs to those 18 years and older. For youth who may benefit from methadone treatment in an OTP, Federal Code 42 CRF § 8.12 offers an

exception for individuals under the age of 18 who have a documented history of at least two prior unsuccessful short-term detoxification or drug-free treatments for opioid use disorder within a 12-month period. Written consent from a parent, legal guardian, or responsible adult designated by the relevant NYS authority is also required. Before treating an individual under the age of 18 with methadone, an OTP must request an opioid treatment exception from the federal Center for Substance Abuse Treatment (CSAT) and a regulation waiver from NYS OASAS.

Buprenorphine is FDA-approved for use in people aged 16 years and older. However, off-label use in younger individuals with OUD is generally recommended to improve outcomes and prevent adverse effects of untreated OUD.

Extended release naltrexone injection is FDA-approved for use in people aged 18 and older. However, off-label use in younger individuals with OUD is generally recommended to improve outcomes and prevent adverse effects of untreated OUD.

It is important to note that although all medications can have side effects, there is no suggestion that any of these 3 medications have any additional specific age-related risks or safety concerns for the target population of adolescents and youth.

Additionally, there is no evidence that such medications should be subject to limitations in their use such as: fail-first requirements restricting their use to those youth who have failed non-medication treatments; considering them 2nd line, only for the most severe cases; or arbitrary predetermined limitations on duration of treatment.

Alcohol Use Disorder (AUD)

People who engage in risky alcohol use are often faced with physical, social, and emotional challenges related to their use.[48] The amount and frequency of use and issues affecting the individual, whether directly or indirectly caused by alcohol use, can inform the course of treatment and recommendations for services. The possibility of complications from withdrawal should be assessed and identified, as they can be medically dangerous and even life-threatening. Like OUD, there are approved medications that can be used in conjunction with therapeutic services to treat AUD. The FDA has approved oral naltrexone, extended-release naltrexone injection, acamprosate, and disulfiram for the management of AUD in individuals 18 and older.

While us of these medications is off-label for adolescents with AUD and further evidence is needed to determine the efficacy of AUD MAT in adolescents, there are no specific safety contraindications for older adolescents for these medications and the available information supports the "safe of judicious use of medications in this population."[48] Specifically, preliminary studies suggest that naltrexone and disulfiram may be relatively safe and well-tolerated medications showing promise for treating adolescents.[49] As with any other aspect of treatment, medication options for adolescents with AUD should be explored in a person-centered manner and should be offered along with counseling and behavioral therapies.

Tobacco Use Disorder (TUD)

Nicotine is the primary addictive substance in tobacco. The magnitude of risks that are associated with the use of nicotine and tobacco products are often underestimated despite the large burden of premature deaths and health issues that result from use or exposure to use.[50] E-cigarettes or vaping products have become very popular with youth over the past several years. These products can deliver high concentrations of nicotine and may also include other substances, such as tetrahydrocannabinol (THC). Vaping nicotine can quickly result in tobacco use disorder (i.e., nicotine dependence), and can also lead to medical complications not previously seen in traditional tobacco products (e.g., E-cigarette or Vaping Product Use-Associated Lung Injury (EVALI)).

Addiction to nicotine products is managed through the use of nicotine replacement therapy (NRT) and other smoking cessation medications. No smoking cessation medications (i.e., NRT, bupropion, varenicline) are FDA-approved for use in children or adolescents under 18 years of age.[51] However, NRT in conjunction with behavioral interventions are recommended in the National Institute for Health and Clinical Excellence (NICE) guidelines for patients with nicotine dependence beginning at age 12 years.[52] When prescribing NRT, using a long-acting formulation (i.e., patch) along with a short-acting formulation (e.g., lozenge, gum) for breakthrough nicotine withdrawal and cravings is generally considered most effective. In addition, some evidence exists from short-term trials that bupropion and NRT are beneficial for smoking cessation and use reduction in adolescents.[52] Although not well studied in adolescents, varenicline generally has higher effectiveness in adult studies than bupropion or NRT, and should be considered, with monitoring, for adolescents as well. When considering medications to treat TUD/nicotine dependence in a young person, risks should be balanced with potential benefits, keeping in mind that cessation is often unsuccessful without pharmacotherapy and the risks of continuing to use tobacco and/or other nicotine-containing products are significant. A young person under 18 should talk to their treatment provider to determine whether the use of TUD/nicotine dependence medications are appropriate for them.

Over the Counter NRTs:
- Skin patches
- Chewing gum
- Lozenges

<u>Elements of Effective Medication-Assisted Treatment:</u>

1. ***Youth have access to medication-assisted treatment, either on-site or by referral***
    - Providers should encourage MAT, and medication should be considered a first-line component of treatment.
    - Providers should have on-site access to prescribing clinicians who have a DEA waiver to prescribe buprenorphine and are familiar with youth development.
    - If MAT prescribing is not available on-site, providers should make arrangements with outside entities able to provide MAT services.
    - Providers should create sustainable health networks consisting of community health centers, specialty substance use treatment settings, and community mental health treatment programs.[53]
    - Barriers to MAT access should be identified, evaluated, and addressed in order to ensure availability.

2. ***Medication choices are determined through informed, shared decision-making between the youth, their family, and their clinical team while providing a space for confidential treatment***
    - Treatment decisions are made in collaboration with clients and their families based on available treatment options, medication side effects, risks including the risks of no medications, benefits, and requirements of various medication options (route of administration, setting, frequency of visits, etc.).
    - Youth and family/caregivers are given essential information regarding treatment options, treatment parameters, safety issues (i.e., safe use of the prescribed medication, potential drug interactions, and safeguarding of medication, such as with a lockbox or safe), patient rights, and roles and responsibilities of those involved.[54]
    - While there is evidence that medication treatment only (i.e., medical management) is effective for addiction and especially OUD, youth can benefit from MAT services that are supplemented with psychosocial treatment (i.e., individual sessions, group sessions, telehealth and asynchronous support such as text messaging, behavioral treatments that support adherence,

and/or community integration activities).

3. ***Staff know, understand, and can assess (formally or informally) for the signs and symptoms of substance withdrawal (including withdrawal from alcohol, opioids, and nicotine) and use best practices to avoid withdrawal complications***
    - Staff should be trained to recognize the signs and symptoms of opioid or alcohol/sedative intoxication and opioid, alcohol/sedative, and nicotine withdrawal as well as injection use, and other medical consequences of misuse (such as abscesses, endocarditis, cellulitis, acute HCV, acute HIV).[55] Staff should offer testing for HIV, HBV, HCV, and sexually transmitted infections to youth and adolescents engaged in active substance use. Youth and adolescents should be linked to treatment services (for HIV, HCV, PEP, PrEP) as indicated.
    - Youth and families are educated about overdose prevention, are trained on the use of naloxone, and provided with a naloxone kit or prescription.
    - Providers have knowledge regarding the administration of appropriate drug testing procedures and interpretation of results.

Additional Resources:

- For more information on the Federal Opioid Treatment Standards 42 CFR 8.12, visit ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=0d945f6e5f6068b536698ccc72159bc8&r=PART&n=42y1.0.1.1.10#se42.1.8_112
- For additional information on FDA-approved medication guides, visit: accessdata.fda.gov/scripts/cder/daf/index.cfm?event=medguide.page
- For more information on medication-assisted treatment, visit oasas.ny.gov/providers/medication-assisted-treatment
- For training on using MAT with adolescent clients, please view OASAS' webinar series.
- For more information on vaping, visit: cdc.gov/tobacco/basic_information/e-cigarettes/Quick-Facts-on-the-Risks-of-E-cigarettes-for-Kids-Teens-and-Young-Adults.html
- For further exploration of alcohol use amongst young people and preventive measures, visit: https://pubs.niaaa.nih.gov/publications/aa68/aa68.htm

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Appendix A: ASE Program Self-Assessment

The purpose of this self-assessment is to identify the ability of your program to provide adolescent substance use treatment that is congruent with NYS OASAS-approved Adolescent Services Endorsement standards that represent clinical excellence. The components within the standards and this tool are intended to reflect the primary features of effective treatment services and are based on the Clinical Practice Standards for Adolescent Programs (CPS-AP), which are supported by scientific research and the robust experience of a team of clinicians.

Instructions

In order to be accepted for review, the following rating tool must be filled out in its entirety. This includes a score and comment(s) providing corroborating information for every component of each standard. **If the provided comment space is not sufficient, applicants may use additional sheets to provide justification for their chosen scores.** Be sure to label any additional sheets with the standard number and component letter. (e.g., justification for the Assessment component that reads, "Trauma-informed screening from a valid tool is administered at intake and whenever otherwise appropriate" would be labeled "2c." The self-assessment must be completed by the Program Director and signed by the Executive Director, attesting that all of the information provided in this tool is accurate to the best of their ability and knowledge. **Programs completing this tool by hand must ensure the resulting submission is legible in order for an accurate review to be completed. Failure to do so may result in a denial or delay of Endorsement.**

Rating Procedure

Using the 4-point Likert scale below, please indicate the extent to which your program has adopted each component of the twelve Adolescent Endorsement standards. The Clinical Practice Standards for Adolescent Programs (CPS-AP) manual provides further description of the elements presented here and should be referenced throughout the rating process.

0	1	2	3
No Activity	Committed/Planning This component is under development	Initial Implementation This component has been introduced to agency practice, but adjustments are being made	Full Implementation This component is integrated into standard agency practice

Program Information and Director Signatures

Note: If a provider is applying to receive the Adolescent Endorsement in more than one of their PRUs, a Self-Assessment Tool must be completed for **each** PRU.

We, the undersigned, of _____ verify that the following Adolescent Services Endorsement self-assessment is completed with accuracy.

Executive Director Name: _____ Executive Director Signature:_____

Program Director Name: _____ Program Director Signature: _____

Program Director Email: _____ Program Director Phone Number: _____

PRU: _____ Operating Certificate #: _____

Clinical Practice Standard	Score	Justification
1. Developmentally Informed Treatment		
a. Clinicians are trained in and utilize evidence-based programs (EBPs) that are developmentally appropriate. These EBPs may include, but are not limited to, The Seven Challenges, MET/CBT, Adolescent Community Reinforcement Approach (A-CRA), and/or Motivational Interviewing. A record of staff training is kept on file. Note: Justification should include EBPs used to fidelity by program staff.	0	
b. Youth clients are educated on addiction, biological factors, and life skill deficits that contribute to youth issues as it relates to substance use and/or problem gambling.	0	
c. Youth are treated with age-appropriate clients, building on youth's strengths and protective factors to promote resiliency.	0	
d. Developmental maturity dictates how information is presented and services are conducted.	0	
2. Assessment		
a. Assessment of substance use and gambling related problems evaluate key domains of developmental functioning, as well as relationships and other social factors that affect youth behavior, using standardized adolescent specific instruments and interviews.	0	
b. Treatment eligibility and level of care is determined with a valid tool (i.e. LOCADTR-A) and appropriate interventions are offered for presenting problems of varying severity among youth.	0	
c. Trauma-informed screening from a valid tool is administered at intake and whenever otherwise appropriate (e.g., CATS).	0	

d. Information gathered from assessment is used to develop youth Treatment/Recovery Plan in a person-centered manner, which emphasizes input and involvement from the youth/family throughout both the initial treatment plan development and the remaining course of treatment.	0	
3. Youth-Specific Outreach, Engagement, and Retention		
a. Policies and procedures exist to engage, retain, and outreach to the adolescent population.	0	
b. Youth Treatment/Recovery Plan includes identification of potential barriers such as current difficulties in participating in treatment (e.g. transportation, childcare) that are addressed at intake and continuing throughout the course of treatment. There is evidence of efforts made to overcome barriers and of timely and appropriate follow-up on missed appointments.	0	
c. Providers have at least one Certified Recovery Peer Advocate on staff who assists in establishing rapport with youth and family members and/or maintaining connection with youth in continuing care.	0	
d. Outreach efforts include connecting with other systems in which the youth may be accessing services [(e.g., education, child welfare, juvenile justice, physical health (including connections to pediatricians)].	0	
e. Program has in place and on file a HIPAA-compliant messaging policy for contacting clients (via encrypted text messages, email, etc), which includes a procedure to report a security breach within 60 days of the breach event.	0	
4. Family Engagement in Treatment		
a. Formal services and supports are offered and provided on site or by referral to families of children/youth experiencing social, emotional, developmental, medical, substance use, problem gambling, and/or behavioral	0	

challenges in their home, school, or community [e.g. Significant Other services, including the use of Community Reinforcement and Family Training (CRAFT), family counseling, family therapy, Peer services)].	0	
b. Informal services and supports are offered and provided on site or by referral to families of children/youth experiencing social, emotional, developmental, medical, substance use, problem gambling, and/or behavioral challenges in their home, school, or community [e.g. psychoeducational groups for family/caregivers, family support and/or peer-led groups, including (but not limited to) Al-Anon, Alateen, and SMART Recovery Families and Friends].	0	
c. Attempts to engage family members in youth treatment sessions are made and documented.	0	
d. Program provides or links to appropriate childcare services for adolescent clients with children.	0	
5. Community Involvement in Treatment		
a. Youth are provided with links, referrals, and/or are otherwise engaged in programs and activities in their home community.	0	
b. Youth are provided with opportunities to engage in recreational activities in their local communities at the cost of the provider in order to promote prosocial fun without substances or gambling.	0	
c. Youth are made aware of resources in their communities that may include, but are not limited to volunteer opportunities, employment opportunities, vocational programs, sexual health services, and resources for daily living (e.g., food pantries, shelters).	0	
6. Integrated Mental Health and Substance Use Treatment		
a. Standardized mental health tools to assess for common co-occurring disorders (i.e., Pediatric Symptom Checklist 17 Youth, Strengths and Difficulties Questionnaire) are used for all admissions.	0	

b. Policies and procedures are in place to ensure continuation of mental health treatment on site or by referral.	0	
c. Linkages are made and maintained with youth-serving medical professionals for medication consultations as needed.	0	
7. Reporting and Complaints		
a. Policies and procedures exist to ensure appropriate steps are taken in the event of an emergency and/or injury, including, but not limited to, having an emergency contact on file for each youth.	0	
b. Policies and procedures exist in the event that a client or family files a complaint. Outcomes are documented.	0	
c. Reports are made regarding any situation in which a person who is receiving supports or services is experiencing abuse, neglect, sexual, financial or emotional exploitation, or is at risk of experiencing any of these incidents in a setting over which the Justice Center has jurisdiction.	0	
8. Comprehensive Coordinated Treatment and Continuing Care		
a. Provider has a dedicated focus on multi-systemic collaboration to promote a continuum of coordinated services for youth within their community, including coordination with other state systems (when indicated) and having documented relationships with local pediatric primary care physicians.	0	
b. Provider addresses physical and sexual health education and needs of youth on site or by an outside provider (i.e. Planned Parenthood) that is documented by an MOU or another form of contract.	0	
c. Program provides the option for supporting the maintenance of long-term recovery by offering continuing care and maintaining connections with prosocial, recovery-oriented community organizations, mentors, activities and/or alternative peer groups during and after treatment.	0	

d. Offers recurrence prevention services, including education for youth and families about continuing care and recovery supports.	0	
e. Youth receive education on life skills and will be linked to services relevant to increasing life skills, where appropriate.	0	
f. Provider develops a comprehensive continuing care plan, including check-ins and re-engagement where appropriate.	0	
9. Culturally Responsive Care		
a. Policies and procedures exist that ensure the emotional and physical safety of youth, including promoting respect for differences and preventing or repairing bullying, victimization, and boundary violations from other youth or staff.	0	
b. Provider maintains connections to community groups and other services that align with the clients' and families' culture, gender, and sexual orientation.	0	
c. Regular training is provided to staff to deepen knowledge of their own cultural identities, as well as pervasive social biases.	0	
10. Trauma-Informed Care		
a. Provider integrates current and research-based knowledge about trauma into agency policies, procedures, and practices.	0	
b. Provider recognizes the signs and symptoms of trauma in youth and their families, as evidenced by ongoing, documented assessment.	0	
c. Policies and procedures exist to actively resist traumatization of youth through established policies and practices.	0	
11. Staff Qualifications and Training		
a. Clinical staff has training in adolescent development, case management, culturally informed treatment, and additional foundational skills for providing youth treatment. All training is documented and kept on file.	0	

b. Staff has ongoing training on the principles of emerging best practices relevant to trauma-informed care, medication-assisted treatment, and other topics relevant to youth treatment and recovery.	0	
c. Program has on staff at least one master's level clinician trained in family therapy or a licensed clinician with experience working with families, one Certified Recovery Peer Advocate (CRPA), and at least one master's level clinician trained in co-occurring mental health disorders and problem gambling.	0	
d. A provider such as a psychologist, psychiatrist, or nurse practitioner with knowledge of the youth population is on-site on at least a part-time basis for medication management services.	0	
e. Staff receive ongoing supervision, feedback, and evaluation regarding adolescent-related clinical skills as outlined in the OASAS Administrative & Clinical Supervision Definitions and Minimum Requirements.	0	
12. Medication-Assisted Treatment/Recovery		
a. Youth have access to medication-assisted treatment, either on-site or by referral. Provider maintains and documents regular coordinated treatment with prescriber.	0	
b. Medication choices are determined through informed, shared decision-making between the youth, their family, and their clinical team while providing a space for confidential treatment.	0	
c. Staff know, understand, and can assess (formally or informally) for the signs and symptoms of substance withdrawal (including withdrawal from alcohol, opioids, and nicotine) and use best practices to avoid withdrawal complications.	0	
d. Youth and families are educated on overdose prevention and are provided with Naloxone, as needed.	0	

Appendix B: ASE Attestation

A program applying to deliver services through the OASAS Adolescent Services Endorsement (ASE) must complete this attestation and submit it to: NYS OASAS, Bureau of Certification, 1450 Western Avenue, Albany, NY 12203 or by e-mail to Certification@oasas.ny.gov. Use additional pages if necessary.

Providers applying for the ASE in more than one PRU may submit one attestation but must complete and submit a separate self-assessment for each PRU.

<table>
<tr><th colspan="4">PROVIDER INFORMATION</th></tr>
<tr><td colspan="4">Applicant's Legal Name</td></tr>
<tr><td colspan="2">Operating Certificate Number(s)</td><td colspan="2">PRU Number(s)</td></tr>
<tr><td colspan="4">Originating Site Address(s)/PRU Location(s)</td></tr>
<tr><td colspan="4">Administrative Office Address (Street, City, State, Zip Code)</td></tr>
<tr><td colspan="2">Name of Contact Person</td><td colspan="2">Position/Affiliation with Applicant</td></tr>
<tr><td colspan="2">Telephone Number for Contact Person</td><td colspan="2">E-mail Address of Contact Person</td></tr>
<tr><td colspan="4">Do you want to include the additional locations that are on the operating certificate addendum?
☐ Yes ☐ No</td></tr>
<tr><td>Number of Youth Served Per Year</td><td>Average Length of Stay (Ages 12-24)</td><td colspan="2">Age Range of Youth Clients Served</td></tr>
<tr><td>Years of Agency Experience Serving Youth</td><td colspan="3">Current EBP(s) Used for Youth Services</td></tr>
<tr><td>Years of Agency Experience Serving Families</td><td colspan="3">Current EBP(s) Used for Family Services</td></tr>
<tr><td colspan="4">Days/Hours of Operation for Youth Services</td></tr>
</table>

Approximate Number of Individual Sessions with Adolescents per Week	Approximate Number of Adolescent Groups per Week
Number of Staff Dedicated to Youth Services	Licenses/Certifications of Adolescent-Serving Staff (e.g., LCSW, LMHC, CRPA)
Partnerships with Outside Youth-Specific Entities (e.g., pediatricians, non-profits, other behavioral health service providers, recovery support programs, schools) (Applicant may attach a list of MOUs/linkages)	
How would the agency benefit from receiving the Adolescent Services Endorsement?	

ADOLESCENT SERVICES ENDORSEMENT ATTESTATION	
1.	The services being offered by the above-noted provider are in accordance with Part 830 regulation.
2.	Clinical staff has training in topics related to adolescent substance use disorder, including (but not limited to) adolescent development, cultural proficiency, trauma-informed care, case management, effective SUD treatment approaches for adolescents, and youth-specific screening and evaluation instruments.
3.	Assessment instrument(s) for substance use and co-occurring mental health issues are standardized, developmentally appropriate, and evaluate key domains, including (but not limited to) demographics, substance use history, developmental functioning, family and other interpersonal relationships, trauma history, and resiliencies/strengths.
4.	Applicant program meets Adolescent Endorsement standards, as evidenced by the Provider Self-Assessment. The self-assessment is completed accurately, and the applicant program agrees to comply with requests for further information from OASAS program staff, where necessary.
5.	Policies and procedures are in place for, at minimum: • Outreach, engagement, and retention strategies • Mental health treatment • Reporting for injuries and emergencies • Filing of client complaints • Emotional and physical safety of youth, including bullying • Availability and use of medication-assisted treatment/recovery for adolescents • HIPAA messaging compliance Copies of the above-listed policies and procedures are included with the applicant's submission. Applicant is encouraged to attach additional youth-specific policies and procedures not listed above.
6.	Applicant can provide medication-assisted treatment to adolescents on-site or by referral.
7.	**To be eligible to participate, all of the Adolescent-Serving OASAS Certified Outpatient Programs must have an OASAS Operating Certificate in good standing.**

Part 830 permits qualifying programs (certified pursuant to Article 32 of the NYS Mental Hygiene Law and if approved to do so by OASAS) to receive designation as an adolescent-serving program via the Adolescent Services Endorsement. Approval shall be based upon acceptance of this Attestation and the ASE Program Self-Assessment.

Statement of Compliance and Signature

I, _____, hereby attest that the Adolescent Services Endorsement standards identified on this attestation form are true, accurate, and complete to the best of my knowledge and that the provider noted above is in compliance with Part 830 "Designated Services" regulation. I understand that any falsification, omission, or concealment of material fact may result in revocation of approval to provide Endorsed Adolescent services at the above-referenced location(s) and/or may subject me to administrative, civil, or criminal liability.

Provider Representative Signature:	Date:
Regional Office Representative Signature:	Date:
LGU Signature:	Date: