

2014

Theoretical and Philosophical Foundations of Therapeutic Adventure.

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**New Mexico
Children, Youth and Families Department**

Adolescent Treatment Manual[©]

A comprehensive treatise about
compassionate and integrated holistic care for
youth and their families



Dedication

To all persons, agencies, Tribes, and entities who strive for personal and community recovery and health, who support recovery and health in others, and who work diligently in the service of their communities.

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Person Centered Perspective on Health & Wellness©

Art by Suzanne Otter, MA, LMHC, Santa Fe, NM

The art on the following page was painted by Suzanne Otter, and depicts the individual within a transpersonal context as central to life. The vision of life flowing out of the transpersonal conception best describes how every person can develop ideals, beliefs, values, and perceptions that support the fulfillment of health and wellness. From this perspective, the individual is empowered to engage resources that will most benefit their own balance and healing.



Adolescent Treatment Manual

PART A

I. Introduction



What you will find:

- **Introduction**
Harrison Kinney
- **Statement of Approach**
Michael Hock
The manual describes an integrated recovery based philosophy to adolescent treatment, shifting the locus of control to the adolescent and their family/support system.
- **Purpose of the Manual**
Michael Hock
The Adolescent Treatment Manual is intended to provide guidance in establishing or improving adolescent services. It offers direction about implementing comprehensive services and best practices for working with adolescents experiencing mental and/or emotional and substance use disorders.

Introduction - Healthcare of Future Past

In his tenure as the Executive Manager of New Mexico's Behavioral Health Services Division, Harrison Kinney was instrumental in fostering competence and capacity in the field of substance, mental, and co-occurring disorders. New Mexico is indebted to him for his tremendous contribution to behavioral health care in our state, and for the wit and sense of adventure that he spearheaded for us working in the field and also for the people we serve. He is currently the Director of Strategic Initiatives at Community Healthcore in Texas. In many ways, this manual is a direct result of his caring and compassionate influence and direction within our State.

The ***New Mexico Adolescent Treatment Manual*** has been crafted to be a document of the 21st Century yet its foundation of care is anchored in holistic healing practices dating back millennia. The consequences of substance use in New Mexico are devastating. It destroys lives, families and communities while filling prisons and cemeteries. Many believe that halting the onslaught of this social pariah is not possible as it is so impervious to eradication, so complex, and so embedded in day-to-day life. The ***Adolescent Treatment Manual*** takes on this challenge and embraces the core belief that human health and wellness are a product of the complex interaction of the DNA-determined tapestry of human biology, the serendipitous location and family of birth, early childhood exposure to trauma, parental guidance, lifestyle decisions, capricious exposure to accidents and contagious disease and access to quality medical care. The ***Adolescent Treatment Manual*** underscores that recovery from substance use disorders cannot be limited to just treating a specific substance use disorder with a specific treatment approach but must be expanded to encompass this complex interplay of treatment, lifestyle, environment and biology. Only by embracing the complexity of substance use disorders can we hope to truly turn back the tide of destruction it brings.

Don Berwick, MD, the former Administrator of the Centers for Medicare and Medicaid Services (CMS) and CEO for the *Institute for Healthcare Improvement* articulates his vision for the American Health system (May 5, 2014) through a story of one of his patients. Isaiah, who in 1984 at the age of 15, was diagnosed with lymphoblastic leukemia. His prognosis was abysmal but the medical community went to heroic efforts and was able to eventually heal his leukemia against all odds. Unfortunately leukemia was not Isaiah's greatest health challenge. Isaiah first smoked dope at age five. He got his first gun before 10. He was on crack at 14. Even on chemotherapy, he was in and out of police custody. The leukemia was ultimately cured but two decades later Isaiah died on a street corner from what Dr. Berwick said was "a prolonged convulsion from uncontrolled diabetes and even more uncontrolled despair." Dr. Berwick's message is quite clear: healthcare requires a focus that encompasses the totality of the person and not just the isolated treatment of a specific disease or set of symptoms.

Is it even possible for a health system to effectively interface with the vast complexities of a person's life in order to facilitate health and wellness? The answer is "yes" and it is happening right now. Dr. Berwick points to the Anchorage Alaska based Southcentral

Foundation (SCF) which is a Native-owned health care organization providing integrated primary care and behavioral health services, as well as dentistry, traditional healing and home-based services.^{1 2} The term Nuka (an Alaska Native word that means a strong, living, and large structure) is used by SCF to describe a system of caring for the whole person that prioritizes achieving physical, mental, emotional, and spiritual wellness. Outcomes have been exceptional as hospital admissions, emergency room use, and specialty visits have all been significantly reduced. Patient satisfaction is very high. The ***Adolescent Treatment Manual*** has embraced these concepts of Nuka. This manual masterfully intertwines how substance use disorder treatment must address intersecting complexities of adolescent brain functioning, early childhood adverse events, friends, family and community life, and spirituality in order to effectively promote recovery.

How will this service system be funded? The ***Adolescent Treatment Manual*** provides the reader with an orientation to substance use treatment embedded within a holistic wellness approach that will be necessary to meet the increasing payment demands of Managed Healthcare Organizations (MCO). Healthcare funding is facing a major crossroad as the weight of healthcare cost is crippling the economy. Healthcare costs comprise almost 18% of the Gross Domestic Product and is by far the most expensive in the world.^{3 4} Yet the World Health Organization ranks the U.S. healthcare system 37th, the lowest among industrial nations, despite employing one of the most highly skilled and trained healthcare workforces in the world.⁵ In response, a critical analysis of the underpinning assumptions of U.S. healthcare has led to the mantra of the Triple Aim:

- Improving the patient experience of care (including quality and satisfaction).
- Improving the health of populations.
- Reducing the per capita cost of healthcare.⁶

In order to accomplish such ambitious goals, MCO's are looking beyond traditional ***fee for service*** payment and are now developing new pay for performance (health outcomes) methods: pay for the positive health outcomes and not just the service. This will be a major "game changer" for the entire healthcare industry including substance use treatment. Within this decade, persons with multiple chronic health conditions such as alcohol use disorders, major depression and Type II Diabetes will most likely be treated within a Patient Centered Medical Home. There will be a team that will have a single *person centered* care plan that, like the Nuka model, integrates primary health inclusive of behavioral health with specialty care and a wealth of community based services and supports which address

¹Southcentral Foundation website link: <https://www.southcentralfoundation.com/nuka>

² National Library of Medicine Director's Comments Transcript Nuka System of Health Care: 07/22/2013
<http://www.nlm.nih.gov/medlineplus/podcast/transcript072213.html>

³ Public Broadcasting Company, (2012) Health Costs: How the U.S. Compares With Other Countries
(<http://www.pbs.org/newshour/rundown/health-costs-how-the-us-compares-with-other-countries/>)

⁴ World Bank-Health expenditure, 2009-2013 (% of GDP): <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>

⁵ Christopher J.L. Murray, M.D., D.Phil., and Julio Frenk, M.D., Ph.D., M.P.H. Ranking 37th — Measuring the Performance of the U.S. Health Care System New England Journal of Medicine 2010; 362:98-99 January 14, 2010
(<http://www.nejm.org/doi/full/10.1056/NEJMp0910064>)

⁶ <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>
<http://www.ihl.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx>

global health and wellness. Reimbursement will not be for services but will come through Managed Care risk-based outcome payment strategies for this individual experiencing the positive outcomes of **not** being treated in the emergency room and **not** being treated within an inpatient setting and **not** having an amputation. As is obvious substance use treatment and harm reduction approaches will be an integral aspect of this service mix. The ***Adolescent Treatment Manual*** provides a conceptual framework on how to address substance use through an integrated systemic approach that will be necessary to bring about the Triple Aim outcomes and be funded by the MCO's. Substance use disorder treatment agencies that understand this major shift and embrace the new way of doing business will thrive.

The ***Adolescent Treatment Manual*** goes far beyond the typical owner's manual for the service program du jour. It is a treatise that provides a glimpse into the future and forces the reader to address the complexities of being human and how substance use disorder treatment embedded within the healthcare system will embrace this complexity in order to craft approaches that can truly lead to health outcomes anchored in the Triple Aim. As Dr. Berwick has stated-this is the future of healthcare. In the spirit of Nuka, the ***New Mexico Adolescent Treatment Manual*** provides the vision of healthcare future past.

1. Statement of Approach

The integrated services and the recovery philosophy and practices described in this document distill the overall purpose and the approach of implementing comprehensive services for youth and adolescents affected by mental/substance or co-occurring disorders. Youth and adolescents are first and foremost our children and not problems to be solved or barriers to a healthy family or society. These are each unique human beings and must be addressed with respect and regard that is not directed to fixing them or their problems, but to helping each person to effectively navigate towards a more functional and healthy life.

The integrated approach shifts the locus of control from an episodic care-taking model of service to one of self-care, self-management and self-efficacy that is youth and family directed. The history of treatment and case management has focused on "doing for." The adolescent client and their family often experience this type of service as disempowering and sometimes disrespectful. Integrated recovery-based care is not intended to reinforce the provider's expert position, nor to "do for" or "to" the adolescent client and their family. To this end the elements described in this manual are focused on shifting the locus of control inherent in traditional models of care to a more self-sustaining adolescent and family driven model of service.

Over the past several years, New Mexico has seen profound and persistent change within the behavioral healthcare system. Many of these changes have been intended to increase effectiveness and control the costs associated with services. Change has become a constant due to limitations of funding, increasing numbers of individuals and families severely

impacted by substance use, psychiatric issues, and co-occurring disorders, increasing costs, along with a host of severe problems in many other life domains. This service implementation manual is intended to address these issues in a systematic fashion so that integrated services will be established and become self-sustaining.

2. Purpose of the Manual

It is not practical or possible to address every potential issue that may arise in working with the youth of New Mexico. The information expressed here is intended to provide a guide for working with adolescents that are experiencing difficulties meeting the challenges and risks imposed upon them by the rapidly changing social landscape, by mismatches in educational processes that sideline them academically, by cultural influences intended more for self-regulating adults, and by inner turmoil and confusion caused by abuse, neglect, or mental/emotional imbalances, trauma, and finally by substance use issues. The problems that beset youth may become pernicious, but most overcome them as they advance into adulthood. It is to those who are most at risk of not overcoming the challenges present in our society that the efforts outlined in this manual are directed. Such efforts must be directed with compassion and care. Our youth are the future of our world, and none deserve to be sidelined or discarded.

This implementation manual is intended to provide guidance in establishing or improving adolescent services, system-wide. It has been written with the highest level of integrated service as a reference so that providers may engage in the process of continual quality improvement and development. The contributing authors recognize that few programs may initially have the capacity or resources available to meet all the criteria set forth in this manual, but encourage all providers to advance services in the directions indicated within each element listed. This manual is intended for use in conjunction with the **New Mexico Adolescent Treatment Assessment Tool (NMATAT)**. These documents used together will facilitate providers to assess and implement effective integrated services.

Part A Chapter 2 provides the fundamental descriptions of some of the challenges facing our youth. Such fundamentals address the development of mental, emotional, or behavioral disorders (inclusive of substance use), and the context in which adolescents formulate relationships and their understanding of themselves. Part B contains 24 essential elements of comprehensive treatment that includes definitions, examples, and descriptions for implementation. There is a companion policy and procedure in Appendix C that operationalizes Part B of this manual and can be adopted by provider agencies. A Microsoft Word version is available upon request.

This manual addresses the systems/administrative level, as well as the clinical staff level of care and expertise. The result of our extensive research and adaptation to New Mexico's unique needs is a manual that is intended to facilitate smooth and

efficient implementation of co-occurring competent integrated services for adolescents.

The application of knowledge must be made at organizational and systems levels and by the people at the client-contact level of service. What happens on the ground in the service setting is difficult to capture and convey in writing. Therefore this manual is intended to describe practical and helpful guidance, but it cannot provide the invaluable and essential creativity, self-awareness, or compassion that drive successful service implementation. The shift in the New Mexico behavioral health care field is intended to establish sustainable services that are effective for providers, the work force, and the adolescent client and their family, enabling all to live a more satisfying life.

Every provider agency must meet unique community needs, and work with capacity and resource challenges while implementing effective evidence-based or best practice programs and models. This process entails a resolute effort to first identify needed organizational change that will increase service effectiveness. Such a process must engage creativity and the urge to achieve a higher level of work-satisfaction with provider staff, higher-quality outcomes for identified clients and families, and sustainable benefits to the provider agency.

Lastly, please consider the use of the terms “client”, “consumer”, and “patient” to be interchangeable depending upon context and the self-describing term the individual receiving services prefers. Also, when speaking with persons in the medical system, such as with an MCO, the word “patient” may get better results than other words describing the service recipient.

II. Fundamental Understandings



What you will find:

- **Executive Function – Who’s in Charge?**

Randy Muck

This refers to the conscious regulation of thought, emotion, and behavior. It is an aspect of intelligence that involves expressing or translating what we know into action. Knowing the individual’s level of development related to executive function is essential to providing appropriate and effective interventions.

- **Trauma and Adverse Childhood Experiences (ACEs)**

Natalie Skogerboe

ACEs are traumatic events in childhood that have lasting negative effects on adults. Understanding the sorts and intensity of trauma the individual and/or family has experienced can aid understanding, provide help in assessing delays in the development of executive function, and clarify behavioral issues for the provider.

- **Mental, Emotional, and Behavioral Disorders**

Olin Dodson

MEBs are often present in adolescents in the juvenile justice system but are often not adequately treated. Untreated MEBs lead to a host of often severe and pernicious disorders later in life, and earlier intervention may have significant benefit to individuals, families, and society. Behavioral disorders often lessen with the maturity of executive function, but the opposite seems to be true of untreated emotional and mental disorders, which can interrupt the maturation process.

- **What are Substance Use Disorders?**

Michael Hock

Substance use may progress from a mild to a severe disorder, thus becoming chronic health condition that requires an array of treatment services. This Section discusses the role of neurotransmitters, habituation to use, as well as the recovery process. Many youth will spontaneously age-out of problematic substance use as executive function matures.

III. Fundamental Understandings (continued)

- **What are Co-occurring Disorders (COD)?**

Michael Hock

This refers to persons who have one or more substance related disorders and one or more mental and/or emotional disorders. Co-occurring disorders must be assumed for all youth until ruled out by comprehensive assessment. This category of disorders is often very severe and very pernicious, and careful assessment and service planning are required to effect change. It is important to note that both disorders must be treated concurrently and not sequentially.

- **What are the Ten Principles of COD Implementation?**

The Co-occurring Center of Excellence

Guidance on implementing services for persons with COD developed by the Co-occurring Center of Excellence.

- **What are Intensive Outpatient Programs (IOP)?**

Michael Hock

This type of program is intended for persons who do not require inpatient or residential rehab for substance disorders, and provides a step-up/step-down bridge for youth needing this level of care.

- **What is the Role of the Family?**

Olin Dodson

This Section describes the profound influence the family unit has on an adolescent and their recovery process.

- **What is the Neuroscience of Thrill and Risk?**

Michael Hock

Emerging science highlights new knowledge about neurotransmitters and their role in how we experience and respond to challenges and risk. Psychoneuroendocrinology introduces the complex interaction of hormones, neurotransmitters, and experience, and how adventure may be the best thing our brain has ever experienced.

- **The Power of Challenge—a Monograph**

Doug Robinson

Describes the potency of high-challenge efforts in changing brain chemistry based on the most recent neurological research and the authors on experience.

3. Executive Function (Who's in Charge?)

Randolph D. Muck, M.Ed., served as the Chief, Targeted Populations Branch of the Center for Substance Abuse Treatment at SAMHSA. Randy is engaged in ongoing efforts providing guidance to various federal agencies and their grant making for youth; providing technical assistance and training to individual programs, jurisdictions, purveyors of evidence-based practice, States and communities in their improvement, adoption, implementation, and how to interweave new programming into a continuum of care responsive to youth with substance use and mental health disorders. He frequently consults with the Department of Justice, Office of Juvenile Justice and Delinquency Prevention, the State of New York, Portland State University, the University of Arizona assisting in research on treatment outcomes, the Council of State Governments, Reclaiming Futures, the State of New Mexico, and numerous treatment programs throughout the U.S. His consultation and assistance with this manual and other NM State efforts to improve capability and capacity of our adolescent treatment system have been invaluable.

Executive functioning is essentially the conscious regulation of thought, emotion, and behavior. It is different from what we usually think of as intelligence, because it is independent of how much we know. It is an aspect of intelligence that involves expressing or translating what we know into action.⁷ One can be exceedingly bright but not able to access and apply knowledge if there is limited executive function. One element that cuts across all areas of executive functioning is the ability to hold something in mind, step back, and reflect on the thought or concept. Without this capacity, it is difficult to have perspective, judgment, or control. Some of these symptoms are found in youth with Attention Deficit Hyperactivity Disorder (ADHD).

For children/youth that have deficits in executive function, following a set of instructions for a game or rules for comportment in the classroom may be difficult. A child attempting to do what is expected often becomes frustrated when they fail. This frustration can appear to others as misbehavior. Children who are frustrated when attempting to do what is requested may look angry, sullen, withdrawn, and may act out in ways that appear threatening to others. Admonishing or punishing children/youth that are not following the rules because of limited executive function is not only ineffective, but can lead to an escalation of negative affect, and behavioral outbursts become more likely the longer this cycle is repeated. In order to intervene effectively with children, we must assess the problem accurately to determine when an issue is due to executive function deficit and not simply childhood or adolescent laziness or rebellion or ADHD.

There is evidence that early intervention with young children can improve their executive function.⁸ The evidence also suggests that there are activities that can fit within almost all youth-serving agencies. These activities can begin as early as preschool and are an option for school curricula through high school as well as community agencies serving youth.

⁷ https://www.chadd.org/Portals/0/AM/Images/Understading/EF_and_School_Success_by_Chris_Dendy.pdf

⁸ Diamond, A., Lee, K., (2011). Interventions Shown to Aid Executive Function Development in Children 4 to 12 Years Old; www.sciencemag.org, VOL. 333, August 9, 2011.

Examples include aerobics, non-computerized games, martial arts, mindfulness training, and yoga.

It appears that children with poor executive function may benefit the most.⁹ Early executive-function training may avert widening achievement gaps later. All successful programs involve repeated practicing of the activity and over time, increasing the challenge to executive function. It may be more effective to address emotional and social development (often covered in curricula) and physical development (shown by positive effects of aerobics, martial arts, and yoga) rather than focusing narrowly on executive function.¹⁰

Most definitions of adolescence list characteristic behaviors of this developmental stage that are strikingly similar across Western society and between youth in any neighborhood or community. What is striking about any list of normal behavior during the stages of adolescence is that they could fit many adults views of an “out of control teen” if removed from the context.

Consider that one of the positive aspects about youth reaching adolescence is that they are able to have a rational discussion with adults and begin to understand what they are learning about themselves during adolescence. As youth can better abstract, they can understand issues such as hypocrisy. With that understanding and the new found ability to communicate rationally with adults, a youth might decide to test their new skill and point out the hypocrisy of an adult. Depending on with whom the youth is trying this out, it could lead to a helpful conversation or an angry admonition by the adult, who might view this behavior as inappropriate.

As a youth moves through the stages of adolescent development the process of brain development intensifies and arrives at the penultimate stage, which boasts of disinhibition.¹¹ This area of the brain, the amygdala, governs the systems of feeling rewarded, encourages risk taking, questions authority and other behaviors that can be exhilarating to youth and bring consternation to adults.¹²

Fortunately most parents and youth survive this period, but it is fettered with cautionary tales, many of which bring youth into contact with juvenile justice, child welfare, or lead to a call from the school about a behavioral problem such as truancy. This is certainly not what occurs with most youth, but reflecting on your own personal development you just might be able to identify with this conundrum presented by youth in their families, at school and in the community.

⁹ T. O’Shaughnessy., K. L. Lane., F. M. Gresham., M. E. Beebe-Frankenberger.,(2003). Children Placed at Risk for Learning and Behavioral Difficulties; Implementing a School-Wide System of Early Identification and Intervention. *Remedial and Special Education*. Volume 24, Number 1, January/February 2003, Pages 27–35.

¹⁰ Diamond, A., Lee, K., (2011)

¹¹ http://www.prearesourcecenter.org/sites/default/files/content/6_stages_of_adolescent_development.pdf

¹² CDC Positive Parenting Tips for Healthy Child Development;
<http://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/pdfs/teen15-17.pdf>

When considering the process of brain development it is difficult not to wonder about the order in which certain parts of the brain develop that can put the youth at the most risk before they develop the capacity to think forward in time and understand possible consequences for their behavior. In the simplest model of understanding development of the brain, it tends to develop from the back to the front, and from the inside out. It is not possible within this publication to discuss all of the changes that occur in the brain in adolescence and early adulthood, but what has been explained thus far and references following this Section will give the individual working with youth plenty of material to explore, much of it free and available on the internet.

Neurosequential Model of Therapeutics (NMT)

www.childtrauma.org

This approach to therapy is informed by the neurobiology of the developing brain and uses that knowledge in clinical problem solving. Correlations between adverse experiences during critical brain development phases and higher developmental risk have been documented. The NMT assessment process examines both current and past experience and functioning. This science maps areas in the brain that appear to have functional or developmental problems, which helps guide the selection and sequencing of developmentally sensitive interventions.¹³

For those adults who work with adolescents and transition aged youth, much of what is frustrating about youth is purely developmental. For some youth/young adults, because of multiple factors that may include mental health or substance use disorders, trauma to the brain, or heritable brain deficits, there may never come a point where they can function without some level of supervision.

During participation in treatment or other medical or behavioral health services that are verbally focused, youth with disabilities in brain function may not be able to process their experiences or incorporate the information they are being taught. Many youth with executive function deficits have learned to hide these by the time they come to treatment. They know appropriate responses to use, but may have no idea what they mean. Treatment that stays verbally focused can allow a youth with deficits in executive function to hide, particularly if the staff is unaware of these dynamics and if treatment looks a lot like educational classes. In a worst-case scenario, a youth may leave treatment, having done well in a supported environment, having gained no skills, and with the underlying problem not identified. Compliance with instructions is often confused with understanding or comprehension of meaning and/or intent.

One very practical implication for the treatment provider is in the choice of an evidence-based practice. Choosing to implement an EBP that has no ability or flexibility to modify the approach for youth with cognitive deficits in general may be a challenge for many youth and staff. Youth who are slow in their development of the prefrontal cortex, where

¹³ Overview of the Neurosequential Model of Therapeutics,
http://childtrauma.org/wp-content/uploads/2013/06/NMT_Description_Overview_6_22_12x.pdf

executive functioning resides, have a much steeper mountain to climb to reach treatment goals and meet expectations of the behavioral health provider, the courts, the justice system, the community and often the family. Youth experiencing a delay of the development of executive function cannot be expected to reach the same place in the same time as those who do not have deficits in this area. Similarly, we know that use of alcohol or drugs can interfere, slow or damage the process of brain development.

Due to the limitations of EBPs (research excludes anyone with co-occurring disorders and selects the participants carefully) and their subsequent lack of applicability, perhaps providers should be looking more at practice-based evidence.

A popular analogy to understand the issue of delayed executive functioning for youth is to think of the individual youth as a corporation. The part of the brain wired to come on line last is the CEO (executive function) of the company. This should sound a bit backwards already, but in a pinch to get the company moving the search committee of the board of directors hires (rather than engage in a slow process of leadership development by grooming the soon to be CEO) an undisciplined and inexperienced youth. This person has just left a college frat house to run the company, or worse, is someone who may still be in elementary school developmentally speaking, and this person is expected to effectively manage the company.

Executive Functioning is a subset of a number of processes that mature over time within the brain, with executive function showing up fully matured, dead last. Unfortunately for some youth whose brains have no problem with the developmental phase that gave rise to disinhibition, they have arrived at the aforementioned job with deficits in crucial executive function. They will party, take risks, have fun and not expect any consequences to come of their behavior, along with their peers. What is unseen by many is that the ongoing slow work on executive function has gone awry and likely been ignored. Many youth progress through this phase relatively unscathed and come out with robust and operational executive function, whereas some do not.

Understanding Executive Functioning and brain development in general is extremely important for all youth serving agencies. Any intervention with youth, to be fully successful, will increase their chances of success or beneficial effect if they address this area and educate all of the youth serving systems through which youth become involved in self-development, to whatever degree that is possible. Measuring and understanding the developmental stage youth are in, and identifying tasks that were not fully mastered, can lead to better treatment planning, case management, individualized incentives and sanctions, and appropriate placement by child welfare, to name some of the systems that mistakenly set youth up for failure with a cookie cutter approach, or total lack of understanding of these principles.¹⁴

Knowing the brain is not fully developed until somewhere in the mid to late twenties is an accepted fact in the medical community. Executive Functioning and ways of measuring

¹⁴ See Appendix A for Stages of Adolescent Development

where youth are in this developmental process is important information for creating a treatment plan for substance use and mental health disorders, devising an individualized group of incentives and sanctions for use in juvenile drug court, or development of a successful Individual Education Plan (IEP) under Individuals with Disabilities Education Act (IDEA).

Treatment for substance use disorders and understanding where an individual youth may have strengths or deficits is an important foundational concept for successful treatment intervention. Ideally it would be noted in progress notes, incorporated into the treatment plan and measured systematically through the treatment process to include: intake, during treatment if the duration of treatment is of sufficient length, at discharge and at follow up points with the youth through continuing care and back to reintegration with family, school and community or to help the youth understand their strengths and areas they may consider opportunities for future growth.

Healthy brain development is no doubt a major key to successful outcomes with youth. The work of Barkle, Brown, and Gioia, has been arranged and briefly explained by Zeigler Dendy in relation to academic achievement.¹⁵

The following elements constitute Executive Functioning:

- Working memory and recall (holding facts in mind while manipulating information; accessing facts stored in long-term memory)
- Activation, arousal, and effort (getting started; paying attention; finishing work)
- Controlling emotions (ability to tolerate frustration; thinking before acting or speaking)
- Internalizing language (using "self-talk" to control one's behavior and direct future actions)
- Taking an issue apart, analyzing the pieces, reconstituting and organizing it into new ideas (complex problem solving)
- Shifting, inhibiting (changing activities, stopping existing activity, stopping and thinking before acting or speaking)
- Organizing/planning ahead (organizing time, projects, materials, and possessions)
- Monitoring (self-monitoring and prompting)

<https://www.chadd.org/Portals/0/AM/Images/Understading/EF and School Success by Chris Dendy.pdf>

¹⁵ <https://www.chadd.org/Portals/0/AM/Images/Understading/EF and School Success by Chris Dendy.pdf>

4. Trauma and Adverse Childhood Experiences (ACEs)

Natalie Skogerboe, MPA, has significant expertise in youth development, substance abuse prevention, risk and protective factor theory, and behavioral health systems and programming. She provides training and technical assistance to agencies and programs around the state and country and has been working in the field of youth development and substance abuse prevention for almost two decades. She has written and secured numerous substance abuse prevention and public health-related grants for the state as well as communities around New Mexico and has significant breadth of knowledge and expertise of behavioral health programs and practices. She has the capability to guide agencies towards comprehensive and well-written services that are actionable and appropriate to the various cultural needs, the economy, and the geographic diversity of New Mexico. Natalie provided the artistic sense to make this manual more readable by clear formatting and organization, as well as adding visual appeal and concise writing.

More research is pointing to the lasting negative effects of traumatic events on young children. In addition to the immediate mental, emotional and behavioral disorders that surface, research confirms that adverse childhood experiences (ACEs) are important risk factors for the leading causes of illness and death, as well as poor quality of life.¹⁶ Research conducted by the CDC and Kaiser Permanente in the mid-1990s led to the identification of ten specific events that are considered ACEs.

Adverse Childhood Experiences (ACEs) include the following events:

- **Abuse:** Emotional, Physical, Sexual
- **Neglect:** Emotional, Physical
- **Family Dysfunction:** Household substance use disorders, Household mental illness, Witnessing violence against household member, Parental separation or divorce, Incarceration of a household member

Such experiences can actually alter brain development, in large part because of elevated stress hormones in the body and the way cortisol floods the brain as a defense mechanism to help children flee dangerous situations and keep themselves safe. However, if the outpouring of cortisol continues over long periods of time, the young child's brain becomes less able to respond to social situations appropriately, and develops a "brawn over brains" mentality. These children become quick to anger, and less able to think rationally in even moderately stressful situations.¹⁷ This cognitive impairment often carries into adulthood and findings suggest the more ACEs a child experiences the more likely they are to

¹⁶ Adverse Childhood Experiences (ACE) Study, <http://www.cdc.gov/ace/prevalence.htm>. Major Findings. <http://www.cdc.gov/ace/findings.htm> Retrieved June 6, 2012.

¹⁷ Grace, A. A. (2010). "Dopamine system dysregulation by the ventral subiculum as the common pathophysiological basis for schizophrenia psychosis, psychostimulant abuse, and stress." *Neurotox Res* 18(3-4): 367-376. & Teicher, M. H., J. A. Samson, et al. (2009). "Length of time between onset of childhood sexual abuse and emergence of depression in a young adult sample: a retrospective clinical report." *J Clin Psychiatry* 70(5): 684-691.

experience other negative consequences later in life including substance use, heart disease, violence between partners, depression, suicide, and early initiation of smoking, to name a few.¹⁸ In addition, ACEs are compounded across generations, so it is critical to address them as early as possible.

Generation 1:

A person with 1-2 ACEs, such as child abuse or family violence has an increased probability of mental illness, substance issues, incarceration, teen pregnancy and school failure.

Generation 2:

Their children are at higher risk of child abuse or family violence plus having a parent with mental illness, substance use disorders or incarceration. With these added ACEs the person has an increased probability of living in poverty, engaging in risky sexual behavior, participating in or witnessing violence in the community, and attempting suicide.

Generation 3:

This child now has an increased risk of child abuse, neglect, domestic violence, mental illness, substance use disorders, incarceration of a family member, and loss of a parent.

The earlier ACEs can be identified in a family unit, the better off the children will be because the issues can be addressed and the cycle can be stopped or the effects can be lessened. Pilot studies that began in 2012 (Johns Hopkins and SAMHSA) are using ACE factors as a screening tool for young mothers and fathers, allowing service providers to make appropriate referrals and offer support services that address the trauma. ACEs should be considered when working with youth in the juvenile justice system and in behavioral health settings as many of their behaviors may be linked to ACEs and can, therefore be addressed as something that they experienced rather than something that is wrong with them.

¹⁸ www.acestudy.org, and Martin Teicher MD, Washington Family Policy Council; Dube, S. R., et al. (2003). "Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study." *Pediatrics* 111(3): 564-572. & Chapman, D. P., et al. (2004). "Adverse childhood experiences and the risk of depressive disorders in adulthood." *J Affect Disord* 82(2): 217-225.

5. Mental, Emotional, & Behavioral Disorders

Olin Dodson has been a licensed therapist since 1986. His varied work history includes work as a home-based family therapist in Rio Arriba County, New Mexico, and as a contract therapist for the New Mexico Crime Victims Reparation Commission. In the mid-2000's he served as Grants Manager for New Mexico's Co-Occurring State Incentive Grant (SAMHSA) and as New Mexico's State Opioid Treatment Authority. A published author, he currently teaches professional workshops on dealing with grief and loss. Olin's contributions to the New Mexico behavioral health system are manifold, and his discerning eye and fine sense of language use have added depth and clarity to this manual.

Adolescence is often characterized by turbulence, both internally as well as socially. As described in the Executive Function chapter of this manual, research directs us to consider normal personality development. There seems to be a lag between the intensification of emotional and behavioral states that accompany the hormonal changes of puberty in early adolescence and the mastery of cognitive and emotional coping skills that are enabled through cortical development during late adolescence and early adulthood.¹⁹

Not every adolescent mental health issue is permanent or even severe, but as demonstrated by the previous chapter on Adverse Childhood Events, it would be unwise to address any mental health disorder without assessments of substance use, family and trauma histories.

Since most youth enter treatment via the Juvenile Justice system this chapter on adolescent mental health begins with a far-reaching study issued in early 2014 by the Mental Health and Juvenile Justice Collaborative for Change. The report is entitled "Better Solutions for Youth with Mental Health Needs in the Juvenile Justice System," and deserves careful consideration. Data found in the report includes:

- More than 600,000 youth are placed in juvenile detention centers around the country and close to 70,000 youth reside in juvenile correctional facilities on any given day.
- **65%-70%** of youth in the juvenile justice system have a diagnosable mental health disorder.
- Over **60%** of youth with a mental health disorder have a substance use disorder.
- At least **75%** of youth in the juvenile justice system have experienced traumatic victimization.
- **93%** of youth in detention reported exposure to "adverse events" and the majority were exposed to six or more events. (See also CSAT Adolescent Treatment Common GAIN Data Set which found that over half of the youth presenting for substance use

¹⁹ "Thoughts of Death and Suicide in Early Adolescence." A.Vander Stoep, E.McCauley, C.Flynn, A.Stone. Dec. 2009. NIH. gov

treatment acknowledge 5+ major problems including depression, anxiety, suicide attempts, ADHD, conduct disorders, etc.)²⁰

The Better Solutions report concluded **“Whenever safe and appropriate, youth with mental health needs should be prevented from entering the juvenile justice system in the first place.”**²¹

One of the obvious implications of this statement is that adolescents’ mental health needs may not be adequately addressed in the JJ system, especially those with higher need. It is a forceful recommendation that mental health services for most youth should be delivered by professionals in the community and not in a “correctional” environment. Expanding diversion services, mental health courts, adolescent drug courts, etc. would be among the ways of advancing progress in providing treatment to individuals with mental health problems. The New Mexico JJ system is embracing this effort and making systematic changes.

The statement also implies that identifying a youth as a law-breaker ignores and in no way ameliorates the burden of mental health issues, which, for some in the jail and prison systems, go untreated for a lifetime.

Consider also the significant instances of trauma in adolescent offenders. When a young person is adjudicated, sentenced, incarcerated or put on parole, there is little if any recognition that his offense is connected to the experience of adverse, even traumatic events at an earlier point in time. This label of ex-offender can become a part of one’s self-image, while influencing family, friends, employers, etc. for years. The report is a corrective call to prioritize a youth’s mental health needs in adolescence

It is not enough to maintain youth in the community, although that would be a major step forward in itself. Treatment is also needed. Experts in the field of mental health and substance use disorder treatment for adolescents have studied these issues by conducting and reviewing research studies. Some of their conclusions include:

- Adolescents need developmentally appropriate and research based screening and assessment tools.
- Multiple co-occurring problems are the norm among adolescents with substance use problems and require, at a minimum, integrated multi-agency service teams.
- Adolescents with co-occurring problems are frequently involved in multiple systems and networks including family, school, peers, JJS, MH and SA counselors, work, etc.
- Adolescents’ responses to treatment are highly variable, sometimes cycling in and out of use.

²⁰ Center for Substance Abuse Treatment, Adolescent Treatment Common GAIN Data set. Randolph Muck.

²¹ “Better Solutions for Youth with Mental Health Needs in the Juvenile Justice System” The Mental Health and Juvenile Justice Collaboration for Change. 2014

- Recycling into and out of treatment and continued problems are the norm among adolescents who receive treatment for co-occurring disorders.²²

Treatment providers and others who are experts in the field will not be surprised by the statistics or the recommendations listed above, but it is reasonable to conclude that the public at large would be.

Therefore, we wish to address the issue of how the greater population will become knowledgeable and supportive of changes in mental health and substance use treatment for adolescents. Stigma attached to mental health diagnoses persists in part because the public is accustomed to thinking about only the most extreme examples of mental disorders when considering the subject.

Providers and other professionals in the field are experts and must use their experience and understanding to inform lawmakers, elected officials and the general public in order to move communities to more humane and evidence-based treatment of those with mental health and/or substance use disorders. Practitioners may not be accustomed to acting in the role of passionate advocates at large, but if not us, then who? Generations will be impacted by our response to the question.

²² "Emerging Models of Effective Adolescent Substance Abuse Treatment" M.White, W.White, and M. Dennis. Counselor, April, 2004.

6. What are Substance Use Disorders?

In 1995, the movie *Braveheart* debuted in the USA. It depicts the story of William Wallace, a 13th-century Scottish warrior who led his countrymen in the First War of Scottish Independence against King Edward I of England. Towards the end of this movie, Wallace is shown being publicly eviscerated, and during the extremity of his pain continuously yells out “Freedom!” with all the power he can muster. This urge to obtain freedom can be a fundamental and driving force which pushes personal freedom from within the perceived or felt meaninglessness and futility surrounding the individual, with no apparent way out, and no possibility of reprieve from existential despair or hopelessness.

This is a haunting and realistic metaphor for what some of our children are facing as they live with the power of substance use disorders. This is what we must address in full awareness of the reality of those most severely afflicted by such potency; throwing every other consideration of life or happiness away for a momentary and passing taste of freedom disguised as a fleeting pleasure.

The calm and peaceful life that most work hard to attain has little to no meaning for a person so tortured, nor does further punishment. The normal hopes and dreams that drive most of us will not likely suffice to motivate, and that is the treatment puzzle we must solve. For some it is a life or death issue. For most youth the issue may not be this severe or dramatic, and more associated with learning self-regulation and self-motivating behaviors, but whatever the severity, it is our ongoing hope to help resolve this issue with each child receiving substance use treatment and support services.

There are multiple aspects of knowledge and attitude related to understanding substance use and co-occurring disorders, but possibly the most challenging is determining what predicates the development of severe substance use disorders and its treatment in persons so affected. Add to this that actual physical dependence for youth may be less common than popularly assumed, and it is essential to fully and competently assess what all the various issues are that affect the adolescent at the unique and personal level of that individual’s whole life.

Definitions from the DSM 5 ²³

Addict/Addiction	Use of these terms is considered to be stigmatizing in the DSM terminology and is no longer used in the DSM 5, therefore this manual will comply with the new terminology. It was used to describe compulsion, loss of control, continued use in spite of negative consequences, and cravings. <i>(The authors do not intend to dictate how persons in recovery identify themselves related to these terms, but the words “addict” and “addiction” are clinically imprecise and are often used to discount persons experiencing serious difficulties with substance use. These terms are not used in this manual.)</i>
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²³ Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM 5), (2013). American Psychiatric Association

Substance Use Disorder (from mild to severe)

- A problematic pattern of use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:
 - 1) The substance must be taken in large amounts or over a longer period than was intended
 - 2) There is a persistent desire or unsuccessful efforts to cut down or control use
 - 3) A great deal of time is spent in activities necessary to obtain, use, or recover from the substance
 - 4) Craving or a strong desire/urge to use
 - 5) Recurrent use resulting in a failure to fulfill major role obligations at work, school, or home.
 - 6) Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by its effects
 - 7) Important social, occupational, or recreational activities are given up or reduced because of use
 - 8) Recurrent use in situations that are physically hazardous
 - 9) Use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by use
 - 10) Tolerance as defined by either of the following:
 - a) A need for markedly increased amounts in order to achieve intoxication or desired effect
 - b) A markedly diminished effect with continued use of the same amount
 - 11) Withdrawal, as manifested by either of the following:
 - a) Characteristic withdrawal syndrome as defined in the DSM 5 for each substance
 - b) Substance is taken to relieve or avoid withdrawal symptoms
-

As understanding of substance disorders and substance related issues and problems has matured within the academic and treatment communities, two fundamentally and seemingly opposing points of view have emerged. First is the disease model, which describes substance use disorders as chronic long-term conditions. Second is the episodic model of substance use disorders, which describes use more in terms of willful (or lack of willpower) cooperation in the use of altering substances, temporary and passing conditions, or lapses in self-control. The episodic model may in-part accurately describe use patterns (particularly the inception stage), but it appears to be inaccurate in describing substance disorders as fixated and often fairly intractable conditions. The fundamental principles of recovery described as long-term and mostly cooperative efforts are similar to the long-term support needed for chronic illness. For some, such support will be life-long.

It is our premise that substance use disorders are complex, chronic health conditions that require an array of treatment options. Drug and alcohol use disorders share many features with other chronic illnesses, including a tendency to run in families (heritability), a course that is influenced by environmental conditions and behavior, along with the potential to respond to appropriate treatment. Substance use by youth must be interrupted at the earliest possible time in the child's life through prevention or early intervention practices. Even before a youth reaches severe substance use disorder diagnosis, he or she will need some level of support depending on their stage of change, developmental stage, and findings of screening and assessment related to the severity of use and need for various levels of services.²⁴ There is no set road map to recovery and no single approach works for each person. An individual over time can find a combination of approaches to help him/her enter and maintain long-term stable recovery. However, it is important to note that at early ages many children and youth will not yet have developed sufficient resources to enable them to engage in self-directed recovery efforts. Substantial and comprehensive supports must be provided to help young individuals overcome the potentially devastating effects of substance use disorders as they mature into responsible adults.²⁵

Renaissance of Adolescent Treatment Research

The field of adolescent substance use disorder treatment is in its infancy as a science-based field of study and intervention. Given that what some refer to as the “Renaissance” of adolescent treatment did not begin until 1997, to expect that scientifically validated approaches to recovery for youth be readily available is implausible. There are some studies of treatment pointing to what “may” be promising approaches for some youth around the concept of recovery. Scientifically proven approaches to recovery for youth with co-occurring substance use disorder (SUD) and mental health disorders have not currently been met.

New discoveries about youth disorders, particularly around substance use disorders, are occurring at a rapid pace and some of the first evidence-based practices that proved efficacious in clinical trials have already been tested in community-based settings and proven effective at rates similar to those in the highly controlled environment of clinical trials. If you are a treatment provider, a school counselor, a child protective services caseworker, part of a treatment team for a Juvenile Drug Court or a physician needing to make a referral to an effective treatment program, they do exist throughout the country.

²⁴ McLellan AT, Lewis DC, O'Brien CP, Kleber HD., (2000). Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. *JAMA*. 2000 Oct 4; 284(13):1689-95.

²⁵ New Mexico House Joint Memorial-21 (2012) Recommendations:
<http://legiscan.com/NM/text/HJM21/id/619977>

A New Mexico program directory is located here:

<https://www.nmresourcedirectory.org/SitePages/Home.aspx>

Other evidence-based practice lists cite more interventions not on the National Registry of Evidence-based Programs and Practices (NREPP) list. To have come so far in so little time is phenomenal for a field of study and treatment. The literature and available information has grown so rapidly that most treatment programs are not aware of all of the new developments. SAMHSA alone went from a budget in 1996 of no funding for adolescent substance use disorder treatment to being the major portion of a budget line item of over \$30 million per year over the last decade. Having that knowledge enabled a move to practice in community based settings with readily available training protocols, quality assurance programs, ongoing monitoring and supervision, and certification of staff and/or programs.

The National Registry of Evidence-based Programs and Practices now contains more than a dozen treatment protocols that help youth with substance use disorders.

<http://www.nrepp.samhsa.gov/>

Building on recent treatment research, there are now data that show rates of relapse and protocols to improve time of abstinence to first use following treatment (a significant marker of future outcomes), as well as how to intervene early in a relapse before youth who have also been involved in the Juvenile Justice System recidivate. Treatment programs can now look at objective data around outcomes and understand what is normative for well-implemented evidence-based practice. Within communities, information can be disseminated about what are the normal patterns of how youth can move toward healthy decisions and benefit from treatment.

There was a time when many, even in Congress, did not think that spending money on treatment for youth with SUDs was useful. The sad part was that in many, if not most cases, this was true, and it remains true in certain locations/jurisdictions/communities that have not been able to take advantage of the rapid progress in research and development of new practices and approaches that have occurred, and continue at a dizzying pace for anyone attempting to stay current. We now know what we already knew at some level, treating youth with adult models or treating youth together with adults is not useful. In fact, either of these practices leads to either no improvement or worsening of problems for youth. The results of a longitudinal study of youth following developmentally appropriate, evidence-based treatment shows the best outcomes to-date for youth in outpatient treatment.

There are cost effective treatments that were developed, tested, and replicated in a relatively short period. There is still much to learn about effective treatment of youth. Based on the rapidity of constructing and testing developmentally appropriate treatment, there is hope that answers to how best support recovery for youth can also be found and implemented quickly. If the treatment outcomes from the post-1997 treatment efficacy/effectiveness trials showed no improvement or a worsening of the condition, then

spending time and money on the studies needed to understand what recovery is and how to provide support for youth would be a question without youth participants already in early recovery to answer the questions. Much as the field was in 1997 around the science of interventions for SUDs and SUDs with co-occurring MH disorders, we are now in a place where we are beginning to learn about youth and recovery.

Reviews of the treatment literature looked for everything published from 1935 – 1997. With successive reviews, a small number of additional studies were found but the most recent identified a total of twenty-one.²⁶ The very first review undertaken identified a total of 16. The chart below illustrates the history of scientific study of adolescent treatment for SUDs and related information on their utility pre and post 1997.

The Current Renaissance of Adolescent Treatment Research		
Feature	1930-1997	1997-2005
Treatment Studies*	16	Over 200
Random/Quasi	9	44
Treatment Manuals*	0	30+
QA/Adherence	Rare	Common
Standard Assessment	Rare	Common
Participation Rates	Under 50%	Over 80%
Follow-up Rates	40-50%	85-95%
Methods	Descriptive/Simple	More Advanced

*Published and publically available

SOURCE: Dembo, R., and R. Muck. 2010

Scientifically validated treatment programs had to be in place before a study of recovery and ongoing supports and services for youth following treatment could be undertaken.

The current state of knowledge regarding youth and recovery represent a compilation of findings from a few treatment studies that were pertinent, the best thinking of experts in the field, and consensus of those who provide these services. Over the coming years there are likely to be new discoveries that will provide important new information, validate the best current thinking and practice, and identify practices, though well intended and logical for adults, are not effective with youth.

²⁶ Dembo, R., and R. Muck. 2010. Adolescent outpatient treatment. In Adolescent substance abuse evidence-based approaches to prevention and treatment, edited by C. G. Leukefeld, T. P. Gullotta and M. Stanton-Tindall. New York: Springer Science and Business Media LLC

I Can't Get No Satisfaction- Neurotransmitters and the pleasure process

Dopamine is a neurotransmitter of pleasure but it also compels desire, craving, and anticipated pleasure. For most of us, it causes an unconscious and instinctual arousal related to an expected reward. *It is not a* neurotransmitter of satiety (such as endorphins, serotonin, oxytocin, anandamide, DMT, etc.) though it can drive a person wild with anticipation and desire for more. The effects can become agonizing with accompanying neurotransmitters related to stress responses that the desired reward might not be achieved.²⁷ Simply translated, this means a person can crave reward, in this case the pleasurable effect offered by the substance or experience, while at the same time anticipating that they will not get the reward, leading to a cascade of stress and fear-related neurotransmitters. This appears to actually reinforce the craving for reward, at the same time causing so much related pain that the experience of pleasure becomes less satisfying, or even is experienced as a net negative effect. The result may cause significant ambivalence and even aversion about the source of pleasure, but which by itself will probably not suffice to help this individual self-regulate the behavior.

While this is a simplification of neuroscience, it is indicative that the substance use disorder spectrum is extremely complex. Neuroscience is just beginning to unravel some of the associated neurochemical issues that are at the root of general dissatisfaction and in achieving some rewards in particular. A person experiencing such conditions related to drugs or alcohol may differ from a non-substance using achievement-driven individual only by the degree of dissatisfaction and what is chosen as the goal to be achieved. Both may innately understand the line, "I can't get no satisfaction." While the circumstances of their lives may be vastly different, their internal neurochemical processes may be nearly identical.

It appears that along with the neurochemical processes related to craving, habits are formed that also have significant driving force related to a compulsory use and experiential patterns. Habituation of use appears to occur in the basal ganglia, a small amount of tissue at the center of the brain.²⁸ Habits often appear to be mechanical reactions to stimuli. They bear some similarity to craving, but craving responses have been collapsed in research settings and habituated behavior remains. As we all know almost any routine can become habitual, and use of substances is easily habituated because of how closely psychoactive substances mimic the neurotransmitters of pleasure. 12 Step programs are very effective at working with habituated responses, but do not appear to have much effect on craving. Research supports the notion that there are likely both of these processes functioning alongside of one another, and it is likely that either one can result in the onset and persistence of substance use disorders.

The reward-punishment cycle is a normal aspect of how we all learn, how we test out behaviors and attitudes in life. Youth are bouncing off the walls as they experiment with

²⁷ Kash et. al. (2008) <http://www.jneurosci.org/content/28/51/13856.full.pdf>; Dopamine Enhances Fast Excitatory Synaptic Transmission in the Extended Amygdala by a CRF-R1-Dependent Process

²⁸ Graybiel, (1998) The Basal Ganglia and Chunking of Action Repertoires

new ways of being or thinking, most of which are quickly adjusted to fit societal norms. Of course, parents and society in general can be perplexed by how a whole generation expresses itself in ways that seem contradictory and confrontational. Yet for some youth, this cycle of pleasure and pain can trump any concern with disapproval, punishment, incarceration, or even death, and substance use is at the center of what drives many into desperation and destruction. This can be just as true of food, money, sex, shopping or gambling as it is of drugs and alcohol, but because drugs and alcohol mimic neurotransmitters, and sometimes deliver more pleasure than normal human experience ever delivers, experimental use can become craving and can soon turn to habituated use. This process hijacks executive function and self-regulation, while conscious choice and negative consequences are disregarded. Even with the stress and fear that may accompany habituated use, the individual using can clearly and consciously know they are on the executioner's table, but that awareness will be overridden by the anticipation of pleasure, which is perceived as the only route likely to achieve even momentary gratification.²⁹

We must impart the best we can offer to every youth who has these issues. As explained in this manual, co-occurring mental or emotional health issues can greatly intensify substance-related issues, as will trauma, familial problems, nutritional deficiencies, medical and dental issues, extreme poverty, and in some cases, simple geographic isolation. It is our charge to answer the call and do all we can to help, and to do so with our fullest, most skillful engagement, empathy, compassion, and clear and consistent practices.

²⁹ Behavioral Theories and the Neurophysiology of Reward, Wolfram Schultz; Annual Review of Psychology Vol. 57

7. Co-occurring Disorders

What is Co-occurring Capable Adolescent Treatment?

As used throughout this manual, the term co-occurring disorders (COD), refers to concurrent substance-related and mental and/or emotional disorders. Persons said to have COD have one or more substance related disorders as well as one or more mental/emotional disorders. At least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder. In addition COD can be characterized by the level of symptom severity, including persistence and recurrence. Substance use disorders co-occurring with mental illness worsens outcomes for a wide range of life domains, including behavioral health, education, stable housing, employment, social functioning, involvement in the legal system, medical and health issues, and overall functional capabilities.

To be clear, COD is differentiated from persons who are multiply-diagnosed. Multiply-diagnosed persons include those who have physical illnesses that may directly impact the COD, and be intertwined in complex cause/effect relationships. This “condition” is sometimes referred to as COD by medical practitioners. An example of this would be a person with diabetes suffering from depression. The depression may be treated with behavioral health interventions, but the diabetes must also be treated with appropriate medical intervention. However, for the purposes of this manual, COD will refer only to co-occurring substance-related and mental and/or emotional disorders, inclusive of trauma.

New Mexicans are very aware of the many serious challenges related to our children, youth, and their families. Far too many behavioral health indicators tell us that we are not achieving fundamental benchmarks of child and family wellness, as well as improving individual child and youth-related mental/emotional, substance, and co-occurring related issues. Most of us have heard this or that statistic related to New Mexico leading the nation in some negative indicator, and last or near last in some positive indicator. However, statistics do not tell the story of people’s lives and cannot capture the day by day triumphs and challenges of people who struggle to live decently while struggling with formidable adverse conditions.

New Mexico is unique within the USA. Our landscape is rich and varied. The history of some of the people who live here reaches back beyond written recorded history. The people of New Mexico have great religious and spiritual depth, and on this foundation a great deal of our collective efforts to help people live better lives has been built and then renovated time and again. We are diverse and inclusive. Families are held in high esteem, yet our children bear many burdens, one of which is limited behavioral health services and too few supportive services, from prevention through inpatient detoxification and stabilization services, life skills training, and family peer supports. The help that is available often comes too late to truly avert the catastrophic consequences of untreated substance use, mental illness or co-occurring disorders.

Instead of “doing to” or “for” these persons, the most effective effort at providing lasting change for persons needing services is to understand and engage them fully, elicit their strengths and natural supports, and as appropriate, help the individual and family translate intrinsic knowledge, skills, and most importantly, willingness to successfully engage in day to day realities and life challenges. For these reasons, all parties must collaborate in the sincere effort to transform dysfunctional conditions to functional conditions.

It is important to note that there is no one-size-fits-all solution to the challenges that some adolescents and their families face every day. This is complicated by the challenges that State agencies must work with, that providers must regularly meet and overcome, and by the

limitations naturally imposed by geography, funding, and the constraints of time. Whatever the effect of these various influences, each and every individual is unique; their individual condition is distinctive and requires undivided attention on the part of the provider, and the numbers of those needing services are many.

The interactions between substance use and mental illness are complex and self-reinforcing. Each can detrimentally reinforce another (e.g., an episode of depression may trigger a relapse into alcohol use, or cocaine use may exacerbate disruptive behavior disorder symptoms). On the other hand, recovery can also be self-reinforcing. To effectively address COD, a comprehensive, integrated service system must be applied at both the systems level, and at the individual and family level. Part B of this manual describes the application of integrated services for persons with co-occurring disorders. For reference to an evidence-based practice that originally championed integrated care for COD, see the Integrated Dual Diagnosis Treatment (IDDT) manual and the NM adapted youth assessment tools.^{30 31}

The references and footnotes in this document cite current and comprehensive documents and manuals available to address both theory and science of the application of planned interventions, treatment, recovery, and resiliency for the described behavioral health services, especially for those individuals experiencing co-occurring substance and mental health disorders. **This manual addresses the systems/administrative level, as well as the clinical staff level of care and expertise. The result of this extensive research and adaptation to New Mexico’s unique needs is a manual that is intended to facilitate smooth and efficient implementation of co-occurring competent integrated services.**

³⁰ Integrated Dual Disorders Treatment (IDDT): Best Practices, Skills, and Resources for Successful Client Care (Center, City, MN: Hazelden, 2010). http://www.hazelden.org/HAZ_MEDIA/3886_IDDT_manual.pdf

³¹ The NM Youth Integrated Community Treatment Fidelity Scale (YICT), and the Youth Organizational Index for Community-based Treatment Services for Youth with Severe Emotional and Behavioral Disorders (YOI). These tools were adapted from the IDDT by Shannon Morrison, Ph.D., Trish Singer, M.D., Win Turner, Ph.D., and Karen Cheman, M.P.H. to blueprint a description of how integrated COD services can be adopted and applied by providers in New Mexico.

8. Ten Principles of COD Implementation from the SAMHSA Co-occurring Center of Excellence

1. Co-occurring disorders, inclusive of trauma, are to be expected in all behavioral health settings, including substance use disorder and mental health treatment, physical health settings, and the juvenile justice system. Systems planning must address the need to serve people with COD in all policies, regulations, funding mechanisms, and programming.
2. An integrated application of mental health and additional services that emphasizes continuity, adequate length of treatment, and quality is in the best interest of the adolescent client and their family, providers, programs, funding agencies, and systems.
3. The integrated system of care must be accessible from multiple points of entry (i.e., “no wrong door”) and be perceived as caring and accepting by the adolescent client and their family.
4. The system of care for COD should not be limited to a single correct model or approach.
5. The system of care must reflect the importance of the partnership between science and service, and support both the application of evidence-based and consensus based practices for persons with COD and evaluation of the efforts of existing programs and services.
6. Behavioral health systems must collaborate with professionals in primary care, human services, housing, criminal justice, education, and related fields in order to meet the complex needs of persons with COD.
7. Co-occurring disorders must be expected when evaluating any person, and clinical services should incorporate this assumption into all screening, assessment, and treatment planning.
8. Within the treatment context, all co-occurring disorders are considered primary and treatment should be simultaneous and integrated.
9. Empathy, respect, and belief in the individual’s capacity for recovery are fundamental provider attitudes.
10. Treatment should be individualized to accommodate the specific needs, personal goals, developmental stage, gender identity, and the cultural, religious, and spiritual perspectives of unique individuals in different stages of change.

9. Intensive Outpatient Programs

What is IOP and why is it helpful?

An intensive outpatient program (IOP) is normally intended to provide specific treatment for people who do not require the need for 24-hour treatment or support such as inpatient or residential rehab for drug and/or alcohol disorders and do not need concurrent medically supervised detoxification services (although some detox facilities may also have inpatient treatment programs that are intensive). Substance use disorders must be clinically determined through appropriate assessment. IOP services provide an intermediate level of care for adolescents who have *current and active* substance use related treatment needs that are too complex to be effectively managed in an office outpatient setting, but do not reach the threshold warranting inpatient hospitalization or clinically managed residential treatment, as determined by the application of the American Society of Addiction Medicine (ASAM) level of care criteria. **Intake of clients for IOP never presupposes abstinence or already achieved treatment goals that the IOP is intended to bring about. Doing so causes further stigmatization of those seeking treatment for the very issue that IOP is intended to achieve.** IOP treatment can operate on a small scale and does not require residential out of home placement, or partial day services.

The State of NM IOP Service Definition

An Intensive Outpatient Program (IOP) provides a time-limited, multi-faceted approach to treatment service for individuals who require structure and support to achieve and sustain recovery. IOP must utilize, at a minimum, a research-based model and target specific behaviors with individualized behavioral interventions.

The ASAM definition also recommends that an IOP provide at least nine hours of treatment per week for adults and at least six hours per week for adolescents. The Matrix Model and The Seven Challenges Model align with this ASAM criteria.

Evidence-based IOP programs and practices help to effectively facilitate a lifestyle of recovery and resiliency (discussed later in this manual) by adolescents and their families, so that they can, with dignity, heal from the devastating effects of substance use and/or dependence. Once a youth and their family/support system have engaged in treatment, negative behavioral patterns can be addressed, worked through, and redirected into more pro-social behavioral patterns or discarded altogether. Youth and their families must be empowered and encouraged through an integrated IOP treatment model to actively re-engage their social systems with new found pro-social behavioral skills (see Part A Chapter 14 on Life Skills, and Part B Element 19 on Youth Support Services).

IOP services will serve as a point of entry into psychiatric care and treatment for some adolescents, or can provide crisis stabilization when less intensive outpatient treatment alone is insufficient or ineffective. For those adolescents exiting inpatient care, it can serve as a step-down program to provide a smoother transition back into the community. It is a

viable and effective service that utilizes evidence-based programs or practices (the Matrix Model, The Seven Challenges, Multi-Systemic Therapy, etc.) to achieve results, and enables justice system authorities, schools, parents, and healthcare professionals to refer to a cost-effective, insurance reimbursable, and Medicaid eligible service.

The typical NM adolescent IOP program offers group and individual services a minimum of 6 hours per week for 1-4 months. In the case of age, developmental stage, and functional capacity related to COD, the intensity of service (hours per day/week) may be reduced while the length of active treatment is extended. To achieve maximum effectiveness, IOP must allow the individual to participate in daily affairs, such as work or school, and also participate in treatment with a provider on an intensive basis as described in the evidence-based program or practice. The typical IOP program encourages participation in social support programs. As described throughout this manual, a co-occurring competent adolescent IOP must provide integrated and comprehensive services to achieve the most benefit to the adolescent and their family.

10.Role of Family

The social network is widely considered to be a critical determinant in the lives of youth dealing with substance use disorders, whether they are actively using, in treatment, or in the recovery process. The family, as the basic social unit, affects the substance use patterns of the child in ways which are not fully understood. We do know that the relationship is reciprocal, so that whether it is the child or the family who first enters into recovery, their relationship with the other changes.

Over the past three decades there has been increased recognition by researchers of the important role that families of substance users can play, both in terms of influencing the course of the individual's substance use problem and contributing to the achievement of positive outcomes when persons using substances are attempting to change their problematic behavior.³² It is critical to remember that the family also has needs for their own recovery and should not be regarded as merely a tool to help the person in receiving services get well.

Within the juvenile justice system and community-based treatment field, the substance using young person has traditionally received the attention, with the family relegated, at best, to a position of "support system." Furthermore, the family is frequently regarded as a significant contributor to the problem, even when there is no clear evidence of abuse or harm. The ubiquitous label of "failed parenting" is enough to encourage the system to put a wedge between the child and family and even tacitly encourage the youth to develop a strong alternative network of peers or an adult in recovery who understands and can "relate."

Many youth, already stressed by a missing emotional attachment with nurturing adults, look to one another for a sense of direction and values. Dr. Gabor Maté states, "Research...has repeatedly demonstrated that extensive peer contact and the loss of adult attachments lead to a heightened propensity to addiction."³³ He cites a study by Dawes et al. which contains this statement: "*Both direct and active peer influence and peer pressure, and active peer affiliation have been shown to cause escalation of affective, cognitive, and behavioral dysregulation, and early substance abuse.*"³⁴

In recent years we have witnessed a shifting tide regarding family engagement in the lives of their children in the juvenile justice system or substance treatment. This shift derives from many developments, including global changes such as family systems theory and practice advanced in the 1970's and 1980's. Research into many areas of substance treatment exploded in the 1990's and continues, attesting definitively to the benefits of family involvement. Inquiries into what works in treatment eventually branched out to

³² Capello, Templeton and Powell. Adult Family Members and Careers of Dependent Drug Users. U.K. Drug Policy Commission, 2009. www.williamwhitepapers.com

³³ Maté, Gabor. *In the Realm of the Hungry Ghosts*. North Atlantic, 2008

³⁴ Dawes, Michael et al. "Developmental Sources of Variation in Liability to Adolescent Substance Use Disorders" *Drug and Alcohol Dependence* 61 (2000):3-14

include families in recovery. For examples, see Brown and Lewis' Family Recovery Research Project (begun in 1989) and the UK Drug Policy Commission (2009).³⁵

Evidence-based practices which include family have also been identified by NREPP, including Multi-systemic Family Therapy (MST), Community Reinforcement Approach for Family (CRAFT) and the Adolescent Community Reinforcement Approach (A-CRA). A-CRA was designed to influence the substance user without him or her even being present!

In May, 2011, Georgetown University's Center for Juvenile Justice Reform (CJJR) released an important monograph, outlining a vision for fostering the interpersonal connections of youth and families so that significant relationships are maintained or restored. Addressing issues with immigrant families, as one example, the report boldly described a new approach:

*"But if practitioners lack exposure to a culture, see themselves as unable to effectively communicate with and relate to the families they serve, and view the local community as having limited resources, they are more likely to remove children from their parents (Baumann et al., 2011). To better serve immigrant families, agencies are identifying that their staff needs to come to know the families and their cultural communities, engage them in planning, and link them to resources that respond to their needs in a holistic way. The group that is most familiar with a family's culture is the family group. Engaging them in planning is a vehicle for increasing understanding of and becoming more responsive to the cultures of families."*³⁶

Families come in all shapes and sizes. A complex mixture, families love and support, enable, absent themselves, and directly or unintentionally harm. They might be abstainers or have severe disorders, even be in a heritable line of multi-generational substance use disorders. Families might suffer from financial instability, homelessness, violence, death, separation due to incarceration, employment necessities, education availability, or military service. Parents sometimes lack solid parenting skills and find themselves at a loss in dealing with a substance using child. To some, family might mean serial step parents and step siblings, a "foster family," or a custodial aunt or grandparent, and also parents representative of all possible combinations of gender and sexual identity. For others it means drug using friends or a gang. Youth providers also serve same-sex and teen parents, in which case "family" might mean only the spouse.

In addition to the many possible definitions of the word family, service providers need to be and in most cases are aware of poverty and homelessness. It is difficult to quantify the impact of poverty and the culture of impoverished neighborhoods and communities on children. In these places there is no classic American belief that one can do great things if only one works hard enough. In some neighborhoods, most young people may be unaware

³⁵ The Family Recovery and Research Project. www.psychotherapy.net

³⁶ "Safety, Fairness, Stability: Repositioning Juvenile Justice and Child Welfare to Engage Families and Communities" Report of the Georgetown University Center for Juvenile Justice Reform, 2011

that recovery from substance use disorders is possible. They and their families know of no person in successful long-term recovery. The essential quality of hope is nowhere to be found.

Kids Count statistics and other surveys of New Mexico children and families' well-being are generally unchanged from year to year. They tell us that the state is near the bottom in indices such as hunger and food insecurity, poverty, child and teen deaths, graduation rates and suicide. In addition, alarmingly high figures of early onset of drug and alcohol use (where NM leads the nation) are predictors of future serious substance-related problems in the adult population.³⁷

There are multiple and daunting challenges facing programs which want to bring parents and families into treatment, educational classes and mutual aid/family support groups. It is important for the service provider to keep in mind the many varieties of family discussed above and the exquisite set of skills necessary to engage families when they have a family member involved with the Juvenile Justice System or in substance treatment. The groundbreaking Adverse Childhood Event (ACE) study (discussed earlier in this manual) connects the number of an individual's ACEs to the risk for future serious health problems including alcoholism, illicit drug use, smoking, liver disease, and depression. While families have often contributed to their children's propensity to substance use, the trend is for them not to be treated, in the words of one expert, as an appendage in the child's recovery.

Past childhood traumatic and stressful events as defined in the ACE study, such as neglect, abuse, "household substance use disorders" and "household mental illness," must not be the central concern when engaging families, maintaining their participation and contributing to their recovery from mental health or substance problems. Obviously family engagement treads on tricky and even controversial issues which require the greatest skill and collaboration by providers and interested parties such as juvenile justice workers.

And whether clinical sessions convene with children and parents meeting in the same room, it is helpful to keep in mind the positive outcomes derived from family participation. Our invitation to families gives them the opportunity to engage constructively on their own behalf and for the benefit of their child before, during, and after his/her treatment, and to participate in long term recovery processes.

It should not be assumed that the parents are in an "action stage" and ready for their own recovery. The family's needs potentially cover a broad range including education on community resources and parenting skills, as well as assistance in achieving stability despite the challenges of parenting a child that may be grappling with mental/emotional, substance, or co-occurring disorders. This may need to be accomplished while also understanding and supporting one another and other children or family members in a shifting family environment.

³⁷ 2013 Kids Count Data Book, Annie E. Casey Foundation. March, 2014.

When homeostasis is destabilized by the entrance of a child into the juvenile justice system and/or behavioral health treatment, family members often experience what has been termed the “trauma of recovery.” Thanks to the work of prominent clinicians such as Dr. Stephanie Brown, we now have improved understandings of family change processes precipitated by a child or adult going into recovery from substance use disorders.

According to Dr. Brown, “The four stages of recovery already defined for the individual hold true for the family:

1. Drinking;
2. Transition (the move from drinking to reduced use to abstinence);
3. Early Recovery, the stabilization of abstinence with new learning, much uncertainty and constant change; and
4. Ongoing recovery, when massive change has been consolidated and the family is guided by the organizing behaviors, values, and beliefs of recovery.”

She goes on to describe how recovery causes the family system to collapse. “The family system which has adapted to the substance user must change radically as the family enters recovery, permitting attention to shift from the system to the individuals. Our data explain how outside support networks provide a ‘holding environment’ for all members of the family, a cushion and substitute for the...family system that has collapsed. Change like this does not occur from inside the family in the vacuum created by abstinence. It requires external guidance and supports.”³⁸

It is important for providers to be knowledgeable about the National Registry of Evidence-based Programs and Practices (NREPP) as well as EBP’s for family participation in or parallel to their child’s treatment. Other important resources are the ACE study and parenting skills curricula. One example of the latter is the “40 Developmental Assets”³⁹ used in Roswell and many other places around the country. Providers should also be prepared to advocate for long term recovery groups and community services for families. There are currently several communities which effectively serve families through organizations such as WINGS for LIFE in Roswell and Albuquerque.

Certified Family Specialists (CFS) should be utilized whenever possible to offer groups and educational classes to families. It is a requirement that a CFS have “lived experience” as a primary caregiver, and expertise in substance-related issues of families. SMART Recovery groups deserve consideration as a science-based resource and can be offered by non-licensed facilitators. There is a promising curriculum called “SMART Recovery Family and Friends” which includes tools developed by CRAFT.⁴⁰

Providers may find it challenging to offer or coordinate long term recovery services for families and individuals. At present, much of this work is not to be found on menus of

³⁸ White, W. *Unraveling the Mystery of Personal and Family Recovery. An Interview with Stephanie Brown, Ph.D.* 2011. www.williamwhitepapers.com

³⁹ 40 Developmental Assets for Adolescents. www.search-institute.org See Appendix B

⁴⁰ Smart Recovery Family and Friends. www.smartrecovery.org

reimbursable services. It is incumbent for providers to work with local and state stakeholders to find funding and actively collaborate with community partners, including faith communities, to develop robust, coordinated services to assist families in recovery.

11. What is the Neuroscience of Thrill and Risk?

The following short essay was written by Michael Hock. As you will see, his personal story is a candid description of his early life and the significant events which have helped him understand the long-term effects, potential dangers and attraction of substance use disorders. It is hoped that this first-person narrative will encourage the reader to explore her/his own story as it relates to risk and important related topics in this manual.

As a research physiologist, my father gained instant world fame when it hit the news that he crawled into the dens of hibernating bears in the deep of Alaska winter to take the bear's rectal temperature. He waited for that minus 40 or 50 degree cold to ensure that the bear would be deep in its long slumber. Later, he constructed artificial dens so he could collect data about gases, breathing and heart rate, but he still had to go in there for the temperature! He also had to remove new born cubs so they would not corrupt his data, and I suckled many tiny bears with a doll bottle. My brothers and I grew up with a sense of the extremity of adventure along with the threat to life and limb such adventure offers.

In my late teens and early 20's, I jumped into outdoor adventure activities, ski-mountaineering, climbing, expedition backpacking, anything that seemed edgy and extreme. Then the drugs that are now everywhere hit the western world with quite a loud crash. Along with the peace, love, happiness flower children experiencing an extreme cultural-revolution, drugs promised an easy path to more of everything- more of that peace, love and happiness than any of us ever dreamed possible. My entire family struggled with substance issues, including family members who injected heroin, who I suspect came close to death at times, but we all survived.

For a brief period (about 6 years) I was obstructed by my choices regarding substance use, and along with the various traumas my brothers and I experienced as a result of divorce, death in our family, and substance use, came to about 10 years after I began a meditation practice. I used that as my recovery model, sometimes meditating eight hours per day. It required quite a while to shed the attitudes and habits of substance use, and adventure and physical risk helped as much as the meditation in the long haul. Eventually, after 16 years the meditation practice was too passive and I took up a different and more active path directed towards self-mastery. Every person who determines the need for any sort of recovery must take recovery up as a personal cause, rather than as an effect of the problem. Taking up such a cause can be very difficult, and there are endless potential pitfalls. Many have little idea what *health* actually is, and that's where the transpersonal qualities of life shine. You do it yourself, but surely none of us exist in a vacuum, and support of some sort is needed.

Risk is for many of us the headiest of all highs. There are few pleasures or other pursuits that compete with the triumph of surviving again, and then again. Risk is hardwired into us. It awakens with power in adolescence and causes youth to do things that either horrify us as parents, or make us unbearably proud. Many of us remember the sometimes dumb and sometimes courageous things we did. We call them unforgettable, formative, incredibly fun, and some we knew did not survive for whatever reasons. We are living in a time when we are seeing significant numbers of our children not surviving, because they take extreme risks with very potent substances. Although the substances are extreme, the risk-taking behavior is what our youth are wired to do. We need to understand that however the substance may twist the character and personality of a youth, this very youth is seeking freedom, peace, love, happiness, and these are *our* children doing so.

The Myth of Risk: Promoting Healthy Behavior by Challenging Teens

by Stephen G. Wallace

It is not news that teens are hard-wired to take risks. What is news is that those risks need not be negative ones. Teens Today research reveals that while many adults have long linked adolescent risk taking with behavior such as reckless driving, drinking, drug use, and early sexual behavior, a majority of young people believe that risk taking refers to positive activities.

Positive Risk Taking

Teens who take positive risks may not make destructive choices when it comes to personal behavior and are more likely to feel good about themselves. For example, teens who take positive risks (Risk Seekers) are 20 percent more likely than teens who do not take positive risks (Risk Avoiders) to avoid alcohol and other drugs.

Risk Seekers are also more likely than Risk Avoiders to:

- *describe themselves as responsible, confident, successful, and optimistic;*
- *report they often feel happy; and*
- *consider potential negative outcomes of destructive behaviors.*

Positive Risk Activities

So, what are these positive risks? Among the most important are the physical, social, and emotional risks. Young people who challenge themselves by engaging in physical or athletic events (e.g., rock climbing, swim meets); joining in social activities with other teens (e.g., dances, skits); or opening up and sharing their feelings about their own life experiences (e.g., being away from home, conflicts with a friend) may benefit the most.

Other examples of positive risk taking include the following:

- *Trying a new activity*
- *Reaching out to make a new friend*
- *Attempting to clear up a misunderstanding*
- *Volunteering to help others*
- *Mentoring younger children* ⁴¹

⁴¹ The Myth of Risk: Promoting Healthy Behavior by Challenging Teens (2005) Stephen G. Wallace: <http://www.acacamps.org/campmag/0505myth>

Why Risk-Taking May Increase Teen Happiness

Marilyn Price-Mitchell PhD

The Teen Brain Craves Risk-Taking

Much of the research on happiness has been conducted with adults. But what we've learned about the teen brain sheds light on their happiness too. Before adolescence, children learn how to fit into society. With parents and teachers as guides, they absorb the norms and unspoken rules of how to behave at home and school. They are like little sponges, soaking up megabytes of information!

As children enter their teen years, they begin to merge what they know about society with their psychological selves. They search for their own identities, separate from their parents. Changes to the limbic system of the brain cause teens to seek risk, challenge, and emotional stimulation. While some parents fear this phase of a child's life, it's really quite natural. And it's a time to be embraced as a positive transition to adulthood.

Of course, we mostly associate teen risk-taking with drinking, drugs, smoking, and sexual experimentation. But risk-taking is equally associated with positive activities, like mountain climbing, community service, politics, faith groups, and other experiences that can push young people out of their comfort zones and reward them handsomely.⁴²

Brain imaging has opened doors in our collective understanding of adolescent behavior. It deepens and complements our knowledge of adolescent psychology, family theory, anthropology and evolutionary biology. Research on the brain potentially assists in re-framing adolescent behavior and countering the stigma it has gained in many circles. Ongoing studies also carry implications for parents and professionals who work with young people. As the next excerpt from NIMH details, the teen brain is a “work in progress.”

According to some experts in brain research, adolescence and its accompanying impulsivity, thrill-seeking, recklessness, need for peer acceptance, emotionality over success and failure, and selfishness are adaptive, functional behaviors. It is a stage where learning and mastering complex, new tasks and environments is an implicit requirement. If there was no predisposition to risk (and if the brain was not continuing to develop), important challenges would never be undertaken.

In all cultures, according to journalist David Dobbs, “adolescents prefer novelty, excitement and peers...The period's uniqueness rises from genes and developmental processes that have been selected for over thousands of generations because they play an amplified role during this key transitional period: producing a creature optimally primed to leave a safe home and move into unfamiliar territory. The move outward from home is the most difficult thing that humans do...”⁴³

⁴² <http://www.rootsofaction.com/why-risk-taking-may-increase-teens-happiness/>

⁴³ “Beautiful Brains” David Dobbs, National Geographic Magazine, October, 2011.

The Teen Brain: Still under Construction

The research has turned up some surprises, among them the discovery of striking changes taking place during the teen years. These findings have altered long-held assumptions about the timing of brain maturation. In key ways, the brain doesn't look like that of an adult until the early 20s.

An understanding of how the brain of an adolescent is changing may help explain a puzzling contradiction of adolescence: young people at this age are close to a lifelong peak of physical health, strength, and mental capacity, and yet for some, this can be a hazardous age. Mortality rates jump between early and late adolescence. Rates of death by injury between ages 15 to 19 are about six times that of the rate between ages 10 and 14. Crime rates are highest among young males and rates of alcohol abuse are high relative to other ages. Even though most adolescents come through this transitional age well, it's important to understand the risk factors for behavior that can have serious consequences. Genes, childhood experience, and the environment in which a young person reaches adolescence all shape behavior. Adding to this complex picture, research is revealing how all these factors act in the context of a brain that is changing, with its own impact on behavior.

A clue to the degree of change taking place in the teen brain came from studies in which scientists did brain scans of children as they grew from early childhood through age 20...

The scans... suggest that different parts of the cortex mature at different rates. Areas involved in more basic functions mature first: those involved, for example, in the processing of information from the senses, and in controlling movement. The parts of the brain responsible for more "top-down" control, controlling impulses, and planning ahead—the hallmarks of adult behavior—are among the last to mature.

Several lines of evidence suggest that the brain circuitry involved in emotional responses is changing during the teen years. Functional brain imaging studies, for example, suggest that the responses of teens to emotionally loaded images and situations are heightened relative to younger children and adults. The brain changes underlying these patterns involve brain centers and signaling molecules that are part of the reward system with which the brain motivates behavior. These age-related changes shape how much different parts of the brain are activated in response to experience, and in terms of behavior, the urgency and intensity of emotional reactions.

In terms of sheer intellectual power, the brain of an adolescent is a match for an adult's. The capacity of a person to learn will never be greater than during adolescence. At the same time, behavioral tests, sometimes combined with functional brain imaging, suggest differences in how adolescents and adults carry out mental tasks. Adolescents and adults seem to engage different parts of the brain to different extents during tests requiring calculation and impulse control, or in reaction to emotional content.

Research suggests that adolescence brings with it brain-based changes in the regulation of sleep that may contribute to teens' tendency to stay up late at night. Along with the obvious effects of sleep deprivation, such as fatigue and difficulty maintaining attention, inadequate sleep is a powerful contributor to irritability and depression. Studies of children and

adolescents have found that sleep deprivation can increase impulsive behavior; some researchers report finding that it is a factor in delinquency. Adequate sleep is central to physical and emotional health.

One interpretation of all these findings is that in teens, the parts of the brain involved in emotional responses are fully online, or even more active than in adults, while the parts of the brain involved in keeping emotional, impulsive responses in check are still reaching maturity. Such a changing balance might provide clues to a youthful appetite for novelty, and a tendency to act on impulse—without regard for risk.

While much is being learned about the teen brain, it is not yet possible to know to what extent a particular behavior or ability is the result of a feature of brain structure—or a change in brain structure. Changes in the brain take place in the context of many other factors, among them, inborn traits, personal history, family, friends, community, and culture.

Scientists continue to investigate the development of the brain and the relationship between the changes taking place, behavior, and health. The following questions are among the important ones that are targets of research:

How do experience and environment interact with genetic preprogramming to shape the maturing brain, and as a result, future abilities and behavior? In other words, to what extent does what a teen does and learns shape his or her brain over the rest of a lifetime?

In what ways do features unique to the teen brain play a role in the high rates of illicit substance use and alcohol abuse in the late teen to young adult years? Does the adolescent capacity for learning make this a stage of particular vulnerability to addiction?

Why is it so often the case that, for many mental disorders, symptoms first emerge during adolescence and young adulthood?

This last question has been the central reason to study brain development from infancy to adulthood.

Scientists increasingly view mental illnesses as developmental disorders that have their roots in the processes involved in how the brain matures. By studying how the circuitry of the brain develops, scientists hope to identify when and for what reasons development goes off track. Brain imaging studies have revealed distinctive variations in growth patterns of brain tissue in youth who show signs of conditions affecting mental health. Ongoing research is providing information on how genetic factors increase or reduce vulnerability to mental illness; and how experiences during infancy, childhood, and adolescence can increase the risk of mental illness or protect against it.

It is not surprising that the behavior of adolescents would be a study in change, since the brain itself is changing in such striking ways. Scientists emphasize that the fact that the teen brain is in transition doesn't mean it is somehow not up to par. It is different from both a child's and an adult's in ways that may equip youth to make the transition from dependence to independence. The capacity for learning at this age, an expanding social life, and a taste for exploration and limit testing may all, to some extent, be reflections of age-related biology.

*Understanding the changes taking place in the brain at this age presents an opportunity to intervene early in mental illnesses that have their onset at this age. Research findings on the brain may also serve to help adults understand the importance of creating an environment in which teens can explore and experiment while helping them avoid behavior that is destructive to themselves and others.*⁴⁴

The Amazing Adolescent Brain: What Every Educator, Youth Serving Professional, and Healthcare Provider Needs to Know

Linda Burgess Chamberlain PhD, MPH

Whether it's skydiving, speeding, or staying out late at night, adolescents' attraction to risks is no coincidence. Puberty and changes in the adolescent brain motivate teens to seek both new experiences and also excitement. Teens perceive risk differently than adults do, and they are more enticed by the challenge than by the reward or outcome. The 'good judgment' area of the brain that helps teens to control impulses is still growing and maturing. This means that teens may not anticipate the consequences of their actions. Teens are also much more likely to take risks in the presence of other teens.

*Chemical changes occurring in the adolescent brain also contribute to risk-seeking behaviors. The levels of serotonin and dopamine fluctuate in the adolescent brain. Serotonin, a chemical messenger in the brain, has a calming effect that helps to control impulsive behavior. Dopamine is part of the brain's 'feel good circuitry' that gives a sense of well-being. Taking risks can elevate dopamine levels.*⁴⁵

In conclusion, the various aspects, conditions, and developmental issues affecting adolescents are complex, intertwined with choices made or not made, and have potent and often life-long effects. This was true for each of us, and it is true for every child that transitions through adolescence into adulthood. Old ideas related to shame, fear-based tactics of repression and suppression often only heighten the sense of risk and the danger of outwitting our adult systems that remain punishment oriented. While we cannot condone or allow youth to express anti-social behavior at the expense of public safety, we must provide guidance and opportunity for each individual to choose towards self-actualizing values and principles with our best effort at guiding choices towards healthy participation in life.

⁴⁴ <http://www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/index.shtml>

⁴⁵ http://www.multiplyingconnections.org/sites/default/files/Teen%20Provider%20article%20%282%29_0.pdf

12. The Power of Challenge – By Doug Robinson

Doug Robinson is a world-renowned climber and mountaineer, and a long-time chronicler of extreme sports with a deep interest in their effects on consciousness and motivation. He was one of the primary proponents of clean climbing, which is a term that describes the use of protection devices and techniques that do not mar the rock when one is climbing. He is the author of *A Night on the Ground*, *A Day in the Open* and just published, *The Alchemy of Action*. This monograph is a much abbreviated description of his latest book, and in part answers questions about why some go to the extremes of self-challenge that often hazard life and limb, which of course is particularly relevant to adolescence. Because this point of view is difficult for many to conceive, and in part may be the cause of risky and intense behaviors of all sorts, we welcome his personal perspective about why so many choose to live beyond what we term normal life. There are countless other means than what we term “normal” to gain a rich and full appreciation of life. Here is one that is just now available to explanation based on advances in science, deep reflection, and illuminating prose.

Challenge: it’s basic to life. It’s usually a good thing, and so is our human response, which at best is a supple resilience. Conceptually, emotionally and physically resilient. We speak admiringly of “rising to a challenge.” Healthy. And that ideal adaptation is especially vivid in adolescence, as young people flex their skills, first of finding themselves a place in a life they had no choice in creating, and then of exploration into the wider world. Genetics points out that this urge into the unknown seems to be especially human, and now we have identified a gene that is provisionally linked to it. DRD4-7R, a gene expressed at about the 20% level in our population, is tied to risk-taking and exploratory behavior. It functions by helping to control dopamine. Behaviorally, we see it manifest as curiosity and restlessness, movement and novelty seeking.

Too little challenge and life goes flat, listless. Too much becomes overwhelming and that flattens people too. We get tempted to revert to the term “stress” to characterize overwhelming challenge. Stress is precisely defined in both physiological and psychological research, yet in popular terms the whole idea has become freighted with negative connotation. So here I prefer “challenge” because it raises instead the image of healthy and resilient adaptation. There’s a sweet spot in the middle, between listless and overwhelmed, where some of our best human responses lie: excitement, vitality, and that optimal state of function called flow. There, life is productive, creative, and brimful.

Civilization: you could see it as a scaffolding we have built around human life. You could call out its job as mitigating challenge. Heat? Crank up the air conditioning. Distance? A ribbon of asphalt stretches over the horizon. Threatening behavior? Pull out the DSM.

This scaffolding of ours changes and adapts, though lately it too is plenty challenged by unprecedented qualities of modern life, beginning with the sheer numbers of us, jostling, crowding into warrens, competing for resources, creating friction. These challenges rise to strain the scaffolding. When it responds by becoming too rigid, hyper-scaffolding can lead to that dulling of life where the challenge is flat lined. More often, though, too much strain has shattered our scaffolding. The human community crumbles, families disintegrate, and our adolescents are turned out to wander rudderless in the desert.

We haven't convened here, really, to address the infrastructure of civilization, though certainly its "discontents," as old Dr. Freud called them, get heaped on our plate. Many of the stridently discontent are adolescent, showing us that, yes, scaffolding matters. Around us in the desert lies the mute testimony of civilizations that didn't make it. Beautifully crafted high-rise cliff dwellings, the intricate constructs of peoples who vanished into the sand. Was it really drought? Or was it something invisible to us? Something in the warp and woof of their social structure that failed to adapt, to encourage their people, especially their young people, to thrive?

Let's return to challenge, and to that sweet spot of optimal challenge leading to high-functioning states of flow. And let's rack-focus as well to our bodies. As those chartered to deal with emotional and behavioral states of being, we too are susceptible to a long habit built into our civilization, an unconscious bias that hyper-focuses our realm to the inside of our heads.

I invoke our bodies knowing full well that brain is a body part, and that it arose over eons through intimate contact with the very physical embodiment of our beings that grounds them on our planet. For example, our dexterously opposable thumb and fleetness afoot. Not to mention cleverness, which sometimes gets skewed into cunning.

How to help our children? Constraint and "No" are necessarily built into our scaffolding, yet we also recognize the vital importance of nurturing that urge to explore. At its most fruitful, human probing into the nature of the reality within ourselves, and into how that reacts with the larger environment abroad on our planet, will reconfigure the shapes of our scaffolding, offering a portal to the future. Tightening the strictures around their lives is often viewed by youth as just one more challenge in their confusing social environment, yet another system to be beat, a further insult to their freedom. More rectilinear junk foisted on them, and all-too-similar to the stale air of classroom, the confinement of paved city blocks and the dicing-up of seamless time into schedules.

All of this poses a conundrum that's plenty daunting. I come to you, an outsider awed by the unique challenges of the therapeutic community, with two perspectives that offer help. I have spent my lifetime as a wilderness guide, facilitating the human urge to step up to the challenging terrain of our quite beautiful planet, from climbing steep rock to striding

toward a snow-covered horizon. That led me to guide my fellow interpreters of wilderness travel into forming the American Mountain Guides Association.

My other perspective that I offer here is brain chemistry. This one arose out of my guiding life, out of watching the human spirit respond positively to those challenges distilling off of landscape. And it too borders on your quest to facilitate the daunting age of adolescence, an unruly period of urge and raw energy. Pondering our human response to activities like climbing, to natural challenges in wild settings, challenges that are at once physical and emotional, has led me to the emerging science of psychoneuroendocrinology. A mouthful, yet so powerful it commands immediate respect as a tool of understanding the most turbulent times in our lives as people. Parallel to my career as a guide of outward surges into wild terrain, I have made a deep study of how stepping up to those challenges affects our mood and attitude – the tone of our consciousness.

Take the word apart knowingly. The study of hormones, yes, like the classics adrenaline and testosterone, which taken together form a cocktail so potent in adolescence that I sometimes refer to its effects in youth as “testosterone poisoning.” Wildly aggressive. But our new word re-focuses to hormones inside the head: neuro-hormones. And then to noticing their psychic effects. This is a realm so new within science that while Wikipedia can list sixty-nine known body hormones, it currently does not dare to venture a similar list of brain hormones. Yet that’s where I would turn our attention here, because the tool of understanding is so powerful.

Classically, we think of neuro-transmitters, carrying the billions of messages inside our skulls across those spark-gaps in our wiring, tiny synapses. Only they leak. Such transmitter molecules – and let’s make this more concrete by calling out one of the most ubiquitous, noradrenaline – get built inside each nerve from the raw material of simple amino acids. In this case tyrosine. In nerve endings, freshly-manufactured transmitters get stored into little globules and are released as a packet to carry just one of those discrete messages across a single synapse. Yes, noticing these mechanisms emphasizes how important dietary protein is to smooth, normal functioning.

All of this is very familiar. I remind us of it only so we can move onward toward noticing a crucial shift that is highlighted by their leakage. Classically, such transmitters get de-constructed after carrying their message. Handy not to have that message confused by repetition: word word word word. So our synapses are equipped with enzymes to take transmitters apart, to render their language mute.

Yes, and they leak. A few molecules float away into the greater molecular soup of the brain. Still potent with signal, they can wander into other synapses, trigger neighboring or even distant neurons. This is hormonal action, not transmitter function, yet it utilizes the very same tiny molecules. This hormonal role is the new news in brain function.

Hormones spread out, they diffuse. As a neurohormone, noradrenaline shifts from transmitting one discrete message to infusing more of a tone to consciousness, and carrying that tone more broadly across whole regions and even the entire brain. In this case, we now see this supremely simple molecule – which is known medically by its more proper name epinephrine – affecting consciousness in precise yet far-reaching ways. It begins by waking us up. It is alertness, simple attention, in molecular form. As we open our eyes in the morning, noradrenaline radiates out from the base of our brains, diffusing alertness. The serotonin that kept us in dreamland diminishes.

If you wake up as I do, often feeling stumbly and obtuse, then it is useful to know that when we reach for the coffee we are deliberately stimulating more noradrenaline. We are adjusting our neurohormones to feel more alert, more alive. Well, exercise does that too. A walk around the block can be just as effective as a cup of coffee. And undertaking larger physical challenges – run, climb, dance – stimulates correspondingly more noradrenaline, with the result that we increase yet again our sense of being alert and oh-so-alive. This is your brain on adventure.

But that's only the beginning. I've taken us through the details of brain chemistry here – and thanks for sticking with it – not for the sake of enzymatic flourishes, but to arrive at the mood that brain hormones are so good at creating. It's a positive mood, and unlike the dark tones of adrenaline, noradrenaline carries the sense of cheerful competence, a can-do attitude in the face of challenging circumstances. Anybody find that useful in your life?

So noradrenaline becomes the first of several hormones we can tap into in a seething brain, the beginning of the hormonal cocktail of adventure itself. Let's look at more ingredients in our cocktail, as it arises from challenge when that turns to adventure.

There's dopamine, the second ingredient in our hormonal cocktail. It is behind pleasure and reward, so of course insight into dopamine's function is vital to understanding what makes adolescents tick. As it courses through our brains, dopamine keys responses that range from the satisfaction of solving a math problem all the way to orgasm. And dopamine too can be stimulated by substances coming from outside the brain. Some of them are a lot less innocent than caffeine. Like cocaine. Which just happens to gain some of its powerful influence by exerting a double-whammy effect on our synapses. That of course leads to the specter of addiction.

However, we quickly recall the counterbalancing potential of that “adventure” gene, DRD4-7R, which is linked to regulating the dopamine in our brains. That in turn suggests once again a healthier avenue toward reward through providing hefty natural challenges for adolescents.

Then there's serotonin, our internal antidepressant. I call it the hormone of equanimity, our roll-with-it juice. It carries a sense of competence: can-do, and let's-get-going here because the future seems bright. Ultimately the story of serotonin is very complex. Notice that a moment ago I identified it with sleep and dreaming. That's right too. Serotonin does so many things, ranging far beyond any one function — or even a mere handful — so we need to be wary of one-dimensional thinking. This is, after all, consciousness we're addressing, and anyone who owns one knows how variable it can be, even on "just" the level of its mood.

Serotonin was first discovered as a gut hormone, and still 90% of it in our bodies is found there. By the time it was noticed in the brain as well, its uses proliferated until now we know of some thirteen distinct receptors for the same little serotonin molecule. Each found in discrete clusters of neurons within the vast complexity of that 84 billion neuron grey mass. Each cluster having a unique function. Or likely many. We simply don't know yet. This is an unfolding picture.

We do know that serotonin is crucial, and in fact that these three ingredients of our emerging hormonal cocktail here are the "big three" that form the basis of brain function and, yes, of consciousness itself. And they all respond positively to exercise, to physical dimensions of challenge.

Our hormonal cocktail of challenge has two more ingredients. Please fasten your seatbelts, because these ingredients are going to take us further out there. Maybe even sweep us away, but in the best possible manner and direction. Serotonin was our clue and our linkup here, going back forty years in the emerging science of brain hormones. It was discovered that certain ones, a couple of specific receptors among serotonin's many distinct ones, were the point of action of psychedelic drugs. That led to speculation, discovery, hot debate, denial, and now finally proof that one of the world's most potent psychedelics, DMT, is a human hormone made every day in our brains and oozing out of the mysterious pineal gland that sits right at the center of the brain. This discovery, to say the least, "colors" our view of consciousness.

With DMT we're on the cutting edge of the emerging science of consciousness, and its arrival on the scene begins to get linked to all sorts of useful qualities such as cutting down on anxiety, amping up a sense of wonder and awe, and stimulating creativity itself. Then too, we might be forgiven for a touch of pride in New Mexico here, for it was the young psychiatrist Rick Strassman, working in Albuquerque in the early 1990s, who braved the considerable hurdles thrown up by the federal government to do the first research with psychedelics to be FDA approved in decades by giving DMT to healthy human volunteers, many of them therapists. Dr. Strassman's Cottonwood Research Foundation has helped develop crucial assay tools a thousand times more sensitive than ever before, which have

just in the past couple of years finally confirmed the presence of trace amounts of this – now definitively organic — most potent psychedelic in healthy human brain tissue. While we await further information on DMT’s relationship to consciousness and intrinsic motivation, we can’t help but notice that it too is raised by the vigorous and healthy challenging of our selves.

The last – for now – ingredient of our hormonal cocktail of challenge is equally surprising. Called anandamide after its discovery in the early nineties, it is the human hormonal equivalent of marijuana. Studies have shown it to rise “strongly” when moderate exercise is sustained for 50 minutes. Informed opinion pegs it as the new and more accurate cause of runner’s high. “Everything that marijuana does, anandamide does,” according to its discoverer, Israeli scientist Raphael Mechoulam. Want proof? It gives you the munchies. Several labs of researchers around the world are working on receptor blockers that show promise of becoming diet pills which may carry us away from the use of appetite suppressants such as crystal meth, which were the very first diet pills in the 1950s.

Anandamide also has anti-anxiety properties, and likewise stimulates a sense of wonder and creativity. Crucial to overcoming the built-in cultural prejudice against its cousin THC, with images of sinking into lethargy, is the recent finding of a two-phase human response to that drug. Only the latter, the high-dose phase, is characterized by the ubiquitous archetype of a couch potato. Lower doses are actually stimulating in good ways of being energetic and curious.

So we have a hormonal cocktail, with all of its ingredients ramped up by exercise and challenge, and all of them working to stimulate in turn positive moods and states of consciousness that add up to a productive stance toward life in the world and an energy and openness that fosters creative problem solving. Anybody here like meeting teenagers with those qualities? (Adults too...) Probably worth fostering that, and likely more productive in social terms than a negativity approach like clubbing them with Thorazine, court-mandated lockdown in expensive jail cells and even the broader and more socially-accepted strictures of old-school “sit down and shut up” modes of education.

Fortunately, we don’t have to rebuild our entire way of raising kids to begin, right away, to take advantage of the insights from modern brain science that can help us, within our current, everyday structure, to just shift our ways of working with troubled people. Perhaps taking a walk while talking with someone can lift her mood enough to add a crucial piece of receptivity to a gentle therapeutic suggestion. And, perhaps, along the way a glimpse of the sky and an awakening sense that we’re all in this together, this business of being human. Maybe, too, placing an inviting basket of high-protein energy bars next to the ubiquitous box of tissues in a therapy room. Or scheduling an afternoon field trip for adjudicated youth to an urban climbing gym. I’ve seen them positively light up — jaded

tough kids sporting fresh knife wounds. I've seen them dig in and engage with the gauntlet thrown down by a wall of colored plastic holds. I've seen such little things become grateful increments. They might even shore-up the therapist's mood too.

And then these larger notions – especially the sweeping idea of wilderness education for all adolescents: do they sound too expensive? Really? What, exactly, is the cost-benefit analysis of saving civilization itself? Of goosing it out of lethargy, hopelessness, terminal fear, ultimate breakdown, and the creeping infusion of a deadly blasé?

It has been said that the dollars being poured into incarceration could more proactively be applied to a broader population of adolescents to provide them with life-enhancing powerful experience. Experience that challenges their latent urge to explore and create. Now more than ever new understanding of the hormonal brain allows us to tune up the design of such a curriculum, and to track, by measuring the positive internal climate it evokes, how that can work to our benefit as a civilization.

Adolescence: the most turbulent and risk-laden period of our lives. If ultimately our kids turn feral, then we have lost this game of civilization

We get tempted to speak of harnessing or channeling the wild energy of our youth, but such thought is fraught with danger. You cannot BS wild impulse. However, it is often possible to turn it toward a horizon big enough to present it with worthy challenge. Wild landscapes are the best I've found. Loping across far mesas and gnawing at vertical terrain can become deeply satisfying, because wilderness responds to human effort in ways that are fair, animally understandable, ultimately freeing. Gravity, distance and weather are a kind of "box" that works, because they reverberate to our spirit from the ground of our being. And, they cannot be manipulated like social systems can. You can't "work" that system. "Gravity:" states a poster on my wall, "It's not just a good idea. It's the law." The laws of nature speak to us as animal. Wilderness challenges us as oh-so-physical beings, a challenge we understand on a primal level, feel within our beings as adventure. Here again we gratefully notice a New Mexico advantage. The venerable Santa Fe Mountain Center has been on the forefront of adolescent wilderness challenge for decades. There, very effective templates have been developed for optimizing the application of adventure to opening up the lives of young people, to helping them blossom.

We can glimpse the explorer hidden in ourselves behind the constraints of civilization. Engaging with wild challenges can release our spirits. Now we are enabled to understand a bit of the hormonal mechanism behind our spirits taking flight.

This is not just talk. It exists on a deep level of our hormonal selves that is only now beginning to come to light. Oh yeah, we nod, adrenaline and the endorphins. But both turn out to be red herrings. They were false leads, a fact we – our scientific selves – are only now

beginning to grasp. The new hormonal landscape that is emerging inside our heads is fascinating, and insights gained from its nature can guide us. Ultimately they may help us to re-design our creaking civilization to better serve the human beings within it, and to engage our youth by understanding better the nature of their internal confusions, and more appropriately challenging their urges and desires. A certain amount of reverting to the wild, it turns out, may become the best way to fulfill their – and really all of our — very human promise.

Eternal respect – and a small Zen bow – to all of you whose lives are devoted to wrestling with this most vital of challenges.

IV. Services and Approaches Critical to Wellness



What you will find:

- **Habilitation and Rehabilitation**

Michael Hock

Habilitation refers to developing new skills and resources for the youth/family. Rehabilitation works to access or improve skills that were once at play – to restore them rather than create them.

- **Life skills and Positive Youth Development**

Randy Muck

This chapter discusses the knowledge, skills, and attitudes that help promote mental, emotional, and physical well-being in adolescence.

- **Theoretical and Philosophical Foundations of Therapeutic Adventure**

Michael Gass and Sky Gray

The practice of reflecting on experiences, learning from them, and applying the lessons to new situations is a foundation of experiential education and therapeutic adventure.

- **Prevention Services for Substance and Mental/Emotional Problems**

Natalie Skogerboe

Prevention promotes the well-being of individuals, families, and communities. Interventions occur prior to the onset of a disorder.

- **Pharmacotherapy Related to Opioid Treatment**

Michael Hock

Medications can assist with detox or maintenance of opioid use disorders and principles from NIDA are provided in this chapter.

- **Traditional, Indigenous, Curanderismo, and Alternative Healing**

Michael Hock

These services are available and can be more appropriate and effective for the youth and their family.

- **Spiritual and Religious Beliefs and Practices**

Father Brennan and Michael Hock

Acknowledging and discussing an adolescent's spirituality is important to the healing process.

- **Exercise and Mental Health**

Michael Hock

Research continues to show the benefits of exercise on behavioral health - not just physical health.

13.Habilitation and Rehabilitation

In clinical practice, there are generally two sets of conditions that individuals and families may present. If a youth or family appear to never have learned necessary life skills in the first place (early onset substance use or mental health problems), they need the support and guidance to learn them for the first time. This is considered habilitation. In the second set of conditions, the adolescent and his or her family usually want help returning to an earlier level of successful functioning. Treatment strategies effective for this set of conditions are referred to as being rehabilitative. The concept has important implications for both medical as well as non-medical psychological/emotional situations. It is important to note that the family may identify the previous state of being OK; whereas the adolescent may perceive that they are doing better than they were previously, regardless of their current behavior, the status of their education, relationships within the family, isolation, social conditions, involvement in the justice system, etc. Children and youth may require habilitative support while caregivers and older siblings require concurrent rehabilitative support.

It is essential for the assessing clinician to consider whether the adolescent or the family/caregiver has ever been better than how they are at the time of assessment. If the answer is yes, it is likely that rehabilitative work is appropriate. If the answer is no, habilitative work is the appropriate strategy, which will entail developing new resources, skills or capabilities that were not previously developed. Individuals and families cannot be restored to something they have never previously experienced. The distinction is more than simply one of semantics.

Even more intricate, children and adolescents who have experienced severe interruptions to the normal acquisition of skills and capabilities due to substance disorders or other behavioral, emotional, or mental disorders may need to restart the development of skills and capabilities beginning at the point of interruption. This would fit more in the habilitation model of services. Co-occurring disorders of long duration may result in imbalances of skills acquisition, delay the normal development of executive function, interrupt some learning capabilities while fully engaging others, or sideline some influences while accentuating others, resulting in a complex, interwoven set of both functional and dysfunctional skills and needs. This sort of complexity must be carefully identified and addressed individually, so that some areas of functioning are addressed with rehabilitative strategies, while others are addressed with habilitative strategies. As is the case with all conditions requiring bio-medical, psychopharmacological, and/or psychological intervention, accurate assessment and diagnosis remain a necessary prerequisite of providing comprehensive and integrated treatment.

14. Life Skills and Positive Youth Development

New Mexico foresees great need for support services for adults, families, and children. Life skill deficits can be caused by many factors, such as poverty, lack of or interrupted education, developmental delays, low resource availability, trauma, mental or substance use issues, etc. The results are often self-reinforcing, leading to low self-confidence and self-efficacy, poor vocational skills, poor social skills, and feelings of hopelessness or despair. To change this for our citizens, especially for our children, we have begun the process of researching and providing skill-based training and education utilizing the Casey Life Skills Youth Support Services (see Part B Element 20).

The World Health Organization has defined life skills as, "the abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life."

UNICEF defines life skills as “a behavior change or behavior development approach designed to address a balance of three areas: knowledge, attitude and skills.” The UNICEF definition is

based on research evidence that suggests that shifts in risk behavior are unlikely if knowledge, attitudinal and skills based competency are not addressed.

“Life skills are essentially those abilities that help promote mental well-being and competence in young people as they face the realities of life. Most development professionals agree that life skills are generally applied in the context of health and social events. They can be utilized in many content areas: prevention of drug use, sexual violence, teenage pregnancy, HIV/AIDS prevention and suicide prevention. The definition extends into the adolescent client and their family(s) education, environmental education, peace education or education for development, livelihood and income generation, among others. In short, life skills empower young people to take positive action to protect themselves and promote health and positive social relationships.”

The World Health Organization (WHO) categorizes life skills into the following three components:
Critical thinking skills/Decision-making skills
<i>These include decision making/problem solving skills and information gathering skills. The individual must also be skilled at evaluating the future consequences of their present actions and the actions of others. They need to be able to determine alternative solutions and to analyze the influence of their own values and the values of those around them.</i>
Interpersonal/Communication skills
<i>These include verbal and non-verbal communication, active listening, and the ability to express feelings and give feedback. Also in this category, are negotiation/refusal skills and assertiveness skills that directly affect one’s ability to manage conflict. Empathy, which is the ability to listen and understand others’ needs, is also a key interpersonal skill. Teamwork and the ability to cooperate include expressing respect</i>

for those around us. Development of this skill set enables the adolescent to be accepted in society. These skills result in the acceptance of social norms that provide the foundation for adult social behavior.

Coping and self-management skills

These refer to skills that increase the internal locus of control, so that the individual believes that they can make a difference in the world and affect change. Self-esteem, self-awareness, self-evaluation skills and the ability to set goals are also part of the more general category of self-management skills. Anger, grief and anxiety must all be dealt with, and the individual learns to cope with loss or trauma. Stress and time management are key, as are positive thinking and relaxation techniques.

Adolescents will learn appropriate life skills not only in the group setting and individual counseling, but also through working on community service projects with their peers in the groups. They may also learn job skills and day to day life skills while participating.⁴⁶

The following paper was developed by a student taking a philanthropic course taught at the Center on Philanthropy at Indiana University. It is offered by Learning to Give and the Center on Philanthropy and describes prosocial behavioral:

*Prosocial behavior refers to "voluntary actions that are intended to help or benefit another individual or group of individuals" (Eisenberg and Mussen 1989, 3). This definition refers to consequences of actions rather than the motivations behind those actions. These behaviors include a broad range of activities: sharing, comforting, rescuing, and helping. Though prosocial behavior can be confused with **altruism**, they are, in fact, two distinct concepts. Prosocial behavior refers to a pattern of activity, whereas altruism is the motivation to help others out of pure regard for their needs rather than how the action will benefit oneself. A familiar example of altruism is when an individual makes an anonymous donation to a person, group or institution without any resulting recognition, political or economic gain; here, the donation is the prosocial action and the altruism is what motivates the doer to action.⁴⁷*

The International Center for Alcohol Policies offers the following brief excerpt related to the effect of life skills:

Impact of life skills education

The impact of life skills education has been debated (Foxcroft et al., 2003; Gorman, 2002; Palinkas, 1996; Plant & Plant, 1999). The basic questions to be addressed are how the impact of this (or any other) approach should be measured and what are its desired outcomes. For some, the acceptable outcome is measured in preventing people from drinking. For others, it is to enable the target audience to make informed choices

⁴⁶ WHO (1999), Partners in Life Skills Training: Conclusions from a United Nations Inter-Agency Meeting, Geneva. WHO (2004), Skills for health: An important entry-point for health promoting/child-friendly schools. Geneva.

⁴⁷ Copyright © LearningToGive.org, Roberta L. Knickerbocker, <http://learningtogive.org/papers/paper52.html>

and decisions about whether to drink and how to drink responsibly. How to measure an intangible result like this clearly presents a serious problem. It is difficult to quantify the development of skills such as coping with stress or the development of interpersonal skills. A qualitative assessment must often be sufficient.

In particular in developing countries where means and resources are often scarce, evaluation is difficult. For example, following up with a group of children in primary school to assess how they have developed can prove difficult due to high attrition rates. However, there is evidence that life skills education can have an impact (Botvin, Baker, Dusenbury, Botvin, & Diaz, 1995; Botvin, Griffin, Diaz, & Ifill-Williams, 2001; International Center for Alcohol Policies, 2000; Smith et al., 2004; Swisher, Smith, & Vicary, 2004).

Some general patterns, nevertheless, have emerged from the evaluations that have been undertaken in this field. Certain "factors of success" have been identified (World Health Organization, 1999, 2003).

Factors of Success

- *long-term programs;*
- *trained educators or providers;*
- *a focus on both generic and specific skills;*
- *developmentally appropriate inputs;*
- *active student involvement;*
- *links to other subjects;*
- *user-friendly materials;*
- *peer leadership components.*

Where these factors have been implemented, life skills programs contributed to a decrease in alcohol misuse, drug abuse, smoking, delinquency, violence, and suicide and to an improvement in pro-social behavior (e.g., Botvin & Kantor, 2001; "LifeSkills Training,"; Perry, 1987). Other findings suggest a positive impact on mental health in relation to self-image, self-esteem, self-efficacy, and social and emotional adjustment and a decrease in social anxiety. School performance has been shown to improve with regard to behavior, academic achievement, and absenteeism (e.g., International Center for Alcohol Policies, 2000).⁴⁸

Since the 1950's, as a result of increases in juvenile crime, the U.S. has had a growing awareness of the importance of attending to the development of youth. This brought federal funding to develop ways to intervene with troubled youth that were mostly punitive. In the 1970's, prevention science established that positive interventions delivered as early as possible were a more cost-effective and humane way to work with these youth. This gave birth to Positive Youth Development programs which advanced a set of principles that came to many of the same conclusions as prevention scientists and

⁴⁸ International Center for Alcohol Policies, [Life Skills](http://www.icap.org/PolicyTools/ICAPBlueBook/BlueBookModules/2LifeSkills/tabid/163/Default.aspx), <http://www.icap.org/PolicyTools/ICAPBlueBook/BlueBookModules/2LifeSkills/tabid/163/Default.aspx>

those who now are the proponents of life skills education. The work in these three areas has converged over the years with the findings from studies on youth with similar deficits pointing toward very compatible and overlapping strategies. Regardless of the orientation and preferred language, what is being discussed here as life skills education encompasses many or most of the constructs of both Positive Youth Development and prevention science.

Most working definitions of life skills will include language regarding the importance of life skills for youth to help them negotiate and mediate challenges and risks. Prevention and positive youth development speak more in terms of the factors that need to be present to develop resiliency. Life skills are seen as enabling youth to become productive participants in society (Refer to the Youth Support Services, Part B Element 20).

Even though the World Health Organization (WHO) and the prevention field in the U.S. have defined life skills, there is not a common, agreed upon definition creating a construct that is elastic and includes a range of skills and knowledge that have one or more common elements running through their current stated view of the construct. One example from WHO that would likely be acceptable to most: “the personal, interpersonal and cognitive psychosocial skills that enable people to interact appropriately, manage their own emotional states and make decisions and choices for an active, safe and productive life.”

Life skills are generally considered regionally, nationally, or universally applicable. Over time, definitions and components of life skills have evolved to meet emerging threats. Currently there are psychosocial life skills that most research identifies as particularly relevant for youth in navigating their developmental pathways. Among those most notable are life skills that are necessary for youth to deal with the specific risks around sexual and reproductive health, HIV prevention, immigration and issues around citizenship, and disaster risk reduction.

Given the full set of psychosocial aims of the best life skills education, there must be an understanding by the developer of the program that the aim is not just outputs (knowledge and skills) but rather outcomes including changes in behavior, attitudes, and values. This requires development of the life skills education program and oversight of its implementation as an intervention infused into the system in which the life skills education work is conducted.

It is likely that youth presenting to behavioral health treatment will have life skills deficits resulting in some degree of functional impairment. In order to address the multitude of deficits, a complex service plan that builds supports to compensate for the deficits must be developed.

To effectively influence behavior, knowledge, and attitudes, skills must be experientially applied in a particular content area, topic or subject. Learning about decision making will be more meaningful if the content or topic is experientially relevant and remains constant or linked, such as looking at different aspects or types of decisions related to relationships, rather than considering decisions about a number of unrelated or irrelevant issues. The

individuals must have input in identifying the relevance of content, and the various components of life skills must be linked as well so that there is crossover in terms of application of knowledge and understanding.

The following discussion of Therapeutic Adventure begins with a discussion of Positive Youth Development which is essential to development of self-sufficient and functional youth developing into functional adults.

15. Theoretical and Philosophical Foundations of Therapeutic Adventure

This Section is co-authored by Michael Gass, PhD, and Sky Gray, MS, who are two of the leading proponents, researchers and thinkers in adventure education and therapy in the USA.

Michael A. Gass, Ph.D., LMFT, is a Professor and Coordinator of the Outdoor Education Program in the Department of Kinesiology at the University of New Hampshire. He is a visionary and leader in the field of Experiential Education, Adventure Therapy and Outdoor Behavioral Health. Mike's current research projects include joining efforts with Play for Peace (Guatemala), the Santa Fe Mountain Center (New Mexico), and the Marimed Foundation (Hawaii). His research interests are in the areas of Adventure Therapy, Social Development of Adolescents in Adventure Programs, Corporate Adventure Training, Adventure Program Accreditation, Adventure Programming and Middle School Students, and Wilderness Orientation Programs.

Sky Gray is the Executive Director of the Santa Fe Mountain Center in Santa Fe, New Mexico. For many years, the Santa Fe Mountain Center has been dedicated to promoting personal discovery and social change among youth, families, and groups through the use of creative learning experiences in wilderness, community, and cultural environments.

What are Resiliency and Positive Youth Development?

Resiliency and Positive Youth Development are fields that share very similar perspectives. Both grew out of research beginning in the 1980's, which focused on children and youth, and showed that while some people who were exposed to high risk situations developed anti-social behaviors, the majority did not. For example, research has shown that one in four children who grow up in an alcoholic home will become alcoholics, while three in four won't. Although they may not develop alcoholism, they are still at higher risk of drug use disorders, marrying an alcoholic, and developing mental health problems.

Building upon this realization, researchers worked to discover what was preventing people from behaving in anti-social ways. Their developing understanding is that people have natural strengths which programs and institutions can develop and enhance that will protect them from negative consequences. Researchers simply showed that people could bounce back from participating in unhealthy behaviors and become competent, well-adjusted people. Resiliency and Positive Youth Development both share approaches which build upon an individual's innate strengths. Positive Youth Development demonstrates how your organization can be a change agent for youth, while working with other institutions in your community to do so. "The resilient child is one who works well, plays well, loves well and expects well."⁴⁹ Social competency, problem solving skills, a strong sense of identity,

⁴⁹ Werner, Emmy & Ruth Smith. *Vulnerable But Invincible: A Longitudinal Study of Resilient Children and Youth*. New York: Adams, Bannister, and Cox, 1989 (1st edition 1982). & Garmezy, Norman. "The Study of Competence in Children at Risk for Severe Psychopathology." In *The Child in His Family*, vol. 3: "Children at Psychiatric Risk," edited by E. J. Anthony, 1974, 77-98.

an ability to work independently, a belief in personal efficacy, and a sense of purpose and future are all commonly identified attributes of resilient children and youth.⁵⁰

In the early 1990s the Search Institute, an independent nonprofit organization, began extensive research to begin to determine what factors promote or inhibit resiliency among children and youth. Through this work, the institute developed a framework of 40 Developmental Assets™ (see the Developmental Asset list in Appendix B). These describe positive experiences and personal qualities that young people need in order to develop into healthy, caring and responsible adults.

Competent experiential or wilderness programs strive to promote resiliency and increase protective factors. Protective factors are also defined as part of effective Prevention practices (see Part A Chapter 16: Prevention Services for a list of protective factors).

Bonnie Benard's exploration of the research led to this conclusion: "The major implication from resilience research for practice is that if we hope to create socially competent people who have a sense of their own identity and autonomy, who are able to make decisions, set goals, and believe in their own future, then meeting their basic human needs for caring and connectedness; for respect, challenge, and structure; and for meaningful involvement, belonging, and power must become the primary focus of any prevention or education intervention with children and youth."

Experiential Education and Adventure

What is Experiential Education?

Experiential and adventure educators believe and practice that at the heart of all learning is a need to bring meaning to our experiences. The meaning-making process is critical to understanding and learning from our experiences. Though there is no one consistent definition of experiential education, many point to the definition set forth by the Association of Experiential Education: "a philosophy and methodology in which educators purposefully engage with learners in direct experience and focused reflection in order to increase knowledge, develop skills and clarify values."⁵¹

What is Adventure?

Adventure is a *way* of doing; it is not just an activity in and of itself. If the word *adventure* conjures up images of things like rock climbing, rafting and parachuting, pause for a moment and imagine instead the *way* in which an activity is performed. A session becomes an adventure for participants if an element of surprise exists, if activities compel them into doing things they have never imagined possible. Adventure exists when there is engagement, and engagement comes from providing participants with experiences that are unique and relevant, hence, therapeutic and/or educational. These concepts are equally true for and applicable to all participants.

⁵⁰ Benard, Bonnie; *Fostering Resiliency in Kids: Protective Factors in the Family, School and Community*; National Resilience Resource Center, University of Minnesota; Minneapolis, MN.

⁵¹ <http://www.aee.org/about/whatIsEE>

Adventure includes challenge—moments when participants are on the brink of both success and failure and where they both succeed and fail. Adventure is about taking risks—not necessarily physical risks, but emotional and apparent physical risks, where participants see the natural consequences before them. Perhaps just connecting action to consequence is vital; knowing it is one thing, experiencing it is another. For participants to experience adventure, a program must provide physical and emotional safety—a space where participants can speak their minds and push themselves to new limits. While all of this is hard, it should also have a purposeful element of fun/play through which participants become willingly engaged.

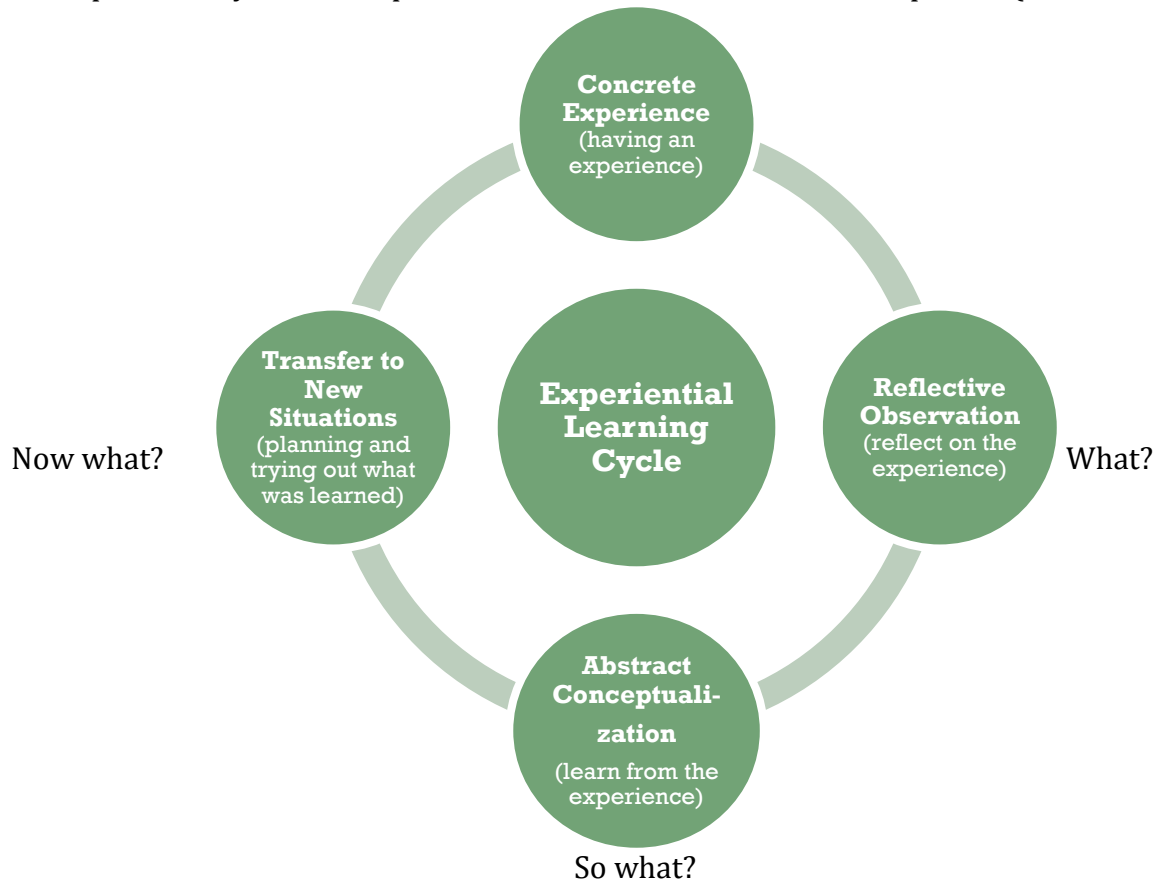
Adventure therapy can be defined as the prescriptive use of wilderness experiences by mental health professionals to meet the therapeutic needs of clients.

Components of Adventure Therapy:

- Extended backcountry travel and wilderness living experiences long enough to allow for clinical assessment, establishment of treatment goals, and a reasonable course of treatment not to exceed the productive impact of the experience,
 - Active and direct use of clients' participation and responsibility in their therapeutic process,
 - Continuous group-living and regular formal group therapy sessions to foster teamwork and social interactions (excluding solo experiences),
 - Individual therapy sessions, which may be supported by the inclusion of family therapy,
 - Adventure experiences utilized to appropriately enhance treatment by fostering the development of eustress (i.e., the positive use of stress) as a beneficial element in the therapeutic experience,
 - The use of nature in reality as well as a metaphor within the therapeutic process, and
 - A strong ethic of care and support throughout the therapeutic experience.
-

How Adventure/Experiential Learning Happens

The Experiential Learning Cycle: David Kolb, an Educational Theorist, provides a cornerstone for understanding experiential and adventure learning. He tells us that helping participants to experience a seemingly isolated event and giving it context (helping them to create meaning) provides them with the opportunity to learn, understand and apply knowledge. The activities deliver a concrete experience. The activity, coupled with reflection on the activity, guides participants through the what, so what and now what of the Experiential Learning Cycle (ELC). Learning is greatly enhanced when accompanied by a complementary reflective process. Kolb's model consists of four phases (see illustration):



This process is dynamic in that the cycle of experience builds on itself, encouraging higher levels of learning and application. When properly managed/applied, key learnings connect one experience to the next.

The Experiential Learning Cycle is further enhanced by H. Stephen Glenn's concept, EIAG (experience, identify, analyze and generalize). He explains that in order to sustain learning we have to pass through four levels of processing.

Experience: become aware of and observe experiences, both negative and positive in the young person's life—as you facilitate activities a major role you'll have is

observing the behaviors and behavioral effects of your participant and helping them process these during the debrief.

Identify: help your participant understand any significant behaviors and/or attitudes conveyed during an activity—or the ‘What?’ of the ELC. This is where your astute observations are key. Your participants, or any of us for that matter, cannot change behaviors and attitudes they don’t know they have.

Analyze: help your participant understand why those behaviors are significant—the ‘So what?’ of the ELC. Dr. Glenn suggests that your probes as to why something is significant will be more effective for the adolescent if you ask questions like: “What made that seem important to you? What were you trying to do? What caused you to feel that way?” These questions can be more effective than “Why?” which is often used against people.

Generalize: help your participant understand how to move forward with and apply the knowledge they have gained—the ‘Now what?’ of the ELC. How can they enhance the good and diminish the bad the next time around? Questions like: “How can you use this information in the future and in other situations? How can you do it differently for different results?” What do you need to repeat to achieve similar results?” will help you mine these insights.⁵²

The Adventure Integrated Model, developed by Project Adventure⁵³ (a leading agency in experiential education), enhances the experiential learning cycle by:

1. Highlighting the importance of aligning activities with goals
2. Identifying the need to promote group development—norms and the ability to care for one another as vital to effective experiential learning
3. Expanding the reflective process to broader life experiences; the ‘Now what?’ discussion includes both how behavior and attitude affects the group and ‘real life’
4. Empowering participants to be active and participatory learners by asking them to define their own stretch zone for optimal learning

Creating an Action Learning Environment

Adventure theory, learning theory and Dr. Glenn tell us that in order to effectively learn, we must feel safe—emotionally and physically. Geoffrey and Renata Caine, learning theorists who have integrated neuroscience, biological and psychological research to help us understand how people learn, explain that human beings cannot learn when they are afraid.

For every human being on the planet, from birth until death, threat tied to fear and helplessness sabotages the most promising kind of learning, including higher order thinking (executive function). Relaxed alertness is the ideal mental state for higher order

⁵² Glenn, H. Stephen & Nelsen, Jane; *Raising Self-Reliant Children in a Self-Indulgent World*: 2000; Three Rivers Press, New York; pp 35-36

⁵³ Project Adventure Inc., 719 Cabot Street, Beverly, MA 01915, info@pa.org - www.pa.org

functioning. Creating an environment that fosters this mental state must be a primary goal for teachers, therapists, and educators.⁵⁴ The Caines describe relaxed alertness as “consisting of low threat and high challenge” delivered most effectively in an environment **which supports social and emotional development.**⁵⁵

Why Use Adventure?

Importantly, adventure helps us practice the resiliency and positive youth development approaches. Adventure values who we are and what we know right now to help us grow.

- Adventure, when well done, is engaging—it is fun and participants want to take part.
- Adventure learning allows participants to experience a behavior (positive or not), reflect on that behavior, learn to replicate or diminish (as is appropriate) that behavior and learn how to transfer that behavior to other settings.
- Adventure requires its participants to be responsible to self, community and others.
- Adventure requires its participants to grow. Participants will not be able to “sit” in their comfort zone, but must learn in their stretch zone.

The adventure process relies on peers—just from whom the developmentally typical youth seeks approval. (While adults are not normally swayed by peer pressure, there is a lot of power in ten people telling you something versus one person alone.)

- Adventure is assets-based, while not ignoring those areas where participants need to grow, it focuses on cultivating and developing strengths.
- Adventure, is well aligned to provide participants with the skills and perceptions advocated by the Search Institute, resiliency theorists and researchers, positive youth development theorists and researchers, Stephen Glenn, and youth organizing principles.

Dr. Glenn’s Concepts for Creating a Learning Environment⁵⁶

Dr. Glenn explains that there are five barriers we adults put up that block the children and youth we work with from becoming capable. However, for each barrier, there is a builder. The presence of these barriers and builders are especially evident in how we talk to and what we expect from young people. The following is each barrier beside its counteracting builder. You want to try to replicate building language and expectations.

As adventure facilitators, the language we use and the behaviors we reinforce will send a powerful message. As we offer activities and hold students to behavioral norms, we must consciously diminish our use of barriers and augment our use of builders. Doing so will demonstrate your commitment to these important and effective concepts. Granted, this is more work than telling your participants what to do, but the results are well worth it. They will actively take responsibility for their learning and support their peers in doing the same.

⁵⁴ <http://www.cainelearning.com/>

⁵⁵ Caine & Caine; *Making Connections: Learning and the Human Brain*; 1994; Addison-Wesley

⁵⁶ Glenn, H. Stephen & Brock, Michael L; *Seven Strategies for Developing Capable Students*; 1998; Prima Publishing, Roseville, CA; pp 10-25

Adventure learning is holistic in that it addresses participants in their entirety—as thinking, feeling, physical and emotional beings. It permits young people to practice making choices they might not ordinarily make as well as observe peers practicing behaviors that might not ordinarily seem possible. “If we create a classroom community, we can then learn what it means to be members of that community. If we want students to act responsibly, we must *give* them responsibility. This microcosm of ‘the real world’ is at the core of experiential education: to learn by doing, and to gain insight from the experience.”⁵⁷

Native American Traditional Ways of Learning:

Experiential education, as it is known today, is essentially an indigenous way of learning. Native American learning styles are community and experientially oriented, often involving games, storytelling, and cultural ceremonies from which lessons are derived. These lessons are intended to be applied to life situations. Furthermore, Native American learning frequently involves physical, group-oriented activities that place participants into compelling situations that demand they believe in themselves and their own abilities, and allow them to experience and acknowledge the need to depend upon and work cooperatively with their fellow human beings. This topic is discussed further in Part A Chapter 18.

⁵⁷ Frank, Laurie; *The Caring Classroom*; Project Adventure, Inc; 2001

16. Prevention Services for Substance and Mental/Emotional Problems

Introduction & Definitions

Prevention is an active process that promotes the personal, physical, and social well-being of individuals, families, and communities to reinforce positive behaviors and healthy lifestyles. Interventions occur prior to the onset of a disorder and are intended to prevent or reduce risk for the disorder. Prevention often uses a public health approach, focusing on the health of the population rather than treatment of the individual. Research continues to show that prevention of mental, emotional, and behavioral (MEB) disorders, is possible and this is inclusive of substance use disorders.⁵⁸ While it is imperative to offer the best evidence-based treatment services to those who are already affected by MEB disorders, implementing interventions before a disorder occurs helps families, schools, justice systems, health care systems, and other societal structures avoid detrimental costs and consequences. Research shows that the younger a child starts drinking alcohol the more likely they are to suffer from alcohol dependence and other substance-related problems later in life.⁵⁹

If we can delay the onset of use even by a little, we will spare our communities untold costs and consequences.⁶⁰ Systems that bear the brunt of the burden of costs from MEB disorders are the education, welfare, primary medical care, and juvenile justice systems. When a young person struggles with a substance use or mental disorder, or co-occurring disorders, they are likely to have a harder time applying themselves in school, experience more stress with relationships, act out inappropriately, and engage in other problem behaviors. However, if we can catch signs and symptoms early, we can interrupt the progression and often prevent a full-blown disorder.

The tendency of many of our social systems is reactionary decision-making with a proclivity to rescue endangered life rather than use theory, science, and data to effectively prevent ailments, hazards, and problems. The field of prevention however, is stringently using data for planning and evaluating efforts, and applying research and science to make interventions more effective at reducing risks that heighten young people's probability of mental, emotional, and behavioral disorders. A recent cost benefit analysis determined that nationwide implementation of effective substance use disorder prevention programs would save an estimated \$18 for every \$1 spent.⁶¹ Prevention emphasizes the avoidance of risks and the promotion of health to support healthy family, school, and community environments. With greater support and collaboration across multiple systems, prevention can be more effectively woven into everyday practices, programs and policies.

⁵⁸ National Research Council and the IOM, (2009) Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities

⁵⁹ National Institute of Alcohol Abuse and Alcoholism (2008) & National Survey on Drug Use and Health Report (2004)

⁶⁰ Miller, T. Hendrie, D. (2008). Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis, DHHS Pub. No. (SMA) 07-4298. Rockville, MD: Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration

⁶¹ Miller, T. Hendrie, D. (2008)

Overview of the Institute Of Medicine

To help conceptualize the definition and understanding of prevention, the Institute of Medicine (IOM) outlines populations targeted by prevention interventions. The model clearly distinguishes between prevention and treatment populations, and puts prevention into a spectrum starting with health promotion and moving through three intervention populations; universal, selective, and indicated. As stated earlier, true prevention occurs prior to the onset of a disorder.

- **Promotion** includes efforts to enhance individuals' ability to achieve developmentally appropriate tasks and a positive sense of self-esteem, mastery, well-being and social inclusion as well as strengthens their ability to cope with adversity. This approach focuses on promoting healthy environments rather than on the prevention of an illness or disorder.
- **Universal** prevention focuses on the general public or an entire population group that has not been identified on the basis of individual risk. The intervention is desirable for everyone in that group.
- **Selective** prevention interventions focus on individuals or subgroups whose risk of developing a mental, emotional or behavioral disorder is higher than average. Risk groups may be identified on the basis of biological, psychological, or social risk factors that are known to be associated with the onset of a disorder. The risk factors may be at the individual level (e.g. biological characteristics such as low birth weight), at the family level (e.g. children with a family history of substance use disorders), or at the community level (e.g. schools or neighborhoods in areas of high-poverty).
- **Indicated** prevention focuses on high-risk individuals who have detectable, but minimal signs or symptoms that foreshadow MEB disorders, as well as biological markers that indicate a predisposition for a disorder, but does not meet diagnostic criteria for a disorder at the time of the intervention.

Domains / Risk and Protective Factors

Many factors influence whether a young person engages in high risk behavior such as substance use, and whether they will suffer from a mental or emotional disorder. Promotion and prevention build protective factors that enhance well-being and provide tools to avoid adverse emotions and behaviors. Research indicates that an ecological model of influence is a comprehensive way of understanding the many levels of influence on an individual. Individual characteristics such as self-esteem, attitudes, perception of risk, and even genetic predisposition all influence whether an individual is at increased likelihood of an MEB disorder. Added to those individual characteristics are the influences of the family including influences such as parents who may or may not use substances themselves, who may or may not monitor their child's behavior and set clear boundaries and expectations, and older siblings who may introduce younger ones, even inadvertently, to substance use. Community and school characteristics also play a role in a young person's development and add more layers of influence. If the school administers anti-bullying policies the child might be more likely to have a commitment to academic achievement. However, if the neighborhood is wrought with crime and poverty, the child might be less

Part A. 16. Prevention Services for Substance and Mental/Emotional Problems

likely to see opportunities to contribute to their community and perceive fewer social supports.

Protective factors are characteristics at the individual, family, or community level that are associated with a lower likelihood of problem outcomes. They are considered to reduce the negative impact of risk factors.

Risk factors are associated with a problem behavior or outcome. They also occur at the individual, family, community and cultural levels. Disorders are more likely to occur when more risk factors are present in a young person’s life. Positive development is more likely when more protective factors are present. The table below outlines some of the factors at the community, school, family and individual levels that influence a child’s development.

Risk Factors for MEB Disorders	Protective Factors for MEB Disorders
Community	
Exposure to violence Transition and mobility Low neighborhood attachment Economic deprivation/poverty Crime Community laws/norms favorable toward drug use, fire arms and crime Residential instability Availability of drugs	Presence of mentors and support for development of skills and interests Opportunities for pro-social involvement in the community Strong attachments to community/collective efficacy Positive relationship with alternative caregiver Social support Physical and psychological safety
School	
Academic failure (beginning in late elementary) Low commitment to school Stressful or traumatic events at the school School violence	Support for early learning School bonding and engagement Effective classroom management Positive partnering between school and family Opportunities for school involvement
Family	
Parental depression or anxiety disorders Neglect or abuse Harsh and inconsistent parenting Family history of problem behavior Family management problems Family conflict / dysfunction Favorable parental attitudes toward and involvement in alcohol/drug use Traumatic events	Consistent discipline Language-based discipline (rather than physical) Extended family support Protection from harm and fear Opportunities to resolve conflict Strong attachments to family Bonding to family with healthy beliefs and clear standards Opportunities for and participation in pro-social activities Recognition for pro-social involvement
Individual	
Apathy, anxiety, depression Poor impulse control, impulsive, aggressive, passive or withdrawn Early and persistent antisocial behavior Rebelliousness	Healthy peer groups Ability to make friends Following rules for behavior at home, school, and public places Social problem solving skills

Friends who engage in problem behavior	Emotional regulation and coping skills
Favorable attitudes toward drug use	Secure attachment
Early initiation of problem behavior	Mastery of language and academic skills

Evidence-based Prevention Practices

Evidence-based prevention interventions should be implemented whenever possible. These are interventions that have demonstrated effectiveness and documented attainment of desired outcomes. Effective prevention efforts typically target one or more levels of influence in order to reduce the likelihood of MEB disorders. Some prevention interventions focus on parents, some on the youth, and some on both. Others focus on changing the school and community environments in which youth interact. Traditional prevention programming focused on the individual and family levels of influence and much of the research and evaluation of the effectiveness of prevention has been conducted at those levels. More recently, however, prevention providers have begun to implement environmental prevention strategies, enabling prevention efforts to be directed at many levels of influence. Some of the environmental strategies that research supports include policy and practice change to: limit access of substances, create safe school climates, or establish universal screening for risk factors related to mental, emotional, or behavioral disorders. Prevention is practiced through the application of multiple strategies and environmental strategies emphasize going upstream: i.e. addressing the causes of a problem and affect community-level change.

Systems Approach

Prevention is an extremely cost effective and a pro-active approach to enhance mental and behavioral health. Unfortunately, it is often not prioritized or adequately supported. A balance of universal, selective, and indicated prevention implementation is needed to address mental, emotional and behavioral needs of young people, and that will require the support and interaction of multiple systems and agencies. Mobilizing resources so that supports are in place for a child from conception through adulthood requires systems to work together in a coordinated effort to align goals. The more we concentrate on healthy starts for children and families and the more effort we put into addressing systems that creatively instill health and safety in our society, the more likely we are to have strong, stable, children, youth, and families. In turn, that creates stronger, healthier schools and communities.

Key Substance Use Data Sources in New Mexico
New Mexico Substance Abuse Epidemiology Profile (2013) http://www.borderhealth.org/files/res_2487.pdf
New Mexico Youth Risk and Resiliency Survey www.youthrisk.org

17. Pharmacotherapy Related to Opioid Treatment

The following discussion of how to work with medications that assist treatment is divided into three parts. The initial Section is a general description of medication assisted treatment in New Mexico. The next section is excerpted from NIDA's Principles of Drug Addiction Treatment, and describes the need for and accessibility of Medication Assisted Treatment (MAT) for adolescent population. For continuity of vision, this manual uses the term **pharmacotherapy** instead of MAT so that stigma related to medication to aid substance use disorders is reduced. We do not say that someone using insulin to treat/manage their diabetes is undergoing medication assisted treatment; it is simply a part of their treatment. Such is the case with substance use disorders; some respond better with medication and behavior change. The third Section is excerpted from a SAMHSA TIP and describes the potential of the use Buprenorphine as an effective **pharmacotherapy** for opioid use disorder treatment. There is a concluding, brief discussion of the topic of "consent" and 42 C.F.R.

Pharmacotherapy

Pharmacotherapy is treatment for opioid use disorders that includes FDA approved medication (e.g. methadone, buprenorphine, naltrexone) for opioid detoxification or maintenance treatment. These medications block withdrawal and are used in combination with counseling and behavioral therapies to provide a whole-patient approach. Research indicates that a combination of medication and behavioral therapies is successful in treating substance-use disorders (CSAT, 2008). There is limited access and capacity for pharmacotherapy specifically for persons under the age of 18 and protocols do not currently exist on how to link the medication services with behavioral health services.

Principles of Drug Addiction Treatment, National Institute on Drug Abuse (NIDA)

What are the unique needs of adolescents with substance use disorders?

Adolescent drug abusers have unique needs stemming from their immature neuro-cognitive and psychosocial stage of development. Research has demonstrated that the brain undergoes a prolonged process of development and refinement, from birth to early adulthood, during which a developmental shift occurs where actions go from more impulsive to more reasoned and reflective. In fact, the brain areas most closely associated with aspects of behavior such as decision making, judgment, planning, and self-control undergo a period of rapid development during adolescence.

Adolescent drug abuse is also often associated with other co-occurring mental health problems. These include attention-deficit hyperactivity disorder (ADHD), oppositional defiant disorder, and conduct problems, as well as depressive and anxiety disorders. This developmental period has also been associated with physical and/or sexual abuse and academic difficulties. Adolescents are also especially sensitive to social cues, with peer groups and families being highly influential during this time. Therefore, treatments that facilitate positive parental involvement, integrate other systems in which the adolescent participates (such as school and athletics), and recognize the importance of pro-social peer relationships are among the most effective. Access to comprehensive assessment, treatment, case

management, and family support services that are developmentally, culturally, and gender-appropriate is also integral when addressing adolescent addiction.

Medications for substance abuse among adolescents may also be helpful. Currently, the only Food and Drug Administration (FDA)-approved addiction medication for adolescents is the transdermal nicotine patch. Research is under way to determine the safety and efficacy of medications for nicotine, alcohol, and opioid-dependent adolescents and for adolescents with co-occurring disorders.⁶²

Special Populations, SAMHSA/CSAT Treatment Improvement Protocols

Buprenorphine

*The use of buprenorphine for the treatment of opioid addiction in adolescents has not been systematically studied. It is known, however, that patients younger than 18 years of age, with relatively short addiction histories, are at particularly high risk for serious complications of addiction (e.g., overdose deaths, suicide, HIV, other infectious diseases). Many experts in the field of opioid addiction treatment believe that buprenorphine should be the treatment of choice for adolescent patients with short addiction histories. Additionally, buprenorphine may be an appropriate treatment option for adolescent patients who have histories of opioid abuse and addiction and multiple relapses but who are not currently dependent on opioids. Buprenorphine may be preferred to methadone for the treatment of opioid addiction in adolescents because of the relative ease of withdrawal from buprenorphine treatment. *Because adolescents often present with short histories of drug use, detoxification with buprenorphine, followed by drug-free or Naltrexone treatment, should be attempted first before proceeding to opioid maintenance. Naltrexone may be a valuable therapeutic adjunct after detoxification. Naltrexone has no abuse potential and may help to prevent relapse by blocking the effects of opioids if the patient relapses to opioid use. Naltrexone has been a valuable therapeutic adjunct in some opioid-abusing populations, particularly youth and other opioid users early in the course of addiction. Naltrexone is most likely to be effective for patients with strong support systems that include one or more individuals willing to observe, supervise, or administer the Naltrexone on a daily basis. In those adolescent patients in whom detoxification is followed by relapse, buprenorphine maintenance may then be the appropriate alternative. Refer to Section 4 (5 Special Populations, SAMHSA/CSAT Treatment Improvement Protocols) for buprenorphine maintenance and detoxification procedures.*

**Providers in New Mexico noticed a drawback to buprenorphine treatment because it is office based and there is no required counseling, and no structure which many youth need.*

The treatment of patients younger than 18 years of age can be complicated due to psychosocial considerations, the involvement of family members, and State laws concerning consent and reporting requirements for minors. Ancillary counseling and social services are important to support cooperation and follow through with the treatment regimen.

⁶² Principles of Drug Addiction Treatment, NIDA, <http://drugabuse.gov/PDF/PODAT/PODAT.pdf>

Parental Consent

Parental consent is a critical issue for physicians who treat adolescents addicted to opioids. In general, adult patients with “decisional capacity” have the unquestioned right to decide which treatments they will accept or refuse, even if refusal might result in death. The situation for adolescents is somewhat different, however. Adolescents do not have the legal status of adults unless they are legally “emancipated minors.” Adolescents’ rights to consent to or to refuse medical treatment differ from those of adults. Rules differ from State to State regarding whether an adolescent may obtain substance use disorder treatment without parental consent. Some State statutes governing consent and parental notification specify consideration of a number of fact based variables, including the adolescent’s age and stage of cognitive, emotional, and social development, as well as issues concerning payment for treatment and rules for emancipated minors.

More than one-half of the States permit individuals younger than 18 years of age to consent to substance use disorder treatment without parental consent. In States that do require parental consent, providers may admit adolescents to treatment when parental consent is obtained. In States requiring parental notification, treatment may be provided to an adolescent when the adolescent is willing to have the program communicate with a parent. Histories of neglect or abuse may be revealed during the care of adolescent patients, so physicians must be aware of reporting requirements in their State. Mandatory child abuse reporting takes precedence over Federal addiction treatment confidentiality regulations, according to Title 42, Part 2 of the Code of Federal Relations (42 C.F.R. Part 2).

Additional difficulties may arise when adolescents requesting treatment refuse to permit notification of a parent or guardian. With one very limited exception, the Federal confidentiality regulations prohibit physicians (or their designees) from communicating substance abuse treatment information to any third parties, including parents, without patient consent. The sole exception allows a “program director” (i.e., treating physician) to communicate “facts relevant to reducing a threat to the life or physical well-being of the applicant or any other individual to the minor’s parent, guardian, or other person authorized under State law to act in the minor’s behalf,” when the program director believes that the adolescent, because of extreme youth or mental or physical condition, lacks the capacity to decide rationally whether to consent to the notification of his or her parent or guardian (42 C.F.R. Part 2, Subpart B, Section 2.14d 2001). The program director must believe the disclosure to a parent or guardian is necessary to cope with a substantial threat to the life or physical well-being of the adolescent applicant or someone else. In some cases, communication with State child protection agencies or judicial authorities may be an acceptable alternative, or the required course of action, if the physician believes neglect or abuse has already occurred.

Treatment Setting

The more intensive a proposed treatment is, the more risk a program assumes in admitting adolescents without parental consent. Outpatient programs may have a better justification for admitting adolescents without parental consent than do intensive outpatient or residential programs.

Summary

*Buprenorphine can be a useful option for the treatment of adolescents who have opioid addiction problems. The treatment of addiction in adolescents is complicated by a number of medical, legal, and ethical considerations, however. Physicians intending to treat addiction in adolescents should be thoroughly familiar with the laws in their State regarding parental consent. Physicians who do not specialize in the treatment of opioid addiction or adolescent medicine should strongly consider consulting with, or referring adolescent addiction patients to, such specialists. Additionally, State child protection agencies can be a valuable resource when determining the proper disposition for adolescent patients.*⁶³

⁶³ Substance Abuse and Mental Health Services Administration (US); 2004. Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction. Treatment Improvement Protocol (TIP) Series, No. 40. Center for Substance Abuse Treatment. Rockville (MD): <http://www.ncbi.nlm.nih.gov/books/NBK25663/>

18. Traditional, Indigenous, Curanderismo, & Alternative Healing

If traditional, Curanderismo, or alternative healing modalities are available and requested by an adolescent or their family in a behavioral health setting, or are otherwise appropriate due to culture, belief, religious or spiritual practice, accessing such services may provide substantial benefit to the individual or family. Reimbursement and other payment systems for traditional healing services in Native American communities are widely accepted. And it's important to note that traditional services are also widely used in Hispanic communities. What follows is a brief discussion of potential benefits/effects that may accrue from these practices, and a description of various practices. Although this first excerpt is written from the allopathic bio-medical model point of view, it reveals how traditional healing practices are complementary to integrated behavioral health practices.

Traditional Healing Systems⁶⁴

The term “ethnomedicine”^{*} refers to the comparative study of medical systems, focusing on beliefs and practices concerning sickness and health in different human populations. It observes and describes hygienic, preventive, and healing practices, taking temporal and spatial references into account.

Typical ethnomedical topics include causes of sickness, medical practitioners and their roles, and specific treatments utilized. The explosion of ethnomedical literature has been stimulated by an increased awareness of the consequences of the forced displacement and/or acculturation of indigenous peoples, the recognition of indigenous health concepts as a means of maintaining ethnic identities, and the search for new medical treatments and technologies. In addition, Kleinman (1995) found ethnographic studies an “appropriate means of representing pluralism...and of drawing upon those aspects of health and suffering to resist the positivism, the reductionism, and the naturalism that biomedicine and, regrettably, the wider society privilege” (p. 195).

Hallmarks of Effective Treatment

In his exhaustive study of cross-cultural practices, Torrey (1986) concluded that effective treatment inevitably contains one or more of four fundamental hallmarks:

- 1. A shared world view that makes the diagnosis or naming process possible;*
- 2. Certain personal qualities of the practitioner that appear to facilitate the patient's recovery;*
- 3. Positive patient expectations that assist recovery;*
- 4. A sense of mastery that empowers the patient.*

If a traditional medical system yields treatment outcomes that its society deems effective, it is worthy of consideration by Western allopathic biomedical investigators, especially those who

^{*}The comparative study of how different cultures view disease and how they treat or prevent it; also the medical beliefs and practices of indigenous cultures: Merriam-Webster dictionary

⁶⁴ Excerpted from *The Impact Of Allopathic Biomedicine On Traditional Healing Systems*, Stanley Krippner, Ph.D. http://www.ceoniric.cl/english/articles/stanley_the_impact.htm / Kleinman, A. (1995). Writing at the margin: Discourse between Anthropology and Medicine.

are aware of the fact that allopathic biomedicine is the dominant health care paradigm for less than 20 percent of the world's population (Mahler, 1977). However, what is considered to be "effective" varies from society to society.⁶⁵

It is also important to note that allopathic biomedicine places its emphasis upon "curing" (removing the symptoms of an ailment and restoring a patient to health), while traditional medicine focuses upon "healing" (attaining wholeness of body, mind, emotions, and/or spirit).

Some patients might be incapable of being "cured" because their sickness is terminal. Yet those same patients could be "healed" mentally, emotionally, and/or spiritually as a result of the practitioner's encouragement to review their life, finding meaning in

it, and becoming reconciled to death. Patients who have been "cured," on the other hand, may be taught procedures that will prevent a relapse or recurrence of their symptoms. An emphasis upon prevention is a standard aspect of traditional medicine, and is becoming an important part of biomedicine as well.⁶⁶

New Mexico has significant indigenous populations with long histories of traditional healing using a variety of modalities. The following service definition was an attempt to provide compensation to either practitioners or to governing bodies, such as tribes, if reimbursement was appropriate. It was written in order to codify payment while very particularly protecting the private rights or practices deemed as sacred by respective communities. It was a very fine line to cut, as government organizations often want to see how funds are expended, and this service definition was written so that practitioners conducting indigenous or Native American ceremonial or healing practices would be shielded from audit or oversight outside of tribal or community traditional bodies. Its inclusion here is an example of how government agencies can work to foster culturally based or traditional healing practices with minimal invasion of privacy.

The New Mexico Human Services Department Access to Recovery (ATR) Handbook service definition for Traditional Healing was written by Michael Hock and Gus Abeyta of Five Sandoval Pueblos in 2007, and states the following:

Traditional healing describes a solitary or group healing practice that assists individuals and their family members in the recovery process. Traditional healing is conducted by an individual or group that subscribes to the customs, practices and rules of the community or tradition they represent, or to the regulation and licensing standards of municipal, county or state law.

⁶⁵ <http://stanleykrippner.weebly.com/-the-impact-of-allopathic-biomedicine-on-traditional-healing-systems.html> Krippner, S. (2002). Spirituality and healing. In D. Moss, A. McGrady, T.C. Davis, & I.

Wickramasekera (Eds.), Handbook of mind-body medicine for primary care (pp. 191-201). London: Sage.

⁶⁶ <http://stanleykrippner.weebly.com/-the-impact-of-allopathic-biomedicine-on-traditional-healing-systems.html> Krippner, S. (2002). Spirituality and healing. In D. Moss, A. McGrady, T.C. Davis, & I. Wickramasekera (Eds.), Handbook of mind-body medicine for primary care. London: Sage. & Krippner, S., & Welch, P. (1992). Spiritual dimensions of healing: From tribal shamanism to contemporary health care. New York: Irvington

Part A. 18. Traditional, Indigenous, Curanderismo, & Alternative Healing

Definitions or guidelines set-forth in this service definition are general where related to traditional healing practices that exist within specific indigenous tribal or cultural groups, and are not intended to constrain, expose, or in any way compromise practices that are protected or guarded from public disclosure.

Indigenous American Indian healing practices

This definition shall include specific tribal, Pueblo or other American Indian traditional healing practices. Interventions must be recognized and approved by a governing body, community or tribe, or may be passed on through written or oral custom, tradition or other teaching. Such teaching, when not sanctioned by ordinance, law or regulation, shall interpret “governing body” as the tradition, custom or other form of governance which establishes the foundation for accepted and appropriate practice. Such practices shall be related to the indigenous people of North America or specific to the cultural heritage of the community being served.

Cultural Healing Practices

Indigenous cultural healing practices refer to those healing practices prevalent within the communities of New Mexico, and may be passed on through written or oral custom, tradition or other teaching. Such teaching, when not sanctioned by ordinance, law or regulation, shall interpret “governing body” as the tradition, custom or other form of governance which establishes the foundation for accepted and appropriate practice. Such practices shall be related to indigenous people or specific to the cultural heritage of the community being served.⁶⁷

⁶⁷ New Mexico Human Services Department Access to Recovery (ATR) Handbook service definition for Traditional Healing was written by Michael Hock and Gus Abeyta (2007)

19. Spiritual & Religious Beliefs & Practices

In society in general and in New Mexico particularly, spirituality and religious beliefs are a fundamental and important part of individual, family and community identity. Denying or downplaying this reality can cause a disconnection between the person seeking help and the care provider. Alternately, inquiring about and showing respect for a youth's or family's beliefs may facilitate the healing dimension of the therapeutic relationship.

At the same time, issues of religion and spirituality can become contentious. It is imperative that persons working with any other individual, family, or group in a treatment setting value without bias all expressions of faith or spiritual hope, personal belief, aspiration, or longing for connection to something greater than self. This does not mean that any person providing services must embrace another's faith, belief, or practice, but simply the recognition that such faith, belief, or practice may be an elemental linchpin in the person's overall health, and expressly, their psychological health.

Adolescents are particularly in need of this fundamental respect. They may approach treatment as atheists, agnostics, embracing or rejecting their parent's religion, actively seeking to find a spiritual or religious path, or not interested or concerned with anything having to do with religion or spirituality, and all need to be respected for their beliefs. This respect must be expressed through the application of compassionate neutrality on the part of the provider staff, and no argument in any direction should be engaged, although discussion of this subject may be very beneficial to the adolescent. If discussion arises around this topic, it is best to be open and honest without any attempt to sway the adolescent or their family to your point of view, and further, no attempt to sway an adolescent to their family's point of view should be made. The following are two examples of how different views about this subject have been expressed:

Concepts and Theories of Religious and Spiritual Development in Adolescence

The study of religion and spirituality in developmental science hinges on whether it is possible to formulate good theories from which scientists derive clear and scientifically tractable definitions of what religion and spirituality are substantively, what they do functionally (Emmons & Paloutzian, 2003; Weaver, Pargament, Flannelly, & Oppenheimer, 2006), and how they develop systematically over ontogenetic time (cf. Lerner et al., 2008; Oser et al., 2006; Roehlkepartain et al., 2006).

Indeed, the challenge of having "good" theories is one that has historically plagued the study of the psychology of religion (Batson, 1997). Having good theory remains a significant challenge in the contemporary study of religious and spiritual development (RSD) during adolescence. Nonetheless, several key theoretical strands can be discerned in current research on religious and spiritual development during adolescence.

Religious and Spiritual Development

1. a relational system affording security and anxiety reduction
2. a meaning system affording existential answers in the context of life's "boundary conditions" (e.g., death) and unexplainable life events
3. the development of cognitive schemas indexing conceptions of religious phenomena such as prayer and God
4. an identity-motivation system organized around particular religious and spiritual goals, values, and ultimate concerns
5. states and stages of awareness that transcend ego-consciousness and its boundedness in time and space (e.g., mystical experiences, construct-aware stages of functioning); and
6. a dynamic developmental systems perspective in which RSD is seen in relation to multiple contexts, people, symbol systems, and opportunities and risks that foster or frustrate such development across the life span.

One prominent a-theoretical approach to distinguishing between religion and spirituality is to conceptualize religion at the level of an organized sociocultural – historical system, and spirituality at the level of individuals' personal quests for meaning, happiness, and wisdom.

Religion may be defined as:

An organized system of beliefs, practices, rituals, and symbols that serve to (a) to facilitate individuals' closeness to the sacred or transcendent other (i.e., God, higher power, ultimate truth) and (b) to bring about an understanding of an individual's relationship and responsibility to others living together in community (Handbook of Religion and Health; Koenig et al., 2001).

Spirituality may be defined as:

A personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, to transpersonal values, which is directed towards higher degrees of the regulation of action, imagination, emotion, and freeing oneself from mental conditioning and indoctrination as far as possible...

Many think of addiction as not only a physical, emotional, and psychiatric disease, but also as a spiritual one. This being the case, addiction treatment requires a spiritual component. What that spiritual component is and how to incorporate it into treatment remain challenging questions for clinicians to consider—ones that generate the strongest disagreements among treatment professionals.

The dictionary definition of spirituality consists of "the spirit or the soul as distinguished from the body" or of something related to religion or religious beliefs. An inability to define spirituality minus its religious connotation is prevalent among the general population, and may creep into the attempt to instill a spiritual component into substance abuse treatment. Spirituality is entirely possible with or without a belief in a supreme being.

During substance abuse treatment, spirituality should be kept clearly distinct from religion and religious interpretation. In the context of adolescent treatment and recovery, spirituality is associated with a profound personality change and the forming of an inner peace and strength. It is also highly personal and specific to the individual. One of the most profound revelations from the Alcoholics Anonymous (AA) model and the 12-Step movement, which both espouse the invocation of a higher power, is the observation that religion itself is not enough to overcome addiction.

In the AA philosophy the definition of a higher power is left to the individual. This higher power can range from a Judeo-Christian view of God to nature or even to the collective wisdom of the AA group. From this context, spirituality becomes a bridge to something beyond oneself. It is a way of connecting to and achieving a sense of association with a universe larger than one's personal existence.⁶⁸

Adolescents' views of spirituality

Adolescence is a time of looking forward and looking backward—a transitional phase fraught with issues of personal identity and the establishment of a value system. It is often marked by experimentation and defiance against authority, which often result in the dismissal or complete rejection of spiritual concepts at a time not conducive to facilitating a spiritual awareness. A large number of substance-abusing adolescents enter treatment with distorted views of spirituality. These can be embodied in statements such as: “There is no such thing as spirituality,” “Prove there is a God or higher power,” or, “I can depend only on me, and I don't need anyone or anything else.”

Spirituality is largely an experiential, non-logical process of association and emulation. The first exposure may come through the example of other recovering persons, either recovering staff members or members of self-help groups attending to adolescents during treatment. Recovering individuals who have achieved a spiritual awakening or spiritual state appear to have a sense of calm, peace, and fullness that contrasts with the gloom and doom many adolescents feel during treatment. This sense of serenity may induce curiosity in those who have never shared such an experience. However, example and knowledge alone are not enough to bring about a transformation necessary for recovery.

In encouraging adolescents to take ownership of their recovery, they also must be encouraged to take responsibility for their past. It is important that adolescents be able to tell their own stories their own way and that counselors be present with them.⁶⁹

Religion is sometimes used as a way to moralize about wrong behavior, which can further stigmatize a person or family that experiences this, or it may form the basis of understanding and accepting societal ethics, when accompanied by a benevolent attitude of

⁶⁸ *Religion and Spirituality in Adolescent Development*, Pamela Ebstynne King and Robert W. Roeser
http://www.robertroeser.com/docs/publications/2009_KingRoeser_Spirituality.pdf

⁶⁹ *Excerpted from: The Spiritual Journey for Youth*, by Fred J. Dyer, PhD, CADAC; Published on-line in *The Addiction Professional*, © 2011, Vendome Group, LLC

approach. It is important that individuals be provided the right to choose for themselves how to take up responsibility for their personal inner struggles, if such exist, and if they are capable of doing so. On the other hand, adolescents involved in a clinical treatment program are often held accountable by the juvenile justice system, by the courts, by schools, by parents, or by other authorities, and providers must support the efforts to hold persons answerable for their actions as determined by law and legal protocol. Adolescents may also be experiencing anxiety, depression and anger, possibly resulting from undisclosed or known trauma. Religion or spirituality, for some people, may be the only approach that brings relief, since trying to explain or account for these issues from a secular perspective may not afford satisfactory resolution. An individual seeking to find balance or peace can become more frustrated or angry unless the individual experiences something beyond what the human mind alone can offer, and religious or spiritual values can supply the needed bridge to accepting both what has occurred and also one's current situation. This will work with some individuals but not with others, as there can often be a strong predisposition to blame others for one's own behavior.

Thus, instructing youth about personal responsibility is a delicate proposition, and youth that have not developed cognitive skills due to age, substance use, co-occurring mental or emotional disorders, effects of trauma, or developmental disability may have limited capability for self-reflection or insight into the cause-effect relationships they find themselves in. Even if this so, it is important to provide guidance towards this end, because it is often the case that persons that embrace religion or spirituality can find the inner strength to see the effect of their choices and actions on others. Faith or transpersonal values also may enable individuals to more fully accept the ways in which they are being held accountable by authorities while developing recognition they are loved and forgiven by a higher authority. In this way, youth can be encouraged to stay the course, and those who appear to be fighting taking personal responsibility can be encouraged to participate with a new outlook and purpose.

In shifting the locus of control to self-care, and in empowering individuals toward a self-directed recovery, especially when transitioning from courts and the juvenile justice system, the individual may be seeking a new peer group and a way to re-integrate into the community. For those individuals who have expressed an interest in exploring spirituality or religious beliefs, or if, in the appropriate situation the care provider suggests the individual consider this avenue, then this may be a significant aspect for both community and personal integration that will benefit the individual.

Although it would be erroneous to assume that an individual should automatically connect with the faith tradition of his/her parents, it also could be incorrect to not invite the individual to consider investigating that faith tradition if the individual is open to such discussion. Since the overall approach advocated within this manual is family-directed, it would be disingenuous not to explore this area of re-integration, especially if it would form stronger family ties and empower the youth towards increased self-worth and sense of contribution.

Acknowledging the co-occurring disorders that accompany individuals seeking help, a faith community or a private path of spirituality can offer a stable support group, a sense of identity, the ability for the individual to express thoughts and emotions, encourage affection for family, and even help the individual accept parents' or personal shortcomings.

In summary, although individuals may be born to parents and into communities of a particular faith, it is important that every person's right to religious and spiritual freedom be respected, as long as those beliefs do not encourage or include the violation of other's human rights (see Part B Element 3, Cultural Competency). Religious freedom is a founding principle of the United States. It is important for the health of our children and our social structure that we continue to honor religious and spiritual freedom in all cases, and for all people.

20. Exercise and Mental Health

Most people who exercise even a little experience some sort of positive results, but why is it so difficult to get off the couch? Humans like to think that they do things that will make them feel good physically, mentally, emotionally, and spiritually. Exercising regularly seems to have some positive effect on all aspects of our lives- therefore why is that first step so hard? Of course the arguments of too little time, too much expense, competing commitments and interests can be made, but given the results of even very low intensity, short duration exercise, it is difficult to find reasons to ignore physical and emotional health related to exercise for almost anything else. Motivation often comes back to neurochemical responses and perceived reward, but interestingly, every aspect of physiology, including the brain, emotions, and even the functions of concentration, stillness, calmness, and feelings of serenity are enhanced by vigorous exercise.

The following two articles detail some of the behavioral health benefits of exercise, but don't stop with these limited examples. One of the most significant benefits of exercise is related to heart rate variability,⁷⁰ which translates into some very fascinating areas just now being researched, including enhancing self-regulation, reduced cravings, and increased brain size and speed of processing. The first article describes effects of exercise related to depression and anxiety, and the second describes the effects of exercise on substance use issues.

Please note that these articles do not describe the effects of exercise on individuals with co-occurring substance and mental health issues. More study is needed but the outcomes described in the following merit consideration alongside more traditional therapies for COD and substance use, especially in light of the preceding chapters.

1. Exercise and Mental Health

The Role of Positive Affect in Mental Health

The field of psychology has undergone somewhat of a revolution in the past decade with the development of the field of 'Positive Psychology'. Traditionally, the field of psychology has primarily been concerned with understanding and alleviating the psychological suffering of human beings. Positive psychology is a scientific approach to understanding the positive aspects of human psychology including positive emotions, positive character traits, and interventions that can increase levels of positive emotions (see Seligman & Csikszentmihalyi, 2000 for a more detailed discussion). In the past decade great strides have been made in formulating a rigorous scientific investigation of the positive motions of human experience, most prominently 'happiness'. In addition, positive psychologists have developed a range of scientifically validated therapeutic intervention methods for increasing psychological wellbeing collectively encapsulated under the domain of 'Positive Psychotherapy' (Seligman, Steen, Park, & Peterson, 2005; Seligman, Rashid, & Parks, 2006).

⁷⁰ Lill Hansen, A. Helge Johnsen, B. Sollers III, J.J. Stenvik, K. Thayer, J.F. (2004). Heart rate variability and its relation to prefrontal cognitive function: the effects of training and detraining. *Eur J Appl Physiol* (2004) 93: 263-272

Results from Motl, Birnbaum, Kubik, and Dishman (2004) found that fluctuating changes in physical activity in adolescents over time inversely correlated with onset of depressive symptomology. Farmer and co-workers studied 1,900 people over an eight year period and were able demonstrate that regular exercise contributed to the prevention of depression.

Exercise Compared to Established Treatments of Depression

Currently the most efficacious psychotherapeutic intervention for the treatment of depression is cognitive therapy (or commonly described as 'Cognitive Behaviour Therapy' or 'CBT'). CBT is widely recognized as the 'gold standard' treatment for depression (see Butler, Chapman, Forman, & Beck, 2006 for a detailed review of the meta-analytic data regarding the efficacy of cognitive therapy). Multiple RCT's have been conducted which have evaluated the efficacy of exercise as a treatment for depression when compared to general psychotherapy and results from these studies generally indicate that exercise is as effective as general psychotherapy (Greist, et al. 1979; Klein, Greist, Gurman, & Neiberyer, 1985; Harris, 1987). In their meta-analysis Rethorst et al. (2009) identified four relevant studies and although exercise produced better outcomes than psychotherapy (ES-0.26), the difference between the treatments did not reach statistical significance. A better comparison would be studies that have directly evaluated exercise as compared to cognitive therapy. In the few studies in which the treatments have been systematically compared exercise emerged as an equally effective treatment for depression as the current gold standard psychotherapy (e.g. Freemont & Craighead, 1987).

Use of anti-depressant medication is recommended as the first line treatment for moderate-to-severe depression according to the American Psychiatric Association's Practice Guidelines (APA, 2000). Anti-depressant medications have proved to be efficacious in the treatment of depression (see Thase & Kupfer, 1996) and are the most common means of treating depressive symptoms (Olfson & Klerman, 1993). A number of studies have scrupulously compared exercise to medication as a treatment for depression. For example, Blumenthal and colleagues (1999) compared these treatments in a cohort of older adults and reported that although those receiving medication improved at a quicker rate than the exercise group, by the end of the intervention at twelve weeks exercise proved as effective as medication in reducing depression. One impressive fact was that the exercise group had maintained their gains to a significantly greater degree than did the medication group at a ten month post-test (Babyak et al., 2000). Later, Blumenthal et al. (2007) compared an individual home-based and a supervised group-based exercise intervention consisting of three exercise regimes, three times per week, with an anti-depressant and a placebo intervention. Again, both exercise groups proved as effective as medication in reducing symptoms of depression.

...A critical factor that is often ignored in the treatment of psychological maladies relates to the fact that the alleviation of unhealthy negative emotions such as depression and anxiety does not axiomatically lead to a simultaneous increase in positive functional emotions. One of the primary goals of the field of positive psychology has been to develop and validate intervention methods, which can supplement conventional treatments such that the eradication of distressing negative emotions can occur along with the development of functional positive emotions. As noted by Seligman et al. (2005), conventional practice in clinical psychology and psychiatry has focused on reducing suffering, without any direct focus

on building happiness. Given the volume of empirical data demonstrating the beneficial psychological, physiological, and societal effects of increasing levels of happiness this is a trend that will likely change in the near future. With increasingly effective methods of reducing negative emotions, there is now a growing trend within conventional psychological treatments to focus on the positive aspects of the individual that can foster the development of positive emotions (see Beck, 2011 for how this changing in the area of CBT). What makes physical exercise based treatments so exciting is that they offer a highly effective alternative to conventional treatment methods for both anxiety and depressive disorders, while being fully accessible to practically all individuals, with few, if any, associated financial costs, and no known or obvious side-effects. An even more exciting prospect is that in addition to being an efficacious method of alleviating depression and anxiety, physical-exercise based interventions hold the very real possibility of also being an efficacious method of increasing positive emotions. Sadly this possibility has not been investigated but we eagerly await research, which attempts to test this possibility.⁷¹

2. Exercise and Substance Use

Exercise Can Curb Marijuana Use and Cravings

Vanderbilt researchers are studying heavy users of marijuana to help understand what exercise does for the brain, contributing to a field of research that uses exercise as a modality for prevention and treatment.

Participants saw a significant decrease in their cravings and daily use after just a few sessions of running on the treadmill, according to a Vanderbilt study published in the journal PLoS ONE. It is the first study to demonstrate that exercise can reduce cannabis use in persons who don't want to stop.

Twelve study participants — eight female and four male — were selected because they met the criteria for being “cannabis-dependent” and did not want treatment to help them stop smoking pot. During the study their craving for and use of cannabis was cut by more than 50 percent after exercising on a treadmill for 10 30-minute sessions over a two-week period. “This is 10 sessions but it actually went down after the first five. The maximum reduction was already there within the first week,” said co-author Peter Martin, director of the Vanderbilt Addiction Center.

“There is no way currently to treat cannabis dependence with medication, so this is big considering the magnitude of the cannabis problem in the U.S.,” Martin continued. “And this is the first time it has ever been demonstrated that exercise can reduce cannabis use in people who don't want to stop.”

Cannabis abuse or dependence and complications have increased in all age groups in the past decade in the United States. In 2009, approximately 16.7 million Americans age 12 or older

⁷¹ Psychology & Society, 2012, Vol. 5 (1), 1151 A Review of the Beneficial Mental Health Effects of Exercise and Recommendations for Future Research. James Swan, University of Chester; Philip Hyland, University of Ulster. http://www.psychologyandsociety.org/assets/original/2012/11/Swan_Hyland.pdf

reported cannabis use in the previous month and 6.1 million used the drug on 20 or more days per month, the authors wrote.

Treatment admissions for cannabis dependence have risen from 7 percent of total addiction treatment admissions in 1998 to 16 percent by 2009. Co-author Mac Buchowski, director of the Vanderbilt Energy Balance Laboratory, said the importance of this study and future studies will only continue to grow with the new knowledge of the role of physical activity in health and disease.

“It opens up exercise as a modality in prevention and treatment of, at least, marijuana abuse. And it becomes a huge issue with medical marijuana now available in some states,” he said. “What looks like an innocent, recreational habit could become a disease that has to be treated.”⁷²

Understanding addiction

Martin sees the study results as the beginning of an important area of research to better understand brain mechanisms of exercise in addiction.

“It shows that exercise can really change the way the brain works and the way the brain responds to the world around us,” he said. “And this is vital to health and has implications for all of medicine.”

Study participants, who reported they smoke on average 5.9 joints per day, came to Vanderbilt five times a week for two weeks to run on the treadmill. Buchowski and his co-workers measured the amount of exercise needed for each individual to achieve 60-70 percent of maximum heart rate, creating a personalized exercise treadmill program for each participant.

Participants were shown pictures of a cannabis-use related stimuli before and after each exercise session and then asked to rank their cravings according to the cannabis craving scale. They also documented cannabis use, which reduced to an average of 2.8 joints per day during the exercise portion of the study.

Martin said it is important to repeat the findings in a much larger study, in a randomized and controlled manner. The study results also should prompt further research into understanding what exercise does for the brain, he added. “Mental and physical health in general could be improved. Unfortunately, young people who smoke cannabis often develop panic attacks, and may develop to psychosis or mood disorders,” Martin said.

⁷² Boerner, C. (Posted on Friday, Mar. 4, 2011). Exercise can Curb Marijuana Use and Cravings. Retrieved from: <http://news.vanderbilt.edu/2011/03/exercise-can-curb-marijuana-use-and-cravings/>

*“Back in the 1960s and 70s people used to say that cannabis is not particularly unhealthy. Well, there have been data coming out over the last five years that have demonstrated pretty conclusively that cannabis smoking may be a predisposing factor for developing psychosis.”*⁷³

⁷³ Retrieved from: <http://news.vanderbilt.edu/2011/03/exercise-can-curb-marijuana-use-and-cravings/>
Vanderbilt co-investigators for this study are [Evyonne Charboneau](#), research assistant professor of psychiatry; [Sohee Park](#), professor of psychology; [Mary Dietrich](#), research associate professor of psychiatry and nursing; [Ronald Cowan](#), associate professor of psychiatry; and Natalie Meade, study coordinator.

V. Interrelated Factors, Principles, Values and Evaluative Measures



What you will find:

- **Organization Competencies & Community Preparedness**
Michael Hock
This Section discusses critical competencies agencies need to build.
- **Program Evaluation**
Shannon Morrison
This is the process of determining the effectiveness of a program.
- **Performance Measures**
Shannon Morrison
These are indicators that help a program monitor their accomplishments and progress toward goals.
- **System Assessment**
Shannon Morrison
This is the internal process designed to assess an agency's system-level competency for delivering integrated services.
- **Medical Marijuana Discussion**
Michael Hock
The facts and figures of the use of parts of the herb cannabis as a form of medicine or herbal therapy.
- **Ethics**
Michael Hock
Ethical conduct of behavioral health providers is discussed, and its importance for every element of adolescent treatment.

21. Organization Competencies & Communities of Care

Organization Competencies

Research demonstrates that an organization's current performance depends on the extent to which organizational strategy is proximate with the demands of the environment. The current behavioral health environment of the State of New Mexico requires that providers specifically address co-occurring disorders for all ages within the context of integrated recovery oriented services. Strategizing achieves importance because it represents a dynamic response to an unfolding and mostly unknowable future and is specifically about creating value in the organization and the services provided. Specific strategic intent, of course, must be followed with successful implementation.

Successful implementation is dependent upon organizational competencies in a similar fashion that successful integrated services are dependent upon staff competencies. Competencies and organizational capabilities must be clearly identifiable, as must be measurable value-adding activities that describe what the organization can do. They include the ability to create high quality outcomes, maintain low cost services, manage knowledge and training, manage human capital, and respond quickly to changes in the behavioral health environment. Structural flexibility within the behavioral health system is the expectation and not the exception, and provider organizations must embrace it as a way of doing business for sustained success.

When both strategy and organizational competencies result in successful implementation, a dynamic alignment occurs between the behavioral health business environment and the organization. This alignment functions within the organization to keep it flexible and on track with both internal and external shifts and changes. The result is that the organization with this kind of dynamic alignment maintains its sustainability and capability to meet the needs of the changing NM behavioral health system.

Specific start-up activities for an agency interested in becoming a community-based co-occurring competent adolescent provider would include having communities, state agencies, consumers and providers:

1. Identify the needs of their community, youth and families
2. Explore use of adolescent services needed to meet those needs
3. Explore feasibility of implementing integrated adolescent services inclusive of at least outpatient treatment, IOP, and Youth Support Services, and best if inclusive of *Other Services Critical to Health & Wellness*.
4. Engage other providers or consultants. It will cost more, but this greatly increases the likelihood that the adolescent IOP will be successfully implemented

It is recommended for adolescent behavioral health implementations in New Mexico that stakeholder advisory groups to support and guide individual program be established if possible. This group should ideally have a membership consisting of predominately behavioral health consumers and family members. It should also include community stakeholders (e.g., homeless services, food-shelf agencies, faith-based entities, juvenile

Justice Services, Protective Services, the housing authority, landlords, employers, and community colleges and schools) that interact with adolescents with mental illness and substance disorders and/or COD. In addition, group composition should represent the local cultural populations; they must be able to develop or adapt adolescent treatment and support interventions and practices that are responsive to the needs and cultural beliefs and values of the local communities they serve.

The proposed methods for accomplishing this goal center around three objectives.

1. Most critical is an expanded effort to build core competencies in communities related to assessment, capacity building, planning, implementation, and evaluation⁷⁴
2. A second objective involves renewed efforts to develop competencies within the behavioral health workforce related to community development and community collaboration.
3. As a final and more immediate objective, it is recommended that every behavioral health organization formally reassess its current connections to local groups, organizations, and coalitions, and implement a plan to increase, strengthen, and diversify these ties.

Concurrent to organization competency, communities must come together so that all persons and helping organizations are supported. The New Mexico Communities of Care model describes this process in the following:

Communities of Care

The Communities of Care model promotes local communities to take the lead in developing and improving services and supports for children and youth and their families who are addressing behavioral health issues.

Community of Care Values

Individual child/youth and family voice and choice:

Individuals and families' needs lead all aspects of their care, from individualized service planning and delivery to state-level policy development.

Community based and community driven:

Services and supports are provided in local community settings that are least-restrictive, integrated, inclusive, de-stigmatizing, and promoting of relationships and connection with families. Communities are empowered to design systems of care that are responsive to local needs and maximize community strengths.

⁷⁴ CADCA / SAMHSA (2013) Handbook for Community Coalitions
<http://www.cadca.org/files/resources/CoalitionHandbook-10-2013.pdf>

Recovery and resiliency focused:

Services are individualized to meet the unique and specific needs of the individual and family. The individual's and family's capacity for recovery and resiliency and their needs, strengths and preferences drive service choices and delivery.

Culturally and linguistically responsive:

The service system and its components provides for persons, youth and families in a manner that meets the continuous cultural, ethnic, religious, preferential, tribal and linguistic needs of the individuals and families receiving services. Such cultural responsiveness is inherently individualized and strength-based as it prioritizes and celebrates the preferences, practices and identities of those it serves.

Adaptable and Sustainable:

Local and statewide networks of support are reliable and responsive to change in the long-term. This includes an ongoing adaptability to incorporate cutting-edge evidence-based practices, continuous development of creative financial strategies and pathways to maintain and build the array of services, and direct information pathways to ensure quick response to the needs of individuals, families and communities.

Strengths based:

Individuals and families are always viewed first and primarily from their strengths, positive attributes, resiliency, skills and capacities. The treatment team works with the individual and family to identify such strengths. These strengths serve as the foundation for visions and goals, strategies and interventions.

Perseverance:

Treatment teams and systems demonstrate patience and perseverance in the change process. Team members and leaders do not give up on families and youth when progress is side-tracked or stalled, crises occur, bureaucracy and regulations complicate service delivery, conflict arises or collaborative efforts are derailed.

22. Program Evaluation

Shannon Morrison is a well-seasoned program evaluator who is passionate about making data meaningful and useful to programs through linking the evaluation and implementation processes. This collaborative partnership allows her to support the programs she evaluates and help them know how well they are doing and to help them get better. She believes this approach to evaluation gives programs a better chance at achieving their goals and, ultimately, improving outcomes for children, families, and their communities. Shannon co-authored the Adult Manual for Co-occurring Intensive Outpatient Programs and has provided incisive consultation and feedback for many parts of this manual. She and her team developed the Adolescent Treatment Assessment Tool based on the Policies & Procedures which she helped to develop.

Program evaluation is a systematic, objective process for determining the success of a policy or program and addresses questions about whether and to what extent the program is achieving its goals and objectives. It is a useful means to understanding program operations, documenting program value and effectiveness, examining the strengths and weaknesses of the program, and providing on-going feedback to the service team. Program evaluation assists in program planning, implementation, and improvement. There are many types of evaluations and methods for collecting information; oftentimes the breadth and complexity of the evaluation is dependent on ease of reporting, access to resources such as reporting tools, reimbursement, time management issues, and requirements set by the agency about fiscal and administrative requirements and management.

Most evaluations fall into one of three categories:

Process - Outcome - Impact

The choice of the most appropriate type of evaluation is guided by several factors, including the availability of resources and whether the evaluation is needed for internal or external purposes:

- Process-based evaluations are useful in assessing how an intervention is being implemented or whether it is producing the necessary measurements.
- Outcomes-based and impact-based evaluations are best for tracking the results of an intervention.

Process assessment is likely to be useful internally, whereas the focus on outcomes and impact can help justify the intervention both internally and externally. Whichever evaluation model is used, data need to be collected in a systematic manner.

Types of Data	
Quantitative	Descriptive and subjective: e.g., counting the number of drunk-driving fatalities or the percentage awareness of a risk
Qualitative	Measurable and definable in absolute numerical terms: e.g., recording subjective views on whether a program has changed perceptions

The following two sections; Performance Measures, and Systems Assessments, are descriptive of evaluative measurements, as well as evaluation processes.

23. Performance Measures

Performance measurement is the ongoing monitoring and reporting of program accomplishments, particularly progress towards pre-established goals. It is typically conducted by program or agency management. Performance measures may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), and/or the results of those products and services (outcomes).⁷⁵

At a minimum, it is recommended that programs evaluate their performance and how well they are achieving their short-term outcomes at regularly scheduled intervals determined by funding agencies, grant requirements, or the provider agency's internal reporting needs. Performance measurement is an ongoing process that monitors and reports on a program's progress and accomplishments by using select measures. Programs need performance measures to know whether the program is performing as it should be related to effect. The program evaluation determines to what degree the program is meeting benchmarks and outcome expectations.

Performance measures for adolescent co-occurring treatment services include (but are not limited to):

- Number and types of services (including mental health treatment, substance use disorder services, co-occurring treatment, IOP, housing, employment, educational, youth support services, etc.) provided by provider agency
- Number of youth screened for services (by service type)
- Number of youth assessed for services (by service type)
- Number of youth receiving services (by service type)
- Number of youth referred to other services (by service type)
- Length of stay in treatment services
- Number of youth routinely discharged
- Number of youth no longer in program (due to drop out because of criminal involvement, lack of engagement, absconding, relocating, death, serious illness, etc.)
- Number of youth arrested while in services
- Number of youth sent to jail or prison while in services
- Changes/improvements in 'quality of life' indicators (mental health, physical health, employment, education, housing, etc.)

⁷⁵ GAO Performance Measurement and Evaluation <http://www.gao.gov/products/GAO-05-739sp>

24. Systems Assessment

Overview

The Adolescent Treatment Manual web-based New Mexico Adolescent Treatment Assessment Tool (NMATAT) is a process evaluation designed to assess the systems-level competency for providing youth with co-occurring substance and mental health disorders outpatient services fully integrated into a comprehensive system of care including IOP. Because IOP is provided using a primarily substance disorders evidence-based treatment curriculum (such as the Matrix Model or The Seven Challenges), and because there is significant research that supports the premise that the *systems integration* of treatment has profound and far reaching impact on the provision of co-occurring competent services, the state is working with the community provider system to develop, enhance, or improve service integration. It is important to assess an agency's self-perception of fidelity or competency of implementation related to the principals and practices described in the Adolescent Treatment Manual. Regular (as in semi-annual or annual) honest self-assessment will make possible adjustments and improvements of both administrative and overall services implementation.

The assessment process of integrated adolescent services focuses on how the provider is internally implementing agency-wide integrated co-occurring competent services at the systems level of the organization. This manual with its accompanying policy & procedure manual and web-based assessment tool contains quality improvement tools intended to enable providers to achieve the highest possible level of competency in all levels of integrated service, especially regarding COD competent integrated services.

The assessment is primarily a quality assurance tool, in that it assesses how well the provider is implementing each of the manual's elements. The aim of quality assurance activities is the development of continuous quality improvement plans. Most importantly, it is not an audit function, but is a self-disclosing assessment of the actual processes, services, attitudes, capabilities, and service integration in place at the time of assessment. The assessment must necessarily capture the correct and complete picture of service implementation in a "snapshot" fashion. The report generated from the assessment process should be utilized to develop comprehensive continuous quality improvement plans to innovate, enhance or sustain services at a high level of excellence.

Because the assessment tool requires self-assessment related to fidelity to the systems model described in the ATM, and because it is not an audit tool that is tied to funding, it is essential that providers look at themselves with a critical eye, and are completely honest regarding operations at both the administrative and service implementation level. Without this level of open and frank self-analysis, this tool will be rendered somewhat useless. The results belong to the provider agencies assessed, and the results inform what and where to apply current and future effort at improving services through a CQI process. The assessment will not be useful as a showcase, but will be

effective to measure improvements of the provider's service capability over time related to service integration of adolescent treatment services.

The collaboration between State and provider will be enhanced by the following:

- Assess: The provider will self-assess using the web-based self-administered ATM Assessment Tool supplied by the State
- Collaborate: The provider will incorporate the assessment report into the CQI work-plan as possible and appropriate to each provider and seek technical assistance from the State as needed.
- Ensure: The provider will make sure that appropriate staff complete the self-assessment.
- Identifying system leaders or advocates and assigning them duties related to the implementation of COD competent services.
- Ensuring that systemic and programmatic changes are communicated to all relevant personnel within the program for their feedback and understanding, with thoughtful education and coaching regarding changes in approach provided to the consumer, and seek technical assistance from State partners as appropriate and needed.
- Incorporation of all the programmatic and systemic changes into agency Policies and Procedures, and/or related mission statements and management documents.

What is Fidelity?

Implementation fidelity is "the degree to which programs are implemented as intended by the program developers." This idea is sometimes also termed "integrity." Implementation fidelity acts as a potential moderator of the relationship between interventions and their intended outcomes. That is to say, it is a factor that may impact on the relationship between these two variables (i.e., how far an intervention actually affects outcomes). This is one of the principal reasons why implementation fidelity needs to be measured. It has been demonstrated that the fidelity with which an intervention is implemented affects how well it succeeds.

It is only by making an appropriate evaluation of the fidelity with which an intervention has been implemented that a viable assessment can be made of its contribution to outcomes (i.e., its effect on performance).⁷⁶

Fidelity and the ATM Assessment Tool

The ATM assessment tool measures fidelity related to the level of service implementation for each of the Elements in Part B of this ATM. Each of these elements consists of components and the provider is guided through a set of five questions for each of these components. These questions are listed below:

⁷⁶ Carroll, C. et al. (2007). A conceptual framework for implementation fidelity. Implementation Science 2007, 2:40 <http://www.implementationscience.com/content/2/1/40>

1. On a scale from 1-5, rate your level of implementation of this practice where '1' indicates not practiced at all and '5' indicates that this practice is implemented all of the time.
2. On a scale from 1-3, indicate whether or not there are policies and procedures in place for this practice where '1' means no, '2' means, partially, and '3' means yes.
3. Describe current application of procedures.
4. Does the agency want or have plans for improvement in this area?
5. Describe plans for improvement and identify any training or technical assistance needs.

During the self-assessment, it is important that staff that can answer questions about systems-level integrated care be involved in completing the tool as well as the clinical director or supervisor, IOP supervisor and/or staff, quality management staff, and any other staff providing integrated COD care. The tool is located in a separate document, which provides more detailed instruction on its completion.

25. Discussion of Medical Marijuana

Medical Marijuana refers to the use of parts of the herb cannabis (also referred to as medical cannabis) as a physician-recommended form of medicine or herbal therapy, or to synthetic forms of specific cannabinoids, such as THC and Marinol, which can be prescribed, and for which dosage can be regulated. It is important to note that in the State of New Mexico, State recognized prescribers can recommend that a patient receive treatment through the use of medical marijuana, but cannot prescribe use. The State approves and provides access to medical marijuana.

The medicinal value of cannabis is controversial, especially for minors. A large majority of national governments do not recognize the use of plant parts from the plant *Cannabis Sativa* as something that doctors can recommend to their patients. A number of these governments, including the U.S. government allow, however, in varying degrees, treatment with one or more specific, synthetic cannabinoids for one or more disorders. There is growing acceptance of the non-smokable form of marijuana (CBD) which is very low in THC and therefore does not produce the euphoria. It is approved for children with intractable epilepsy as well as other conditions.

While cannabis for recreational use is illegal in most parts of the world, many countries (and states in the US) are decriminalizing it. Specified use as a medicine is legal in a number of countries including Canada, Austria, Germany, the Netherlands, Spain, Israel, Italy, Finland, and Portugal. In the United States, federal law outlaws all use of herb parts from *Cannabis*, but 23 States and the District of Columbia (as of July 31, 2014 ⁷⁷) have approved use of herb parts from *Cannabis* as medical cannabis in obvious conflict with federal law. The United States Supreme Court has ruled in *United States v. Oakland Cannabis Buyers' Coop* and *Gonzales v. Raich* that the federal government has a right to regulate and criminalize cannabis, even for medical purposes, but rarely intervenes. Some states or municipalities have legalized or decriminalized use and/or possession of marijuana.

Despite these rulings, the State of New Mexico has a legalized medical marijuana program, which allows adults to receive a marijuana recommendation from a certified physician, apply for a State-issued Medical Marijuana ID Card, and grow and/or purchase marijuana for medicinal use per state guidelines.

Pros and Cons:

Joycelyn Elders, MD, former US Surgeon General, wrote the following in a Mar. 26, 2004 article titled "Myths About Medical Marijuana," published in the Providence Journal: "The evidence is overwhelming that marijuana can relieve certain types of pain, nausea, vomiting and other symptoms caused by such illnesses as multiple sclerosis, cancer and AIDS — or by the harsh drugs sometimes used to treat them. And it can do so with

⁷⁷ <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881>

remarkable safety. Indeed, marijuana is less toxic than many of the drugs that physicians prescribe every day.”⁷⁸

Mark L. Kraus, MD, former President of the Connecticut Section of the American Society of Addiction Medicine (ASAM) stated the following in his Feb. 26, 2007 testimony to the Judiciary Committee in Hartford, Connecticut: “Proponents of the legalization of medical marijuana create the impression that it is a reasonable alternative to conventional drugs. But unlike conventional drugs, smokable marijuana has not passed the rigorous scrutiny of scientific investigation and has not been found safe and effective in treating pain, nausea and vomiting, or wasting syndrome... It has no credibility. It has not passed the rigors of scientific investigation. It has not demonstrated significant efficacy in symptom relief. And, it causes harm.” The following is excerpted from the NM Department of Health FAQ related to medical marijuana:

New Mexico Department of Health Medical Cannabis website FAQs:

Q: What conditions make a patient eligible for the program?

A: Currently, there are 16 qualifying conditions: Severe chronic pain, painful peripheral neuropathy, intractable nausea/vomiting, severe anorexia/cachexia, hepatitis C infection currently receiving antiviral treatment, Crohn’s disease, Post-traumatic Stress Disorder, Amyotrophic Lateral Sclerosis (Lou Gehrig’s disease), cancer, glaucoma, multiple sclerosis, damage to the nervous tissue of the spinal cord with intractable spasticity, epilepsy, HIV/AIDS, inflammatory autoimmune-mediated arthritis, and hospice patients.

Q: Can other conditions be added to the list?

A: Yes. Individuals can request a new condition be added by petitioning the Medical Advisory Board to add the new condition. The Medical Advisory Board then makes a recommendation to the Secretary of Health. The Secretary then makes a determination to add the new condition if there is sufficient scientific evidence presented that the conditions could be helped by medical cannabis and that the addition of new conditions meets the purpose of the state law, which is to provide relief from pain and suffering associated with debilitating medical conditions. Petition requirements are available on the program website.

Q: Can a minor apply to be a patient in the program?

A: Yes, so long as a parent or legal guardian is enrolled as the minor’s Caregiver (see chapter on Caregivers).

Q: What is a caregiver?

A: Someone empowered by the patient to help manage the patient’s medical care and medication. Caregivers must enroll in the program. An enrolled caregiver is issued a medical cannabis registry ID card that allows them to possess up to six (6) ounces of medical cannabis on behalf of their patient. It is not legal for caregivers to use medical cannabis (unless they are certified patients themselves).⁷⁹

⁷⁸ Elders, J., (2004). Myths About Medical Marijuana. The Providence Journal Company. March 2004

⁷⁹ New Mexico Department of Health Medical Cannabis Program: <http://nmhealth.org/publication/view/help/132/>

More psychiatric risk than benefit

Part of the reason marijuana works to relieve pain and quell nausea is that, in some people, it acts as a sedative, reducing anxiety and improving mood. But so far the few studies evaluating the use of marijuana as a treatment for psychiatric disorders are inconclusive about benefits, partly because this drug may have contradictory effects in the brain depending on age, the dose of the drug and inborn genetic vulnerability. Much more is known about the psychiatric risks of marijuana (whether used for recreational or medical purposes) than its benefits. The biggest problem may be the effect of any psychoactive substance on the developing brain.

Spectrum of Cannabis Use Disorders

Observational studies suggest that one in nine people who smokes marijuana regularly becomes dependent on it. Research both in animals and in people provides evidence that marijuana is an addictive substance, especially when used for prolonged periods.

Addiction specialists note with concern that THC concentration has been increasing in the herbal form of marijuana. In the United States, THC concentrations in marijuana sold on the street used to range from 1% to 4% of the total product; by 2003, average THC concentration had risen to 7%. Similar trends are reported in Europe. This increased potency might also accelerate development of dependence. Current average percentages are around 14% with some samples as high as 35%.

Less conclusive is the notion that marijuana is a "gateway drug" that leads people to experiment with "hard" drugs such as cocaine. The research is conflicting.

Anxiety

Although many recreational users say that smoking marijuana calms them down, for others it has the opposite effect. The different reactions are likely a result of which strains of the plant are dominant. In fact, the most commonly reported side effects of smoking marijuana are intense anxiety and panic attacks. Studies report that about 20% to 30% of recreational users experience such problems after smoking marijuana. The people most vulnerable are those who have never used marijuana before.

Dose of THC also matters. At low doses, THC can be sedating. At higher doses, however, this substance can induce intense episodes of anxiety.

It is not yet known whether marijuana increases the risk of developing a persistent anxiety disorder. Observational studies have produced conflicting findings. Studies of recreational users suggest that many suffer from anxiety, and it's difficult to know what underlies this association. Possibilities include selection bias (e.g., that anxious people are more likely to use marijuana), a rebound phenomenon (e.g., that marijuana smokers feel worse when withdrawing from the substance), and other reasons (e.g., genetic vulnerability).

Mood disorders

Little controlled research has been done about how marijuana use affects patients with bipolar disorder. Many patients with bipolar disorder use marijuana, and the drug appears

to induce manic episodes and increases rapid cycling between manic and depressive moods. But it is not yet clear whether people who use marijuana are at increased risk of developing bipolar disorder.

The small amount of research available on depression is also muddled. In line with what studies report about anxiety, many marijuana users describe an improvement in mood. Animal studies have suggested that components of marijuana may have antidepressant effects. Yet several observational studies have suggested that daily marijuana use may, in some users, actually increase symptoms of depression or promote the development of this disorder.

For example, an Australian study that followed the outcomes of 1,601 students found that those who used marijuana at least once a week at ages 14 or 15 were twice as likely to develop depression seven years later as those who never smoked the substance — even after adjusting for other factors. Young women who smoked marijuana daily were five times as likely to develop depression seven years later as their non-smoking peers. Although such studies do not prove cause and effect, the dose-outcomes relationship is particularly worrisome.

Psychosis

Marijuana exacerbates psychotic symptoms and worsens outcomes in patients already diagnosed with schizophrenia or other psychotic disorders. Several large observational studies also strongly suggest that using marijuana — particularly in the early teenage years — can increase risk of developing psychosis.

An often-cited study of more than 50,000 young Swedish soldiers, for example, found that those who had smoked marijuana at least once were more than twice as likely to develop schizophrenia as those who had not smoked marijuana. The heaviest users (who said they had used the drug more than 50 times) were six times as likely to develop schizophrenia as the nonsmokers.

Question of Causation

Although these findings between marijuana use and psychosis are associative, a causal relationship has not been established. More research and studies are needed to determine if marijuana use causes psychosis of any kind.

Until recently, the consensus view was that this reflected selection bias: Individuals who were already vulnerable to developing psychosis or in the early stages (the prodrome) might be more likely to smoke marijuana to quell voices and disturbing thoughts. But further analyses of the Swedish study, and other observational studies, have found that marijuana use increases the risk of psychosis, even after adjusting for possible confounding factors.

Although cause and effect are hard to prove, evidence is accumulating that early or heavy marijuana use might not only trigger psychosis in people who are already vulnerable, but might also cause psychosis in some people who might not otherwise have developed it. Certainly genetic profile mediates the effect of marijuana. People born with a variation of the gene COMT are more vulnerable to developing psychosis, for example. To date there is no reliable way for clinicians to identify vulnerable young people in advance, therefore it is safest to restrict use of medical marijuana to adults.

Other effects

A review of side effects caused by medical marijuana found that most were mild. When compared with controls, people who used medical marijuana were more likely to develop pneumonia and other respiratory problems, and experience vomiting, and diarrhea.

There's no question that recreational use of marijuana produces short-term problems with thinking, working memory, and executive function (the ability to focus and integrate different types of information). Although little research exists on medical marijuana, anecdotal reports indicate that some patients take the drug at night to avoid these types of problems.

A more important issue might be what effect marijuana, or any other psychoactive drug use, has on a developing brain and whether long-term use of marijuana (either for medical or recreational purposes) produces persistent cognitive problems. Although early studies of recreational users reported such difficulties, the studies had key design problems. Typically they compared long-term marijuana smokers with people who had never used the drug, for example, without controlling for baseline characteristics (such as education or cognitive functioning) that might determine who continues to smoke the drug and who might be most at risk for thinking and memory problems later on.

Studies suggest that although overall cognitive ability remains intact, long-term use of marijuana may cause subtle but lasting impairments in executive function. There is no consensus, however, about whether this affects real-world functioning.

Additional research focused on the benefits and consequences of medical marijuana use for specific disorders may help to clarify some issues. In the meantime, there is not enough evidence to recommend marijuana as a medical treatment for any psychiatric disorder.

26. Ethics

Ethics and ethical conduct are essential elements to all behavioral health services provided in New Mexico. All provider staff and all business or professional associates of providers are expected to meet the highest standards of ethical conduct. Such conduct includes originating and maintaining honest and principled client relations, honest and respectful relations with other providers, trustworthy and honest relations with the state agencies, funders and community stakeholders, and avoiding circumstances or conditions that could lead to dual relationships or conflict of interest, either personal or professional. Laws, regulations and funding sources stipulate various ethical practices and guidelines and must be adhered to in all cases. Specific care and attention for HIPAA and 42 CFR Part 2 must stress all service ethics related to confidentiality and protected health information as well as care for the principles of gender competent protection of health data.

For all children and youth, the State requires strict adherence to the Children's Code, including conducting criminal background checks, adherence to age requirements, mixing children (under 18 years of age) with adults in all types of service settings, ages of consent, and required and mandatory reporting of such information as intent to harm or self-harm. The provider must adhere to all codes and regulations governing specific treatments or interactions. In all cases it is incumbent upon the provider to seek and understand these codes and regulations.

Understanding Health Information Privacy

Electronic Health Records Systems must be maintained in full compliance with all HIPAA regulations and 42 CFR Part 2, and must assure that the provider agency follows all applicable Federal, State, Tribal, and/or municipal laws and regulations. The Office for Civil Rights (OCR) enforces the HIPAA Privacy Rule which protects the privacy of individually identifiable health information; the HIPAA Security Rule, which sets national standards for the security of electronic protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety. In addition, the **Health Information Technology for Economic and Clinical Health (HITECH) Act** enacted as part of the American Recovery and Reinvestment Act was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology.⁸⁰ Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

⁸⁰ <http://www.hhs.gov/ocr/privacy/hipaa/administrative/enforcementrule/hitechenforcementifr.html>

The HIPAA Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities to use to assure the confidentiality, integrity, and availability of electronic protected health information.

Health and Wellness from the Western Treatment Perspective©

By Suzanne Otter, MA, LMHC, Santa Fe, NM

The art on the following page painted by Suzanne Otter depicts the individual & family in our Western conception of behavioral health as isolated—as if on an island apart—from the schools, community and environment. It puts the transpersonal in the sky and distant from personal interaction rather than central to the person’s life, and it focuses primarily on observable behaviors rather than overall health and well-being in the *whole life* of the individual or family. This is changing, in part driven by research as cited in this manual, and in part because the people providing services observe this and are increasingly implementing new and more holistic practices.



I. Description of Integrated Adolescent Services by Element



What you will find:

Philosophy of Approach & Principles of Practice:

Seven Governing Elements that Organize Effective Treatment Practices

- Engagement, Alliance, & Rapport
- Guiding Principles of Recovery
Randolph Muck
- Cultural Competency
- Gender Competency
- Stage-wise Interventions
- Motivational Approaches
- Trauma Sensitive Systems of Care

These seven philosophies of approach and regard, and their accompanying practices, can be utilized as lenses through which every individual can be perceived with more compassion and understanding. The seven elements listed in this Section can be integrated into a comprehensive attitudinal and philosophical approach to every individual, both at the overall administrative level, and within the day to day processes of accomplishing services.

Please note that the attached Policies & Procedures (P&P) Manual in Appendix C matches Part B of this manual element by element.

The Policies and Procedures are specifically and carefully crafted to facilitate easy and thorough adoption and/or adaptation and implementation of the treatment elements of the ATM by providing explicit instructions beyond mere description and discourse, and are available in Microsoft Word format by request.

1. Engagement, Alliance, & Rapport

Engagement is a fundamental element of the treatment process. It is essentially customer care, and much can be borrowed from the business sector about how to utilize customer care principles. This element is specifically about how to develop and maintain a trusting and effective relationship between the entire agency, including all staff, and those persons being served. Fundamentally, engagement is simply about meeting another being, human or otherwise, with respect and attention.

Effective engagement will increase retention and active participation in treatment. Engagement is accomplished through successful and respectful communication and support, and the recognition of equality and valuing of diversity, regardless of cultural or linguistic background, religious affiliation, sexual orientation, etc. Engagement is also fully applicable within any organization, and will generally increase sense of team cooperation and support and overall job satisfaction. Engagement strategies are approached as the foundation and building of trust, alliance, and rapport with the individual and/or family being served, and are continuously applied. There should be awareness of engagement in every interaction with the adolescent and his or her family, to assure retention in all aspects of treatment and other integrated services, from the waiting room staff through intake and all treatment. Creating an alliance could be briefly stated as the qualities and expertise which the client perceives as potential for help in the therapist, and therefore becomes willing to engage into a therapeutic relationship of alliance.

Rapport is a description of awareness whereby the clinician actively aligns his interaction to the level and capability of the client which results in more successful communication on a moment to moment basis. An example of this might be demonstrated in skillful Sand Tray therapy where clients are encouraged to use miniature toys, figurines and objects in a tray of sand. The design of the sand tray is guided by the individual's imagination and their subconscious. The world within the sand tray is expressed through symbolism and metaphor, and may not even make immediate sense to the client. But aided by the therapist, a client, even a child, can begin to recognize the relationship between the creation in the sand and their own inner world. The effective therapist consciously aligns all levels communication to the client; in tone, posture, expression, and complexity of verbal communication.⁸¹

Rapport skills are learned and applied by specific observation and reflection of the person being worked with. In a clinical setting this may occur by happenstance related to similarities in culture, gender attitudes and identity, or similar backgrounds, but an assumption that the other person is anything other than unique is likely to lead to imprecise rapport, which is likely to hamper effective communication. Classroom examples abound, such as highly kinesthetic (physically active) children being told to sit still, with resulting inability to focus on anything other than sitting still!

⁸¹ http://www.goodtherapy.org/sand_tray_sand_play_therapy.html#

The following description of nine principles relates to how we can modify our interactions to more effectively and more succinctly communicate with another person. As with all such principles, they must be generally applied and are not rules about how every person will respond.

A few useful principles for recovery-based engagement:⁸²

1. Communication occurs on multiple levels: staff, provider environments, and general organizational culture are always communicating non-verbally and verbally. Non-verbal communication is often more powerful than verbal communication.
2. The meaning of your communication is the response that you get: communication is not about what you intend, or about saying the right words; it's about creating an experience in, and getting a response from the listener. The bottom line is the response you elicit. In other words, if the other person doesn't like something you do or say, their response has been elicited by you. It is more useful and generative for you to think about how you spoke and acted to elicit the response than it is to focus on their behavior. If you change your language or behavior skillfully, you'll get a response closer to what you intended.
3. People work perfectly: it's simply a matter of discovering how a person functions now so that you can effectively engage the person in changing towards more useful or functional behavior in the appropriate context for the behavior.
4. People almost always make the best choice they can perceive as available to them in the moment: there are usually many other possible choices. Effective interventions help the person determine and implement those choices that are more beneficial for them.
5. Every behavior is useful in some context: re-contextualizing or reframing a specific behavior can be a significant event in shifting perspective and understanding.
6. Choice is almost always better than no choice.
7. People already have most of the resources they need: they may need help to access those resources at appropriate times and places, or specific help to develop or adapt new resources. Resources can mean physical and cognitive skills, capabilities, attitudes, concentration, playfulness, and self-regulation, to name just a few. Youth are in the process of building resources based on experiences.
8. There is no such thing as failure, only feedback: every response can be utilized to help determine effective change at the next available opportunity. This statement is primarily about reducing stigma. People who experience significant challenges must be engaged with hope and optimism that change is possible and even likely if mistakes can be utilized as teachers for changed future behaviors.
9. Anything can be accomplished by anyone if the task can be broken down into small enough portions, which includes both amount of information and the duration of the individual's attention span: one of the most important tasks of effective communicators is about determining effective portion size and then communicating what the other person can hear and process.

⁸² <http://www.nlpls.com/articles/presuppositions.php>: 2014 John David Hoag

2. Guiding Principles of Adolescent Recovery

Fall Down 1000 Times, Get Up 1

We look out near and far and see our friends, our brothers and sisters, mothers, fathers, grandfathers, grandmothers, and youth and children who are being ravaged by substance use and dependence. We see our family members fall down repeatedly. It may seem endless and hopeless and it can wound us and wrench our hearts in anguish, yet this simple statement is the whole of recovery distilled into a single phrase: fall down 1000 times, get up 1. If we can help our human family to stand one more time, to take even a single step towards recovery before they fall again, we must do so, as long as we are able.

We can build our systems, hone our skills, and know the best practices ever developed, but without this fundamental and crucial understanding of support and ongoing engagement, we will continue to offer the episodic models of intervention versus long-term support and the encouragement of self-development currently best described as recovery. If our youth and children need life-long support in maintaining recovery, or in rediscovering that recovery is possible over and over again, we must step up to this challenge and meet it. Few of us are capable of doing this as individuals in a sustained fashion, and our governmental, school, faith, law-enforcement and treatment systems are already severely taxed by overwhelming need. To meet this, we must restructure our fundamental understandings and approaches and no longer cast aside those who we do not know how to help. All of us, every community, every citizen, must unite and work together to address this challenge to our social health and by extension our public safety. When youth are detained, disciplined, expelled or ignored when a disorder or early signs of a problem first begin or are first identified and we do not act out of concern and compassion we have missed an opportunity to quickly restore the youth, the family and the community before the harm to the individual and our communities has escalated to the point where successful intervention is exponentially more difficult, and the likelihood and magnitude of harm outpaces our ability to provide aid.

Michael Hock

The field of adolescent treatment is very early in its development and suffered for many years with repeated failure and very little success as youth were provided the same type of treatment as adults, which we now know, is either ineffective at best or harmful. Even worse, in an attempt to help, were programs that treated youth along with adults. This same dynamic has plagued the recovery movement where adults have made the assumption that the same mechanisms they use effectively to live a life of recovery or wellness would automatically translate to youth. The working models of principles of recovery that exist have not been tested scientifically for the adult populations that created them. There have been several attempts to have the voice of youth heard in the development of a definition of recovery that is youth focused. There is information from focus groups with youth in recovery/wellness. Many youth choose not to use the term recovery and forcing it on them is likely not particularly useful if they are having success

with their own explanatory model and lexicon for what adults would typically want to label as recovery.

At a 2004 National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation convened by SAMHSA, patients, health-care professionals, researchers and others agreed on 10 core principles undergirding a recovery orientation:

- Self-direction: Consumers determine their own path to recovery.
- Individualized and person-centered: There are multiple pathways to recovery based on individuals' unique strengths, needs, preferences, experiences and cultural backgrounds.
- Empowerment: Consumers can choose among options and participate in all decisions that affect them.
- Holistic: Recovery focuses on people's entire lives, including mind, body, spirit and community.
- Nonlinear: Recovery isn't a step-by-step process but one based on continual growth, occasional setbacks and learning from experience.
- Strengths-based: Recovery builds on people's strengths.
- Peer support: Mutual support plays an invaluable role in recovery.
- Respect: Acceptance and appreciation by society, communities, systems of care and consumers themselves are crucial to recovery.
- Responsibility: Consumers are responsible for their own self-care and journeys of recovery.
- Hope: Recovery's central, motivating message is a better future — that people can and do overcome obstacles.

The intention is for these principles of recovery to apply to both substance use and mental health disorders. However, the reliability and validity of these principles is unknown, particularly for youth.

To work with a youth in recovery it is helpful to have a working definition of recovery. There have been few attempts to codify principles of recovery for youth. One of the few attempts to begin the dialogue and understanding around recovery for youth included conducting focus groups with youth in recovery. Participants were asked to define recovery and were informed that their perspectives would be shared with participants at the National Summit on Recovery in 2004.

Adolescents in recovery offer their own definitions of recovery:

- Recovery is growing in every respect...physically, spiritually and mentally. I have grown so much in every single way ever since I have been in recovery.
- Recovery is a choice. It is an ongoing process that is like cancer in remission. At any point in time it can turn back to the way it was before.
- Recovery is a whole lifestyle change. Everything has to revolve around and support staying sober. It is an intense and hard process, but, at the

same time, it is the only choice.

- Recovery is a healing process...like having physical therapy after a car accident. A person doesn't realize what strength they have until they work the program. It means healing mentally and physically.
 - Recovery is the chance to grow into the woman that I have wanted to be. Before I was in a dead end. Now I can be happy and proud of myself.
 - Recovery is different from being sober or abstinent. It is actively working some kind of program to maintain a state of sobriety.
 - Recovery is when you actually believe in yourself. When you recover, you are staying sober for yourself and not your parents or the recovery system.
-

While the definition of recovery is expansive and differs from person to person, it often includes growing in several capacities (mentally, physically and spiritually) and embracing a complete lifestyle change.

Adolescents face a number of barriers in the recovery process:

- Lack of individualized/appropriate care during treatment;
- Lack of post treatment follow-up;
- Lack of access to resources;
- Returning to non-supportive environments;
- Failure to address trauma or sexual histories; and
- Maintenance of past peer networks.

Several critical factors are necessary for success in the recovery process:

- Developing coping skills;
- Maintaining a supportive treatment environment;
- Developing accountability and self-worth;
- Providing a transitional environment;
- Providing a constructive school environment; and
- Including family in the recovery process.

The information gathered from the adolescent focus groups provides a valuable resource to service providers and policy makers examining adolescent services and systems of care. As stated in the introduction, the voices of youth are often not incorporated into treatment and recovery policy and systems change efforts for adolescents. However, the voices and experiences of adolescents in recovery can contribute greatly to improving the quality of current and future services. Although numerous barriers to recovery were identified, adolescents also provided great insight into factors that are critical to an individual achieving a successful recovery process and recommendations for improving treatment and supporting recovery. This report should serve as a guide for those in the substance use

disorder field to develop recovery-oriented systems for adolescents. Further efforts to engage the perspectives of adolescents should be considered in system improvements.⁸³

The Shift to Recovery Oriented Care

With the founding of Alcoholics Anonymous (AA) in 1935, the fellowship has grown to be the most influential self-help/mutual aid group for addiction in the U.S. AA was not the first, but arguably has had the greatest impact on current society of any mutual aid group. William White documents mutual aid groups that have existed in the U.S. beginning in the 1700's through the present.⁸⁴

AA and other self-help/mutual aid groups, as well as the faith community were traditionally not fully embraced by the scientific and medical fields. AA began in part because of the failure of the medical community to respond in an effective way with those suffering from addictive disorders. The medical field has learned much since 1935 about addiction and appropriate responses to addiction. Self-help/mutual aid groups have also added to their knowledge base regarding the physical, emotional, and spiritual harm that accrues to the individual and those around them as their addiction progresses. The faith community continues to provide hope and healing to some who choose that direction for help. We find ourselves at a point where there is at least tolerance and at times appreciation for the work of the disparate organizations and disciplines that have not given up, and continue to seek more understanding of addictive disorders and improvement in their responses to the suffering that addiction brings, extending well beyond the person with the disorder.

Many have long recognized that there is no one way to recovery or wellness. As alternative treatment methods arose, there has been some debate about some approaches, but for the most part, methods scientifically supported have gained acceptance. Currently there are multiple lists of Effective or Evidence-Based Treatments. Many Evidence-Based Treatments incorporate at least some principles of AA or require some attendance at AA or other self-help groups during treatment, but not all.

The mutual-aid/self-help groups are for the most part friendly to AA. Some include spiritual principles, but not all. Some purposefully have chosen an approach that does not include any elements of a religion or spirituality. Examples of AA, NA, and other self-help groups that do not employ the concepts of AA include SMART Recovery (which has meetings on the web as well as in person), Secular Organizations for Sobriety as well as Rational Recovery. What is sure is that you will not have every mutual-aid self-help group that is friendly to youth in your area. In many cases, you may need to foster youth attending a group that you know will be receptive to teens. On-line groups are particularly

⁸³ Center for Substance Abuse Treatment. National Summit on Recovery: Conference Report. DHHS Publication No. (SMA) 07-4276. Rockville, MD: Substance Abuse and Mental Health Services Administration 2007. (from Voices of Recovery, Partners in Recovery, SMAHSA 2004)

⁸⁴ The Addiction Recovery Mutual Aid Groups in the United States: A Chronology of Founding Dates (as of February 2010)
http://www.williamwhitepapers.com/pr/file_download.php?fn=2010+Addiction+Recovery+Mutual+Aid+Groups&ext=pdf.

helpful in remote areas where other groups are unavailable. A part of the responsibility of the program is to work with other community agencies, organizations and individuals to develop a recovery oriented system, or community of care. This is a new direction for the field and sorely needed. A conversation with CYFD about how your agency might prepare to apply for a ROSC grant, by incrementally improving community support for those who are in, have completed, or who are in need of treatment.

The treatment field and its mandate has shifted to one of following any patient, youth or adult, for as long as is needed and providing periodic check-ups on how those who have completed treatment, left treatment, or have been discharged by a program they were attending.

Recovery Oriented Systems of Care (ROSC) is one response that came from recognition that the more approaches available and the more coordinated the response to the individual/youth with a substance use disorder, the more likely the youth can find a path with a system of supports that works for them. This still is a point of irritation for some who cling to the notion that their path to recovery is THE path to recovery.

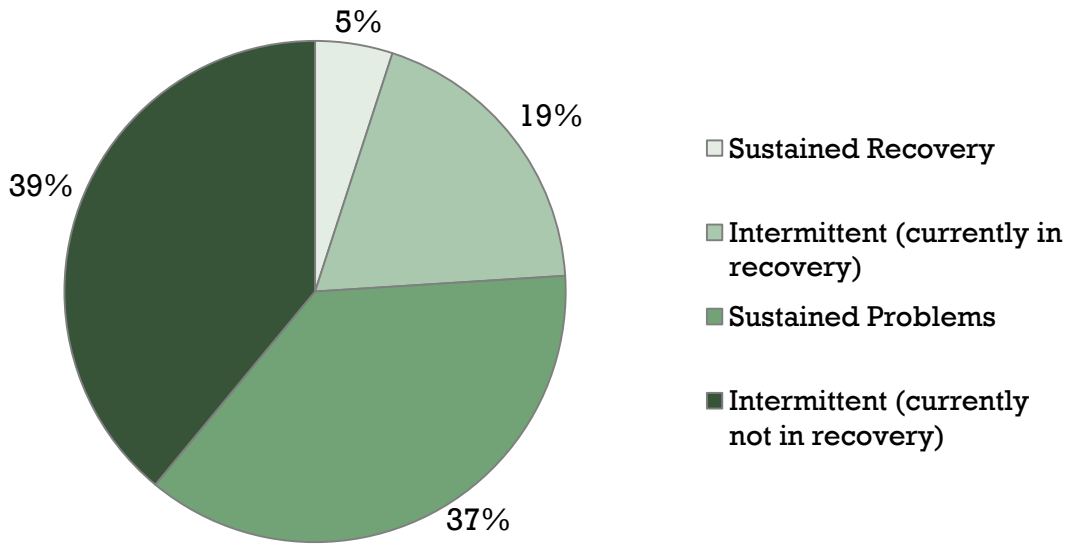
Recovery support services for youth has in most cases not been a reimbursable Medicaid service within States, and adolescent treatment programs with a focus on treatment of SUDs were typically not communicating with their State Medicaid offices to increase benefits for other services than the menu that was already available. In most States, treatment programs for adolescent SUDs do not have a rudimentary working knowledge to enable them to be a helpful partner with their State Medicaid offices to develop plans to fund services under categories that that they easily could have used, such as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). New Mexico is a State that stands far above others in utilization of Medicaid to gain access to Intensive Outpatient Treatment Services for youth and has a broad array of programs authorized for the State.

Programs interested in increasing their Medicaid reimbursable services would benefit from beginning an exploration of possible changes in benefits should review the following link:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>

To better understand the non-linear process of youth with substance use disorders it is helpful to also be realistic about measures of success that are taken from outcomes of EBPs performed with fidelity to the model and then followed for at least a year using the same instrumentation and data points so and apples to apples comparison can be made. The pie chart below shows the experience of youth following treatment in the Cannabis Youth Treatment experiment out to 36 months post-treatment.

The Majority of Adolescents Cycle in and out of Recovery



SOURCE: Dennis et. al. 2005

In most cases, recovery has been left to the self-help movement. Often AA or other self-help was required during treatment and recommended for youth following treatment, but most youth did not follow through on passive referrals to AA (as opposed to attendance being a requirement of the treatment process). A current study of youth and adults and their participation in AA during and following treatment demonstrated that the median number of AA or self-help groups attended by youth was zero following treatment.⁸⁵ There are many reasons why youth do not follow through with passive referrals to AA or other self-help groups.

John Kelly who is currently at Harvard has done the most work in this area. John noted the following as the most prominent reasons for youth not attending AA or other self-help groups:

- the composition of most groups are middle aged or older adults, creating an age mismatch

- severity and chronicity of use by youth is much lower than typical adults attending AA

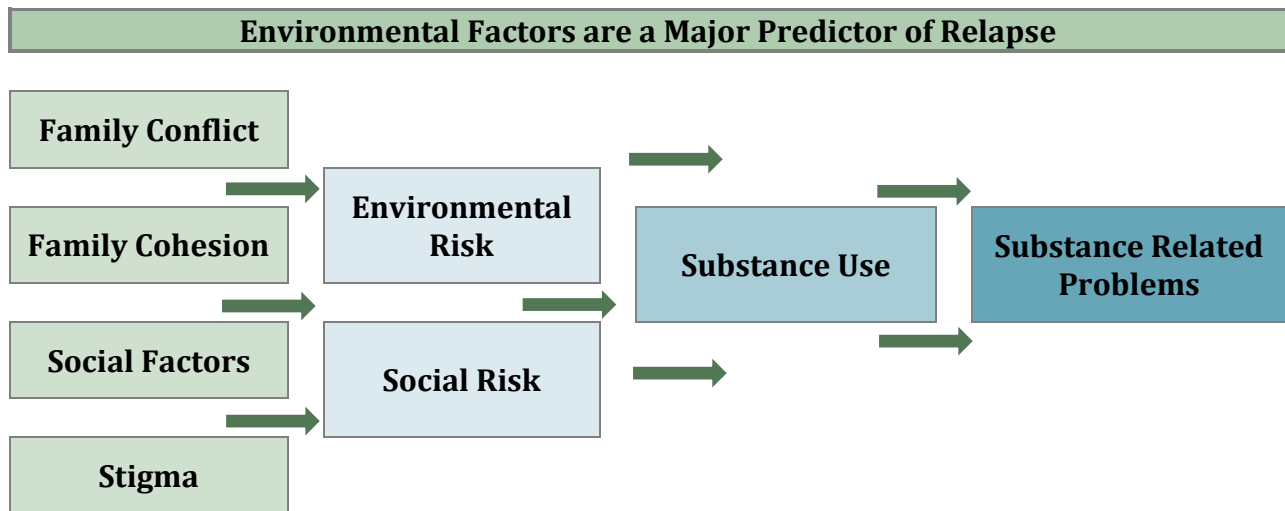
- there is a life-stage/content mismatch that impedes any sense of youth belonging or adults accepting them

⁸⁵ Godley, M.D.; Godley, S.H.; Dennis, M.L.; Funk, R.R.; and Passetti, L.L. The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders. *Addiction* 102(1):81-93, 2007.

- There are also cases of predatory “sponsorship” when adolescent females did try to avail themselves of support through self-help.⁸⁶ One should not forget that predatory practices, though less reported, do happen to adolescent youth.

Recovery for youth has no current depth of research to demonstrate effective components, settings, or methodologies, and it may be difficult to find one working definition that fits for everyone. Currently, assisting each youth during treatment to find their definition of recovery and how to best work on their recovery is extremely important. What we know so far is that youth in general do not see AA or self-help as the answer. This is not to say that AA is not beneficial for youth. Fortunately, the field is in a position that to be effective they need to address recovery and help youth define what may work for them. This runs counter to many efforts to find one working definition of recovery for youth and adults with both substance use and mental health disorders. Given adult treatment models do not work for youth, treating youth and adults together does not work, what might the odds be of finding a definition of recovery for youth and adults that works for both substance use and mental health?

The logic model below depicts two major correlates of relapse: environmental and social risk.



Environmental Risk includes the level of family conflict and family cohesion. Relapse is more likely to occur if there is alcohol and other drug use in the home, family problems, homelessness, fighting, or victimization, and less likely to occur if the adolescent participates in self-help groups or structured activities. **Social Risk** includes social factors, such as peer alcohol or other drug use, fighting, illegal activity, treatment, recovery, or vocational activity. Examining these factors is a good place to begin developing a recovery

⁸⁶ Kelly, J. F. and Urbanoski, K. (2012), Youth Recovery Contexts: The Incremental Effects of 12-Step Attendance and Involvement on Adolescent Outpatient Outcomes. *Alcoholism: Clinical and Experimental Research*, 36: 1219–1229.

plan with youth. Youth should never leave treatment without a recovery plan and a plan to revisit that recovery plan for as long into the future as the program can afford to do so. The point of a Recovery Oriented System of Care is that there will be others who can pick up where treatment can no longer be involved, and bring a youth into a community of recovery.

The logic model above demonstrates that recovery plans need to focus on family and social factors so that an adolescent's social and environmental risks are minimized. The more support an adolescent in recovery receives from his/her environment, peer group, and family, the less likely he/she is to slip up when challenging situations arise and the less likely he/she will be to use substances and suffer further consequences.

William H. White describes substance abuse/addiction recovery in the following way:

Like other severe and potentially chronic health problems, the resolution of substance use disorders can be categorized in terms of levels of recovery, e.g., a state of full recovery (complete and enduring cessation of all AOD-related problems and the movement toward global health) or a state of partial recovery (Jorquez, 1983). The term partial recovery can convey two different conditions: 1) a reduced frequency, duration, and intensity of AOD use and reduction of related personal and social problems, or 2) the achievement of complete abstinence or stable moderation but the failure to achieve parallel gains in physical, emotional, ontological, relational or occupational health. Partial recovery can constitute a permanent state, a stage preceding full recovery, or a hiatus in AOD problems with eventual reversion to a previous or greater level of problem severity.

Falling between the parameters of no recovery and full recovery are individuals who cycle in and out of periods of moderate use, problematic use, and abstinence (Hser, Hoffman, Grella, & Anglin, 2001). A recent review of alcoholism treatment outcome studies drew three major conclusions: 1) treatment-related remissions (persons no longer meeting DSM-IV criteria for a substance use disorder following treatment) average about one-third of those treated, 2) substance use (measured by days of use and volume of use) decreases by an average of 87% following treatment, and 3) substance-related problems decrease by an average of 60% following treatment (Miller, Walters, & Bennett, 2001). People who are constitutionally incapable of permanent sobriety at particular points in their lives may achieve partial recovery—significant decreases in AOD-related problems, improved levels of health and social functioning, and significant reductions in the costs and threats they pose to the larger community (Zweben 1996).

Partial recovery is reflected in individuals who cycle through multiple episodes of treatment, recovery initiation and relapse (Scott, Foss & Dennis, 2005; Dennis, Scott, Funk & Foss, 2005). Such cycling is evidence that recovery is not fully stabilized, but the continued help seeking within such cycles also suggests that addiction is no longer stable. Cycling in and out of recovery (with reduced frequency, intensity and duration of use episodes) can be a precursor to stable recovery or a chronic state.

Partial recovery can also refer to residual levels of impairment that continue after the cessation or deceleration of AOD use. While most recovering alcoholics establish levels of personal and family functioning comparable to non-alcoholics (Moos, Finney & Cronkite,

1990; Chapman, 1987), early recovery can be marked by poor levels of adjustment e.g., depression, anxiety, poor self-esteem, guilt, and impaired social functioning (Kurtines, Ball & Wood, 1978; Polich, Armor & Braiker, 1980; Gerard & Saenger, 1962; Behar, Winokur & Berg, 1984). De Soto and colleagues (1985) distinguished recovery status by length of recovery in a study of 312 members of Alcoholics Anonymous. They concluded that: 1) the early months and years of recovery from alcoholism are marked by continued impairment of emotional and social functioning, 2) these symptoms continue to improve and remit over the first ten years of recovery, and that 3) some residual symptoms of cognitive dysfunction may continue in long-term recovery. The achievement of only a partial reversal of alcohol-related cognitive impairments is most common in alcoholics who began their recoveries after long drinking careers (Goldman, 1983; Schutte 1994, 2001). The principle that global health and functioning improves with earlier onset of recovery and length of sobriety is further confirmed in follow-up studies of persons recovering from cocaine addiction (Selby, Quiroga, Ireland, Malow & Azrin, 1995).⁸⁷

⁸⁷ The Varieties of Recovery Experience: A Primer for Addiction Treatment Professionals and Recovery Advocates, William White, MA and Ernest Kurtz, PhD

3. Cultural Competency

A workable definition of culture: A shared system of symbols, beliefs, attitudes, values, expectations, and norms of behavior.

Cultural Competence is defined as:

a set of congruent practice skills, behaviors, attitudes and policies that come together in a system, agency, or within a community, and includes the adolescent client and their families, providers, and professionals that enables that system, agency, or those professionals and community providers to work effectively in cross-cultural situations.

Human rights and cultural competency:

*Everyone is entitled to human rights without discrimination of any kind. This non-discrimination principle is a fundamental rule of international law. This means that human rights are for all human beings, regardless of "race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status." Non-discrimination protects individuals and groups against the denial and violation of their human rights. Human rights are intended for everyone, in every culture.*⁸⁸

Cultural competency considerations must also extend to race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, ethnicity, national origin, age, developmental stage, mental or physical disability or medical condition, gender identity, sexual orientation, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or other conditions, and disparate treatment based on source of payment for services.

Service providers are encouraged to become familiar with the National Standards for Culturally Linguistically Appropriate Services⁸⁹ (CLAS) in Health and Health Care. The National CLAS standards are the blue print for providing services to people in terms they can understand and accept as valid and meaningful. The standards were developed by the Office of Minority Health with broad input from communities across the United States.

Provider agencies should demonstrate:

- The capacity for staff to increase their knowledge and understanding of cultural differences
- The ability to acknowledge personal cultural assumptions and biases
- The willingness to encourage and support staff changes in thought and behavior to address those biases
- The program is built on unique values, preferences, and strengths of adolescents, the adolescent client and their family, and their communities.

⁸⁸ Ayton-Shenker, D. (1995). The Challenge of Human Rights and Cultural Diversity. United Nations Background Note. Retrieved from: <http://www.un.org/rights/dpi1627e.htm>

⁸⁹ <http://clas.uiuc.edu/>

- Cultural considerations are adapted into treatment practices to promote traditions and cultural strengths, including racial, ethnic, age and language preferences, and should include natural and informal supports.
- The physical plant meets minimum compliance requirements for access per the American's with Disabilities' Act (ADA).
- The provider agency has a plan on how services will be made available to persons who are communication impaired (blind, deaf, etc).

Further, diagnoses and interventions that do not recognize cultural differences in demeanor, attitudes, or other biases can lead to misdiagnosis and resulting misapplication of appropriate interventions and support.

Misunderstanding the culture may cause unintentional negative consequences for the adolescent client and their family. It is the provider's and service personnel's responsibility to educate themselves about the client and family cultural identity being served. If asked, most individuals will inform the provider regarding cultural beliefs, practices, etc.

A culturally competent system includes the recognition that recovery and rehabilitation are more likely to occur where services and providers have and use knowledge and skills that are culturally competent and compatible with the backgrounds, families and communities of the population they serve. Cultural competence includes the attainment of knowledge, skills and attitudes that enable administrators and practitioners to provide effective care to diverse populations.

The following categories are appropriate to address within cultural competency (*SAMHSA/CMHS 1997*)

- Age
- Sex (male/female)
- Race
- Culture
- Socio-economic level
- Disability
- Corporate/employer culture
- Religion/Spirituality
- Gender (See Gender Competency, Part B Element 4)
- Justice and Provider agency culture, including Courts, Juvenile Justice System, all related service agencies, and medical and prescribing practitioners
- Personal beliefs and self-concepts and how these affect interactions with individuals and families
- Access to services related to any of the above

In the context of co-occurring disorders, there are a number of issues related to culture of great import:

- Cultural differences related to ethnicity and place of origin may exist and exert dynamic influence on interactions.
- Linguistic barriers may exist that are significant.
- Individuals with severe mental illness (SMI), severe emotional disturbance (SED) and COD may not fit into existing treatment cultures, and may have experienced multiple unsatisfactory treatment episodes.
- The communities of origin and traditional culture carriers (parents, grandparents, clans, etc.) may have communicated, or be communicating, attitudes regarding justice system involvement and behavioral health services that are negative and stigmatizing.
- Individuals with serious mental illness, severe emotional disturbance, and co-occurring disorders face challenges in multiple domains, and may be affected by various cultural norms of those domains, including increased risk of violent and/or sexual victimization, suicidality, criminal activity, and long-term health issues. These persons may be affected by cultural norms of various domains i.e., substance of choice culture, education environment, friends, justice system involvement, recreational and vocational environment, homelessness, medical access, religious and spiritual influences, gender definitions, sexual orientation, and diagnosis of specific mental and emotional disorders.
- Stage-wise considerations may tend to affect overall cultural understanding and states of readiness for new information, change of all sorts, and individual insight and awareness. While not specifically cultural in nature, all interactions with another individual, especially a person experiencing COD, must take into account the individual's stage of change (see Part B Element 5 Stage-wise Interventions).

4. Gender Competency

Prior to discussing gender competency, it is important to provide the following three definitions that are essential to understanding gender competency. They include: biological differentiation, sexual orientation, and gender identity.

Biological Differentiation

Sex defines the differences related to our biology; the physiology we are born with, the genetic inheritance and differentiation related to sex, and/or the effects related to the divergence of biological function.

Sexual Orientation

This term describes erotic and emotional attraction to others. Terms related to gender identification are often used interchangeably with sexual orientation, such as “gay” referring to men who are attracted to men. However, it is important to maintain awareness that any term applied to many individuals can only describe the behavior, and not the self-conceptual identity of the individuals being described by a definition. For this reason, it is incumbent upon all persons involved in the care of youth to ask and verify the gender identity of youth within their care.

Gender Identity

The terms “gender” and “gender identity” are often used interchangeably, but are specifically different terms used to indicate either sex or self-identification. Gender identity will generally fall within one of the identities listed, but it should always be left to the individual to self-identify. One example of the lack of cultural competence are program forms that provide only choices for “male” or “female.” Biological differentiation is what is often being referred to in the use of the term “gender.”

The dominant social and cultural paradigm often uses “gender” interchangeably with “gender identity.” Gender identity more aptly describes the qualities that a society or culture delineates as masculine or feminine which they attribute to a particular sex and that are perceived to enhance biological function.

The way a society defines a boy or a man depends upon what is perceived as masculine or manly, which depends on male biology plus the culturally favored male social role. Likewise what constitutes a girl or woman and what is considered feminine or womanly in any culture depends upon female biology plus the culturally favored female social role. In other words, while sex does not vary cross-culturally, how a society interprets what is masculine or feminine behavior, dress, status, and social liberty/constraint varies across all types of cultures and cultural subsets from nations, religious beliefs, and ethnicities to communities, organizations of all types, and families.

According to Anne Fausto-Sterling, a professor of biology and gender at Brown University, there are multiple layers to sex, including genital, chromosomal and hormonal. While the

layers for the majority of the population align with the categories that we consider male and female, 1 to 2 percent are not so easily described.⁹⁰

"There is no one right definition," added Fausto-Sterling. "You have to look at it developmentally and you have to understand that there are multiple layers to sex and sex determination. We don't normally see those multiple layers because they normally have given sort of the same message to the body. But there are cases where some layers get one message and others get another message."

Self-identification of gender plays a significant role in how the sex of the individual is expressed in the social context. For the purposes of this manual, gender is a descriptive word used to illustrate perceived differences in the social expression of biology, not as a way to describe what is correct for any individual to express their identity. With this in mind, it is important to understand that specific competencies related to the individual's overall culture and cultural norms must be taken into account when addressing the issues related to gender identity for a specific individual. It is also important that gender not be used synonymously as a specific reference to either boys or girls, so that gender competency describes practices that are appropriate to either sex, and to the self-identified values and beliefs of the individual, as far as those values and beliefs do not violate the human, legal, or social rights of others.

The following lists some of the terms that individuals use to describe themselves, but is by no means an exhaustive list:

- Traditional female/girl; describes the predominate perception of the cultural norm of female or girl.
- Traditional male/boy; describes the predominate perception of the cultural norm of male or boy.
- Gay/gay man; a man who is attracted to and/or forms intimate relationships with other men.
- Lesbian; a woman who is attracted to and/or forms intimate relationships with other women.
- Bisexual; an individual who is attracted to and/or forms intimate relationships with men and women.
- Straight or Heterosexual; Individuals who are sexually attracted and/or form intimate relationships with individuals of the other sex.
- Transgendered; an individual who lives either part or full time as a member of the opposite sex. These individuals may be heterosexual, homosexual, or bisexual. This includes transvestites (cross-dressers) and transsexuals (those who choose to live as the opposite gender of his/her genetic sex at birth, independent of whether he/she undergoes sex reassignment surgery).

⁹⁰ <http://news.yahoo.com/tricky-case-caster-semenya-sports-science-classify-sex-050803514.html>

See also *The Five Sexes; Why Male and Female Are Not Enough*, published by The New York Academy of Sciences, 3/93

- Intersex;⁹¹ individuals with medically established physical or hormonal attributes of both the male and female sexes. These conditions include androgen insensitivity syndrome and congenital adrenal hyperplasia.
- Questioning people; when an individual self-identifies gender that differs from biological sex, individuals may experience what is called gender dysphoria. Some individuals are questioning whether their gender identity corresponds to their biological sex. Questioning people may include transsexual people, transgender people, and many intersexed individuals. Consequently, inner turmoil can arise when social norms insist that an individual adopt a manner of social expression (gender role) which is based on sex, and which the individual feels is inconsistent with their gender identity. Both internal and external struggle may be expressed through stereotyping or gender typing.
- Coming Out; The process of accepting and publicly disclosing sexual orientation or gender identity. Adolescents may be out in certain situations or to certain people and not in other situations or to other people. Safety and confidentiality regarding youth and gender identity is of paramount importance due to the possible exposure to physical and emotional abuse, bullying, or assault.
- Two-Spirit (2-S): Culture specific gender identity for some Native Americans (American Indians and Alaska Natives) regarding any of the previously listed gender identities (other than heterosexual). Traditionally a role-based definition, two-spirit individuals are perceived to bridge different sectors of society (such as, the male-female dichotomy and the spirit and natural worlds). **Two-Spirit is not a term generally used in New Mexico, and each tribe, Pueblo, or indigenous culture may have dissimilar and unique beliefs and approaches to this subject, from disapproval to inclusion.**

Sexual prejudice and Homophobia

Hostility or hatred occurs far too often, ranging from verbal comments to physical attacks directed at individuals solely on the basis of *perceived* differences of sexual orientation or gender identity. In a 1998 address, author, activist, and civil rights leader Coretta Scott King stated that "Homophobia is like racism and anti-Semitism and other forms of bigotry in that it seeks to dehumanize a large group of people, to deny their humanity, their dignity and personhood." Some may consider homophobic attitudes as the norm, but it is urgent

⁹¹ **Gender identity disorder in children (GIDC)** is the formal diagnosis used by psychologists and physicians to describe children who experience significant gender dysphoria (discontent with their biological sex and/or assigned gender). The differential diagnosis for children was formalized in the third revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980. Children assigned as males are diagnosed with GIDC 5 to 30 times more often than children assigned as females. The majority of children diagnosed with GID in childhood cease to desire to be the other sex by puberty, with most growing up to identify as homosexual with or without therapeutic intervention. Controversy surrounding the pathologization and treatment of cross-gender identity and behaviors, particularly in children, has been evident in the literature since the 1980s. Proponents argue that therapeutic intervention helps children be more comfortable in their bodies and can prevent adult gender identity disorder. Critics of treatment cite limited outcome data and questionable efficacy, and some liken it to conversion therapy. The World Professional Association for Transgender Health states that treatment aimed at trying to change a person's gender identity and expression to become more congruent with sex assigned at birth "is no longer considered ethical."

that any such attitudes that are identified be noted and addressed, through interventions such as psycho-education, anger management or referral to appropriate care.

Gender Competence Related to Treatment

Gender competence describes the capacity of the service individual to identify where difference on the basis of both sex and gender is significant, and act in ways that produces fair and just outcomes for all youth, whether they identify as male, female, or any other term describing their gender identity. As with most social concepts, the meaning of gender competence is contextually specific and is therefore multidimensional. This issue is of particular importance especially if a practitioner embraces the notion that any sexual orientation other than heterosexuality is an abnormality that can be corrected.

In both justice and behavioral health settings this refers to the caregiver's and client's individual knowledge and capacity, to the interaction between authorities, service professionals and the adolescent, the individuals culture and environment, to policies, procedures and legal constraint, and to the perception of alliance and rapport. When present, gender competence will help promote more positive outcomes for all persons within the Justice and treatment system.

5. Stage-wise Interventions

All interventions (including comprehensive community support services and/or rehabilitation services) are consistent with and determined by the adolescent client and their family's stage of treatment/stage of change.⁹² In addition to stage of treatment, the adolescent client's developmental stage must be accurately assessed and the assessment findings must be used to guide treatment.

Stages of Treatment are comprised of 4 stages related to the adolescent client's objective state, and include the intervention or strategy stage of treatment that informs external approach to the adolescent client and their family(s) by the treatment provider. These stages are: Engagement, Persuasion,⁹³ Active Treatment, and Relapse Prevention.

Stages of Change are comprised of five stages related to the subjective, internal stage of readiness to change experienced by the adolescent client. These stages are: Pre-contemplation, Contemplation, Preparation, Action, and Maintenance, Relapse and Recycling.

<i>Relationship between Stages of Change and Stages of Treatment</i>	
Stage of Change Subjective, internal stage of readiness experienced by the adolescent client and their family(s)	Stage of Treatment Objective, intervention or strategy stage of treatment that informs external approach to the adolescent client and their family(s)
<u>Pre-contemplation</u> No intent to change behavior in the near future	<u>Engagement</u> Outreach, practical help, crisis intervention, develop alliance
<u>Contemplation</u> Openly state their intent to change, but remain ambivalent <u>and Preparation</u> Intend to change, transition rather than stable	<u>Persuasion</u> <ul style="list-style-type: none"> • Commit yourself to understanding the adolescent clients' goals • Help the adolescent client and their family(s) understand the pros and cons of personal change • Help the adolescent client and their family establish the discrepancy between their goals and their lifestyles (e.g., thoughts, feelings, behavior) • Help the adolescent client and their family begin to reduce substance use and take medications regularly

⁹² Toward a Comprehensive Model of Change: James O. Prochaska, Carlo C. Diclemente (1986). Treating Addictive Behaviors, Applied Clinical Psychology

⁹³ In this context, persuasion means the act of persuading somebody to do something, to begin to engage in the change process, which is different than convincing the person to a point of view, or even a course of action. One can thus think of persuasion as an act of collaboration whereas convincing is the ascendance of one person's point of view over another person's point of view.

	<ul style="list-style-type: none"> • Help the adolescent client and their family recognize and take pride in their own strengths and successes
<p><u>Action</u> Has made overt, perceptible lifestyle modifications</p>	<p><u>Active Treatment</u> Substance use counseling, medication treatments, skills training, self-help groups</p>
<p><u>Maintenance, Relapse, and Recycling</u> Working to prevent relapse and consolidate gains secured</p>	<p><u>Relapse Prevention</u> Relapse prevention plan, continue skill building in active treatment.</p>

Measurement tools could include:

- University of Rhode Island Change Assessment (URICA): <http://www.uri.edu/research/cprc/Measures/urica.htm>
- *Stages of Change, Readiness and Treatment Eagerness Scale (SOCRATES)*. Available from: casaa.unm.edu/inst.html
- Readiness to Change Questionnaire from The Center for Alcohol and Drug Studies: Nick.heather@unn.ac.uk

Stage-wise implementation strategies	
Here the subjective, internal stages of readiness experienced by the consumer are reviewed, along with corresponding stage of intervention strategies.	
Stage of Readiness	Implementation Strategy
<p>1. <u>Pre-contemplation:</u> Consumer has no intent to change behavior in the near future. In part because they have not yet accepted that they have a problem. When asked about their substance use and/or mental health issues, a consumer in this stage might respond “I am not worried,” or: “I haven’t thought about it.”</p>	<p><u>Engagement:</u> The goal of interaction in this stage is to establish a relationship that gives the clinician access to the client on a regular basis. Suggested strategies include outreach, practical help, crisis intervention, and developing rapport and alliance.</p>
<p>2. <u>Contemplation:</u> Consumer openly states their intent to change, but remains ambivalent; and in <u>Preparation</u> the consumer intends to change and transition rather than remain stable. When asked about their substance use and/or mental health issues, a consumer in the</p>	<p><u>Persuasion:</u> The goal in this stage shifts to helping consumers develop motivation to change their substance use and mental illness management behaviors. Strategies include:</p> <ul style="list-style-type: none"> • Commit yourself to understanding

<p>contemplation stage might respond, “I sometimes think it is a problem.” Someone in the preparation stage might say, “I sometimes think it is a problem and I might have to do something about it.”</p>	<p>consumers’ goals</p> <ul style="list-style-type: none"> • Help consumers understand the pros and cons of personal change • Help consumers establish the discrepancy between their goals and their lifestyles (e.g., thoughts, feelings, behavior) • Help consumers begin to reduce substance use and take medications regularly • Help consumers recognize and take pride in their own strengths and successes
<p>3. <u>Action:</u> The consumer has made overt, perceptible lifestyle modifications. When asked about their substance use and/or mental health issues, a consumer in this stage might respond, “I have decided to stop drinking.”</p>	<p><u>Active Treatment:</u> In this stage, the goal of the clinician is to provide the consumer with the skills and tools necessary to succeed in changing illness management, substance use, or both. Strategies include:</p> <ul style="list-style-type: none"> • Provide or refer to substance use disorder counseling, medication treatments, skills training and self-help groups.
<p>4. <u>Maintenance, Relapse, and Recycling:</u> Consumer is working to prevent relapse and consolidate gains secured. When asked about their substance use and/or mental health issues, a consumer in this stage might say, “I am working on my goals.” Because substance use disorders share many features with other chronic illnesses, including a tendency to run in families (heritability), a course that is influenced by environmental conditions and behavior, long-term care and support must be expected and planned for to address relapse and recycling.</p>	<p><u>Relapse Prevention:</u> The goal of treatment in this stage shifts from maximizing success in a narrowly defined objective for the short term to maintaining that success for a sustained duration. Strategies include:</p> <ul style="list-style-type: none"> • Develop relapse prevention plan, continue skills building in active treatment. • Support consumer in developing and maintaining a healthy lifestyle.

6. Motivational Approaches

All motivation related to behavioral health improvement is signified by increasing an individual's and families interest and commitment to advancing in stage (see Stage-wise Interventions above) or progressing towards the goal of gaining a more integrated sense of self-identity and self-efficacy, and a healthy footing in the his or her community.

Motivational Interviewing (MI) refers to a counseling approach that is a client-centered, semi-directive method of engaging intrinsic motivation to change behavior by developing discrepancy and exploring and resolving ambivalence within the client. MI refers to a set of therapeutic strategies that are designed to help clients understand the impact of substance use disorders and mental illness in their lives on their own terms.⁹⁴

Although Motivational Interviewing has been conceptualized as an intervention for addressing substance use in ambivalent people, the principles have broad applicability for addressing other problematic behaviors that interfere with adolescent clients and their families achieving their personal goals. Motivational interviewing differs from direct confrontational approaches by shifting the focus away from the consequences of COD most apparent to a provider, and exploring the possible consequences from the adolescent and family's own perspectives.

The 4 Primary Motivational Interviewing Tools

Motivational interviewing is based upon the four fundamental principles of expressing empathy, developing discrepancy, rolling with resistance, and supporting self-efficacy. General guidelines and strategies for practicing them are provided below.

1. Express Empathy: guides the provider to share with clients their understanding of the clients' perspective. The aim for expressing empathy is to understand the adolescent client and his/her family's world.

Implementation strategies include:

- Practice active listening behaviors like good eye contact, responsive facial expression, body oriented toward the client, and verbal and nonverbal “encouragers” (e.g. head nods, saying “I see”)
- Use reflective listening
- Ask clarifying questions
- Avoid challenging the client, expressing doubt, passing judgment, giving unsolicited advice

⁹⁴ Motivational Interviewing, Third Edition: Helping People Change (Applications of Motivational Interviewing) by William R. Miller, Stephen Rollnick (2013).

2. Develop Discrepancy: guides providers to help clients appreciate the value of change by exploring the discrepancy between how clients want their lives to be vs. how they currently are (or between their stated values and their day-to-day behavior).

Implementation strategies include:

- Use the Socratic Method to help the adolescent client and their family. The Socratic Method is comprised of series of logical questions arising from the subject being discussed and which lead to a reasoned conclusion. There is no specific set of questions; instead the clinician must creatively apply this method on the spot. Rather than being told the answer, the adolescent client and their family reaches a conclusion based on their own answers to the progression of questions
- Break large, long-term goals into smaller, more manageable steps
- Use questions to explore with the adolescent client and their family how substance use and/or mental health issues may interfere with achieving personal goals
- Avoid direct argumentation

3. Roll with Resistance: guides providers to accept client reluctance to change as natural rather than pathological. The goal of rolling with resistance is to overcome the adolescent client's resistance to change by acknowledging and dealing with it but avoiding direct confrontation.

Implementation strategies include:

- Realize resistance is normal
- Rather than opposing resistance, explore it
- Identify and problem-solve the adolescent client and their family's specific concerns about his/her behavior
- Use simple reflective listening or amplified (exaggerated) reflection

4. Support Self-efficacy: guides providers to explicitly embrace client autonomy (even when clients choose to not change, as in remain pre-contemplative or contemplative) and help clients move toward change successfully and with confidence. The aim of supporting self-efficacy is to foster hope in the adolescent client and their family that he or she can achieve desired changes.

Implementation strategies include:

- Express optimism that change is possible
- Review examples of the adolescent client and their family's achievements in other areas
- Reframe prior "failures" as examples of the client's personal strengths in coping with such problems as homelessness, suicidality, persistent psychotic symptoms, and time in jail
- Use reflective listening
- Acknowledge past frustrations, while remaining positive about the prospects of change

Contingency Management⁹⁵ – Also known as **Motivational Incentives**

Most of us want to win, be successful, do a good job, or in some way add value to our own lives and the lives of others, but sometimes we lose our focus. Substance use and process disorders often contribute to one’s loss of focus on life supporting beliefs, attitudes and actions. Some of these disorders are profoundly life-altering afflictions, and some are potentially fatal. However, in every extremity there usually exists some hope for change or potential for improvement in reducing or eliminating the more harmful effects of the disorder. To this end, contingency management can provide hope and a sense of achievement while reducing harm and improving the sense of self-worth and self-efficacy.

Research has demonstrated the effectiveness of treatment approaches using contingency management (CM) approaches, which involve offering individuals tangible rewards to reinforce positive behaviors such as abstinence or reductions in use (frequency or quantity).⁹⁶ Studies conducted in both methadone programs and psychosocial counseling treatment programs demonstrate that incentive-based interventions are highly effective in increasing treatment retention and promoting abstinence from drugs.

Here are two examples of contingency management:

Voucher-Based Reinforcement (VBR) augments other community-based treatments for adults who primarily misuse opioids (especially heroin) or stimulants (especially cocaine) or both. In VBR, the patient receives a voucher for every drug-free urine sample provided. The voucher has monetary value that can be exchanged for food items, movie passes, or other goods or services that are consistent with a drug-free lifestyle. The voucher values are low at first, but increase as the number of consecutive drug-free urine samples increases; positive urine samples reset the value of the vouchers to the initial low value. VBR has been shown to be effective in promoting abstinence from opioids and cocaine in patients undergoing methadone detoxification.⁹⁷

⁹⁵ Although training may be available through other sources, in New Mexico, The Life Link Training Institute offers Contingency Management Trainings. The contact information for the institute is:

Life Link Training Institute; 2325 Cerrillos Rd.; Santa Fe, NM 87505; Tel: (505) 438-0010

www.lltraininginstitute.org

⁹⁶ Fishbowls and Candy Bars: Using Low-Cost Incentives to Increase Treatment Retention, Nancy M. Petry, Ph.D. and Michael J. Bohn, M.D

⁹⁷ NIDA: Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)

<http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-0>

Prize Incentives Contingency Management applies similar principles as VBR but uses chances to win cash (*or other*) prizes instead of vouchers. Over the course of the program (at least 3 months, one or more times weekly), participants supplying drug-negative urine or breath tests draw from a bowl for the chance to win a prize worth between \$1 and \$100. Participants may also receive draws for attending counseling sessions and completing weekly goal-related activities. The number of draws starts at one and increases with consecutive negative drug tests and/or counseling sessions attended but resets to one with any drug-positive sample or unexcused absence. The practitioner community has raised concerns that this intervention could promote gambling—as it contains an element of chance—and that pathological gambling and substance use disorders can be comorbid. However, studies examining this concern found that Prize Incentives CM did not promote gambling behavior.⁹⁸

⁹⁸ Petry, N.M. Tedford, J. Austin, M. Nich, C. Carroll, K. M. Rounsaville, B. J. (2004). Prize reinforcement contingency management for treating cocaine users: how low can we go, and with whom? *Addiction*. Volume 99, Issue 3, pages 349–360

7. Trauma-Sensitive Systems of Care

Trauma-informed care is defined as care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological, and social effects of trauma and violence on humans.⁹⁹

Psychological trauma is theorized to be a type of damage to the psyche that occurs as a result of a traumatic event or events. When that trauma leads to posttraumatic stress disorder, damage may involve physical changes to brain neurology and to brain chemistry, which can harm the person's ability to effectively cope with stress.

A traumatic event involves a single experience, or an enduring or repeating event or events. Such events overwhelm the individual's ability to cope or integrate the thoughts and emotions involved with that experience. The awareness of being overwhelmed can be postponed for extended periods of time, even years, while the individual copes with immediate circumstances, especially if the trauma is of long duration.

Trauma can be caused by many conditions or circumstances, but there are a few common characteristics:

- There is often a violation of the person's familiar ideas of reality and of their human rights, putting the person in a state of profound confusion and insecurity.
- Those persons or institutions depended upon for survival can betray or abuse the individual, leading to distrust, disillusionment, and helplessness. Such a betrayal is usually frightening, shocking, intensely negative in its effect and unexpectedness, and results in shame, fear, and deeply embedded feelings of self-doubt, self-loathing, and shame.
- Adverse Childhood Experiences are introduced in Part A Chapter 4

Psychological trauma may be accompanied by physical trauma. Typical causes of psychological trauma are the threat, witnessing, or experience of sexual abuse, and/or violence, particularly in childhood. Historic or intergenerational trauma can be characterized as cumulative, collective emotional and psychological wounding over an individual's lifespan and/or across generations, regardless of age or gender identity (Native American peoples, Aboriginal peoples of Australia, Jewish Holocaust survivors, Tibetan people, etc). Natural disasters, such as earthquakes, hurricanes, volcanic eruptions, war or other mass violence can also cause psychological trauma. Enduring exposure to situations such as extreme poverty or milder forms of abuse, such as verbal abuse, can be traumatic (though verbal abuse can also potentially be traumatic as a single event). Persons who have been tortured, prisoners of war, persons incarcerated in jails and prisons, hostages, refugees, servicemen and women, especially combat veterans, first responders to natural and human-caused disasters, and even those persons counseling and providing support to the various persons on this list, can all experience various levels of traumatic impact.

⁹⁹ Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services, (2004) Ann Jennings

Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatizing an individual.

Trauma-specific interventions are designed to address the consequences of trauma in the individual and to facilitate healing. Treatment programs generally recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own

recovery; the interrelation between trauma and symptoms of trauma (e.g. substance use disorders, eating disorders, depression, anxiety, etc.); and the need to work in a collaborative way with survivors (and also with family and friends of the survivor) and with other human services agencies in a manner that will empower survivors and adolescent clients and their family.

Additional information regarding trauma-informed care and trauma-specific interventions can be found here:

<http://mentalhealth.samhsa.gov/nctic/trauma.asp>

It must be kept in mind that everyone is unique and may react very differently within the same set of circumstances. There is evidence that being informed by a trusted individual or institution that one has experienced trauma results in increases of the incidence of reported trauma by the person so informed. When such information is not supplied, and instead the strategies developed in Psychological First Aid are applied, reporting of trauma is decreased.

Additional information regarding Psychological First Aid can be found here:

<http://www.nctsn.org/content/psychological-first-aid>

The evidence-informed practice “Psychological First Aid,” although primarily intended for catastrophic events, uses the following guidelines for first responders, which clearly describes many approaches advocated for all trauma-sensitive care:

- Engage by establishing a human connection in a non-intrusive, compassionate manner.
- Enhance immediate and ongoing safety, and provide physical and emotional comfort.
- Calm and orient emotionally overwhelmed or distraught persons.
- Help individuals and families, if appropriate, to articulate immediate needs and concerns, and gather additional information from them as appropriate.
- Offer practical assistance and information to help individuals and families address their immediate needs and concerns.
- Connect the adolescent client and their family as soon as possible to social support networks they have specified and determined as acceptable, including family

members, friends, neighbors, and community helping resources and natural supports.

- Support positive coping, acknowledge coping efforts and strengths, and empower the adolescent client and their family; encourage adults, children, and families to take an active role in their recovery.
- Provide information that may help the adolescent client and their family to cope effectively with the psychological impact of disasters/crisis situations).
- Facilitate continuity in crisis response efforts by clarifying how long the provider will be available, and (when appropriate) linking the adolescent client and their family to another member of a crisis response team or to indigenous recovery systems, mental health services, public-sector services, and organizations. And, most importantly,
- Remember that the goal of crisis response is to reduce distress, assist with current needs, and promote adaptive functioning, not to elicit details of traumatic experiences and losses.¹⁰⁰

As stated earlier, casual discussion of trauma can reinforce the trauma, or cause it to become more entrenched. The intent of this Section is to provide guidance to all persons interacting with trauma survivors so that the appropriate course of action can be decided within the appropriate service setting. Not all people who experience a potentially traumatic event will become psychologically traumatized.

Trauma-informed implementation strategies

In the behavioral health service system, it is likely that a significant percentage of adolescents needing service will be trauma survivors, and this may be especially true for adolescent females, or any youth who may have a gender identity different from the norm. Trauma survivors are likely to have histories of physical and sexual abuse and other types of trauma-inducing experiences, and this often leads to co-morbid and co-occurring disorders related to:

- Health problems
- Eating disorders
- Age
- Developmental stage
- Homelessness
- Isolation
- HIV/AIDS issues
- Involvement with the juvenile justice system
- Mental health disorders
- Severe Emotional Disturbances
- Disruptive Behavior Disorders
- Substance use disorders
- Co-occurring disorders
- Dissociative Identity Disorder

¹⁰⁰ National Childhood Traumatic Stress Network and the National Center for PTSD
<http://www.nctsn.org/content/psychological-first-aid>

When a behavioral health provider takes the step to become trauma-informed, every part of its organization, management, and service delivery system should be assessed and potentially modified to include a basic understanding of how trauma impacts the life of an individual receiving service. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors.

Trauma-Informed Steps to use

Safety: Ensure the physical and emotional safety of the adolescent client, their family and the staff. This means match level of experience and skill with the adolescent client and their family(s) need, provide for training and support for field work situations that may expose workers to unsafe conditions and situations, certify that staff understand and use trauma-sensitive care practices to avoid triggering and/or escalating trauma-related episodes, and provide for staff backup (additional qualified and trained staff, etc.) during crisis situations.

Trustworthiness: Make tasks involved with service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program. If the clinician wants the adolescent client and their family to listen to him/her, the clinician must listen to the adolescent client and their family. Many persons who have experienced severe trauma know when a situation is beginning to trigger them, and will inform people near them of what is occurring. Pay attention to such warnings! A person who is experiencing trauma may not react as expected in any situation, and may become seemingly irrational and potentially violent. Use trauma sensitive care practices to prevent or alleviate trauma responses, and maintain personal safety as necessary and appropriate to each situation. Remember, it is you that must be trustworthy. The traumatized person has experienced extreme challenges to normal trusting, and your behavior will inform the adolescent client and their family about how trustworthy you are. Inform the adolescent client and their family about how treatment will proceed. Give examples. Talk about ethics and confidentiality, along with your obligation to disclose suicide ideation, violent intent and physical or sexual abuse, as appropriate to regulation and statute.

Choice: Maximize the adolescent client and their family's experiences of choice and control. One of the symptoms of trauma is that the individual has suffered a loss of choice in their own behavior and in other people, situations, conditions, or possible natural threats. An overwhelming fear or a significant preoccupation with negative consequences can cause significantly reduced awareness of other possible choices, in part because biological mechanisms may be engaged (fight or flight, the Moro Reflex, loss of mobility and temporary paralysis, hyper vigilance, and even catatonia).¹⁰¹ In addition to these, the individual's visual field can become constricted, sounds may be overwhelming or distorted, small movements may cause startling reactions, the individual can feel helpless and terrified. At the same time, they maintain cognition that

¹⁰¹ The David Mulhall Centre, 31 Webbs Road, London: <http://www.davidmulhall.co.uk/why-are-reflexes-retained>

they are caught in a trauma response, are unable to escape or manage appropriately. In any situation resembling this, maintain calmness and reduce agitation as much as possible. If the individual's environment cannot be made safe, consider removing them to a safe place. Keep in mind that you must engage them in a collaborative process that helps them to let go of the current episode of trauma, and re-establish a sense of control.

Collaboration: Maximize collaboration and sharing of power between staff and the adolescent client and their family. This translates to an approach that is respectful of strengths and their vulnerabilities with the overall intent to help people become empowered to act as the directors of their own lives. Introduce yourself and your organization carefully, taking the time to explain any situations that may help you build rapport. Inform them about what you can accomplish together, and how you will interact with the person to accomplish his or her goals. Once the service plan is in place, the adolescent client and their family should have a solid idea of what they will be working towards accomplishing. Prior to this, staff may need to provide interim planning and goals for how immediate practical assistance will be provided, and what sort of reciprocal behavior is expected from the client and their family. Being authentic and trustworthy in your approach to collaborating with the adolescent client and their family will reassure them that they can safely explore self-management with you. Build hope that recovery is possible and achievable. Build the sense of autonomy and self-directedness while providing practical assistance to the adolescent client and their family. Avoid chaotic and restrictive conditions, and be exceptionally careful to avoid argumentation, reactive behavior, or resistance to the adolescent client and their family's ideas.

Empowerment: Prioritize the adolescent client and their family(s) empowerment and skill building. The core of effective treatment is empowering the adolescent client and their family to maximum possible self-efficacy, parental or self-regulation of behaviors, attitudes and expressions, and parental or self-management of the adolescent's whole life, as far as functional ability will allow. In terms of trauma-sensitive care, help the person plan for and manage situations that may trigger a trauma episode. Help the person establish a sense of control in their environment, as well as helping them to establish better social connections and a heightened sense of meaning in their lives. Strive to meet the person where they are (psychologically and emotionally) and engage them fully in their own recovery effort. The clinician provides the service, but self-empowerment and self-management can only be accomplished by the person served.

II. Initial Procedures of Care & Planning



What you will find:

- **Initiation and Retention in Behavioral Health Services**
This Section describes how the provider agency conducts outreach, accesses and retains referrals, and implements policies and practices to reduce drop outs and no shows while maintaining engagement into treatment.
- **Intake Processes**
The purpose of this Section is to guide providers on a smooth, consumer friendly admission process that establishes the foundation for lifelong recovery.
- **Screening and Assessment**
Screening serves to quickly and accurately identify persons who may have one or more behavioral health disorders, suggesting the need for referral to behavioral health assessment.
The assessment gathers information and engages in a process with the client that establishes (or rules out) the presence or absence of substance dependency, mental or emotional disorders, co-occurring disorders, and related functional impairments.
- **Individualized, Comprehensive, Integrated Service Plan**
 - a. **Safety Planning**
 - b. **Crisis Planning**
 - c. **Recurring Use Planning**
 - d. **Aftercare/Discharge Planning**

8. Initiation & Retention in Behavioral Health Services

Whereas engagement is about meeting someone where they are with respect and attention, initiation of and retention into treatment describes how the provider agency conducts outreach, accesses and retains referrals, and implements policies and practices to reduce drop outs and no shows. Since there is an awareness that people who remain in a treatment system for a longer period of time have better outcomes, retention takes on an even more important significance. Customer satisfaction is a significant aspect of retention into services. No amount of engagement will offset poorly delivered services unless individuals have been mandated by courts of juvenile justice to attend. Given that the circumstances individuals may be facing are often severe, and the difficulty of working with entrenched substance and co-occurring disorders, assessment and careful collaborative service planning are essential, as is the use of an effective evidence-based program or practice.

The following are important aspects regarding initiation and retention:

- Foster respectful and understanding relationship using engagement principles and the five evidence-based frames of Recovery and Resiliency Philosophy and Approach orientation, Cultural Competency, Stage-wise Interventions, Motivational tools, and Trauma-sensitive Care. Using these approaches and orientations to the adolescent client and their family helps staff to understand and interact in more helpful and effective ways.
- Learn treatment history related to prior treatment episodes and what your treatment program has to offer related to services provided. This must be regarded as initial information, as a more thorough treatment history will be taken during the intake procedures.
- Provide flexible schedules.
- Provide for increased frequency of contact in early stages of treatment.
- Provide friendly, engaging reminders and on-going supports to remind individuals to attend services.
- Provide transportation if possible.
- Provide motivational incentives to attend (see Contingency Management)
- Provide childcare for attending parents with children.
- Provide links to external resources that will help people meet needs and overcome external barriers to attending of receiving services.
- Provide collaborative service planning and clear and obtainable goal setting
- Provide a menu of possible services, service intensity, and clear definitions of duration of service.
- Provide integrated services that enable the person to overcome obstacles and address multiple domains of life in a comprehensive fashion.
- Provide experiential activities that engage the person in learning in multiple formats other than discussion-only treatment and that engage and inspire the individual's imagination and hope for more normalized life experience.

9. Intake Process

The intake process covers the administrative aspects of initiation of services with an individual or family, and specifically must address access to services. Access to treatment must be straightforward, easy, and welcoming. The concept of “no wrong door” means that the provider has the responsibility to address the range of the adolescent client and his/her family(s) need (as appropriate to statute and service regulation) with effective and comprehensive services. Where this is beyond the capacity or qualifications of the provider or staff, appropriate referral must be carefully conducted to ensure that the person being referred receives appropriate care.

This “no wrong door” approach includes incorporation of a culturally competent, trauma informed system of care. A welcoming environment is essential to developing an effective service alliance and retaining the adolescent client and families in services.

The first contact that the adolescent client and their family will have with a provider agency is with non-clinical staff. Some persons may come to an office setting seeking help with housing, medical issues, employment help, or for several issues at once. In either situation, the first contact is of vital importance to the successful outcome of all consequent services. To this end, all staff that have any contact with the adolescent client and their family must have training that enables them to interact appropriately with the adolescent and all caretakers. This is doubly true for persons experiencing COD due to the potential stigma and trauma of multiple unsatisfactory interactions with treatment and case management. Training must be designed to allow service staff to make a fundamentally different and more collaborative approach to engage the adolescent client and their family wherever they are, and this client-centered approach should be the rule for every interaction.

Immediate Crisis Issues at Intake:

If the youth or family is in obvious crisis, appropriate care shall be taken to refer to, obtain or provide service as needed. For this purpose, current crises must be assessed at intake, and should include bio-medical crises, nutrition, hydration, risk of harm to self or others, adequate shelter, and other significant crisis conditions. An interim crisis plan can be discussed at intake, and put into immediate effect. Clients that are identified as experiencing a crisis that may cause threat to life or limb, are in withdrawal, or may endanger themselves or others shall be addressed by the clinical supervisor or other senior program authority to ensure that they receive referral to the appropriate level of care, whether hospitalization, immediate intake, involvement of law enforcement, homeless shelters, food or clothing referrals, etc., to secure the individual's and/or families continued well-being as far as possible.

**The New Mexico Crisis and Access line is located at nmcrisis.com
855-662-7474 or 855-227-5485 (TTY)**

10. Screening & Assessment

Screening

For the purposes of this manual, the topics of Screening and Assessment have been combined, in part, to highlight the difference between the two. In everyday conversation, even among professionals, these two words are often used interchangeably. We must be more exacting in our language because screenings and assessments are vastly different processes and services (often performed by persons with differing licenses), differing billing codes and most importantly, different purposes.

Screening serves to quickly and accurately identify persons within general populations who may have one or more behavioral health disorders, suggesting the need for a referral for a behavioral health assessment. Screenings also rule out those who would not be identified as having behavioral health disorders. Screenings may also serve as a brief and easily applied periodic measure of change over time for individuals and families receiving behavioral health services.

During 2012, the Children, Youth and Families Department Juvenile Justice Services and the Children's Behavioral Health Division worked together to research and identify a brief screening tool appropriate for administration to all youth presenting to a Juvenile Probation Officer. There was a need to screen in or out for behavioral health needs so that appropriate referral could be made at earliest possible moment in a youth's life. After much research, the tool that was identified as most appropriate was the Global Assessment of Needs Short Screen (GAIN-SS).

The five-minute GAIN-SS¹⁰² is primarily designed to accomplish three purposes. First, as stated above, it serves to quickly and accurately identify clients who would be flagged as having one or more behavioral health disorders with the use of a diagnostic assessment, suggesting the need for referral. It rules out those who would not be identified as having behavioral health disorders. Second, it serves as an easy-to-use quality assurance tool across diverse field-assessment systems for staff with minimal training or direct supervision. Third, it serves as a periodic measure of change over time in an individual's behavioral health. It is designed for self- or staff-administration with paper and pen, on a computer, or on the web. It can be easily scanned and/or incorporated into existing instrument batteries or systems. The GAIN-SS uploads to the GAIN Assessment Building System (ABS), which allows for the collection and use of prevalence data for all youth who present to the juvenile justice system, about 16,000 youth per year in New Mexico.

The GAIN ABS is a HIPAA-compliant, web-based system hosted by Chestnut Health Systems that allows for computer-based and interactive administration and reporting

¹⁰² <http://gaincc.org/GAINSS>

of the GAIN instruments. The GAIN ABS was designed to ensure agencies meet HIPAA (1996) standards and the updated requirements outlined in the HITECH Act (2009).

Assessment

By contrast, an assessment often follows and is a more involved activity than a screening. It gathers a depth of information unfeasible in a brief screening and engages in a process with the adolescent client and family that enables the provider to establish (or rule out) the presence and specific nature of a substance dependency, severe mental illness, co-occurring disorder, and/or related functional impairments. An assessment also determines the adolescent client's readiness for change, identifies strengths and problem areas that may affect treatment processes towards individual and/or family recovery and is the beginning phase of engagement with the adolescent client and family in an appropriate service relationship.

Assessments may also be called psychiatric evaluations, psycho-social assessment or evaluation, diagnostic evaluations, or by various other names. In New Mexico, providers must refer and be informed about and implement the various Medicaid, MCO or other regulatory guidelines to determine what must be assessed to justify the validity of services being rendered and further, the assessment must be administered by persons with appropriate levels of education and licensure.

Assessment of co-occurring disorders is often conducted by different providers with different engagement approaches, in separate locations by clinicians with little or no contact with staff of other service agencies. This uncoordinated approach is ineffective, and significant information that may be available during the assessment interview is lost or not adequately communicated. Screening for COD must be done prior to all mental health and substance assessments to adequately identify and treat functional impairment arising from COD.

Assessments conducted for IOP do not supersede other required assessments as specified by contractual or funding source obligations, such as State or Federal grant requirements.

Juvenile Population Statistics (2003)

1. At the beginning of the 21st century, 1 in 4 U.S. residents was under age 18
2. The juvenile population is increasing similarly to other segments of the population
3. For 2002, the U.S. Census Bureau estimated that 72,894,500 persons in the United States were under the age of 18, the age group commonly referred to as juveniles.
4. The juvenile population reached a low point in 1984, at 62.5 million, then grew each year through 2002, increasing 17%. Current projections indicate that the juvenile population will continue to grow throughout the 21st century. The Census Bureau estimates that it will increase 14% between 2000 and 2025—about one-half of one percent per year.
5. By 2050, the juvenile population will be 36% larger than it was in 2000. In 2002, juveniles were 25% of the U.S. resident population. The Census Bureau estimates

that this proportion will remain essentially constant through at least 2050; i.e., the relative increases in the juvenile and adult populations will be equivalent during the first half of the 21st century.¹⁰³

Such things as immigration status of youth, stigma, parents or other caretakers, or other legal issues, may affect willingness to share personal information, especially related to treatment history in another country. Acute episodes of mental illness, substance use disorders, or other crises may lead to inaccurate assessments, therefore, assessments will need to be updated when the individual is more mentally stable, has experienced some relief from substance use, and other crises are resolved or in the process of resolving. In addition, the information provided to the team by staff that have a direct service relationship over time may prove to be the most accurate and relevant information possible for service planning.

Due to prevalence of COD, the assessor must assume and expect the presence of COD. The assessor must communicate openly in a friendly and engaging manner with the adolescent client and their family regarding this assumption, with the intent of making more open and honest disclosure possible. Within the assessment process, the complex interactions of COD must be carefully determined by understanding and specifying the multi-dimensional, self-reinforcing interactions within the symptom cluster of the co-occurring disorders. When assessment is carefully conducted, the symptoms of each diagnosis that contribute to the functional impairment(s) will be clearly ascertained, communicated, and addressed. What this means in practical terms is that a simple diagnosis of SED or SMI or substance use patterns will not suffice to present a clear picture of how an individual experiencing COD will manifest symptoms; a presentation of impairment may be powerfully increased or decreased based upon the person's constitution and susceptibility and the specific interactions between substance use and the mental illness. It is unlikely that the symptoms of one disorder will not have an effect on the other disorder, or that one disorder may be in remission at the initial assessment. Assessments need to be strengths-based, longitudinal, and take into account the complexity of issues previously mentioned in this element.

Assessing Young Women

"Gender-neutral" screening and assessment tools and procedures are not generally considered adequate for girls as they do not identify health issues such as sexual victimization and pregnancy as effectively as do instruments and procedures designed exclusively for girls. There are, however, very few instruments nationally that are designed and validated for girls. For example, the most widely used mental health screening tool, the MAYSI-2, (Massachusetts Youth Screening Instrument), was not originally designed for girls. The MAYSI-2 is a brief screening tool designed to assist juvenile justice facilities in identifying both boys and girls at admission who may have special mental health needs. In the past, there has been some question as to whether

¹⁰³ Taken from US Dept. Justice Office of Juvenile Justice and Delinquency Prevention, Juvenile Justice Report August 2008 Retrieved from: <http://ojjdp.gov/ojstatbb/nr2006/downloads/section1.pdf>

*the trauma-related items on the tool adequately address the trauma needs of girls entering detention. One way to more accurately identify the unique physical and mental health needs of girls might be to deliver the Girls Health Screen and the MAYSI-2 side by side for girls at intake.*¹⁰⁴

The assessment process minimally gathers the following:

- Gathers information and engages in a process with the clients that enables the provider to establish (or rule out) the presence or absence of a co-occurring disorder;
- Determines the client's readiness for change;
- Identifies client strengths and problem areas that may affect the processes of treatment and recovery; and
- Engages the client in the development of an appropriate treatment relationship.

Assessments also collect American Society of Addictive Medicine (ASAM) criteria in all domains:

1. *Acute intoxication and/or withdrawal potential*
2. *Biomedical conditions and complications*
3. *Emotional/behavioral/Cognitive conditions and complications*
4. *Readiness to Change*
5. *Relapse/Continued Use/Continued Problem potential*
6. *Recovery environment*

A 7th significant domain for New Mexico IOP assessment includes spiritual, religious, and cultural considerations especially regarding indigenous populations, or other groups and individuals, and impacts service populations and provider organizations.

Integrated or Interpretive Summary: The assessment assists in the development of an integrated summary for all co-occurring disorder diagnoses and documents specific priorities to the service plan that clearly and specifically addresses the interactions and self-reinforcing processes related to the co-occurring disorders diagnosis. The integrated summary should be considered an educational document for all persons who will interact with the adolescent client and their family during the course of services, and may need to be updated or modified dependent upon new understanding, remission of symptoms, stabilization, and increased sobriety. This document, and the assessment it distills, must be considered a living document of the clients (and family's) **current** need for services.

¹⁰⁴ BluePrint for the Future of Girls: *Linking Girls in the New Mexico Juvenile Justice System to Health, Mental Health, Substance Abuse, Family Support, Parenting and other Community Services*, July, 2011 Prepared by, Leslie Acoca, MA, MFT

11. Individualized, Comprehensive, Integrated Service Plan

Service planning develops a comprehensive set of staged, integrated program placements and treatment interventions that are calculated to take into account issues related to each identified disorder. The plan reflects the individual needs, readiness, preferences, personal goals, and natural supports of the adolescent and family. Service plans describe the long-term effort of the practical application of normalizing attitudes, behaviors and general capabilities. The process of creating the plan builds understanding of the adolescent client and their family meets the individual and family where they are currently “at,” and is client centered and strengths-based. The individual service design planners attempt to “walk in the person's shoes,” in essence asking what it would be like to experience the events in the person's life. On the basis of key themes derived from reconstructing the adolescent client and family's history, the group identifies the most important needs in a person's life and specifies the activities necessary to meet these needs.

In tandem with the assessment process, service planning should be ongoing and result in a living clinical document that allows for continual changes. The service plan is a single plan that consists of integrated components, including a treatment plan, a discharge plan, a crisis plan, and a recovery and resiliency plan. Because the primary focus of service within this manual is integrated services, for persons experiencing COD it is imperative that all domains that are negatively affected by the co-occurring disorders be addressed concurrently.

Integrated service planning for adolescent COD diagnosed clients addresses both mental health and substance use, each in the context of the other disorder. In the initial phases, decisions are made about what services the client needs and wants, where these services will be provided, who will share responsibility with the client for monitoring progress, how the services of different providers will be coordinated, and how services will be reimbursed.

Service plans allow for client and family input. Plans should contain the overall recovery goal/vision of the adolescent and family, the client and family strengths/skills and barriers, the client and family-specific goals and objectives and interventions that address these objectives. Client and family participation in the service planning process will add to the investment in and ownership of goals and foster a long-term collaborative relationship between the service team and the person receiving services. The following four documents need to be created in collaboration with the client and his or her family. Copies of each must be signed by the clinician and the youth or guardian and given to the youth as guidance documents.

a. Safety Planning

Safety plans are intended to manage risk of suicidal, homicidal and assaultive behaviors, and elopement. A safety plan is a prioritized written list of coping strategies and sources of support for clients who have been deemed to be at-risk of hurting themselves or others as

well as those clients who are currently stabilized, but have a history of at-risk behavior. Clients should be instructed of these strategies before or during a crisis. It is essential that the plan be brief, be in the client’s own words and be easy to read.

The following six steps need to be developed to implement a safety plan:

1. Warning signs (thoughts, images, mood, situations and behavior) that a crisis may be developing;
2. Internal coping strategies are activities that a client can do to take their mind off their problems without contacting another person, e.g. relaxation techniques, physical activities);
3. People and social settings that provide distraction;
4. People whom the client can ask for help;
5. Professionals and agencies the client can contact during a crisis;
6. Making the home and neighborhood environment safe.

NOTE: Research does not support “safety contracts” as effective for suicide prevention.

b. Crisis Planning

A useful definition of crisis is: “A dangerous or worrying time: a situation or period in which things are very uncertain, difficult, or painful, especially a time when action must be taken to avoid complete disaster or breakdown.” It is important to keep in mind that for persons with COD, any crisis in one set of symptoms will tend to exacerbate the co-occurring disorder. Stressors affecting the mental health disorder are likely to increase the desire to self-medicate using the substance of choice.

The purpose and intent of crisis plans are dual:

1. determine signs, symptoms, and triggers that enable the adolescent client and their family to determine an impending crisis, so that it can be foreshortened in duration or avoided entirely, and
2. determine the specific steps, processes, and signs of recovery and remission from the crisis state.

The crisis plan must contain sufficient information and provide adequate guidelines so that the individual or his/her caretakers have essential information regarding resources, and the individual’s preferred course of treatment or intervention. Crisis plans are intended to avoid the use of emergency services, avoid loss of competency and self-control that might result in incarceration, loss of housing, loss of employment, or any other adverse consequences.

c. Relapse Prevention Planning

The adolescent client receiving integrated services will benefit from anticipating and planning for what to do if there is a relapse into substance use, and include family members in the planning process if possible and appropriate. Due to the potential need for episodic treatment related to substance relapses or psychiatric crisis, or the concurrent relapses associated with COD, flexibility of service intensity according to the adolescent client and their family’s need is required for effective recovery management. The adolescent client and family, in collaboration with the clinician, can plan how to minimize the occurrence and the severity of relapses. Past relapses can be used to develop such a plan, using the adolescent client and the family’s own relapse history. Like the crisis plan, it must include how the individual will identify triggers, stressors, or other reasons that may cause or encourage relapse. In addition, relapse prevention planning should include lists of resources available, how to obtain intervention, pre-planning symptom management of co-occurring mental health disorders, and also how to maintain a healthy, functional lifestyle as an alternative to relapse.

Axis IV of the DSM IV can be used as an assessment for stressors that might precipitate a relapse. These topic areas include problems with: primary support group, social environment, education, occupation, housing, economic, access to health care services, legal system, and other psychosocial or environmental problems (exposure to war, disasters, etc.).

For the purpose of this document, the distinction between a crisis and a relapse is separated. Although any event that substantially interrupts the recovery process over a sustained period of time can be termed a crisis, , this term “crisis” will be applied to events that are not related to substance use relapses. The provider agency’s crisis plan may incorporate relapse prevention within the crisis plan.

Relapse Definition:

A return to the use of psychoactive substances after a significant period of time of abstinence/recovery in an individual who has completed a course of inpatient or outpatient treatment or has had extensive recovery group experiences, as a result of which that patient/client has made and internalized certain changes in functioning. These changes allowed the patient to cope without resorting to the use of psychoactive substances in the interim period.

In contrast to relapse, a lapse is defined as a brief return to substance use after a sustained period of abstinence (a month or more). The adolescent client and their family will still be committed to recovery and will not experience a loss of control.

Relapse symptoms often appear prior to the relapse event. As an example, individuals do not

suddenly become drunk, but experience progressive warning signs that relapse is impending. Such signs and symptoms might be related to withdrawal symptoms, cravings, to stress in relationships or employment, feeling victimized, disappointed, uncertain housing or other negative environmental conditions, or attenuation of self-control related to worsening mental health. The clinician can aid the adolescent client and family immensely by helping them to identify the signs they may be unconscious of, and therefore

reactive to. In addition, the understanding that recovery from substance use disorders may be episodic in nature can inhibit feelings of failure and shame that may worsen relapses, although some triggers can result in sudden onset of relapse behaviors.

d. Continuing Care/Discharge Planning

The continuing care plan is developed sufficiently in advance of discharge, or dropping out, to ensure transition into the community and long-term supports and counseling. The agency and adolescent (and family) together develop a plan that identifies services and supports needed or desired and specifies steps for obtaining these services. This must occur as early as possible in treatment so that if the youth drops out of treatment, is incarcerated, moves, etc., that a basic plan of care has been outlined and can be followed by the youth and family. It is important to remember that recovery is a life-long process and “discharge” may not be a viable concept unless recovery in all other dimensions of life is addressed.

The provider then follows up on the continuing care plan to ensure commitment to the recovery path. If the provider is not to be the community agency the adolescent will work with upon discharge from treatment, it must contact the receiving community agency as to adolescent’s discharge/graduation from treatment, relevant evaluation findings and assessment of unmet needs in writing, or as appropriate to the agreement and with the permission of the youth or his/her legal guardian.

Research has shown, through a prospective, longitudinal 15 year, ten cohort study of youth who receive intensive aftercare and long term follow-up found that a low attrition rate, gains in employment experience and matched savings, educational achievement and, with at least two years in the five year program, a positive self-sufficiency trajectory. Findings that education achievement rates compared very favorably with the comparison group, U.S. Hispanic youth, NYC Hispanic, Black, and Special Education rates, and U.S. youth in poverty, support conclusions that aftercare services should be long-term, intensive, flexible, and provided by paid professional mentors with reasonable caseloads (15-20 youth). These findings are consistent with evidence that mentoring can work along with necessary services.

Young adults who receive aftercare services related to independent living more often obtain safe and stable housing, develop life skills and competencies including work readiness, achieve educational and financial growth goals, and establish healthy, supportive adult and peer relationships.¹⁰⁵

As indicated earlier in this manual, professional care and attention is given to ensure that the adolescent is matched with the appropriate service(s) to meet his or her need. In New Mexico, recent data suggests that after the receipt of treatment services, adolescents rarely engage further in the behavioral health system. Best practice points out that upon leaving treatment services for any reason, an adolescent should maintain some supports from an

¹⁰⁵ Children of Incarcerated Parents: A Handbook for Researchers and Practitioners, edited by J. Mark Eddy and Julie Poehlmann, is available from the Urban Institute Press

Part B. 11. Individualized, Comprehensive, Integrated Service Plan

outpatient provider through access to ongoing Youth Support Services, individual, family or group therapy, Comprehensive Community Support Services, possible medication management, and crisis counseling in response to traumatic events occurring in the adolescent's post-treatment life.

A sample service plan can be found here:

<http://w3.cpsarbha.org/providermanual/index.cfm?action=listForms>

III. Personnel, Team, and System Competencies



What you will find:

- **Staff Competencies**
The ability to deliver effective recovery-focused integrated services depends significantly upon the competency of its clinical practitioners and support staff.
- **Supervision**
Appropriate, compassionate, supervision is critical to the successful treatment and provision of services to adolescent clients and families.
- **Service Team/Multi-Disciplinary Team**
Behavioral health teams meet to develop new strategies to assist the client (and family, as appropriate) to move toward goal attainment.
- **Quality Management**
This is a process used to identify shortcomings, lead to new approaches, redefine staff roles, or improve morale.

12. Staff Competencies

A program's ability to deliver effective recovery-focused integrated services depends significantly upon the competency of its clinical practitioners and support staff.

Staff training and in-service trainings are warranted to ensure that evidence-based services, recovery focus, and program philosophy are incorporated in a consistent manner by all staff members and over time. It is recommended that all employed staff receive training within 2 months of hiring and as needed, based on supervisory assessment specific to his/her role in the IOP program. In general, all clinical staff training must be guided by required competencies in support of the program's use of primary EBP and subsidiary services. A staff development plan shall be utilized to determine specific education and training needs. Individual need for supplementary training in support of the IOP program can be determined by the clinical supervisor. Staff training related to engagement practices, recovery, gender, cultural competencies, and trauma-informed care should include all provider staff who have contact with clients and their families, including administrative support staff.

Implementing COD-competent services requires consistent, on-going training of staff. It is important that the skills from training are practiced immediately after they are learned and that a supervision process is in place to reinforce those skills. It is essential for the agency to review and modify their policies, procedures, documentation, and other structures that may pose as barriers to implementation of these skills. Likewise, it is important that the agency rigorously review and modify internal documentation processes that functionally support staff members to practice skills learned. For example, progress notes may include an area to describe the client's stage of treatment and what interventions are being provided based on that stage.

13. Supervision

Supervisors perform the critically important role of educating, encouraging, guiding, and monitoring staff. Supervisors in small agencies may maintain a caseload whereas those in larger agencies may have little or no client contact. Supervisors are concerned primarily with:

- Relationship between staff and the adolescent client and their family
- Professional credibility
- Cultural bias and/or unfair treatment
- Staff performance evaluations
- Liability concerns
- Impaired counselors
- Oversight and maintenance of fidelity to EBP of choice
- Initial and on-going training to support and maintain the adolescent client and their family(s) recovery outcomes
- Maintaining confidentiality of all the adolescent client and family interactions and PHI
- Regular chart reviews
- Streamline required paperwork of the adolescent and family's documentation to reduce time burden on staff and maintain accurate and precise clinical and administrative records

Supervisors for co-occurring competent providers should meet the following requirements:

- Is a NM licensed independent practitioner with one year demonstrated supervisory experience.
- Holds the appropriate educational degree and license.
- Provides regular and ongoing clinical supervision for all staff engaged in clinical services.
- Is trained and is proficient in the programs and practices used in the organizations service settings.

Supervisory practice is critical to the successful treatment and provision of services to COD adolescent clients and families. The internal capacity to train and supervise staff is crucial to maintaining skilled workers providing integrated services to clients and their families.

Supervision Implementation Strategies	
Key Components for COD Supervision	Implementation Strategy
1. Supervisory training regarding how to manage and maintain rapid response and integrated service teams is incorporated in supervisor and clinical training.	In addition to being trained in supervision models, clinical supervisors must be trained regarding how to manage and maintain service teams.
2. Provider ensures that supervisors are trained and/or experienced in the evidence-based programs and practices in use and have expertise in substance use disorders, mental health, and co-occurring disorders, as well as supports and adjunct services as far as is possible.	Supervisors are trained and experienced in practices and programs in use and have expertise in substance use disorders, mental health, and co-occurring disorders.
3. All substance use, mental health, and co-occurring disorders competent supervision must focus on the client and/or family as well as the clinical practices.	Supervision sessions for COD clients are client and family centered.
4. Clinical supervision explicitly addresses specific modalities and levels of treatment for substance use, mental health, and co-occurring disorder issues and applications to specific client and family situations.	Supervision specifically addresses both the level of care and the specific implementation of practices towards ensuring fidelity.
5. Each client and the implementation goals, progress, and referrals must be discussed a minimum of every other week.	Either in a group or individual supervisory session, each client and his/her progress/issues should be staffed a minimum of every other week.
6. Supervision follows a specific documented format and is, in part, designed to develop staff clinical effectiveness. Typical team meetings consist of administrative announcements, medical team updates, vocational updates, vacation coverage, crises and sometimes successes. While these are necessary components of the work, it is <u>not</u> clinical supervision.	Professional and administrative supervision are clearly delineated and structured as separate functions.

14. Service Team / Multi-Disciplinary Team

All clients identified for treatment services receive care from a multidisciplinary or service team. A team can consist of any combination of the following: the client and caretakers, CCSS workers, psychiatrist, prescribers, counselors and clinicians, case workers, and other ancillary providers (vocational, school, courts, residential, housing, justice system, hospital liaison).

Although a major focus of substance use treatment is the elimination or reduction of substance use, this goal is more effectively met when other domains are also addressed. COD-competent providers coordinate all elements of treatment and habilitation and/or rehabilitation to ensure that all interested parties are working toward the same goals in a collaborative manner.

The clinical supervisor or clinician (as assigned) will act to coordinate attendance at team meetings by all appropriate members. In the event that members of the team are unable to attend the team meeting, an assigned staff member will act as communication liaison to members not present.

Integrated service teams are a cornerstone of COD competent services. The team meeting follows a specific form with primary goals being to assess progress and, when necessary, develop new strategies to assist the adolescent client and their family attain their goals. Team meetings that do not follow a structured format tend to get side-tracked by a variety of tangents, and do not produce the level of in-depth clinical review that optimizes progress.

Service Team Philosophy:

Functional teams have a number of advantages that organizations can leverage to their benefit. Working in a team helps individuals develop skills they will need when the organization changes; in particular, the ability to establish relationships, to manage interactions with different disciplines and parts of the organization as well as to adjust to changes in the behavioral health system and to varied service implementation models.

Teams that are multi-disciplinary and focused within the behavioral health environment are particularly likely to help staff understand the client's need for comprehensive recovery strategies inclusive of treatments, medical care, youth and natural supports, pro-social engagement, and positive youth development. Effective teams also provide individual staff with feedback about how effectively they are providing services.

Teams must have clear accountability and evaluation about results that are visibly tied to the adolescent client and family satisfaction. Well-defined accountability and evaluation will result in higher motivation, acquisition of new skills, and staff that are more accepting and adaptable to the ongoing change required by the behavioral health business environment. Multi-disciplinary teams can be very powerful aids to the organization in developing skills that help sustain overall organization adaptability and effectiveness.

Motivation for individual participation and involvement in a team is dependent upon the degree to which the individual feels that their contributions are valued. Successful teams integrate equality, empower all members to share, and are a non-hierarchical structure that is open and inviting as a learning environment. It's important for team interaction that individuals perceive they are critical in some fashion to the functioning of the team.

The recommended practice to be implemented is that all adolescent clients assessed to receive care from a provider will best be served by a multidisciplinary team. A COD competent multi-disciplinary team should coordinate all elements of services and rehabilitation to ensure that everyone, including the adolescent client and family, are working toward the same goals in a collaborative manner.

Service team implementation strategies	
1. Team Structure: Integrated service team	Implementation Strategy
The primary individual who will guide the recovery effort will be the individual and/or family member served by the team. The second person guiding the recovery effort of the individual is likely to be the clinician assigned primary responsibility for the adolescent client and their family(s). The clinician's efforts are informed by the integrated service team. It is not practical to assume that any one person is capable of meeting all needs of a person experiencing severe substance, mental health, or co-occurring disorders. To this end, teams are established to provide a multi-disciplinary perspective so that all aspects of approach to the individual's recovery can be met. All parties should continually review client and family feedback.	The integrated service team will schedule and conduct team meetings regularly or as needed. Staff provides information about the adolescent client and the family, which needs to be received as both valuable and pertinent to the adolescent client recovery process. See recommended steps below.

As stated, the team meeting should be structured and documented. The format of the meeting may look something like the following:

Step 1: Distribute Assessments and/or Service Plans - The presenting staff person makes copies of these documents for every team member. The process will NOT work unless each team member has his or her own copy of the assessments for the person being presented. The time and material to make large numbers of paper copies may be prohibitive. Many agencies have electronic medical records and can access service

plans and notes through internal electronic systems. If this is not available, a laptop with a projector can be used to project treatment plans so staff can quickly familiarize themselves with the service plan.

Step 2: What does the adolescent client and the family need? - The presenting staff person concisely states what the adolescent client and their family needs from the team (i.e., better engagement, ability to reach his/her goals, etc.). This helps keep the provider and team focused on what is to be accomplished in this meeting.

Step 3: Thumbnail sketch - The presenting staff person gives a one to two minute description of the situation, including the Stage of Treatment, and a few things that have already been tried.

Step 4: Questions only - For five to ten minutes the team asks questions of the staff person to further clarify things written on the strengths, longitudinal and contextual assessments. For example, “It says here that the mother is supportive. Tell me more about her role in the person’s life.” Advice is not typically given in this section; focus of questions should be based on the material in the various presented for each COD the adolescent client and their family(s).

Step 5: Brainstorming - For five to ten minutes the team brainstorms ideas. The presenting staff person should write down ideas provided by the team. For example, “The client could ask the mother to call her every Saturday to see how she is doing.” The list usually includes 20 to 40 ideas.

Step 6: Review List with The adolescent client and their family(s) - The presenting staff person reviews the ideas and asks for clarification on any ideas if necessary. Depending on the nature of the goal being reviewed, the provider may present the list to the client (at their next meeting) as possible strategies to help him or her reach the goal, or may choose two or three strategies he or she will employ in order to make progress toward the goal.

Step 7: Team Follow Up - Before the next meeting the supervisor or team leader will follow up on implementation of ideas and get feedback on the progress.

Service team implementation strategies	
2. Team Structure	Implementation Strategy
The service team must be made aware of the stage of change/treatment the adolescent client and their family is currently in, and if need be, provided education about what sort of interventions are appropriate to that stage. Keep in mind that persons with COD may be in various stages for	The service team monitors stages of change for each disorder, and responds to each disorder with the appropriate stage-wise intervention. For example, an individual experiencing pre-contemplation regarding medication for bi-polar illness while concurrently in the preparation stage of change for alcohol

different diagnoses, and that many factors influence readiness and motivation to engage in learning about personal change and self-management.	use must be worked with using distinctly different approaches.
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The most effective process is to simply engage the person, work with alliance and continue providing practical assistance for the bi-polar issue, while using motivational approaches with the alcohol use and its effects in order to fully engage the person into active treatment. All interactions of the clinician and team are guided by recovery principles and a strengths-based approach.

Service team implementation strategies	
3. Team Structure	Implementation Strategy
The service team and the rapid response team act to ensure that services are integrated as far as possible. This means that the provider agency shall employ appropriate resources to ensure that all co-occurring disorder-functional impairments are addressed in an integrated and comprehensive manner. It is essential that supervisory staff maintain positive working relationships within the team environment, so that contributions from all members are utilized to develop the integrated practice being described.	The expertise and skills of all staff, clinicians, prescribers, supervisory staff, and other members of the team represent both substance use and mental health disorders, and specifically address COD as needed. If CCSS is provided, as far as possible the provider agency will seek input regarding the adolescent client and family being served with careful observance of all Protected Health Information (PHI) related laws and regulation.

Decisions as to participation in the integrated service team or the rapid response team must be decided by administrative staff. The team must review service plans regularly, and all meetings must be documented and appropriately recorded.

Service team implementation strategies	
4. Team Structure	Implementation Strategy
The integrated service team ensures that comprehensive and integrated care is provided to the adolescent client and family specifically addressing the issues identified by the comprehensive service plan.	Documentation of service team meetings and roster, cases reviewed and decisions adopted by the team are recorded in logs or in the service plan, as appropriate. Provider agencies must amend Policies and Procedures to reflect support and allocation of time for team meetings.

15. Quality Management

Quality Management is an essential and highly challenging component of any provider agency. Well-run quality management departments may be found in all stable and effective providers. The term (its acronym is QM) refers to a set of structured activities and processes which identify, assess and review program performance and objectives at all levels, including but not limited to fiscal, contractual, consumer satisfaction, and service delivery.

In QM processes, targeted outcomes and data can be measured once against benchmarks, or repeatedly, over time, to chart progress, including the ups and downs of program performance. This process can identify shortcomings, lead to new approaches, to redefining staff roles and responsibilities, to improve morale or even rethink a program's ongoing mission and goals. QM processes and reports enable programs to assess themselves in multiple dimensions, to gauge progress in reaching budgetary or contractual goals, and to determine their effectiveness in the lives of those they serve. QM activities also enable course corrections to be tested for results. For example, the average length of stay by consumers could be targeted for study and measurement. After analysis of the topic, a strategy (or strategies) to improve engagement and retention could be implemented and results reviewed in 3-to 6 months. Should there be no appreciable improvement, other strategies could be tested.

Quality Management is a creative, demanding program activity which allows administrators, staff, board members, contractors and consumers of services to identify critical goals and objectives and measure the relative success in achieving those goals and objectives. A QM Director and related staff such as data personnel, are central to a provider agency and work collaboratively with all staff to ensure effective participation in the gathering of information and providing feedback on progress related to goals and objectives.

This process is:

- 1) required by funders and purchasers,
- 2) essential to program personnel in understanding how effective their services are,
- 3) helpful to the public in making personal choices to become donors and or consumers, and
- 4) is required by accrediting agencies (e.g. JCAHO and CARF).

When program goals and objectives are identified, a variety of interested parties must be kept in mind. For example, contractors may be interested in one set of measures, while donors or consumers are interested in a different set. As a result, a provider's total quality management activities can be quite complex as varying sets of data are maintained and monitored. To further complicate matters, many QM measures need to be gathered and reviewed over a period of years, while others are more short-term/time-limited.

QM data may be aggregated monthly, quarterly and/or annually, although in certain circumstances data may need to be measured weekly or even daily. Agency leadership needs to determine the composition of a QM Committee and what sets of objectives and sets of data will be reviewed by that committee or other designated committees. For all QM measures pertaining to program effectiveness and consumer satisfaction, it has been a tradition in New Mexico to have consumer input on the collection and review of certain data. In general, a broad representation of all sectors of the staff and community serve the process well. Certification entities such as Joint Commission or CARF, and certain contractors may set standards regarding a QM and similar committees involving participation of consumer and/or family members.

While the challenges in managing QM activities can be imposing, the rewards are significant in the ability to review measures related to program achievements, change over time, and relative success or shortcomings. Outside entities, boards of directors, staff and consumers can gain a window into program performance, engendering trust, pride and satisfaction. In addition, outcome data can reveal the state of contract compliance in ‘real time,’ reveal which areas of services are doing well and/or needing improvement, and assist leadership in setting a course for future program viability and success.

What is quality in the behavioral health setting?

With regards to behavioral health services, the funding source (whether federal, State, Tribal, County, City, foundation, private insurance, private pay, or a blend of these) buys services on behalf of the adolescent client and their family, and has the right of significant input regarding the types and quality of service being provided.

Although the adolescent client and his/her family is the ultimate judge of the effectiveness of the services provided, the interplay between the funding source and the provider of services to the client and family involves a complex array of elements. These elements must be constantly assessed and evaluated to determine viability, service fit, alignment with need and mission, and the fundamental competencies of the staff employed with the agency. Effective assessment and evaluation via quality management processes will help the provider steer a more successful business course, provide more effective services to the client and family, retain high quality staff for longer periods of time, and implement or even play a leading role in innovations in the behavioral health field.

Quality Management has three major components

Quality Assurance - Quality Control - Continuous Quality Improvement

Quality Assurance (QA)

This term refers to the systematic monitoring, assessment, and evaluation of various aspects of the provider's services, physical facility, changes in the healthcare system, attention to funding source directives, funding opportunities, cultural competency, recovery orientation, and shifting needs for services to the community.

Three key principles of QA:

1. The service effort must match the need.
2. The service effort must achieve the intended outcome, i.e. specific and verifiable.
3. Barriers to service, implementation challenges, deficiencies, misalignments, or errors will be improved or corrected in a formalized manner. All processes and protocols must be assessed and evaluated so that new processes can be discovered and implemented, and in order that existing processes and protocols can be adjusted as needed to attain the most effective achievement of specified outcomes.

The following are three key considerations in QA processes and procedures:

- **Outcomes and evaluation:** In order to clearly determine practice efficacy and develop strategies that enhance services, it is imperative that agencies measure benchmarks and outcomes resulting from their services. Outcome measures relevant to services and best practices (applied whenever possible) should be tracked to inform provider goals and objectives and effect improvement to services. Key outcomes areas include: reduced use/abstinence, mental health symptomology, employment, school participation, criminal justice involvement, housing, social connectedness, access to services, and health care.
- **Organization Fluidity:** In the context of QA, "organization fluidity" refers to the ability of the organization to utilize QA principles and practices to steer the course of the agency towards the highest quality of services possible while maintaining the most adaptable stance related to: change in the overall fiscal environment, community needs and health indices, the behavioral health system, and the overall healthcare system. Fluidity may also be required with regards to technological innovations, funding opportunities, emerging practices, and rapid response to staff turnover.
- **Best practices:** Techniques, methods, processes, activities, incentives, or rewards that are believed to be more effective at delivering a particular outcome than other techniques, methods, and process when applied to a particular condition or circumstance. Best practices can be viewed as the most efficient and effective way of accomplishing a task, based on repeatable procedures that have proven themselves over time for large numbers of people. A given best practice is only applicable to particular condition or circumstance and may have to be modified or adapted for similar circumstances. In addition, a "best" practice can evolve to become better as improvements are discovered.

Quality Control

This refers to the array of management and administrative responsibilities which require monitoring. These responsibilities include but are not limited to Policies and Procedures, record keeping, fiscal management, compliance and budgeting, staff hiring and competencies, facility maintenance and safety. Staff trainings are held when deemed necessary.

Quality Assurance processes serve Quality Control responsibilities. The following is a list of 15 Quality Control areas, followed by examples of how QA processes might be applied to each area.	
Quality Control Area	Quality Assurance Process
1. Administrative structure: Mission, Vision and Values, Policies and Procedures, Standard Operating Procedures, and organizational support of QA and CQI processes, maintenance of a functioning QA officer and committee.	QA oversight ensures that the review, evaluation, editing, changes or adaptations of all Policies and Procedures, Standards of Practice, etc., occur on a regularly scheduled basis and are current with all other applicable change and modifications to the organizational business stance, funding changes, service implementation changes, staff changes, etc.
2. Supervisory practices, internal and external review processes, performance and integrity criteria.	Professional and clinical supervision processes are reviewed and evaluated to ensure that all required supervisory practices and targets are adequately accomplished and implemented.
3. Record keeping and data management, HIPAA, CFR 42, etc.	The QA officer and committee review records and record-keeping processes to assess and ensure that satisfactory records and documentation are maintained and protected adequately.
4. Staff competencies, such as knowledge, skill, experience, licensures, certifications, integrity, individual alignment with the organizational mission, individual motivation, and related qualifications.	QA processes evaluate and confirm (or deny) that staff are monitored and that competencies are maintained.
5. Organizational issues, including integrity, overall competence of service implementation, internal culture, and alignment with stated mission.	Assessment of organization issues occurs semi-annually to assure organization success.
6. Team quality, training agendas, and regular meeting schedule.	The QA committee interviews the supervisor and reviews and evaluates team meeting logs to provide oversight and feedback to the organization.

Quality Control Area	Quality Assurance Process
7. Adaptation and implementation of research or evidence-based practices.	The QA officer or committee evaluates fidelity to implemented research or evidence-based practices through review of internal and external fidelity assessments.
8. External Controls: laws, regulations, service definitions, licensure requirements, professional standards and ethics.	Monitors and documents alignment with all applicable law, regulations, professional standards, etc.
9. Fiscal compliance with funding sources and state entity regulations and reporting responsibilities.	Assesses fiscal compliance based on audits and reports.
10. Engagement rate: Must include initial engagement and re-engagement following discharge or service interruption.	Monitors engagement rate and evaluates best practices for increasing or sustaining high engagement to initial service rates. Report findings to agency administration.
11. Retention in service rate and duration up to discharge, and drop-out or no-show rate.	Monitors, evaluates and reports on retention to service, service duration, drop-outs and no-shows, and discharge data.
12. Key adolescent client and family process and outcome measures relevant to the program model are tracked, inform provider goals and objectives, and quality improvement to services. Key outcomes include: reduced use/abstinence, decreased mental health symptomatology, employment, skills training, school, criminal justice involvement, housing, social support/connectedness, access to services, increased engagement in primary care and hospitalizations.	Monitors, evaluates and assesses outcome measures identified by the adolescent client and their family, the provider or by the purchaser of services.
13. Comprehensive and appropriate training related to the mission and values of the organization.	Monitors, assesses, and evaluates all training efforts to assure alignment with all applicable quality controls.
14. Current quality management processes and protocols.	Assess, evaluate, report, and develop workplans to address needed changes or sustain current quality management processes and protocols for fit to agency/program need and effectiveness.
15. Internal controls and standards as identified by the organization.	Assess, evaluate, report, and develop workplans to address needed changes or sustain quality management related to controls and standards.

Continuous Quality Improvement (CQI)

The term CQI describes an ongoing activity carried out to improve the quality of services and program activities. CQI assumes that opportunities for improvement are unlimited. CQI is customer-oriented, data-driven, and results in implementation of improvements. CQI requires continual measurement of implemented improvements and modifications of improvements. CQI processes can create an environment in which management and staff collaborate to perpetually re-examine the results of their efforts.

Internal and external benefits of CQI:

- Improved accountability.
- Improved staff morale.
- Refined service delivery process.
- Flexibility to meet service needs changes.
- Enhanced information management, client tracking & documentation.
- Means to determine and track program integrity and effectiveness.
- Lends itself to design of new programs & program components.
- Allows creative/innovative solutions.

The goals of CQI are to:

- Guide quality operations.
- Ensure safe environment & high quality of services.
- Meet both external and internal standards and regulations.
- Assist agency programs and services to meet annual goals & objectives.
- Help ensure fiscal solvency.

One popular CQI model is called PDCA (or PDSA – Planning, Doing, Studying, Acting). Computer grids or hard copy formats can be created based on these four activities, along with dates and responsible parties for each activity.

1. Planning

Collect data and establish a baseline – what is the current process doing now? Identify the problem and the possible causes. Identify barriers to service, implementation challenges, deficiencies, misalignments, or errors and possible causes and solutions, and to prioritize corrective actions.

2. Doing

Make appropriate changes designed to correct or improve quality of operations, quality of services, environment, alignment with external and internal controls and standards, accomplishment of goals and objectives, and support for fiscal solvency.

3. Studying

Study the effect of these changes on the situation. Collect data on the new process and compare to the baseline assessment and evaluation findings. Identify what has changed/improved, what has not. Track the effects of changes on a process over time. Evaluate the results and then replicate the change or abandon it and try something different.

4. Acting

If the results are successful, standardize the changes and then work on further improvements or the next prioritized problem. If the outcome is not yet successful, look for other ways to change the process or identify different causes for the problem.¹⁰⁶

Quality Management in a program that serves adolescents has any number of key components. What follows are examples of those components and suggested implementation strategies.	
Quality Management Component	Implementation Strategy
1. A quality assurance steering committee that meets at least every six months and specifically addresses COD-competent service delivery issues is critical in developing and sustaining COD-competent practices or as a result of a critical incident.	Develop and maintain a QA steering committee that meets at least every six months and specifically addresses COD-competent service delivery issues.
2. A thorough assessment of COD competent IOP services should be conducted, preferably by an external reviewer, using the IOP AFT.	Review fidelity to COD competent IOP, preferably by an external reviewer with knowledge of COD-competent IOP and the use of the IOP AFT.
3. Regular chart review ensures that service plans appropriately address all assessed functional impairments, mental health and/or substance use issues, and the integration of services for COD clients.	Verify through regular chart reviews that service plans address, with separate goals and objectives, all assessed functional impairment, substance use, mental health, and COD issues and how interventions appropriately integrated.

For example, while reviewing charts, a checklist could be used to check for key service components, such as:

- Are the client’s goals stated in the plan?
- Do goals meet both strengths and Medicaid criteria?
- Do objectives match what staff are actually doing?
- Are objectives written in such a way as to generate movement or progress?
- Is there missing information or areas that could be further explored?
- Do progress notes clearly reflect the work being done and demonstrate progress toward goals and objectives?
- Is information from assessment being reflected in practice?
- Are naturally occurring resources identified and used?
- Do the notes reflect a continuous search for or development of client strengths?
- Does the work reflect purposeful movement toward goals and objectives?

¹⁰⁶ Institute for Healthcare Improvement (Harvard, Cambridge MA).
<http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>

Quality Management Component	Implementation Strategy
<p>4. As a result of regular steering committee meetings and chart reviews, agency staff can then make recommendations to appropriate stakeholders for improvement to services for individuals with COD.</p>	<p>Make recommendations to steering committee for improvement to services for individuals with COD.</p>
<p>5. The agency actively develops a culture among providers and the community that promotes COD-competent service practices.</p>	<p>Advocate and promote COD-competent service practices within the agency and in the community.</p>
<p>6. Key adolescent client and family process and outcome measures relevant to the program model are tracked, inform provider goals and objectives, and quality improvement to services. Key outcomes include: reduced use/abstinence, decreased mental health symptomatology, employment/school, criminal justice involvement, housing, social support/connectedness, access to services, increased engagement in primary care, and timely hospitalization.</p>	<p>Collect and track adolescent client and family process and outcome measures relevant to the program model in areas described above.</p>

IV. Treatment Implementation Practice Standards

What you will find:



- **Research and Evidence-Based Treatment Approaches**
Interventions that are based on solid scientific evidence.
- **Eight Elements of Substance Use Disorder Treatment**
Lessons from a City that dared to ask “Is treatment in our program / community / state working as well as it can”?
- **System Adaptations for Particular Populations**
Systemic adaptations describes the systems-level adaptations required to address specific needs of discrete populations, which may include exclusive populations of individuals.
- **Youth Support Services**
Supports of all types help to develop resilient physically, emotionally, mentally, and spiritually healthy beings. Their wellness cannot be simply defined by the absence of disease, illness or stress.
- **Pharmacotherapy and Medication Management**
- **Encouraging and Monitoring Abstinence**
Methods to recognize progress that the adolescent and their family(s) make towards recovery and maintaining abstinence. For some populations, harm reduction may be more appropriate than abstinence.
- **Multifamily Group Engagement Practices**
The therapeutic involvement of families throughout the recovery process is associated with improved treatment outcomes.
- **Service Integration**
Utilizing multiple avenues of treatment interaction and with flexibility of service intensity according to client need.
- **Afterword**

16. Research & Evidence-Based Treatment Approaches

Definition of an Evidence-Based Practice (EBP)

Behavioral health practice is a multidisciplinary field that promotes optimal mental and physical health by maximizing bio-psychosocial functioning. Evidence-based behavioral practice entails making decisions about how to promote healthful behaviors by integrating the best available evidence with practitioner expertise and other resources, and with the characteristics, state, needs, values and preferences of those who will be affected. This is done in a manner that is compatible with the environmental and organizational context. **Evidence is comprised of research findings derived from the systematic collection of data through observation and experiment and the formulation of questions and testing of hypotheses.**¹⁰⁷

The systems model presented in this document is grounded in a thorough review of the available professional literature and collaboration with clinical experts in treatment applications, but it has not been researched, so it would be incorrect to call the model proposed in this manual evidence-based.

Evidence-based interventions have in general been developed to address either substance or mental health issues, and not co-occurring substance and mental disorders. Because of this, application of evidence-based practices in the co-occurring setting poses certain challenges.

We recommend use of the practice standards and elements of comprehensive, integrated treatment listed in this manual. Each agency must develop well thought-out EBP adaptations and rationales for services that specifically meet the needs of the clients with co-occurring disorders. Although both individual and group sessions may focus primarily on substance use issues, the complex nature of co-occurring disorders may need to be addressed through specific interventions that are not currently contained in evidence-based programs and practices. Ideally, adaptations will result in the development of practice-based evidence, which is replicable for COD treatment. Integrated service requires that staff have facility with both fields and have resources available that are applicable to the immediate needs of the clients. Such needs may shift significantly within a single treatment session, and require expert facilitation and adaptability on the part of the clinician.

An agency can and should make a policy decision to deliver, as much as possible, treatment interventions that are based on solid scientific evidence. This would be a commitment to EBPs in general, as distinguished from the provision of particular EBPs.

Most EBPs are treatment programs or practices, while some, such as the Matrix Model, are adult-focused curricula adapted for use with adolescents; they describe specific procedures

¹⁰⁷ The EBBP.org project creates training resources to help bridge the gap between behavioral health research and practice. Professionals from the major health disciplines are collaborating to learn, teach, and implement evidence-based behavioral practice (EBBP). <http://ebbp.org/ebbp.html>

but do not prescribe the details of the many day-to-day operational decisions within a provider's program that must be made to accommodate EBPs. Implementing EBPs may require significant changes in program philosophy, procedures, and training and hiring practices. In programs where EBPs are new, this involves a commitment to train or retrain clinicians to deliver EBPs. The best possible practice model will enable the provider to attend train-the-trainer trainings, so that sustainability at least cost possible is embedded internally.

For a current list of many EBPs, please go to:

http://www.azdhs.gov/bhs/guidance/catsu_attach_c.pdf

IOP services in New Mexico must be rendered through a research-based model, including but not restricted to:

- Matrix Model Adult Treatment Model
- Matrix Model Adolescent Treatment Model
- The Seven Challenges (Approved by the NM Medical Assistance Division for Medicaid reimbursement as an intensive-outpatient bundled service. This is a co-occurring competent EBP)
- Minnesota Treatment Model
- Integrated Dual Diagnosis Treatment (IDDT) Model (The IDDT does not contain an IOP curriculum. To use the designation of IDDT, the provider agency must be approved by HSD/BHSD, and submit the agencies IOP curriculum that meets the IDDT standards of practice.)¹⁰⁸

In addition, the following short list of other complementary practices and EBP's may be included:

- Comprehensive Community Support Services
- Motivational Interviewing
- Contingency Management *or* Motivational Incentives
- Motivational Enhancement
- Double Trouble
- Stage-wise interventions
- Cognitive behavioral therapies by name (i.e., CBT for Depression, CBT for Anxiety, Trauma-focused CBT, etc.)
- Dialectical Behavior Therapy (DBT)
- Group counseling and therapy
- Relaxation techniques/stress management skills
- Multi-systemic Therapy (MST)
- Adolescent Community Reinforcement Approach (ACRA)
- Anger management
- Family psycho-education and counseling

¹⁰⁸ NM Medicaid Regulation: F. IOP services must be rendered through a research-based model:

(1) Matrix Model Adult Treatment Model; (2) Matrix Model Adolescent Treatment Model; (3) Minnesota Treatment Model; (4) Integrated Dual Disorder Treatment; (5) any models other than those identified above must be approved by HSD or its authorized agents.

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- Community Reinforcement Approach (CRA)
- CRAFT and/or Modified CRAFT
- Psychological First Aid
- Mental Health First Aid
- SMART Recovery (Self-Management And Recovery Training)
- 12-step programs
- Self-help, community-based groups
- Vocational and educational services
- Housing/shelter
- Others as designated by the provider or as available in the community served

Financing EBPs

There are risks when an organization does not have appropriate financing and infrastructure for evidenced-based practices and programs. The provision of treatment services may become available only to a few persons based on eligibility to pay, rather than all who are in need of services. In addition, if financial constraints are too severe, the EBP can become difficult to sustain related to fidelity to practice, which then impacts consumer outcomes. The fidelity to practice issue is sometimes difficult for the provider to navigate, because there can be significant lag between EBP implementation and improved customer outcomes. This lag is due to the learning curve necessary for the clinician and also the lag in getting results. However, if there is drift from fidelity it is likely to increase consumer dissatisfaction, as outcomes are not reached. When any or some of these results occur with a poorly introduced and practiced EBP, it can lead to ideas by providers and consumers of a particular EBP not being useful or helpful, when the actual issue may be related almost entirely to fidelity to practice. For example, driving within the speed limit and monitoring speed based on road conditions is a best practice supported by vast evidence. People who attend to speed limits and conditions are less likely to sustain accidents (or get tickets from law enforcement).¹⁰⁹

Several decades of EBP implementation have suggested that there are a few critical components of EBP needing financing, to include:

1. start-up activities to explore the need, feasibility and installation of a program in a community or provider agency
2. the direct service provided to consumers by the EBP and its likely effect
3. the infrastructure needed to successfully implement and sustain the quality of the EBP, including supervision requirements, ongoing training, fidelity monitoring, etc.

One way prevention programs in New Mexico have been able to monitor fidelity of EBPs is by designating 15-20% of overall contracts to evaluation. This allows a local evaluator to monitor progress and program outcomes in addition to conducting fidelity checks.¹¹⁰

More specifically, the actual activities during the adolescent IOP startup process that require funding will likely be:

¹⁰⁹ Contributed by Karan Northfield, LPCC, Manager of Quality Improvement, OptumHealth New Mexico

¹¹⁰ New Mexico Office of Substance Abuse Prevention Contracting Specifications 2014

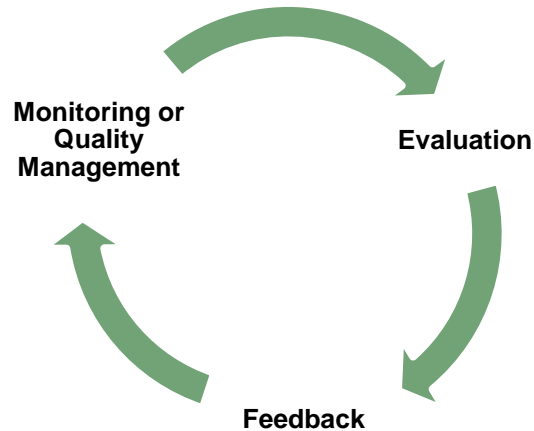
Part B. 16. Research & Evidence-Based Treatment Approaches

- Staff time for creating referral mechanisms- CYFD has worked with provider agencies to develop sustainable referral pathways so that programs such as MST or IOP will be successful.
- Re-aligning current staff functions to support the EBP. Many EBPs require that staff discretely implement the EBP and not another so that there is no tendency to “creep,” or mix practices and lose fidelity.
- Hiring new staff who are qualified to provide the treatment specified by the evidence-based program or practice
- Securing required space
- Purchasing necessary technology
- Reimbursing the time in meetings with stakeholders
- Reimbursing staff training time for EBP. CYFD has worked for many years to assure that providers have new and current training in EBP available, including MST, ASAM, Seven Challenges, the Matrix Model, Motivational Interviewing, Seeking Safety, IDDT, Contingency Management, and most recently The Seven Challenges, to name a few.

The term ‘direct service’ in this instance is referring to a discrete evidenced-based clinical practice (e.g., Trauma-Focused Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, The Seven Challenges, etc.) or an evidenced-based program (e.g., Multi-Systemic Therapy, Assertive Community Treatment, Intensive Outpatient Program, etc.). Direct clinical services that are characterized as a discrete clinical therapy or practice are often covered under typical medical funding sources such as Medicaid, or may be paid for through private insurance policies. Such treatment sessions also may be funded through state contracts for children who do not qualify for Medicaid or have insurance coverage. Keep in mind that direct clinical services that incorporate non-traditional services and supports into a more comprehensive evidenced-based program are more difficult to define as medically necessary and therefore difficult to cover under Medicaid. If Medicaid agrees to incorporate such a treatment program, they must usually apply to Centers for Medicare/Medicaid Services in order to incorporate this service into the Medicaid State Plan, a process that is resource-consuming without a guaranteed outcome.

An agency considering a new EBP needs to be able to support appropriate infrastructure, which, at the very least, encompasses the training, coaching, fidelity monitoring, and outcomes measurement systems for the program. Training occurs through the process of providing knowledge, developing skills and enhancing the abilities of the practitioners who will be delivering and EBP, usually through demonstration and rehearsal of the EBP theory, philosophy and rationale for program components. Coaching is typically the direct observation, feedback and attention to adherence to the principles and practices that make a program successful and occurs through continued supervision, support and assessment and development of the practitioner’s EBP skills and abilities. Fidelity monitoring ensures that the program is implemented as intended and that the practitioners delivering the EBP demonstrate skill and attention to essential program components when interacting with consumers.

Lastly, remember that research indicates that consumers that receive services with high fidelity to the core components of a program seem to have significantly better treatment outcomes. Outcomes monitoring of an EBP is essential for the reinforcement to the provider that the program is operating as it should, by resulting in specific identified results for the consumer. If the expected results for consumers are not being achieved, a regularly scheduled Monitoring-Evaluation-Feedback loop will indicate to the agency where issues may reside in EBP service delivery. In addition, the providers increasing ability to show funders efficacy of programming will be beneficial in maintaining funder confidence, and thus, continued financial support.



If an EBP produces results that are not as positive as expected, the provider needs to be able to determine if it is an implementation problem, effectiveness problem or a combination of both.

Low fidelity + poor outcomes = improve staff adherence to the model

High fidelity + poor outcomes = look at target population and interventions

Current EBP funding sources in New Mexico include:

Federal Block Grants

- SAPT
- CMHS
- SOC

State General Funds

- BHSD
- CYFD

Private Foundation Grants (local regional and national foundations may fund specific areas of behavioral health, but not all; check foundation guidelines for more detail)

- McCune
- Con Alma
- Daniels Fund
- ACT
- MST
- IOP
- CCSS
- City and county contracts
- Medicaid

17. Eleven Fundamentals of Substance Use Disorder Treatment

In 2004, the City of Philadelphia, under the leadership of Dr. Arthur Evans, initiated a radical self-examination of its behavioral health System of Care.¹¹¹ The SOC was well funded but there were concerns about its value, including outcomes and results in the lives of individuals and the community.

The task force came to believe that the city's system was "broken and in need of recovery." Their first strategic action step was to methodically listen to stakeholders and gather multiple points of view in order to develop an informed vision of a new system. Providers everywhere should be inspired by the courage and commitment evidenced by the Philadelphia group. As we examine the impact on our families and communities of drugs and alcohol use, it is more important than ever to ask, is treatment in our program/community/state working as well as it can?

A "fearless self-inventory" (as the Philadelphians described it) would undoubtedly lead to a conclusion that treatment is, in most instances, not well grounded in sound evidence and research. The best research we have, combined with qualitative reports (lived experience), tells us, in part, that there are a few stand-out items regarding effecting treatment for SUDs.

Although these are all listed elsewhere in this manual and integrated care will use all listed elements described and in greater detail, the brief list for SUD treatment is:

1. For many youth substance use disorders are chronic conditions, which require long-term treatment and are best approached as "**a meet the youth where they are at**" manner that is respectful and engaging, specifically related to readiness for the various stages of treatment.
2. Recovery approaches are codified in policy and procedure, and **all youth are approached within the context of ongoing recovery care**. Program staff must be knowledgeable, creative experts in engagement and motivation.
3. **Recovery approaches and trauma-informed care are understood and embraced by all staff, agency wide.**
4. The complexities of adolescent substance use require **individualized, strengths-based approaches, high-level assessments and service planning, and a menu of engaging and developmentally appropriate services that are focused on harm reduction** rather than abstinence only. Early intervention practices are used to help those youth that may not demonstrate severe use disorders but have evidence of some use.
5. **Co-occurring mental or emotional disorders are carefully considered**, particularly in the context of intertwining effects of substances possibly being used to self-medicate.

¹¹¹ R. Lamb, A. Evans, W. White. (2009) The Role of partnership in Recovery Oriented Systems of Care: The Philadelphia Experience. www.williamwhitepapers.com & <http://files.ireta.org/resources/RoleOfPartnershipInRecoveryOrientedCare2009.pdf>

6. **Parents/caregivers need to be included** in the process and are worked with as partners. Goals and objectives are set collaboratively with the youth and the family.
7. **All clinical staff use the mandated evidence-based practices** chosen or approved for use by Executive Staff and all practicing staff are required to practice to fidelity.
8. **Continuing care/recovery management and re-intervention are essential.**
9. **Rigorous supervision and ongoing education and training must be offered** to all staff at regular intervals determined by need, new hire, and are codified in policy.
10. **Supervisors have learned experience as well as advanced training/education** in the EBPs used by the agency so that supervision provides both oversight and learning opportunity for clinicians being supervised.
11. **Staff are familiar with medical and pharmacological resources** in the treatment of substance use and co-occurring disorders and make recommendations to medical practitioners as appropriate.

It would likely be challenging to find a substance use treatment program for adolescents that operates according to the eleven principles and practices listed above.

All that we are learning about substance use disorders and recovery may soon lead to a time where “treatment” as we traditionally know it ends, is folded into an array of services and even redefined. In the future, we may be providing and funding a sequence or combination of recovery services on which treatment is but one component (in early recovery). In this case, the role of the therapist will change, and mentors and coaches may end up playing the most critical roles.

With so many encouraging developments taking place in the field of research and application, it is imperative that clinicians, programs, funders at private and governmental levels stay abreast of current evidence and recovery based treatment models.

For many years, substance use and mental health services were siloed in funding resulting in unwanted disparities and the population with co-occurring disorders falling through the cracks. Ironically, by combining mental health and substance use under the heading of behavioral health, an undesirable blurring of definitions has occurred. We need to be clear that substance-abusing youth are not merely a sub-type of mental health consumers, amenable to mental health counseling.

Setting aside co-occurring disorders (which are addressed elsewhere in this manual), the two populations are fundamentally different. Substance-using adolescents often enter treatment through the juvenile justice system. They bring varying sets of background, attitudes, complications and abilities to treatment. By contrast with mental health patients, most individual’s entry into substance use and their recovery related to substance use disorders seems to involve some level of initial choice, however constricted choice may have become with continued use. While few if any set out to acquire a substance use disorder, their presenting problem may have resulted from a simple desire to numb pain, feel safe or experience pleasure.

Because personal choice, broadly speaking, *appears* to be another element differentiating the substance user from the mental health consumer, expertise in motivation and science-based approaches should predominate in the skill set of practitioners. However, regardless of appearances, substance use is clearly marked by profound failures at nearly every stage regarding recovery, and this is not because youth are simply resistant. The evidence mounts daily that substance use causes immediate and long-lasting changes to neurotransmitters and hormones, to the physical brain, to attitudes and motivation, to emotional balance, and negatively affects judgment related to executive function. Any person can argue with this, but it seems fairly irrefutable, and to blame any person for making “bad choices” related to substance use is futile and stigmatizing. Instead, the potentials for recovery must be introduced and made available, if necessary for the rest of this person’s life, for it may be that they have acquired something akin to a chronic physical illness. While evidence points to the importance of empathy and the therapeutic relationship in all clinical work, the similarities in treating substance users and mental health consumers are not extensive, but conversely, treating substance users with some of the methodologies learned over time regarding long-term care are vital.

Mark and Susan Godley, experts in treatment of substance using youth, comment on one aspect in this way: **“Our patients need a lot of encouragement to try new things, and counseling is at best about one-third of the role of a good clinician. Being a coach and a cheerleader may be more important...In the Community Reinforcement Approach, this is now known as the “systematic encouragement procedure.”** William White describes the role as a “sustained recovery consultant.”¹¹²

Perhaps the most challenging/frustrating aspect of treatment concerns its lasting impact. We still do not have a clear understanding of the relationship between adolescent treatment and the prospects of long-term recovery. In addition, according to Godley and White, “Studies confirm low rates of voluntary attraction to treatment, low rates of sustained sobriety following treatment and high treatment re-admission rates.”¹¹³ As a result, there must be an increased attention on post-treatment follow-up and the successes reported by these types of activities. Programs, communities and funders must take a serious look at developing recovery management/continuing care as an essential component of treatment. Stakeholders should demand vigorous continuing care services for adolescents whether they are successful in treatment or not—and it is vital to note that successful treatment does not likely indicate that the individual is cured, but that the current episode has been addressed and the person can for a time proceed. To proceed in this fashion requires ongoing support, just as the person with diabetes will receive ongoing support even while they are living a functional and healthy lifestyle—the healthcare system

¹¹² White, W. (2013). Extending the effects of addiction treatment for adolescents: An interview with Mark Godley, PhD and Susan Harrington Godley, PhD. Posted at www.williamwhitepapers.com; published in abridged form in *Counselor*.

¹¹³ White, W. & Godley, S. (2007) *Adolescent recovery: What we need to know*. *Student Assistance Journal*, 19(2), 20-25.

does not forget about the person with diabetes, but makes ongoing care and check-ins part of the individual's health-maintenance plan.

All of these factors lead to the conclusion that a self-inventory, whether on a systematic or personal level, should examine possible restructuring of roles, services and resource allocation. It will serve each of us to remember the Philadelphia Experience and its "listening tour." Perhaps the most productive activity we could commit ourselves to is to continually listen—to experts in the field, but even more to consumers and families, those who have entered recovery successfully, as well as those who have struggled with our programs and our systems. Listening and learning leads us to keep up in the field, and continually evaluate and hone our services to the highest level.

18. System Adaptations for Particular Populations

Systems-level adaptations aim to work with whole populations, or distinct issues (homelessness, justice populations, etc.). These are not descriptive of specific changes to the evidence-based models that take place on a case-by-case basis. Instead, the term describes systems-level alterations needed to effectively address needs relative to unique populations vs. changes to the evidence-based program or practice. As examples, such changes might encompass location of entrances and exits, discreet parking, office arrangement, staff receiving specific training regarding protocols for interacting with law-enforcement or military personnel, making certain that outside noise is minimized, etc. Such changes will be specific to the targeted service population.

These populations may include:

- Youth with opiate use disorders, elders misusing prescription medications, etc.;
- subsets of co-occurring substance and mentally/emotionally disordered persons based on race, ethnicity, and/or developmental disability;
- adults or adolescents with existing employment conditions, and/or single parents;
- sex, gender identity, and/or sexual orientation;
- spiritual values and religion;
- age, such as adolescent in transition to adulthood or elderly populations;
- unique or isolated geographic locations (e.g., rural vs. urban);
- military personnel, law enforcement, veterans, or others in need of discreet services
- therapeutic adventure and experiential education adaptations

Some examples of evidence-based practices that have been adapted to meet the needs of specific populations include Seeking Safety, Native American Motivational Interviewing, and trauma-sensitive care.

Examples of Adaptations for Specific Populations:

Programs Adapted for Native American Populations

Spiritual and religious values and the need for traditional practices and traditional medicine may more effectively welcome and serve Native American populations. Recognizing and valuing different worldviews by including traditional values, healing practices and indigenous experience/perception in clinical practice enables diverse persons to enrich and inform evidence-based practices to the end that treatment is culturally supportive. For example, Project Venture is an evidence-based experiential prevention program developed in Gallup, NM for Native youth.

Justice System Programmatically Adapted IOP

Justice system populations are challenged with many psychosocial, medical, and financial problems. Adaptations need to include such things as: parameters for treatment, responsibilities of referring agency, the client (and family, if appropriate) provider capacity, consequences of non-compliant behavior, time tables for communications and reports, and definitions of critical incidents and reporting requirements.

Gender-specific Programmatically Adapted IOP

Effective treatment for women cannot occur in isolation from the social, health care, legal issues, justice system, parenting, financial concerns, school, education, employment, and other challenges to engagement into successful treatment and recovery facing female clients. Some studies suggest that gender-specific treatment may be advantageous for female clients, producing higher success rates in women-only groups or programs.

19. Youth Support Services

The purpose of Youth Support Services (YSS) is to promote wellness for all New Mexico children, and to help NM youth steer a course towards a healthy adulthood, free of substance disorders or unrecognized and untreated mental health disorders. YSS provide experiential and developmental supports intended to replace or enhance natural supports deficits and must result in the acquisition of skills and capabilities to aid the individual in living a satisfying life.

Some youth experience robust natural supports and will have little need of such services, while some youth will have few natural supports and would benefit from these services. Those youth most in need of these services may have experienced significant difficulties in school and community settings, with peers, with family dysfunction or disintegration, with substance use and/or mental health conditions, or with the justice system. Therefore, support services must be available on a broad continuum of need, from low need to high need.

Youth development can be defined as:

"The ongoing growth process in which all youth are engaged in attempting to (1) meet their basic personal and social needs to be safe, feel cared for, be valued, be useful, and be spiritually grounded, and (2) to build skills and competencies that allow them to function and contribute in their daily lives."¹¹⁴

As the definition implies, it is a process or journey that automatically involves all people around a youth; family, friends and community. A young person will not be able to build essential skills and competencies and be able to feel safe, cared for, valued, useful, and spiritually grounded unless others provide them with the supports and opportunities they need along the way. Thus, youth development is also a process in which family and community must actively participate. Youth development as a service currently exists in a variety of different places, forms and names.

Supports of all types help to develop resilient physically, emotionally, mentally, and spiritually healthy beings. Their wellness cannot be simply defined by the absence of disease, illness or stress. The youth support services being described here must be available for all youth as far as possible. Some youth experience robust natural supports and will have little need of such services, while some youth will have few natural supports and would benefit from these services. Those youth most in need of these services may have experienced significant difficulties in school and community settings, with peers, with family dysfunction or disintegration, with substance use and/or mental health conditions,

¹¹⁴ Pittman, K. (May 1993) Seminar with 4-H Faculty, St. Paul, University of Minnesota.
<http://www.extension.umn.edu/youth/training-events/understanding-youth-development-work/>

or with the justice system. Therefore, support services must be available on a broad continuum of need, from low need to high need.

Recovery Support Services For Youth

Recovery Support Services are one type of youth supports designed for youth with substance use issues, although they are appropriate and adaptable for all youth. ¹¹⁵

The SAMHSA Center for Substance Abuse Treatment’s Recovery Community Support Program has identified four types of RSSs:

Emotional support

Demonstrations of empathy, love, care, and concern in such activities as peer mentoring and recovery coaching, as well as in recovery support groups.

Informational support

Provision of health and wellness information; educational assistance; and help in acquiring new skills, ranging from life skills to skills in employment readiness, making appropriate referrals for immigration issues.

Instrumental support

Concrete assistance in task accomplishment, especially with stressful tasks such as filling out applications and obtaining entitlements, providing child care, or providing transportation to support-group meetings and clothing assistance outlets (clothing closets).

Companionship

Helping people in early recovery feel socially connected especially in recreational activities in alcohol-and drug-free environments. ¹¹⁶

The New Mexico Youth Support Services

Because youth are often resistant to being identified as “in recovery,” an alternative descriptive name for these services has been adopted by the Children’s Behavioral Health Division: **Youth Support Services**.

For service provision, the following three categories may receive support services:

1. Youth supports for youth that do not need treatment but have need of support services based on a perceived lack of natural supports
2. Support services provided concurrent to behavioral health treatment
3. Aftercare services/relapse prevention and reintegration for youth who have graduated from behavioral health treatment

Access to Recovery Support Services

1. **Youth Support Services Life Skills Coach (YSS LSC) with listed responsibilities:**

¹¹⁵ The Prevention Researcher; Youth in Recovery; By John de Miranda, Ed.M., and Greg Williams, B.A. 16 April 2011, Volume 18(2). www.TPRonline.org

¹¹⁶ Center for Substance Abuse Treatment, What are Peer Recovery Support Services? HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009. <http://store.samhsa.gov/shin/content/SMA09-4454/SMA09-4454.pdf>

The purpose of life skills coaching is to ensure that clients receive the services they need in a timely, appropriate, effective, efficient, and coordinated fashion. The general purpose of the LSC is to coordinate and monitor services and to assess client progress toward specific identified goals. LSC provides services when necessary to serve clients who have few natural supports or who assess with life skills deficits. The LSC services are client centered, family member- focused, culturally competent and strengths-based. LSCs specifically engage the youth and his/her family to maintain interest and involvement in services being provided.

The LSC provides assistance in promoting youth development, linking and brokering services, resources and assets, and shall be delivered by persons who have a broad exposure to community and life experiences. LSCs will assist youth with the development of goal oriented action plans.

The most useful skill for any youth to achieve is the ability to acquire new skills, thus, comfort in learning new things is a primary goal of Life Skills coaching.

The LSC shall provide the following services:

1. Engagement strategies are utilized as the foundation and building of trust, alliance, and rapport with the individual and/or family being served, and are continuously applied;
2. Coordination and facilitation of the Casey Life Skills (CLS) Assessment at intake and at 120 day intervals;
3. Assist in the development of the client's Service Plan;
4. Participate in the 120 day review of the service plan with the service planning team;
5. Follow-up and in-home meetings with youth and families related to sustaining engagement into services;
6. Provide Life Skills Coaching as described in the YSS Service Definition and in the CLS curriculum;
7. Facilitate Casey Life Skills group meetings utilizing the CLS Curriculum;
8. Facilitate Casey Life Skills individual meetings utilizing the CLS Curriculum;
9. Complete the required case notes and the monthly, quarterly and final reports;
10. Assist the client in getting transportation to and from scheduled appointments and the delivery of services outside of the office, when necessary;
11. Complete referral paperwork and coordinate services related to YSS;
12. Advocate for client and family during treatment team meetings and/or to the service provider related to family and/or youth needs and accomplishments.
13. Provide or refer client/family for appropriate family support or other services, such as medical care, housing, education, and ongoing care.

Life Skills Services

1. Administration of the **Casey Life Skills assessment**;
2. **Engagement:** The Life Skills Coach uses engagement skills to build a relationship between the coach, the program and the individual and family, and to determine if the specific services available or offered are appropriate for the youth and his/her family. The LSC works to connect, or reconnect, a youth and his or her family to

needed support services. The LSC attempts to engage youth and families who might not use services due to lack of awareness or active avoidance, and who might otherwise be ignored or underserved. Engagement services may be used in an office or in-home setting, or in the community at any time;

Casey Life Skills Curriculum

2. **Life Skills:** Life skills services address activities of daily living, hygiene, budgeting, time management, interpersonal relations, household management, anger management, career exploration and future development planning, navigating school and healthcare systems and other issues appropriate to functioning in New Mexico society;
3. **Job Preparation:** The purpose of this component is to develop the age-appropriate knowledge and skills for youth to gain and maintain employment. The program shall recognize that short-term job goal development is most appropriate for youth. Job services include and are not limited to: providing instruction in the areas of resume writing, completing job applications, and appropriate job interview responses. Job service activities also emphasize the importance of being ready to seek and hold employment, proper nutrition, cleanliness, and physical appearance, allocating daily costs, and work ethic;
4. **Education:** The purpose of this component is for the LSC to enhance client functioning and knowledge by developing skills that reinforce client strengths and assist the client to receive a High School Diploma, GED, or completion of vocational training, etc. They would also help to explore and plan for future educational needs and to create a career pathway. Link to <http://www.mynextmove.org/explore/ip> for help with career planning and development;
5. **Parent Education and Child Development:** Parenting assistance is a service to assist with parenting skills; teach, monitor, and model appropriate discipline strategies and techniques; and provide information and advocacy on child development, age appropriate needs and expectations, parent groups, and other related issues;
6. **Family/Marriage Education:** The CLS Curriculum guides a family system to address interpersonal communication, conflict management, marital issues and concerns, and parenting issues, and *is not* a psychotherapeutic or counseling intervention, and;
7. **Transitional Planning:** The LSC provides coaching and support to youth transitioning into adulthood. LSCs act to improve youth transitions in the following areas: employment, education, life skills, housing and social functioning.

In addition, the following two services can be provided through YSS:

1. **Child Care:** These services include care and supervision provided to a client's child(ren), less than 14 years of age and for less than 24 hours per day, while the client is participating in treatment and/or youth support activities. These services

must be provided in a manner that complies with state, municipal, and tribal laws regarding child care facilities.

2. **Transportation:** Reimbursement for costs associated with transport in a provider agency vehicle, public transport, and gas cards. Youth and caregivers with contractor verified need for transportation services or gas card reimbursement to a driver for the youth, and with the specific goal of attending scheduled meetings, events or appointments as determined by the contractor. Eligibility determined by need related to a lack of transportation, financial hardship of the caregivers related to the provision of transportation only, or other cause that is consistent with determination of need. Youth who have access to willing or regular transport should be deemed as ineligible for this service.

20. Pharmacotherapy & Medication Management

For an in-depth discussion of Pharmacotherapy Related to Opioid Treatment, please refer to this element in Part A, Chapter 17.

Access to Pharmacotherapy is an essential component of integrated treatment services. Pharmacotherapy and medication management includes the use of appropriate medications to manage substance, mental health or co-occurring disorders and use of a recovery-based approach including shared decision making, informed consent, and an active role on multi-disciplinary teams.

It can be tempting to overlook the fact that prescription medication alone, whether addressing MH or SA symptomology or cravings for opiates, cannot fundamentally improve one's life without associated changes in life style. This caveat also applies to parents who may need to modify their parenting styles or other aspects of the home environment. Consistent with the holistic approach of this manual, pharmacotherapy for individuals with one or more MH/SA disorders should be considered as but one of an array of possible and even essential therapeutic approaches and services.

The following components describe effective practice for pharmacotherapy:

1. **Prescribe psychiatric medications despite active substance use** as appropriate, with particular care regarding substance related conditions, cravings, and effects of medications on substance use issues.
2. **Prescribe medications to support substance use recovery** and to manage urges and cravings.
3. Work closely with clinicians or multi-disciplinary team and consumer and **maintain open communication** regarding effects and/or side effects.
4. **Maintain active participation** on multi-disciplinary clinical team (MDT).
5. **Focus on increasing collaboration** and partnership among prescriber, clinical staff, consumer and family to assure understanding of effects, advantages, and support for and appropriate use of medication.
6. **Provide education and educational materials** to consumers and families about medications and advantages and side-effects
7. **Assure access to appropriate prescriber** that understands adolescent development.
8. **Allocate time** to prescriber, clinician, and team for collaboration regarding pharmacotherapy for individuals and for education regarding overall issue of psychiatric and substance medication
9. **Utilize prescriber** with COD training and/or prior COD experience.
10. **Incorporate ethno-pharmacology** as appropriate, which takes into account the study of the effect of ethnicity on responses to prescribed medication, especially drug absorption, metabolism, distribution, and excretion (recommended, but not a required component).

Medication Assisted Treatment (MAT) / Pharmacotherapy

This Section provides an overview of the medications and therapies that comprise MAT. However, MAT is a term that likely perpetuates stigma related to singling out substance use disorders as specifically needing medication assisted treatment. Other common health disorders, such as diabetes, make no specific reference to their need for medication as integral to treatment (e.g. medication assisted diet). Specific medications for substance use disorders generally fall into two larger categories: medications to treat opioid use disorders and medications to treat alcohol use disorders. Several medications have been found effective in treating addiction to opioids, alcohol, and nicotine in adults. There are currently no FDA approved medications to treat addiction to cannabis, cocaine, or methamphetamine. Three medications have received FDA approval for treating opioid use disorders.

Methadone prevents opioid withdrawal symptoms and reduces craving by activating opioid receptors in the brain. It has a long history of use in treatment of opioid dependence in adults, and is available for addiction treatment only in specially licensed methadone treatment programs. In some States, opioid dependent adolescents between the ages of 16 and 18 may be eligible for methadone treatment, provided they have two documented failed treatments of opioid detoxification or drug free treatment and have a written consent for methadone signed by a parent or legal guardian. Counseling, medical exams drug testing are standard requirement for everyone enrolled in a methadone treatment program.

Buprenorphine reduces or eliminates opioid withdrawal symptoms, including drug cravings, without producing the euphoria or dangerous side effects of heroin and other opioids. It does this by both activating and blocking opioid receptors in the brain. It is available for sublingual (under the tongue) administration both in a stand-alone formulation and in combination with another agent called naloxone. The naloxone in the combined formulation is included to deter diversion or abuse of the medication by causing a withdrawal reaction if it is intravenously injected by individuals physically dependent on opioids.

Physicians with special certification may provide office-based buprenorphine treatment for detoxification and/or maintenance therapy. It is sometimes prescribed to older adolescents on the basis of two research studies indicating its efficacy for this population, and has proven efficacy to treat those 16 years and older. By contrast with methadone treatment, there is no federally required counseling for patients receiving buprenorphine, although individual doctors may want their patients to receive counseling as part of their treatment regimen.

Naltrexone is approved for the prevention of relapse in adult patients following complete detoxification from opioids. It acts by blocking the brain's opioid receptors, preventing opioid drugs from acting on them and thus blocking the euphoria the user would normally feel and/or causing withdrawal if recent opioid use has occurred. It can be taken orally in tablets or as a once monthly injection given in a doctor's office.

In addition to the above medications for opioid use disorder treatment, naloxone is a medication used to prevent opioid overdose deaths. The medication binds to opioid receptors and can rapidly reverse or block the effects of other opioids. In doing so, naloxone can very quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of heroin use or the misuse of prescription opioids.

Naloxone's availability varies from state to state. In 2014, New Mexico became the first state to authorize pharmacists to prescribe naloxone.

In a memorandum released in August 2014, Attorney General Eric Holder urged Federal Law Enforcement agencies to identify, train, and equip agents who may interact with a victim of a heroin overdose with naloxone.

Medications for Alcohol Abuse

There are three FDA approved medications to treat cravings for alcohol. They are Disulfiram, Acamprosate, and Naltrexone, both tablets and long-acting injectable. The long-term effects of these drugs on individuals under 18 have not been well researched.

Pharmacology and Ethnicity

The impact of culture and ethnicity on psychopharmacological drug response continues to be a topic of interest and research. Diagnostic issues among patients of different races and cultures and also the influence of race and culture of the treating clinician are factors to consider before pharmacotherapy is even prescribed although it also appears to affect the type of pharmacotherapy prescribed as well. Culture and ethnicity may also influence the response rates to treatment with pharmacotherapy along with affecting the reporting of adverse effects, compliance with the treatment regimen, perception of need for such treatments compared to alternative health beliefs. African Americans may be diagnosed with a more severe disorder compared to Caucasians, and African Americans may also receive comparatively different, and higher, doses for the same level of symptoms compared to white patients. Asian patients may require different doses of psychotropics compared to Caucasian patients. Some of these dosing differences may be explained by pharmacogenetic differences, whereas some may be explained by cultural perceptions of illness among the different patient populations. This interface between biology, ethnicity, and cultural issues poses a challenge for the practitioner to pay attention to the multiple factors that may influence an individual's response to pharmacotherapy.¹¹⁷

A PDF of the following manual is available by request from Michael Hock:

Managing Co-Occurring Mental and Substance Use Disorders: A Guide for the Busy Primary Care Provider

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Produced by the University of New Mexico, Department of Psychiatry, Center for Rural and Community Behavioral Health (CRCBH) and the New Mexico Consortium for Behavioral Health Training and Research

¹¹⁷ The Interface of Multiculturalism and Psychopharmacology (2006) : Jose A. Rey, PharmD, BCPP
<http://jpp.sagepub.com/content/19/6/379.abstract>

21. Encouraging & Monitoring Abstinence

Programs may utilize monitoring methods to recognize progress that the adolescent client and their family(s) make towards recovery and maintaining abstinence. For some populations, harm reduction may be more appropriate than abstinence. Relapse and reduced use are part of the recovery process and the cyclical nature of substance use disorders, relapse, and recovery must be recognized and thoughtfully addressed by provider agencies. The COD adolescent client and the family should not be discharged or referred out by provider agencies for substance use relapses; especially as such relapses may be directly related to mental or emotional health issues. In the words of William White, “Those who are least likely to complete treatment are not those who want it the least but those who need it the most.” And in the words of Jerry Schulman, “Most patients who are administratively discharged are discharged for the same reasons they were admitted.”

To implement monitoring:

- The provider has determined appropriateness of monitoring abstinence
- Policies and procedures are adopted that inform protocol regarding monitoring abstinence
- Encouraging and monitoring abstinence is recovery oriented and staff are informed that harm reduction regarding substance use is a significant element in the recovery process
- Staff are trained and supervised regarding encouraging and monitoring abstinence in a strengths-based recovery perspective
- Monitoring abstinence may be mandated by an element of the juvenile justice system, and rules and protocols specified by such agencies must be adhered to; however, the provider may still approach a failed drug or alcohol screen as an opportunity for applying recovery principles with the specific intent to use a relapse as an educational opportunity regarding avoiding future use and relapse prevention
- A failed alcohol or drug screen should redirect the provider to revising a treatment plan.

22. Multifamily Group Engagement Practices

The therapeutic involvement of families throughout the recovery process is associated with improved treatment outcomes. Planning for family-based services involves defining the client's family in broad and flexible terms, setting essential goals, and determining the desired outcomes.

Multifamily group engagement practices are led by clinicians and are designed to educate family members about substance use and/or mental health disorders, to reduce stress in the family, and to promote collaboration with the IOP Team. The clinician may need to take on different roles in different settings, or with different families and different cultural and gender dynamics, sometimes acting as a consultant, or a teacher, and sometimes in the counseling role. The stage of change of the client and family must be determined, and the appropriate strategies applied.

Essential components included in the provision of family services consist of:

- Employ family engagement strategies, including alliance building, skills development and problem solving. Determine and emphasize the family strengths and supports to enhance them. Recognize the barriers to change and help the family to work through these. Determine roles, family and cultural values, and norms of behavior within the family unit, and develop the alliance that includes the clinician, the client and the family members.
- In most cases, families are part of the solution, even when identified as part of the problem. Families can be successfully engaged into committing to significant change, they can be coached to be part of their child's treatment process, and can be significant partners in furthering the therapeutic progression.
- Instill hope and focus towards recovery in both the adolescent and their family.
- Provide family related skills education and coaching, so that family members and the client recognize their common goals of recovery.
- Provide coaching for basic communication skills. Help resolve family conflict through application of structured problem solving techniques, setting boundaries, removing triggers, and managing behaviors. Habilitation of behavior may be in order if the adolescent has not achieved the level of functioning sought in the therapeutic process.
- Provide family oriented psycho-education related to their child's disorder(s). This will help the family understand what their child is dealing with, what the treatment entails, and what to expect in terms of recovery, as well as timeline and signs and symptoms of recovery or relapse.
- Provide solution-oriented input for distress related to the client's condition. This distress is of two types; practical distress related to finances, time, obtaining services, and supervision of the youthful client, and distress related to emotional and psychological responses and reactions to the client's condition.
- Encourage family participation in recreational activities with the client. This can be framed as cooperative and therapeutic whole-family activity. The multi-family group described in this element may provide an alternative environment where it's

possible to meet new friends and develop social support, which can help reduce the sense of social stigma and isolation.

- Provide referrals to individual family therapy, as appropriate.
- Provide referrals to crisis lines and other urgent services in case of relapse or difficult behavior.

The family

The therapist needs to engage both parent and child. The younger the child, the more the parents will need to be included in the therapy and to be instructed in the cognitive-behavioral model and its application to their child's problem.

The parents may also need specific instruction in self-management and/or parenting techniques/skills, for example avoiding reassuring obsessive compulsive behaviors for a child diagnosed with OCD but using positive reinforcement for compliance with a child with a conduct disorder.

The therapist must be aware of the family's structure and its belief system, the systemic implications of any intervention and reality factors such as use or a specific learning disability.

Complementary behavioral input for parents is particularly important for oppositional defiant disorder and conduct disorder, for which parent management training has been shown to be effective.¹¹⁸ Parent training also enhances problem solving skills training for children, giving a consequent decrease in aggressive behavior problems at home and at school and an improved overall adjustment.¹¹⁹ It is also useful for parents whose own anxiety provides powerful modeling for their children's anxiety disorders to have CBT in their own right.¹²⁰

¹¹⁸<http://www.fnc.org.ar/pdfs/Basics%20Padres.pdf> Webster-Stratton, C. (1984). Randomized Trial of Two Parent-Training Programs for Families With Conduct-Disordered Children. *Journal of Consulting and Clinical Psychology*, 1984, Vol. 52, No. 4, 666-678. American Psychological Association, Inc.; Patterson, G. R. (1982) *Coercive Family Process*. Eugene, OR: Castalia.; Webster-Stratton, C. (1982) Teaching mothers through videotape modelling to change their children's behaviours. *Journal of Pediatric Psychology*, 1, 279-294.

¹¹⁹ Kazdin, A.E. 1995. *Conduct Disorders in Childhood and Adolescence*. Thousand Oaks, CA: Sage Publications; Kazdin, A.E., Siegel, T.C., & Bass, D. (1992). Cognitive problem-solving skills training and parent management training in the treatment of antisocial behavior in children. *Journal of Consulting and Clinical Psychology*, 60, 733-747.

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23. Service Integration

The most effective orientation of behavioral health providers and state related initiatives and programs is to utilize and develop resources in ways that are responsive to the variety of community behavioral health needs. Such an orientation allows for the provision of appropriate services, specific to functional impairment caused by mental illness, substance disorders, and co-occurring disorders to individuals and their significant others/families throughout their life span, with careful consideration to transition-aged youth. These youth often drop off the treatment map after their 18th birthday or discharge from adolescent services. Individuals and families that need additional services beyond behavioral health care are assisted and empowered to access services (e.g. primary healthcare, education and training, housing, employment, etc.) appropriate to identified needs.

The reference to a cohesive, unitary system of care for persons experiencing mental health and substance disorders or co-occurring disorders means that transitions from one level of care to another level of care, or from the youth to adult system, are relatively simple and not stressful to the adolescent client and their family. The purpose of integrated services is to enable providers to make available high quality, comprehensive evidence-based behavioral healthcare that maximizes integration of mental health and substance services while generating self-efficacy, self-care, and self-empowerment. Such care enables the individual and their significant others to live satisfying lives in their community.

Employment of an integrated treatment, habilitation/rehabilitation model along with flexibility of service intensity according to the adolescent client and family need is indicated by the complex bio-psychosocial issues being addressed. Integrated services will maximize contribution to the client and the community when it successfully assists the client in addressing functional impairment, which may include education, independent living, learning and work, socialization, and recreation skills. The successful initiation and maintenance of improved functionality requires sustained and conscientious effort by the adolescent client and their family(s) and his or her support system.

Effective integrated services for persons with COD require that organizations have the capacity to provide continuity of services that are responsive to changes in individual functioning. As functioning changes, the intensity of supportive interaction and alliance can either increase or decrease.

All of the following listed services must be present for the provider to have advanced co-occurring treatment planning:

- individual counseling
- IOP
- liaison with Juvenile Justice authorities
- access or referral to education and/or training for employment and career
- Multifamily group engagement and treatment practices
- evidence-based substance related program or practice
- multi-disciplinary team meetings and staffing

- appropriate supervision
- prescribers on staff who participate in staffing as appropriate, and are available in person or via internet or phone for consultation on an as needed basis
- clinical assessment capability, including assessment specific to developmental stage
- demonstrated substance dependence treatment capacity
- demonstrated mental illness treatment capacity
- all services can be provided concurrently as needed and appropriate (there is no clinical or administrative barrier present within the organization)
- Organization Quality Management processes are in place
- IOP specific Quality Management processes are in place

Service Integration/Continuum of Care implementation strategies

Service integration must be uniformly applied to all eligible persons, and must be faithful to the recovery and resiliency philosophy and cultural competence. In the case of CCSS, IOP and medication management, the service will determine specific methods and modalities of interaction, but in general, the principles that guide service integration will remain the same.

IOP providers shall strive to provide individualized, integrated and effective services.	
Principles of Service	Implementation Strategy
1. Recognition of the need for concurrent approaches to both mental health and substance disorders where present, and which are consistent with motivational and stage-wise intervention strategies. Concurrent approaches must recognize the stage of readiness for change for each identified co-occurring condition- individuals are not likely to be in the same stage for multiple disorders.	Integrated treatment for COD requires that multiple functional disorders be addressed concurrently. The various components of services being provided must address different dimensions and domains affecting the adolescent client and their family(s), with the intent and effect to optimize client functioning. In addition, staff must have the ability to provide services or refer to services that match the individuals' level of need. The adolescent client and their family(s) may be referred to CCSS, prescribers, or other professionals as appropriate.

IOP providers shall strive to provide individualized, integrated and effective services.	
Principles of Service	Implementation Strategy
2. Staff team integration and collaboration takes place across disciplines, agencies and locales, as allowed by the adolescent client and their family(s)) permission and PHI regulations. A quality review process	Staff builds a long-term service relationship with the adolescent client and their family(s) that relies on the principles and practices of recovery and resiliency, cultural competency, and alliance and rapport. All services are

<p>conducted by supervisory staff ensures that integrated COD services are consistent with level of need and functional impairment.</p>	<p>intended to engage the adolescent client and their family(s) the adolescent client and their family(s) to the highest level of functional capability possible for that person, in order to foster self-care, self-management, and self-efficacy. Such interactions may entail multiple service approaches in multiple domains of functioning, and may be characterized by slow pace, and learning over extended periods of time. The organization assures that staff have knowledge of existing service options for persons with COD across the continuum of care.</p>
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<p>IOP providers shall strive to provide individualized, integrated and effective services.</p>	
<p>Principles of Service</p>	<p>Implementation Strategy</p>
<p>3. Recognition that COD requires multiple intervention strategies, may be life-long, is directed by the adolescent client and their family(s) for the client the adolescent client and their family(s), requires a commitment to the long-term principles of recovery and building self-efficacy, and that integrated services is the current acceptable course of interaction with the adolescent client and their family(s).</p>	<p>The provider’s intensive outpatient program must be identified by the ASAM criteria as an appropriate service option. The intent of the IOP is to provide therapeutic intervention that enables the adolescent client and their family(s) to function more ably within the normal setting of his or her life.</p>

<p>IOP providers shall strive to provide individualized, integrated and effective services.</p>	
<p>Principles of Service</p>	<p>Implementation Strategy</p>
<p>4. Service is provided primarily in a clinical setting.</p>	<p>Staff has the ability to provide integrated COD services, which means that they have been trained related to signs and symptoms regarding substance use and mental health issues, medications and medication management, considerations that may be unique to COD, Motivational Interviewing skills, understanding of stages of change and Treatment, trauma-sensitive care, and have proven capability related to alliance and rapport</p>

	building skills.
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IOP providers shall strive to provide individualized, integrated and effective services.	
Principles of Service	Implementation Strategy
5. The organization assures that staff have the skill to identify level of care needs in collaboration with the client and/or families specific to COD.	Staff conducts crisis and discharge planning from time of entry into services through discharge from the program with particular emphasis for COD interactions and complexity. Policies and Procedures specify the organizations' continuum of care.

Afterword

It is guaranteed that a great deal of the information relayed in this manual will change rapidly. Our knowledge and understanding is expanding at a very swift pace. The exciting research and application of genetics and epigenetics promises dynamic results for health and wellness. The *Neurosequential Model of Therapeutics (NMT)* and Brain Mapping are very promising for working with children and youth who have experienced trauma at an early age. The *Attachment, Regulation and Competency Framework (ARC)* for working with trauma growing out of the Brain Mapping work is very promising and is being developed in New Mexico now. There is new and expanding research into neurotransmitters, into methylation pathways, how organ systems work in harmony, and new research that will further define some of the alternatives to office or school-based treatment described previously. There are recent research findings concerning the *Emotional Freedom Technique (EFT)*, *Matrix Reimprinting*, research into how human and animal interactions provide healing, and ongoing refinements of how our physical nervous systems work in conjunction with psychology, thought and emotional states.

Stay tuned—it’s bound to be exciting!

Contributing Author Bios

<p>Craig Pierce</p>	<p>Craig Pierce has a PhD, LMFT, and LPCC. He is the President / CEO of Southwest Family Guidance Center, which provides trauma informed services for adolescent substance abuse and co-occurring disorders. Dr Pierce is a certified trainer in trauma informed treatment, an author, and keynote speaker. He has 35 years of experience working with youth in clinical and educational settings.</p>
<p>Doug Robinson</p>	<p>Doug Robinson is a professional mountaineer known internationally for his climbing, guiding and backcountry skiing, as well as his poetic writings about the mountains and why we climb them. Closely identified with California’s High Sierra, Doug has been called “the modern John Muir.”</p> <p>WRITING</p> <p>Doug’s long-awaited book, <i>The Alchemy of Action</i>, offers a fresh—even shocking—explanation of why people climb mountains, by delving into the brain chemistry behind climber’s euphoria. The intriguing story behind why we are so much more than “adrenaline junkies” leads deep into the psyches of all adventure athletes as they push toward the ragged edge of human potential and return with shimmering new awareness from a heady brew of hormonal cocktail that includes the surprising ingredients of home-made organic psychedelic compounds.</p> <p>Doug’s writing and photography credits include National Geographic, Sports Illustrated, Esquire, Outside, Men’s Journal, California, Los Angeles Times Magazine, Alpinist, Ascent, Climbing, Mountain, Rocky Mountain, Mountain Gazette, Powder, Rock & Ice, with translations in several foreign languages. Co-wrote Climbing Ice with Yvon Chouinard. Co-wrote screenplay “Hard Rock” with William Broyles, Jr.</p>

	<p>Recipient of the American Alpine Club’s Literary Award, 2010.</p> <p>CLIMBING “The father of clean climbing.”—Climbing magazine Doug helped lead the “Clean Climbing” revolution in the early 1970s, an environmental movement that changed forever the way climbers anchor themselves to steep rock. Clean climbing eliminated the traditional hammer-driven pitons that were increasingly damaging even hard granite. It substituted aluminum wedges slotted by hand into cracks in the rock. The result has lightened the impact of climbers on mountain environments around the world. Doug’s essay, “The Whole Natural Art of Protection,” sparked the movement. And then his first clean ascent of the face of Half Dome, made in 1973 with Galen Rowell and Dennis Hennek, slam-dunked the revolution when it was featured as the cover story of National Geographic magazine.</p> <p>Fifty-five years including dozens of first ascents on ice, rock, and alpine terrain. Doug cut his teeth on Yosemite granite during the Valley’s Golden Age in the sixties, a time when all the climbers in Yosemite could fit around one campfire at Camp 4. First Ascent Dark Star on Temple Crag, the longest alpine rock climb in the Sierra. Developed Buttermilk bouldering. First ice ascents V-Notch and Lee Vining Icefall with Yvon Chouinard, the founder of Patagonia. First ascent Ice Nine, the hardest alpine climb in California. Second ascent of Ama Dablam (22,495’) in Nepal, 1979, filmed for ABC Sports.</p> <p>VIDEO Produced, wrote and hosted Moving Over Stone (1988), which was ground-breaking in its fusion of instruction and entertainment, basics to cutting-edge.</p> <p>GUIDING First President, American Mountain Guides Association. AMGA Certified Rock and Alpine guide. 50 years experience, US and foreign countries. Guide to Fortune 500 leaders (e.g. William Randolph Hearst III) and corporate training (Apple, Sun Microsystems, Levi’s). Teaching and mentoring to apprentice guides. Palisade School of Mountaineering, 12 years. Royal Robins Rockcraft, 2 years in southern Yosemite “hinterlands.” Catalyst Consulting Team, corporate climbing programs, 12 years. Founded Foothill College climbing program.</p>
<p>Harrison Kinney</p>	<p>Harrison Kinney is the Director of Strategic Initiatives at Community Healthcare in Texas. He previously was the Executive Manager for the New Mexico Behavioral Health Services Division from 2008-2012. He has worked for over forty years in behavioral health in Texas, Colorado and New Mexico. His area of focus over the years has been in developing systemic recovery anchored approaches to address complex and severe behavioral health disorders. He has authored or been the principle investigator for over 65 grant funded projects that address co-occurring mental health and substance use disorders, homelessness, veteran services, substance misuse, trauma, recovery, integrated healthcare and peer services. He received his Bachelors and Master’s degree from the University of Texas at Austin.</p>
<p>Michael Gass</p>	<p>Michael Gass, Ph. D., LMFT, is a Professor and the Coordinator of the Outdoor Education program at the University of New Hampshire. He also directs the OBHRC and NATSAP Research initiatives, serves as the Editor for the <i>Journal of Therapeutic Schools and Programs</i>, and is Chair of AEE’s REAP initiative. Some of his past international professorships have been in Taiwan, China, Australia, and Germany. He was the inaugural Chair of the AEE Accreditation Council for its first 10 years of existence as well as president of the Board of Directors of AEE in 1990.</p>

<p>Michael Hock</p>	<p>Michael has a master's degree in counseling, and extensive knowledge of adult and children's mental health, substance and co-occurring disorders within state and local contexts, and demonstrated abilities in planning and building service systems, management, policy, and strategic planning. Mr. Hock is a 29 year resident of New Mexico with 26 years of experience in the behavioral health field and is familiar with the needs of the provider system throughout the state.</p> <p>Michael currently works with the NM Children, Youth and Families Department, Children's Behavioral Health Division (CBHD) as the Adolescent Substance Use Reduction Effort Manager (ASURE). He is the adolescent substance use reduction coordinator for the Department and team leader of the Adolescent Substance Use Reduction Effort. His primary responsibilities are to provide oversight of the expansion of adolescent co-occurring competent outpatient and intensive outpatient program services statewide, including review and amendment of application tools, audits, technical assistance, support, creative problem-solving, and feedback to providers. He provides leadership, conducts research and develops partnerships within CYFD and with other NM Departments. In June, 2010, he co-authored of the State of New Mexico Adult Implementation Manual for Co-occurring Intensive Outpatient Programs with Shannon Morrison and with Olin Dodson, which was copyrighted and published by the New Mexico Human Services Department Behavioral Health Services Division. He has worked in schools, private practice and in outdoor and wilderness settings with youth, families and adults. He attended Southwestern College in Santa Fe, NM to obtain his Master's Degree in 1989 after working in the construction field for 16+ years.</p>
<p>Natalie Skogerboe</p>	<p>Natalie has worked as a program coordinator and consultant in the substance abuse prevention, youth development, early childhood, and behavioral health fields for over a decade. She is a trainer, researcher, grant writer, program planner, and evaluator. She has a Master's in Public Administration with a health policy concentration and is a Certified Prevention Specialist. She helped write numerous substance abuse prevention grants for the State and local community programs.</p>
<p>Olin Dodson</p>	<p>Olin Dodson, LPCC, is an author, teacher and a licensed individual and family therapist since 1986. He is the recipient of awards from both the New Mexico Counseling Association and the New Mexico Mental Health Counselors Association. The former New Mexico State Opioid Treatment Authority, Olin has provided clinical program consultation in Co-occurring Treatment, Medication Assisted Treatment and Recovery Oriented Systems of Care. With a Native American colleague, he offers professional workshops in cross-cultural approaches to grief and loss and is currently working on his second book.</p>
<p>Randy Muck</p>	<p>Randolph D. Muck, M.Ed., served as the Chief, Targeted Populations Branch at SAMHSA. Upon his retirement after thirty-three years of federal service devoted to treatment for youth and families, and the development and training of evidence-based practice leading to two highly successful Type IV Clinical Trials, he founded Advocates for Youth and Family Behavioral Health Treatment, LLC, focusing on improving identification, access, screening, assessment, treatment, continuing care and ongoing supportive services for youth and families. He provides assistance in research efforts, training, and consultation to Federal Agencies, States, Foundations, Universities, Communities, Jurisdictions, and individual programs all related to the improving quality, access, engagement, outcomes, continuing care and ongoing supportive services for youth and their families/primary care givers,</p> <p>Randy is engaged in ongoing efforts providing guidance to Federal Agencies and their grant making for youth, providing TA and training to individual programs, jurisdictions, purveyors of evidence-based practice, States and communities in their improvement, adoption, implementation, and interweaving new programming into a continuum of care responsive to youth with substance use and mental health disorders. His work spans across Child Welfare, Child Protective Services,</p>

	<p>Family Dependency Courts, Juvenile Justice Systems, Juvenile Drug Courts, substance use and co-occurring treatment systems/programs. He frequently consults with the Department of Justice, Office of Juvenile Justice and Delinquency Prevention, the State of New York, Portland State University, the University of Arizona assisting in research on treatment outcomes, the Council of state Governments, Reclaiming Futures, the State of New Mexico, and numerous treatment programs throughout the U.S.</p> <p>Randy has his M.Ed. in Counseling from Boston University, and has served as a field site practicum supervisor for Boston University, was a field site supervisor for the American Association of Marriage and Family Therapy, was employed by the military to develop courses in family therapy and advanced treatment skills for service members and their families with substance use disorders, and provided training in these courses in Munich, Germany, and in Korea for clinical and management staff throughout Korea and the Philippines.</p>
<p>Shannon Morrison</p>	<p>Shannon Morrison, Ph.D. is a sociologist with 23 years of program planning, evaluation, and research experience in the areas of substance use disorders, co-occurring disorders, mental health issues, domestic violence, education, child and maternal health issues, criminal justice, and homelessness and taught undergraduate courses in sociology and research methodology for four years at the University of New Mexico. She has been the Principal Investigator for several federal grants and has been a speaker at many National and local conferences. Some of her current work includes: program support and evaluation of CYFD’s Justice and Mental Health Collaboration Program; the development of a Best Practices Manual for New Mexico’s Safe Exchange and Supervised Visitation Program; an evaluation of a grant supporting pregnant and parenting teens, and the evaluation of school-based health care systems in New Mexico and Colorado. She has extensive experience in conducting strength-based program evaluation, quantitative and qualitative data collection and analysis, writing grant proposals and research reports, and working with culturally diverse populations.</p>
<p>Sky Gray</p>	<p>Sky has been involved in Experiential Adventure Based Education since she was a participant as an adolescent. She has been a field instructor for at risk youth and played a variety of roles at the Santa Fe Mountain Center. She worked as the Director of Accreditation for The Association for Experiential Education, served on the Accreditation council for 9 years and is currently the Executive Director of the Santa Fe Mountain Center. Sky is deeply engaged in social justice and social change work.</p> <p>Sky has facilitated groups using both classroom and outdoor action based learning methodologies for the last 25 years. Having served as the Executive Director for the Santa Fe Mountain Center for the last 14 years, she understands the complexities running a mission based multicultural organization during demanding and challenging economic times. She also knows the power and success that comes from building strong work teams with clear priorities, communication and negotiation skills so needed to be successful in our current environment.</p>

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Online Resources

- The Addiction Recovery Mutual Aid Groups in the United States: A Chronology of Founding Dates (as of February 2010)
http://www.williamwhitepapers.com/pr/file_download.php?fn=2010+Addiction+Recovery+Mutual+Aid+Groups&ext=pdf
- Adverse Childhood Experiences (ACE) Study, www.cestudy.org
<http://ajp.psychiatryonline.org/cgi/content/full/164/3/402>
- Amazing Adolescent Brain
<http://www.multiplyingconnections.org/sites/default/files/Teen%20Provider%20article%20%282%29%20.pdf>
- Annie E. Casey Foundation. (March 2014). Kids Count Data Book 2013. <http://datacenter.kidscount.org/>
<http://articles.mercola.com/sites/articles/archive/2013/03/16/high-health-care-costs.aspx>
- Association for Experiential Education <http://www.aee.org/about/whatIsEE>
<http://www.azdhs.gov/bhs/finalreport.pdf>
- Behavior Management through Adventure (MGtA): <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=260>
<http://www.bhrm.org/guidelines/Minkoff.pdf>
- CDC Positive Parenting Tips for Healthy Child Development;
<http://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/pdfs/teen15-17.pdf>
- <http://coce.samhsa.gov/>

- <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>
- Evidence-based Behavioral Health Practice <http://ebbp.org/ebbp.html>
- Family Recovery and Research Project. www.psychotherapy.net
- 41 Developmental Assets <http://www.search-institute.org/research/developmental-assets>
- General Organizational Index, 2004, (GOI) IDDT fidelity Tool: <http://integratedrecovery.org/wp-content/uploads/2010/08/0-IDDT-GOI-short2.pdf>
- http://www.goodtherapy.org/sand_tray_sand_play_therapy.html#
- <http://www.ihl.org/Engage/Initiatives/TripleAim/Pages/default.aspx>
- <http://www.ihl.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx>
- Institute for Healthcare Improvement (Plan-Do-Study-Act):
<http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>
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<http://www.icap.org/PolicyTools/ICAPBlueBook/BlueBookModules/2LifeSkills/tabid/163/Default.aspx>
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- <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881>
- <http://mentalhealth.samhsa.gov/nctic/trauma.asp>
- <http://mentalhealth.samhsa.gov/nctic/default.asp> - Trauma-informed care
- <http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/cooccurring/default.aspx>
- <http://ncadi.samhsa.gov/>
- http://ncadistore.samhsa.gov/catalog/SC_Itemlist.aspx - Matrix Counselor's Treatment Manual
- http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/DDWorkbookAJ1_04.pdf
- http://download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/IDDTUsersguideAJ1_04.pdf
- <http://www.drugabuse.gov/publications/principles-drug-addiction-treatment>
- <http://www.nejm.org/doi/full/10.1056/NEJMp0910064>
- <http://www.nlm.nih.gov/medlineplus/podcast/transcript072213.html>
- <http://www.nlpls.com/articles/presuppositions.php>: 2014 John David Hoag
- National Survey on Drug Use and Health (NSDUH) <http://www.samhsa.gov/data/NSDUH.aspx>
- New Mexico Department of Health Medical Cannabis Program - FAQs:
<http://nmhealth.org/publication/view/help/132/>

- Network for the Improvement of Addiction Treatment, 2007 (NIATx); Improvement Workbook:
<http://www.niatx.net/Content/ContentPage.aspx?PNID=2&NID=21>
- <http://www.oasas.state.ny.us/hps/research/documents/MINIScreenUsersGuide.pdf>
- http://www.prearesourcecenter.org/sites/default/files/content/6_stages_of_adolescent_development.pdf
- Project Adventure Inc., 719 Cabot Street, Beverly, MA 01915, info@pa.org - www.pa.org
- Project Venture: <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=102>
- Roots of Action: <http://www.rootsofaction.com/why-risk-taking-may-increase-teens-happiness/>
- <http://samhsa.gov/>
- SAMHSA's National Center for Trauma-Informed Care <http://beta.samhsa.gov/nctic>
- Smart Recovery Family and Friends. www.smartrecovery.org
- <http://stanleykrippner.weebly.com/-the-impact-of-allopathic-biomedicine-on-traditional-healing-systems.html>
- World Bank-Health expenditure, total (% of GDP): <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>

PART C

Appendix A: Stages of Adolescent Development

Appendix B: 41 Developmental Assets

Appendix C: CYFD Policy & Procedure Manual

Appendix A

Stages of Adolescent Development			
Stages of Adolescence	Physical Development	Cognitive Development	Social-Emotional Development
Early Adolescence Approximately 11 – 13 years of age	<ul style="list-style-type: none"> • Puberty: grow body hair, increase perspiration and oil production in hair and skin • Girls – breast and hip development, onset of menstruation • Boys – growth in testicles and penis, wet dreams, deepening of voice • Tremendous physical growth: gain height and weight • Greater sexual interest 	<ul style="list-style-type: none"> • Growing capacity for abstract thought • Mostly interested in present with limited thought to the future • Intellectual interests expand and become more important • Deeper moral thinking 	<ul style="list-style-type: none"> • Struggle with sense of identity • Feel awkward about one’s self and one’s body; worry about being normal • Realize that parents are not perfect; increased conflict with parents • Increased influence of peer group • Desire for independence • Tendency to return to “childish” behavior, particularly when stressed • Moodiness • Rule- and limit-testing • Greater interest in privacy
Middle Adolescence Approximately 14 – 18 years of age	<ul style="list-style-type: none"> • Puberty is completed • Physical growth slows for girls, continues for boys 	<ul style="list-style-type: none"> • Continued growth of capacity for abstract thought • Greater capacity for setting goals • Interest in moral reasoning • Thinking about the meaning of life 	<ul style="list-style-type: none"> • Intense self-involvement, changing between high expectations and poor self-concept • Continued adjustment to changing body, worries about being normal • Tendency to distance selves from parents, continued drive for independence • Driven to make friends and greater reliance on them, popularity can be an important issue • Feelings of love and passion
Late Adolescence Approximately 19 – 21 years of age	<ul style="list-style-type: none"> • Young women, typically, are fully developed • Young men continue to gain height, weight, muscle mass, and body hair 	<ul style="list-style-type: none"> • Ability to think ideas through • Ability to delay gratification • Examination of inner experiences • Increased concern for future • Continued interest in moral reasoning 	<ul style="list-style-type: none"> • Firmer sense of identity • Increased emotional stability • Increased concern for others • Increased independence and self-reliance • Peer relationships remain important • Development of more serious relationships • Social and cultural traditions regain some of their importance

Adapted from the American Academy of Child and Adolescent’s Facts for Families. © All rights reserved. 2008

http://www.prearesourcecenter.org/sites/default/files/content/6_stages_of_adolescent_development.pdf

Appendix B

41 Developmental Assets® for Adolescents ages 12-18¹²¹Search Institute: <http://www.search-institute.org/system/files/40AssetsList.pdf>

External Assets	Support	<ol style="list-style-type: none"> 1. Family Support: Family life provides high levels of love and support 2. Positive Family Communication: Young person and her/his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents 3. Other adult relationships: Young person receives support from 3 or more nonparent adults 4. Caring Neighborhood: Young person experiences caring neighbors 5. Caring School Climate: School provides a caring, encouraging environment 6. Parent Involvement in Schooling: Parent(s) are actively involved in helping young people succeed in school
	Empowerment	<ol style="list-style-type: none"> 7. Community Values Youth: Young person perceives that adults in the community value youth 8. Youth as Resources: Young people are given useful roles in the community 9. Service to Others: Young person serves in the community 1 hour per week 10. Safety: Young person feels safe at home, school and in the neighborhood
	Boundaries & Expectations	<ol style="list-style-type: none"> 11. Family Boundaries: Family has clear rules and consequences and monitors the young person's whereabouts 12. School Boundaries: School provides clear rules and consequences 13. Neighborhood Boundaries: Neighbors take responsibility for monitoring young person's behavior 14. Adult Role Models: Parent(s) and other adults model positive, responsible behavior 15. Positive Peer Influence: Young person's best friends model responsible behavior 16. High Expectations: Both parent(s) and teachers encourage the young person to do well
	Constructive Use of Time	<ol style="list-style-type: none"> 17. Creative Activities: Young person spends three or more hours per week in lessons or practice in music, theater, or other arts 18. Youth Programs: Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community 19. Religious Community: Young person spends one or more hours per week in activities in a religious institution 20. Time at Home: Young person is out with friends "with nothing special to do" two or fewer nights per week
Internal Assets	Commitment to Learning	<ol style="list-style-type: none"> 21. Achievement Motivation: Young person is motivated to do well in school 22. School Engagement: Young person is actively engaged in learning 23. Homework: Young person reports doing at least one hour of homework every school day 24. Bonding to School: Young person cares about her/his school 25. Reading for Pleasure: Young person reads for pleasure three or more hours per week
	Positive Values	<ol style="list-style-type: none"> 26. Caring: Young person places high value on helping other people 27. Equality and Social Justice: Young person places high value on promoting equality and reducing hunger and poverty 28. Integrity: Young person acts on convictions and stands up for her/his beliefs 29. Honesty: Young person "tells the truth even when it is not easy" 30. Responsibility: Young person accepts and takes personal responsibility 31. Restraint: Young person believes it is important not to be sexually active or to use alcohol or other drugs

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<p>Social Competence</p>	<p>32. Planning and Decision Making: Young person knows how to plan ahead and make choices 33. Interpersonal Competence: Young person has empathy, sensitivity and friendship skills 34. Cultural Competence: Young person has knowledge of and comfort with people of difference cultural/racial/ethnic backgrounds 35. Resistance Skills: Young person can resist negative peer pressure and dangerous situations 36. Peaceful Conflict Resolution: Young person seeks to resolve conflict nonviolently</p>
<p>Positive Identity</p>	<p>37. Personal Power: Young person feels he or she has control over “things that happen to me” 38. Self-esteem: Young person reports having a high self-esteem 39. Sense of Purpose: Young person reports that “my life has a purpose” 40. Positive view of Personal Future: Young person is optimistic about her/his personal future 41. Positive Cultural Identity: Young person feels proud of her/his cultural background</p>

Appendix C – Policy and Procedure Manual by Element in Part B

The New Mexico CYFD Adolescent Treatment Manual Policies & Procedures ©

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<ITEMS IN ALL CAPS AND BRACKETS> are meant to be adapted or modified as needed into existing policies and procedures if such exist and a Microsoft Word version is available upon request from the CYFD Children’s Behavioral Health Division.

The highlight alerts the reader to the need to insert agency specific information. These policies apply to each Part B Element listed in this manual, and are used within the ASURE Adolescent Treatment Manual web-based provider self-assessment (ATMPA) (Page 87).

Part I: Policy and Procedure: General Systems
TABLE OF CONTENTS

This document provides a listing of Policies and Procedures for <INSERT PROVIDER NAME>.

- A. Organization Description**
 - 1. Organization Overview
 - 2. Organization Management & Governance
 - 3. Mission Statement
 - 4. Statement of Values, Principles and Ethics
 - a. Confidentiality Related to HIPAA and 42 CFR Part 2
 - 5. Consumer Rights & Grievance Policy
 - 6. Organization Non-Clinical Policies
 - a. Other Standard Operating Procedures
 - 7. Links to other organizations, consortiums, or information related to intended mergers, service area expansions and changes or additions to geographic locations, etc
 - 8. Community Collaboration
- B. Hazard Plan/Emergency Management**
 - a. Hazard
 - b. Fire Plan
- C. Funding and Financial Management**
- D. Human Resource Management**
 - a. Human Resource Policy
 - b. Agency Non-discrimination Policy
 - c. Employees
 - d. Contract Staff
 - e. Personnel File Management Plan
 - f. Job Descriptions
 - g. All forms related to the preceding P&P
 - h. Organizational Chart
- E. Overview AND Clinical Policies of Services Provided (list all, such as)**
 - a. Outpatient Counseling Services
 - b. School-based Counseling Services
 - c. Intensive Outpatient Program
 - d. Case Management
 - e. Trauma-informed Work
 - f. Justice System/Drug Court Engagement & Services
 - g. Related forms
- F. Philosophy of Approach & Principles of Practice**
 - 1. Engagement, Alliance and Rapport

2. **Guiding Principles of Recovery**
3. **Cultural Competency**
4. **Gender Competency**
5. **Stage-wise Appropriate Care**
6. **Motivational Approaches**
7. **Trauma-Sensitive System of Care**

Related forms

G. Initial Procedures of Care & Planning

8. **Initiation of and Retention Into Behavioral Health Services**
9. **Intake Processes**
10. **Assessment**
11. **Individualized, Comprehensive, Integrated Service Plan**
 - a. **Safety Planning**
 - b. **Crisis Planning**
 - c. **Suicidality**
 - d. **Relapse prevention**
 - e. **Aftercare/discharge planning**

12. **Individual Case Files**

Related forms

H. Personnel, Team and Systems Competencies

13. **Staff Competencies**
14. **Co-Occurring Disorders Competencies**
15. **Organization Supervision**
16. **Service Teams/Multi-Disciplinary Teams**
17. **Quality Management**
18. **Electronic Systems Competencies and Records Keeping (if applicable)**

Related forms

I. Treatment Implementation Practice Standards

19. **Research and Evidence-based Treatment Approaches (EBP)**
20. **Adaptations for Particular Populations Served**
21. **Life and Prosocial Skills**
22. **Encouraging and Monitoring Abstinence**
23. **Multifamily Group Engagement Practices**
24. **Service Integration**

Related forms

General, Part I: Organization Description

A. Organization Description

1. **Organization Overview**
2. **Organization Management and Governance**
3. **Mission Statement**
4. **Statement of Values, Principles and Ethics**
 - a. **Confidentiality Related to HIPAA and 42 CFR Part 2**

Ethics and ethical conduct are essential elements to all behavioral health services provided at <INSERT PROVIDER NAME> regardless of funding source.

All provider staff and all business or professional associates of providers are expected to meet the highest standards of ethical conduct. Such conduct includes originating and maintaining honest and principled client relations, honest and respectful relations with other providers, trustworthy and honest relations with the State of New Mexico and community stakeholders and avoiding circumstances or conditions that could lead to dual relationships or conflict of interest, either personal or professional. Laws, regulations and funding sources stipulate ethical practices and guidelines and must be adhered to in all cases. Specific care and attention for HIPAA and 42 CFR Part 2 must underscore all service ethics related to confidentiality and protected health information.

5. Consumer Rights/Grievance Policy

Grievances/Complaints: Clients have the right to be treated ethically, professionally and with respect by all <INSERT PROVIDER NAME> staff members. If you have any issues/complaints about your therapy, please call the Chief Clinical Officer at <PHONE NUMBER>.

If the response you receive is not satisfactory for you, contact the CYFD Children's Behavioral Health Division at 505-827-8008 or the Fair Hearings Bureau at 800-432-6217. Also contact the MCO <PHONE NUMBER>
(Please refer to the PROVIDER Clinical Policies statement)

Legal Rights: All clients have the legal right to:

- Refuse services.
- Seek alternative mental health services elsewhere.
- Address needs/complaints via appropriate channels listed in the Complaints/Grievances Section of this document.

The following Consumer Rights statement is <POST STATEMENT HERE>

Organization Non-Clinical Policies

a. Other Standard Operating Procedures

6. Links to other organizations, consortiums, or information related to intended mergers, service area expansions and changes or additions to geographic locations, etc. <LISTED HERE>

7. Community Collaboration

B. Hazard Plan/Emergency Management Plan

Policy and Procedure:

I. Purpose

Integration of hazards management into the core responsibilities of executive management is intended to provide safe and healthy conditions for employees, contractors, clients and their families and visitors to properties.

<INSERT PROVIDER NAME> *maintains a separate policy related to clinical hazards and emergency management.*

A. Definitions

1. **Hazard:** The potential to cause harm to a person, to property, or to the natural environment.
2. **Hazards management:** The structured process of hazard identification, risk assessment and control aimed at providing a safe and healthy environment for employees, contractors, clients and their families and visitors to properties.
3. **Risk:** A combination of the potential frequency and severity of harm arising from a hazard.
4. **Risk assessment:** The process of evaluating likely frequency and severity of harm arising from a hazard.
5. **Risk control:** The process of implementing measures to reduce as far as *reasonably practicable* the risk associated with a hazard.
6. **Reasonably practicable:** Means practicable having regard to:
 - ✓ the severity of the hazard or risk in question
 - ✓ the state of knowledge about that hazard or risk and any ways of removing or mitigating it
 - ✓ the availability and suitability of ways to remove or mitigate that hazard or risk
 - ✓ the cost of removing or mitigating that hazard or risk.

II. Policy

A. Scope

The following policy applies primarily to executive staff, but also defines responsibilities for all staff. It applies to all properties and facilities owned, occupied, or managed by <INSERT PROVIDER NAME>.

1. <INSERT PROVIDER NAME> has determined that the appropriate management of incidents, injuries, illnesses and emergencies is an essential element of its health and safety responsibilities and shall also function to preserve the organization well-being and business viability.
2. <INSERT PROVIDER NAME> will develop and publish lists or guidelines (Emergency Action Plan) and/or publish procedures for:
 - Contacting emergency services
 - Staff is informed as to who has the authority to determine that a situation or event requires emergency response.
 - Staff is informed as to who is assigned the role of agency “spokesperson” to authorities and to media
 - Guidelines/restrictions related to disclosure of client or staff PHI in cases of emergency or crisis
 - The appropriate treatment of on-site injuries and illnesses
 - Safety procedures related to housekeeping and janitorial supplies.
 - The prompt treatment and investigation of incidents, injuries and illnesses and reports, as appropriate, to:
 - Executive supervisory staff.
 - Medical authorities.
 - Emergency or law enforcement authorities

- NM State authorities (HSD, CYFD, DPS, Homeland Security, etc) as appropriate to the nature of the incident
- The implementation of corrective actions following incidents, as appropriate.
- Monitoring the implementation of the Hazards policy and related procedures; and,
- Assigned responsibilities in relation to the implementation of this policy and related procedures.

III. Staff Responsible for Implementation

- Chief Executive Officer (CEO or ED, etc.)
- Director of Operations
- Human Resources Manager
- Other Executive staff as assigned by the CEO
- Clinical Supervisors
- Staff as assigned to specific duties.

IV. Procedure

General Emergency Instructions <LISTED HERE>

1. **Assess** the situation
 2. **Should this building be evacuated, or is it safer to stay put in the facility?**
 3. **Alert** others about the situation clearly and succinctly.
 4. **Assist** any person in immediate danger, **if safe to do so.**
 5. **Secure** support and help
 6. **If alone call emergency services if appropriate to do so and then provide first aid, CPR, or resuscitation efforts.**
 7. **Assume command of the situation or incident if appropriate to do so, Contain or combat** the emergency **only if safe to do so.**
 8. **If evacuation is appropriate, which can mean either *it must be safe to leave* the structure you are in, or you *must leave* the structure you are in, a near-by post-evacuation destination must be predetermined and upon arrival a headcount of all persons is immediately conducted. Emergency responders must be notified if any person is missing and of the location of all other persons present at the time of the incident. If contamination, injury from exposure to smoke or chemical fumes, burns or other physical wounds may have resulted from the incident, insist that all persons so exposed are assessed by appropriate emergency responders before you agree to them leaving the site. Secure a witness to any person who refuses such assessment to protect yourself and your organization.**
 9. **Do not lock doors when evacuating if emergency response service providers will need access to the property.**
-

Fire Plan

The Fire Plan is part of the provider Hazard/Emergency Plan. The Fire Plan shall be specific to all separate geographic provider sites or locations. Each geographic location maintains a printed copy of the Plan and site specific escape routes and keeps these posted in view of all staff/clients (a copy of which shall be kept in a specific file for this purpose at the main business office). Each geographic site shall conduct a fire evacuation drill at least 1X a year.

C. Funding and Financial Management

Provider (PROVIDER or the Agency) is organized as a XXX business (for-profit, 501c3, etc.)

<LISTED HERE>

D. Human Resource Management

a. Human Resource Policy

<LISTED HERE>

Agency Non-discrimination Policy

<LISTED HERE>

➤ Title VII of the Civil Rights Act.

Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e and following) prohibits employers from discriminating against applicants and employees on the basis of race, color, religion, sex and national origin (including membership in a Native American tribe). It also prohibits employers from retaliating against an applicant or employee who asserts his or her rights under the law.

Title VII prohibits discrimination in all terms, conditions and privileges of employment, including hiring, firing, compensation, benefits, job assignments, promotions and discipline. Title VII also prohibits practices that seem neutral but have a disproportionate impact on a protected group of people. Such a practice is legal only if the employer has a valid reason for using it. For example, a strength requirement might be legal — even though it excludes disproportionate numbers of women — if an employer is using it to fill a job that requires heavy lifting. Such a requirement would not be valid for a desk job, however.

Title VII makes it illegal to harass someone on the basis of a protected characteristic (race, sex and so on).

Title VII applies to employers that fit into the following categories:

- private employers with at least 15 employees
- state governments and their political subdivisions and agencies
- the federal government
- employment agencies
- labor organizations and
- joint labor-management committees and other training programs.

➤ **Age Discrimination in Employment Act**

The ADEA prohibits age discrimination in all terms and conditions of employment, including hiring, firing, compensation, job assignments, shift assignments, discipline and promotions. A separate law, the Older Workers Benefits Protection Act (OWBPA), protects employees over the age of 40 from discrimination in benefits.

➤ **Americans With Disabilities Act**

The ADA protects not only applicants and employees with disabilities; it also protects those who have a history of disability and those who are perceived -- incorrectly -- as having a disability. For example, an employee who was diagnosed with cancer and has been in remission for ten years may not have a current disability, but his employer is still prohibited from making job-related decisions based on the employee's former disability. Similarly, an employee who walks with a limp may not have a disability, but an employer who makes job-related decisions based on the mistaken belief that the employee is disabled (for example, by refusing to promote the employee to a managerial position that would require her to walk a shop room floor) violates the ADA. The ADA also prohibits employers from discriminating against someone because that person is related to or associates with someone who has a disability.

➤ **Equal Pay Act.**

The Equal Pay Act (29 U.S.C. 206(d)) requires employers to give men and women equal pay for equal work. Employees do equal work when they perform, under similar working conditions, jobs that require equal skill, effort and responsibility. Two jobs may be equal even if they have different job titles. For example, a hotel may not pay its janitors, who are primarily men, more than its housekeepers, who are primarily women, if they are doing the same work.

There are a few exceptions to the Equal Pay Act. Employers can pay men and women different salaries for doing equal work if the difference is based on seniority, merit, an incentive system, or any factor other than gender.

➤ **Immigration Reform and Control Act**

IRCA prohibits employers from discriminating against applicants and employees on the basis of their citizenship or national origin. IRCA's prohibition on discrimination applies to all terms, conditions and privileges of employment, including hiring, firing, compensation, benefits, job assignments, promotions and discipline. This antidiscrimination provision applies to federal, state and local governments and to private employers with at least four employees.

IRCA also makes it illegal for employers to knowingly hire or retain employees who are not authorized to work in the United States. Employers are required to examine employee documents and keep records verifying that their employees are authorized to work in this country.

➤ **Civil Rights Act of 1866 (Section 1981).**

The Civil Rights Act of 1866 (commonly referred to as Section 1981 because of its location in the United States Code) declares African Americans to be citizens, entitled to a series of rights previously reserved to white men. The law confers a number of rights, including the right to sue or be sued in court, to give evidence in a lawsuit and to purchase property. It also confers the right to make and enforce contracts, which courts have found prohibits racial discrimination in the employment relationship.

Although the law's original purpose was to protect African Americans, courts have interpreted it to protect people of all races from discrimination and harassment. Section 1981 has also been interpreted to prohibit discrimination on the basis of ethnicity, if the discrimination is racial in character.

Section 1981 protects all private employees and all employees of state and local governments. It also protects independent contractors from discrimination by hiring firms and protects partners in a partnership from discrimination. It does not apply to federal employees, however.

➤ **Genetic Information Nondiscrimination Act**

This 2008 law prohibits employers from using an applicant's or employee's genetic information as the basis for employment decisions and requires employers to keep genetic information confidential.

GINA also prohibits employers from requiring or asking employees to provide genetic information. The law includes exceptions for information the employer learns inadvertently, information gathered pursuant to the certification requirements of the Family and Medical Leave Act and information used for genetic monitoring, among other things. Even if one of these exceptions applies, however, the employer must keep the information confidential and may not use it when making employment decisions.

GINA applies to:

- private employers with at least 15 employees
- the federal government
- state governments
- private and public employment agencies
- labor organizations and
- joint labor-management committees.

b. Employees

1. Clinical License
2. Resume
3. CYFD Background Check Form
4. Confidentiality of <INSERT PROVIDER NAME> Records Form

c. Contract Staff

1. Documents Provided by Contractor to <INSERT PROVIDER NAME>
 - Resume
 - Business License
 - Clinical License
 - CYFD Background Check Form
 - Confidentiality of PROVIDER Records Form
- d. **Personnel File Management Plan**
- e. **Job Descriptions**
 - Duties and Responsibilities
 - Supervisory structure
 - Education required
 - Licensure required
- f. **All forms related to the preceding P&P**
- g. **Organizational Chart <Insert here>**

E. Overview of Services Provided <LISTED HERE>

- a. **Outpatient Counseling Services**
- b. **School-based Counseling Services**
- c. **Intensive Outpatient Program (*REQUIRES A SEPARATE P&P*)**
- d. **Case Management**
- e. **Trauma-informed Work**
- f. **Justice System/Drug Court Engagement & Services**
- g. **Etc. for all services**
- h. **Related forms**

Part II: Philosophy of Approach & Principles of Practice
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7. **Trauma-informed System of Care**



Policy and Procedure: General, Part II: Philosophy of Approach & Principles of Practice:

1. Engagement, Alliance and Rapport

Policy Number: II.1

I. Purpose

Engagement is a fundamental element of the treatment process. Effective engagement increases retention and active participation in treatment. Engagement is accomplished through successful and respectful communication and support and the recognition of equality and valuing of diversity regardless of cultural or linguistic background, religious affiliation, sexual orientation, etc. Engagement strategies are approached as the foundation and building of trust, alliance and rapport with the individual and/or family being served and are continuously applied, in every interaction with the adolescent and his or her family, to assure retention in all aspects of treatment and other integrated services.

II. Policy

1. The <INSERT PROVIDER NAME> organizational structure promotes and supports engagement strategies and assures the use of developmentally and functionally appropriate interventions for each identified presenting issue of each individual.
2. <INSERT PROVIDER NAME> trains and supervises staff regarding matching treatment and support interventions to the individual's or family's capacity to work on identified issues and how to develop and/or maintain alliance and rapport.
3. <INSERT PROVIDER NAME> supports engagement with the assumption of the prevalence of COD and plans appropriate engagement strategies related to multiple disorders.
4. <INSERT PROVIDER NAME> trains clinicians and other staff to provide empathic understanding of the client's state of awareness and how to foster rapport to support effective interactions.
5. <INSERT PROVIDER NAME> trains all personnel regarding how to incorporate the youth's culture into treatment and support services towards enhancing the development of alliance (Culture may indicate other factors than societal norms and include gender, group identity, etc.).
6. <INSERT PROVIDER NAME> requires that clinicians receive specific supervision and coaching regarding establishing and maintaining engagement at frequent intervals.

III. Staff Responsible for Implementation

Clinical Supervisor and all staff interacting with clients and their families.

IV. Procedure

1. Staff trained regarding how to establish an alliance using developmentally and functionally appropriate motivational strategies actively and specifically apply these skills.
2. <INSERT PROVIDER NAME> staff actively and as accurately as possible match interventions to the adolescent client and their family's capacity to work on identified issues.
3. <INSERT PROVIDER NAME> requires clinicians to actively build alliance and rapport with the adolescent client and their family so that the individual can be retained in services with co-occurring disorders as a specific concern due to its complexity.
4. The clinicians develop a collaborative alliance that fosters the sense of having a caring relationship between staff and the adolescent client and their family.
5. Staff apply knowledge and skills related to cultural competency to foster rapport and alliance.

6. Staff attend supervision, coaching sessions, or ongoing training related to engagement practices.



Policy and Procedure: General, Part II: Philosophy of Approach & Principles of Practice:

2. Guiding Principles of Recovery

Policy Number: II.2

I. Purpose

This <INSERT PROVIDER NAME> P&P are two aspects of Recovery that are distinct, but are interrelated and support one another:

Recovery-oriented care is what the <INSERT PROVIDER NAME> clinical staff offer in support of the individual/family's own recovery efforts.

The recovery process refers to how persons with or impacted by a mental and/or substance disorder actively manage the disorders and reclaim their lives in the community.

Recovery focuses on rehabilitation, self-sufficiency and community integration rather than only on stabilization, maintenance and entitlements. All <INSERT PROVIDER NAME> clinical services are integrated within a continuum of care and work to help adolescents and families manage the day to day challenges of life instead of focusing on illness and pathology. Treatment is strength-based and relies on developing an individual's own qualities.

II. Policy

Recovery-based care, as part of an integrated service model shall support sustained recovery towards client (or family) directed self-management towards more functional self-efficacy and stabilization and positive and rewarding integration into the community.

III. Staff Responsible for Implementation

Clinical Supervisors and <INSERT PROVIDER NAME> staff.

IV. Procedure

1. Hiring practices: Due to the complexity of potential negative effects of substance use on persons with mental or emotional disorders, staff must be both knowledgeable and compassionate towards persons experiencing any of these disorders to reduce stigma and restore confidence in the potential for self-management and self-care, as far as functional considerations will allow for the individual.
 - Recovery Resiliency Philosophy shall direct hiring and training decisions for new staff and is a significant determinant in training and support for currently employed staff.

- The Recovery and Resiliency philosophy is consistent with recovery definitions addressing both or either substance use and mental health issues and the self-reinforcing nature of COD.
2. <INSERT PROVIDER NAME> Executive Management and staff demonstrate understanding of the complexities of substance, mental and emotional and co-occurring disorders and how to apply recovery and resiliency philosophy as suitable and appropriate to duties performed.
 - The recovery philosophy is actively applied in performance evaluations and is used for referral to continued training.
 3. <INSERT PROVIDER NAME> will determine, within guidelines set forth by the State, appropriate comprehensive, integrated services that have been researched and developed for the treatment populations identified for services and which have demonstrated effectiveness in reducing the negative impact of the functional issues being addressed while increasing the positive functioning of the individual or family being served. The intent of <INSERT PROVIDER NAME> is to reduce stigma, functional impairment and other negative impacts of both mental health and substance disorders, build self-efficacy and self-management skills and provide the opportunity for the individual being served to live a more meaningful life in the community.
 - <INSERT PROVIDER NAME> uses research-based practices, including culturally competent and trauma-informed services.
 - <INSERT PROVIDER NAME> will adopt or adapt written educational materials that reflect the recovery and resiliency approach specific to educating the adolescent client and their families about the complex issues of behavioral health treatment.
 - <INSERT PROVIDER NAME> maintains a commitment to a service orientation based on the recovery and resiliency philosophy.



Policy and Procedure: General, Part II: Philosophy of Approach & Principles of Practice: 3.Cultural Competency
Policy Number: II.3

I. Purpose

<INSERT PROVIDER NAME> supports cultural competence as defined as a set of congruent practice skills, behaviors, attitudes and policies that come together in a system, agency, or within a community and includes the adolescent client and their families, providers and professionals that enables that system, agency, or those professionals and community providers to work effectively in cross-cultural situations.

For this policy, the definition of cultural competency is intended to include race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, ethnicity, national origin, age, developmental stage, mental or physical disability or medical condition, gender identity, sexual orientation, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or other conditions.

II. Policy

<INSERT PROVIDER NAME> endeavors to:

1. Encourage and aid staff to increase their knowledge and understanding of cultural differences and acknowledge and surmount personal cultural assumptions and biases
2. Encourage and support staff changes in thought and behavior to address culturally based biases
3. Maintain awareness of the unique values, preferences and strengths of adolescents and their families and communities.
4. Adapt cultural considerations into treatment practices, as appropriate and possible, to promote traditions and cultural strengths, including racial, ethnic, age and language preferences and include natural and informal supports.
5. <INSERT PROVIDER NAME> shall train staff in cultural competency for the populations served upon hire and/or annually.

III. Staff Responsible for Implementation

All <INSERT PROVIDER NAME> staff

IV. Procedure

1. <INSERT PROVIDER NAME> utilizes input from community and the adolescent client and their family to effectively address community needs. Staff actively pursue knowledge of the community served.
2. <INSERT PROVIDER NAME> maintains a strict non-discrimination stance related to race, ethnicity, sexual orientation, religious background, social group, or cultural subset (see the list in the Purpose statement of this P&P)
3. Staff recognize cultural differences in belief, attitude and how that affects rapport and alliance building and actively engages in non-prejudicial practices.
4. Staff have the capacity or are trained to provide culturally appropriate services (e.g., are flexible, informed and trained in their approach to service to meet the needs of the identified population.
5. <INSERT PROVIDER NAME> supports familiarity and linkages to cultural resources in the community (e.g., community leaders, traditional healers, elders) and are culturally and linguistically representative of the community served, if possible.
6. <INSERT PROVIDER NAME> staff participate in annual cultural competency training, specifically regarding the various cultures and possible adolescent cultural subsets being served by the provider.



Policy and Procedure: General, Part II: Philosophy of Approach & Principles of Practice: 4.Gender Competency **Policy Number: II.4**

I. Purpose

<INSERT PROVIDER NAME> recognizes that self-identification of gender plays a significant role in how the sex of the individual is expressed in the social context. For <INSERT PROVIDER NAME> staff, the use of the term gender is a descriptive word used to illustrate

perceived differences in the social expression of biology, not as a way to describe what is a correct for an individual expressing their identity. Gender may at times be used interchangeably with the term sex, denoting biological male/female differentiation.

Additionally, girls have become the fastest growing segment of the juvenile justice system across the United States over the past twenty years. Girls in behavioral health settings may experience complicated mental health, substance abuse and primary health care needs and may not fare well in systems designed for boys. Gender competency is often discussed in application to the girls' population only. <INSERT PROVIDER NAME> recognizes the unique needs of girls and boys in the treatment population and strives to provide treatment appropriate to either boys or girls and in segregated groups as possible and appropriate.

II. Policy

<INSERT PROVIDER NAME> recognizes that gender competence describes the capacity of the service practitioner to identify where difference on the basis of both sex and gender (identity and sexual orientation) is significant and:

1. Conducts routine business in ways that produces effective and empowering outcomes for all youth, whether they identify as male, female, or any other term describing their gender or sexual identity. Some of these are determined as:
 - a. Encouraging and aiding staff to increase their knowledge and understanding of gender competency issues, concepts and practical implementation related to engagement practices.
 - b. Training and supervising staff changes related to appropriate behaviors to address gender identity biases.
 - c. Maintains systems and individual staff awareness of the unique values, preferences and strengths of adolescents and their families and communities.
 - d. Adapts gender competency considerations into treatment practices, as appropriate and possible and includes natural and informal supports.
 - e. Supervisory process actively monitors staff and agency gender competency practices and initiate feedback or corrective action related to a perceived breach of stated policy or consumer complaint.
2. <INSERT PROVIDER NAME> maintains a strict non-discrimination stance related to sex, gender identity and sexual orientation.
3. <INSERT PROVIDER NAME> maintains commitment to gender competence throughout the organization as evidenced in the active application of these policies and procedures and annual QA review.

III. Staff Responsible for Implementation

All staff

IV. Procedure

1. <INSERT PROVIDER NAME> conducts research to identify service population needs and trends related to gender competency services to guide the effective implementation of services for both male and female youth and those who self-identify with a specific gender identity (gay, lesbian, bisexual, transgendered, queer,

questioning, coming out, etc.) and implements business and treatment practices as appropriate. Practices will include:

- a. Support and coaching related to staff comprehension and behavior supportive of gender and sexual identity differences.
 - b. Consistent and regular training and supervision to develop and enhance gender competency and diminished expression of bias.
 - c. Conducts internal reviews of practices and staff competencies related to gender competency and develops CQI as appropriate and needed.
 - d. Maintains consistent best practice application related to gender competency.
 - e. Quality assurance processes assess supervisory practices related to how individual staff are monitored for gender competency and reports findings and recommendations to the executive board.
2. <INSERT PROVIDER NAME> staff recognizes gender identity differences in belief, attitude and how that affects rapport and alliance building and actively engages in non-prejudicial practices.
 3. <INSERT PROVIDER NAME> clinical staff shall demonstrate or acquire the practical capacity to provide gender appropriate services (e.g., are flexible, informed and trained in their approach to service to meet the needs of treatment populations related to gender competency and the provider conducts routine quality reviews with reports to the executive team.



Policy and Procedure: General, Part II: Philosophy of Approach & Principles of Practice:

5. Stage-wise Appropriate Care

Policy Number: II.5

I. Purpose

Ensure that treatment interventions are consistent with and determined by the adolescent client and their family's developmental stage of treatment/stage of change.

II. Policy

<INSERT PROVIDER NAME>:

1. Ensures staff receive training in developmentally appropriate interventions.
2. Ensures that developmentally and functionally appropriate interventions are applied to substance use and mental health issues and other co-morbid conditions that the individual may be experiencing.
3. Ensures that developmentally and functionally appropriate interventions are documented in the service plan
4. Ensures training in stage-wise interventions to ensure staff familiarity and support of stage-wise interventions.
5. Ensures that stage-wise interventions are applied independently to substance use and mental health issues and other co-morbid conditions that the individual may be experiencing.

6. Ensures that Stage-wise interventions are documented in the service plan

III. Staff Responsible for Implementation

All treatment staff

IV. Procedure

1. Training for developmentally and functionally appropriate interventions is conducted in-house or staff are supported to attend training at other locations
2. Developmental stages training will be conducted within 90 days of hire for new staff, or annually, or more often as determined through supervisory practices.
3. Staff receives training that ensures the skills development to recognize, value and interact appropriately to youth who are at different developmental stages and related to different conditions, circumstances and diagnoses, including functional capacity.
4. Staff receives training that ensures the skills development to comfortably recognize and apply appropriate stage of treatment interaction to the individual's *current* developmental and/or functional stage.
5. Supervises to ensure that staff matches the developmentally and functionally appropriate interventions to the appropriate stage of intervention.
6. Supervises staff such that the stage of change is matched by appropriate stage of treatment intervention.



Policy and Procedure: General, Part II: Philosophy of Approach & Principles of Practice

6. Motivational Approaches

Policy Number: II.6

I. Purpose

The purpose of using MI is to help clients understand the impact of substance abuse and mental illness in their lives on their own terms.

II. Policy

<INSERT PROVIDER NAME>:

1. Ensures staff receives training in motivational Interviewing (MI) to ensure staff familiarity and support in use of MI.
2. Ensures that MI is applied independently to substance use and mental health issues and other co-morbid conditions that the individual may be experiencing.
3. Ensures that MI interventions are documented in the service plan
4. Ensures that staff are trained and understand contingency management principles and practices.

III. Staff Responsible for Implementation

Clinical Supervisor

IV. Procedure

1. Training for MI interventions is conducted in-house or staff are supported to attend training at other locations.
2. MI training will be conducted within 90 days of hire for new staff, or annually, or more often as determined through supervisory practices.
3. Staff receives training that ensures the skills development to recognize, value and interact appropriately to different stages of readiness related to different conditions.
4. Staff receives training that ensures the skills development to comfortably recognize and apply appropriate MI interactions to the individual's *current* stage of change.
5. Supervises to ensure that staff maintain fidelity to the MI model and principles.
6. Supervises to ensure that staff effectively utilize contingency management principles and practices.



Policy and Procedure: General, Part II: Philosophy of Approach & Principles of Practice: 7.Trauma-informed System of Care

Policy Number: II.7

Approval Date:

Revision Date:

I. Purpose

Trauma-informed care is defined as care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and informed by knowledge of the prevalence of these experiences in persons who receive behavioral health services.

II. Policy

1. Current and past trauma is assessed during intake.
2. Current or past trauma is addressed in treatment planning as appropriate.
3. A trauma related safety plan is developed that includes triggers that lead to maladaptive behaviors, early warning signs and strategies to manage and minimize stress.
4. Staff ensures trustworthiness: make tasks involved with service delivery clear, by ensuring consistency in practice and by maintaining boundaries that are appropriate to the program.
5. Staff Collaborate: maximize collaboration and sharing of power between staff and the adolescent client and their family. This translates to an approach that is respectful of strengths and their vulnerabilities with the overall intent to help people become empowered to act as the directors of their own lives.
6. Safety: ensures the physical and emotional safety of the adolescent client and their family and staff. Ensuring staff safety must include adequate supervision and respite planning to prevent and/or mitigate the accumulative stress of working with traumatized persons. (See Staff Handbook for client interaction safety guidelines.)
7. Choice: maximize the adolescent client and their family's experiences of choice and control

8. All staff that interacts in any regard with the adolescent client and their family has been trained in trauma sensitive care.
9. Ensure that referral sources and consultation for trauma related issues are available if appropriate to need.
10. <INSERT PROVIDER NAME> develops, adopts, trains staff, implements and conducts quality management re trauma-sensitive policies, procedures and continually evaluates the physical and therapeutic environment regarding safety for staff and persons who have experienced trauma.

III. Staff Responsible for Implementation

<INSERT PROVIDER NAME> Clinical Supervisor and clinical staff

IV. Procedure

<INSERT PROVIDER NAME> staff addresses trauma care in all meetings and interactions within the following 5 dimensions:

1. <INSERT PROVIDER NAME> will provide **Safety**: Ensure the physical and emotional safety of the adolescent client, their family and staff. Training about ethics, confidentiality and reporting issues is ensured and conducted regularly.
 - a. Ensures the physical and emotional safety of the adolescent client and their family and staff.
 - b. <INSERT PROVIDER NAME> strives to match level of clinician's experience and skill with the adolescent client and family need.
 - c. <INSERT PROVIDER NAME> will provide for training and support for field work situations that may expose workers to unsafe conditions and situations.
 - d. <INSERT PROVIDER NAME> will certify that staff understand and use trauma-sensitive care practices to avoid triggering and/or escalating trauma-related episodes.
 - e. <INSERT PROVIDER NAME> will provide for staff backup (additional qualified and trained staff, etc.) during crisis situations.
2. PROVIDER NAME will engender **Trustworthiness**: Service staff will make tasks involved with service delivery clear, by ensuring consistency in practice and by maintaining boundaries that are appropriate to the program.
 - a. Staff will maintain engagement through careful application of alliance and rapport strategies.
 - b. Staff will ensure consistency in practice and maintain boundaries that are appropriate to the program.
3. <INSERT PROVIDER NAME> will provide **Choice**: Maximize the adolescent client and their family(s) experiences of choice and control.
4. <INSERT PROVIDER NAME> will provide **Collaboration**: Maximize collaboration and sharing of power between staff and the adolescent client and their family.
 - a. <INSERT PROVIDER NAME> will maximize a collaborative approach that is respectful of strengths and their vulnerabilities with the overall intent to help youth and families become empowered to act as the directors of their own lives.
5. <INSERT PROVIDER NAME> will encourage and support individual and family **Empowerment**: Prioritize the adolescent client and their family's empowerment and skill building.

- a. <INSERT PROVIDER NAME> recognizes and supports effective treatment and support as empowering the adolescent client and their family to maximum possible self-efficacy, parental or self-regulation of behaviors, attitudes and expressions and parental or self-management of the adolescent’s whole life, as far as functional ability will allow.

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8. Initiation of and Retention into Behavioral Health Services
Policy Number: III.8

I. Purpose

Initiation of and retention of clients into treatment describes how the provider agency conducts outreach, accesses and retains referrals and implements policies and practices to reduce drop outs and no shows while maintaining engagement into treatment. The following are important aspects regarding initiation of and retention into treatment:

- Foster respectful and understanding relationship using engagement principles and the five evidence based frames of Recovery and Resiliency Philosophy and Approach orientation, Cultural Competency, Stage-wise Interventions, Motivational tools and Trauma-sensitive Care. Using these approaches and orientations to the adolescent client and their family helps staff to understand and interact in more helpful and effective ways.
- Learn treatment history related to prior treatment episodes and what your treatment program has to offer related to services provided. This must be regarded as initial information, as a more thorough treatment history will be taken during the intake procedures.
- Provide flexible schedules
- Provide for increased frequency of contact in early stages of treatment
- Provide integrated services

II. Policy

<INSERT PROVIDER NAME> shall:

1. Maintain protocols/training/supervision for developing collaborative alliances that foster the sense of having a caring relationship between staff and the adolescent client and their family.
2. Maintain capacity to allow for increased frequency of contact in the early stages of services and flexible schedules with particular care regarding adolescents attending school.
3. Maintain protocols/training/supervision regarding matching treatment interventions to the client and their family's capacity to work on identified issues.
4. Maintain protocols/training/supervision for collaboratively setting goals and tasks of treatment for all identified disorders.
5. Maintain protocols/training/supervision that fosters the incorporation of the adolescent client and their family's culture into treatment.
6. Maintain protocols/training/supervision that integrates plans for discharge in the Intake/Initiation paperwork

III. Staff Responsible for Implementation

Executive Management and the Clinical Supervisor

IV. Procedure

1. <INSERT PROVIDER NAME> provides training and coaching to all staff regarding engagement strategies, provides oversight of staff scheduling and flexibility for the earliest possible face-to-face contact with the clinician or other suitable staff and manages intake authorization so that the adolescent client and their family are quickly inducted into appropriate services agreed upon with the client.
2. <INSERT PROVIDER NAME> ensures that the organizational structure fosters engagement and retention such as reduced waiting time between request for service and enrollment and that staff provide outreach and other supportive services that foster engagement and retention into services.
3. <INSERT PROVIDER NAME> will match treatment interventions to the client and their family's capacity to work on identified issues and document match in the service plan.
4. <INSERT PROVIDER NAME> will collaboratively set goals and tasks of treatment for all identified disorders with the youth and his/her family.
5. <INSERT PROVIDER NAME> will actively strive to incorporate cultural values into the treatment and support services components.
6. <INSERT PROVIDER NAME> integrates plans for discharge in the Intake/Initiation paperwork and updates and refines discharge over the course of treatment.



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9. Intake Processes

Policy Number: III.9

I. Purpose

The purpose of the Admission Policy and Procedure is to ensure a smooth, consumer friendly admission process that establishes the foundation for lifelong recovery. The Intake

P&P also ensures that all new clients complete initial assessments and orientation to the Agency including client responsibilities, rules, regulations and rights, that <INSERT PROVIDER NAME> meets State and local regulations related to intake and admissions and that <INSERT PROVIDER NAME> shall ensure quarterly review and revision to this policy and procedure as needed per QMT decisions.

II. Policy

1. New clients admitted into services will be admitted in a calm, friendly and professional manner (new shall be defined as not having been admitted to <INSERT PROVIDER NAME> within the previous 90 days).
2. Least restrictive level of care shall be determined at intake. All new clients will be assessed prior to initiation of treatment or within the specified term for assessment. *The American Society of Addiction Medicine (ASAM) Patient Placement Criteria, or its equivalent, shall be used for determination of level of care for substance use conditions or disorders inclusive of COD.*
3. All clients will be informed during the intake process regarding financial responsibility for services received.
4. All new clients will receive a client orientation informing them of provider responsibilities related to services, client responsibilities, client rights and grievance procedures.
5. Access to services shall be straightforward, easy and welcoming as far as this is possible to circumstances and conditions of funding, workforce and appropriate fit of client with the skills and capacity of employed staff.
6. Referral as necessary to match service to the client shall be made to appropriate service providers and documented.
7. Integrated services and resources necessary to promote recovery, rehabilitation and resiliency for those negatively affected by the adverse functional impairment caused by substance abuse, mental and/or emotional illness and co-occurring disorders shall be managed and supervised by <INSERT PROVIDER NAME>.

Access to treatment shall be straightforward, easy and welcoming as far as this is possible to circumstances and conditions of funding, workforce and appropriate fit of client with the skills and capacity of the <INSERT PROVIDER NAME> employed staff.

III. Staff Responsible for the Implementation of this P&P (in part or in whole) Include:

The Chief Executive Officer, the Clinical Supervisor and licensed clinical staff are responsible for implementation of this P&Ps. In all cases related to admission/intake, the designated Clinical Director/Supervisor shall maintain administrative and clinical oversight, monitor appropriate assignment to the least restrictive level of care as indicated by clinical assessment and review documentation for completeness and accuracy.

IV. Procedure

A. Intake Appointments

1. Appointments for all screenings will be arranged following the procedure for Intake processing, including a pre-screening, meeting and scheduling with the Intake Coordinator.
2. Appointments are set for Monday through Friday. If a client will be late for the intake appointment they must notify the Intake Coordinator prior to their appointment. A missed intake appointment will result in a reschedule at the earliest open appointment opportunity. Due to capacity issues related to <INSERT PROVIDER NAME>'s caseload, this may affect the time of entry into treatment. In all cases, <INSERT PROVIDER NAME> shall endeavor to meet treatment needs at the earliest possible time following admission in the program.
3. **Crises and Emergencies**
4. If the individual is in obvious crisis, appropriate care shall be taken to refer to, obtain or provide service as needed. For this purpose, current crises must be assessed at intake and should include bio-medical crises, nutrition, hydration, risk of harm to self or others, adequate shelter and other significant crisis conditions. An interim crisis plan can be discussed at intake and put into immediate effect. Clients that are identified as experiencing a crisis that may cause threat to life or limb, are in withdrawal, or may endanger others, shall be addressed by the clinical supervisor or other senior program authority to ensure that they receive the appropriate level of care, whether hospitalization, immediate intake, involving law enforcement, homeless shelters, food or clothing referrals, etc, to secure the person's or families continued well-being as far as possible.
5. No-Shows: Missed appointments must be rescheduled with the clinician's approval. The third time a failure to notify the Provider of an inability to attend a scheduled appointment may result in a No-Show classification and review of eligibility for services. Clients referred by the courts may be referred back to their referral source for non-compliance determined by the eligibility review.
6. When a client arrives for the intake appointment, he/she checks in with the front office staff or clinician. Staff persons greet the new client in a courteous manner and ask the client to wait in the lobby for the Intake Coordinator to escort them into their meeting or session.

B. Initial Intake Interview

1. The parent/guardian completes the Intake Assessment form and once complete the family meets with the clinician. The clinician goes over the intake assessment with the family and gathers additional information for the psychosocial assessment. Demographic and contact information shall be collected at this time.
2. At the first appointment, the intake clinician will meet the new client and inform her/him that an intake interview will be conducted in order to gather basic information. The intake appointment requires the following:
 - Initial Screening, as appropriate.
 - Assessment and/or bio-psychosocial assessment.
 - Discussion and interview related to diagnoses and assessment findings.
 - Initiation of case file.
 - Explanation of HIPAA and confidentiality.
 - Discussion of goals of treatment.

- Signing of consent forms and Clinical Policies
 - Medicaid eligibility is determined
 - The Statewide Entity registration process for the client is completed
3. The specifics of treatment are described and discussed, including:
 - Schedules and program intensity and duration.
 - Attendance agreements, graduation requirements and absences.
 - School and work barriers, as well as other barriers to treatment.
 - Drug and alcohol screening protocols (when required), requirements and required reporting.
 - Treatment and recovery subjects that will be addressed during treatment.
 - Individual and family counseling, IOP, case management, as well as educational groups, psycho-education groups, parenting groups, etc, as appropriate and as offered at the determination of the clinician, the Clinical Supervisor and/or the CEO.
 4. The intake interview information is entered into the client's case file during the interview. This packet gathers basic client information including demographics, contact information, social security number, emergency contact information, educational status, reason for seeking service and other information needed such as all original signatures. This information will be gathered in a way that is respectful and considerate of the client's: age or developmental level; gender; sexual orientation; social preferences; cultural and ethnic background; psychological characteristics; physical conditions; spiritual beliefs; method of payment for services; or outcome expectations. All information gathered will be kept confidential in accordance with all State and Federal confidentiality requirements. Family members or friends may be present for this portion of the intake procedure.
 5. The Intake Interview is responsive to the changing needs of the client. The Intake Interview may include information obtained from the client's family members when applicable or permitted, friends or other peers when applicable or permitted and other appropriate and permitted collateral sources. This information is reviewed annually.

C. Billing Coordination and Medicaid Eligibility

1. During the intake interview, the intake clinician shall determine if any additional information is needed for Medicaid or other billing. The intake will determine eligibility of private or insurance payment, or other payment arrangements as appropriate to the climate and availability of such resources.
2. **Paperwork Requirements:** <INSERT PROVIDER NAME> is responsible for completing all documentation necessary for billing and payment.

D. Initial Assessments

1. The client will be assessed at initial intake processes.
 - The Clinical Supervisor /Intake Coordinator, will conduct the assessment portion of the intake interview, as appropriate, which includes the psychosocial and substance abuse assessments.
 - The Intake Coordinator will then inform the assigned clinician to proceed with services and Service Plans.

E. Initial Service Plan (see P&P III.4. Individualized, Comprehensive, Integrated Service Plan)

1. Initial service goals shall be developed by Intake Coordinator, then within the first 4 therapy sessions, an assigned clinician will complete an Initial Service Plan in collaboration with client (and his/her family as appropriate) for treatment services.
 - The first service plan review will be conducted at a minimum within 90 days and every 90 days following for the duration of active treatment.
3. In addition to the initial treatment overview, all clients will be provided an orientation at the beginning of the treatment program and will be provided information related to services.
 - The orientation will describe rules and regulations of the program, including attendance and UA/drug testing (only if required); expectations of the client; client's rights and grievance procedures; procedures to follow in case of fire or other emergency, including location of fire exits; and guidelines for group conduct and sharing.
 - Initial barriers to engaging treatment will be addressed, such as transportation, work schedules, childcare, medication, competing appointments, etc.



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10. Assessment

Policy Number: III.10.

I. Purpose

The assessment gathers information and engages in a process with the client (and family, as appropriate) that establishes (or rules out) the presence or absence of a substance dependency, mental or emotional disorders, co-occurring disorders and related functional impairments across multiple domains. It determines the client's readiness for change, identifies strengths and problem areas that may affect treatment processes towards individual and/or family recovery and engages the client (and family) in an appropriate service relationship.

II. Policy

1. <INSERT PROVIDER NAME> consistently uses appropriate assessment tools/processes.
2. Conduct both clinical and Youth Support Services assessments as appropriate to perceived or potential need.
3. <INSERT PROVIDER NAME> provides a protocol and procedures detailing the use and application of appropriate assessment tools that must be informed by the complex considerations related to assessing a person experiencing substance dependency, mental or emotional disorders, or co-occurring disorders.
4. A formal assessment instrument shall be used that demonstrates integrated assessment of both psychiatric and substance disorders (Assessment (H0031-U8) or a Diagnostic/Evaluation (90801) or other diagnostic evaluation as approved by the Medical Assistance Division). The assessment shall be current, (within 12 months)

completed, signed and dated by a licensed clinician under the supervision of a licensed Independent Clinician.

5. The assessment will include all of the following domains of information
 - ✓ DSM Diagnoses
 - ✓ The client's deficits, functional impairment, cognitive impairment, limitations, barriers to service and strengths, goals and desired behaviors/capabilities
 - ✓ Treatment history, including past substance use patterns and mental health symptom patterns
 - ✓ Issues related to trauma including trauma history, crisis history and crisis resolution
 - ✓ Hospitalizations, incarceration, legal system involvement, housing and employment status
 - ✓ Current medications and medication history
 - ✓ Medical history
 - ✓ Readiness to change and developmental stage
 - ✓ The assessment process identifies all other concurrent issues that may adversely affect recovery efforts
6. Assessments that identify COD shall have an integrated summary documenting specific priorities related to COD interactions and self-reinforcing processes
7. The staff providing services is familiar with the integrated summary priorities that inform service planning, especially regarding functional impairment resulting from COD.
8. The assessment specifically informs the development of an individualized and recovery oriented service plan.
9. The assessment informs appropriate intensity and duration of service and service review and will be revisited at regular intervals, or as the symptom picture changes due to mental health remission, substance related recovery, changes in medication and effects, resolution of crises, etc.
10. The assessment findings are used to formulate a collaboratively developed Service Plan that specifically addresses the client's stated treatment goals and assures appropriate discharge and referral to aftercare when those goals are met to the client's satisfaction, even if the assessment indicates that other issues may need to be addressed.
 - f. Initial Risk Assessment and Safety Planning**
 - If the individual or family is in obvious crisis, appropriate care shall be taken to refer to, obtain, or provide service as needed.
 - If needed, emergency services will be utilized and appropriate supervisory staff shall oversee all emergency situations.

III. Staff Responsible for Implementation

The Chief Executive Officer, the Clinical Supervisor and licensed clinical staff: In all cases related to assessment, the designated Clinical Director/Supervisor shall maintain administrative and clinical oversight, monitor appropriate assignment to the least restrictive level of care (intensity and duration) as indicated by clinical assessment and review documentation for completeness and accuracy.

IV. Procedure

1. <INSERT PROVIDER NAME> shall identify and adopt and use appropriate screening and assessment tools as needed per services provided.
2. <INSERT PROVIDER NAME> will maintain protocols and procedures detailing the use and application of appropriate assessment tools. Protocols for use shall specifically detail how the complex considerations related to assessing a person experiencing substance dependency, mental or emotional disorders or co-occurring disorders will be conducted.
3. Assessment will be conducted of the following domains with the suggested added domain specific to NM: cultural considerations of religion and spirituality:
 - DSM Diagnoses
 - Behavioral health service history
 - Substance use
 - Psychiatric problems
 - Functional impairment related to diagnosis, medical necessity and life domains
 - Biomedical conditions and complications
 - Causality
 - Interim Service Plans
 - Referrals to other services
4. In addition, the assessment will ensure that the following information is determined or gathered:
 - DSM Diagnoses
 - The client (and family, as appropriate) deficits, functional impairment, cognitive impairment, limitations, barriers to service and strengths, goals and desired behaviors/capabilities
 - Treatment history, including past substance use patterns and mental health symptom patterns
 - Hospitalizations, incarceration, legal system involvement, housing and employment status, child welfare history
 - Current medications and medication history
 - Medical history
 - The assessment process identifies all other concurrent issues that may adversely affect recovery efforts.
5. The assessment shall develop an integrated summary for COD clients that documents specific priorities to the service plan that clearly and specifically addresses the interactions and self-reinforcing processes related to the co-occurring disorders diagnosis.
6. The assessment and summary shall be considered an educational document for all persons who will interact with the adolescent client and their family during the course of services and shall be updated or modified dependent upon new understanding, remission of symptoms, stabilization and increased sobriety. This document and the assessment it distills must be considered a living document of the adolescent client and their family's **current** need for services.
7. <INSERT PROVIDER NAME> staff providing services will be familiar with the integrated summary priorities that inform service planning, especially regarding functional impairment resulting from COD.

8. The assessment specifically informs the development of an individualized and recovery oriented service plan.
9. The assessment is regularly updated (at least once per year) and updates should be informed by simple questions asked by all appropriate provider agency staff interacting with the client.
10. The assessment informs appropriate duration of service and service review and will be revisited at regular intervals (at least one time per year), or as the symptom picture changes due to mental health remission, substance related recovery, changes in medication and effects, resolution of crises, etc. Updates should be informed by simple questions asked by all appropriate provider agency staff interacting with the client.



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11. Individualized, Comprehensive, Integrated Service Plan

Policy Number: III.11.

I. Purpose

The purpose of the Service Plan Policy and Procedure is to ensure that all clients receive appropriate, thorough, timely, integrated and effective treatment through the development of an individualized service plan and regularly scheduled reviews and updates.

**Service plan, plan of care and treatment plan are often used interchangeably. This document shall use "service plan" to indicate all treatment planning documentation.*

II. Policy

1. The <INSERT PROVIDER NAME> clinician and the client (and family as appropriate) shall engage in an interactive process to develop the service plan based on the diagnostic assessment.
2. The client-centered treatment plan is the joint responsibility of the clinician and/or the multi-disciplinary team and the client.
3. "Individualized" services means that steps, strategies, services, interventions and intensity of involvement are focused on *specific* measurable and objective client goals and are unique for each client (and family).
4. The service plan is consistently updated and reviewed, at 90-day intervals at minimum.
5. The plan addresses the needs of the client across domains and must address treatment goals, crisis planning and relapse prevention planning
6. The service plan is built on appropriate strengths, needs and assessment findings and must specifically address both substance and mental health disorders as appropriate and clearly and specifically addresses the interactions and self-reinforcing processes related to a COD diagnoses with an integrated approach to services provided.
7. Each goal will be arrived at through specific and clear collaboration with the client and have outcomes stated in measurable terms.
8. <INSERT PROVIDER NAME> executive management supervision and oversight ensures service plans are written and progress notes are maintained in a way that ensures they meet billing codes

9. <INSERT PROVIDER NAME> service plan documents are formatted to allow for client (and family) input.
10. The plan addresses the needs of the client across domains and must address treatment goals and the following:
 - a. **Safety Planning**
 - Safety plans shall be maintained and updated as changing circumstances or signal events warrant.
 - b. **Runaway, missing person and elopement risk management**
 - c. Individuals shall be assessed for willingness to participate in the treatment programs offered by the provider. If there is risk of runaway or elopement, the safety plan will describe how risk will be managed.
 - d. **Crisis Planning**
 - A crisis plan shall be developed and maintained related to specific client or family need.
 - Crisis planning will address appropriate interventions that may have been previously successful, preferred courses of treatment, self monitoring of triggers and stressful conditions and natural supports and resources.
 - e. **Suicidality**
 - <INSERT PROVIDER NAME> will maintain protocols for suicidality as part of clinical policies, inclusive of assessment of risk, referral to appropriate care if needed and information pathways to communicate risk to parents/guardians and other supports for the youth.
 - f. **Relapse Prevention Planning**
 - <INSERT PROVIDER NAME> identified as experiencing past or present substance use disorders shall have a relapse prevention plan developed that addresses issues and conditions of possible or actual relapse.
 - Relapse prevention planning will attempt to identify triggers to use and help the client manage such triggers.
 - If the client is engaged in a treatment program utilizing an EBP that specifies relapse prevention planning, the EBP in use may provide the primary model and documentation of such planning to prevent duplication of clinical services. <INSERT PROVIDER NAME> shall use the <SPECIFY EBP HERE> Model for this planning.
 - g. **Continuing care/discharge planning**
 - <INSERT PROVIDER NAME> shall conduct aftercare planning beginning at Intake and shall continuously plan for aftercare services in collaboration with the person and his/her evolving circumstances.

III. Staff Responsible for Implementation

Clinical Supervisor and assigned staff

IV. Procedure

1. The service plan service plan is formulated using a collaborative style of engagement. Service planning shall address the issues/diagnoses identified in the assessment and the youth's developmental stage.

2. The client-centered plan is guided by what the person wishes (and/or family) to accomplish and the methods that are acceptable to him or her. The team and the youth arrive at the service plan through collaborating with one another.
3. The service plan is formulated to describe the steps, strategies, services, interventions and intensity of involvement focused on measurable and objective client goals aligned with the assessment findings.
4. The supervisor shall assign and oversee service plan updates and reviews.
5. The individuals providing services incorporate strengths as well as challenges into the service plan document and work together to develop a plan that will best serve the individual.
6. Progress on goals is monitored and documented in case notes.
7. The case notes accurately document services provided for all areas identified in the service plan.
8. Formatted documents allow for the recording of substance and mental health issues that will be addressed, as well as functional and other bio-psychosocial issues, stage-wise placement and also individual adolescent client and family specific goals.
9. The following procedures will be used and reviewed by supervisory staff:
 - a. **Safety Planning**
 - If the individual or family is in obvious crisis, appropriate care shall be taken to refer to, obtain or provide service as needed. For this purpose, current crises will be assessed at intake and should include bio-medical crises, nutrition, hydration, risk of harm to self or others, adequate shelter and other significant crisis conditions.
 - An interim crisis plan can be discussed at intake and put into immediate effect.
 - Clients that are identified as experiencing a crisis that may cause threat to life or limb, are in withdrawal, or may endanger themselves or others shall be addressed by the clinical supervisor or other senior program authority to ensure that they receive referral to the appropriate level of care, whether hospitalization, immediate intake, involvement of law enforcement, homeless shelters, food or clothing referrals, etc., to secure the individual's and/or families continued well-being as far as possible.
 - b. **Runaway, missing person and elopement risk management:**
 - If the assessment findings indicate the individual requires a level of care and supervision beyond the scope of the program (e.g., considered a high risk for noncompliant behavior and/or elopement), services may be deferred or denied and referral to the appropriate level of care will be made.
 - Verification of underage elopement must be judged based on parent/guardian knowledge, questioning other members of the group (if available) and questioning other staff that interact with the youth about whereabouts and plans of the youth in question and if the youth has explicitly stated plans about runaway to the clinician upon leaving the treatment setting.
 - If an underage person elopement occurs, the CEO, Clinical Supervisor, parents and guardians, law enforcement, JPO, CYFD and/or all other parties with jurisdiction shall be notified as soon as the suspected elopement is verified. Staff will make note of gender, age, clothing worn, emotional state and other details that may be of help in locating the youth.

- Staff will cooperate to their full ability, but all decisions, notifications and communications with authorities shall be made with the full knowledge and consent of the provider's administrative and clinical management.

c. Crisis Planning

The crisis plan must contain sufficient information and provide adequate guidelines so that the individual or the individual's caretakers have information regarding resources, specifics of the individual's care and needs and the individual's preferred course of treatment or intervention. Crisis plans are intended to avoid the use of emergency services, avoid loss of competency and self-control that might result in suspension or expulsion from school, incarceration, loss of housing, loss of employment, or any other adverse consequences that can be mitigated by timely and appropriate intervention.

d. Suicidality

A <INSERT PROVIDER NAME> staff member who has reason to believe that a client is at risk for suicide will notify their supervisor immediately. The therapist, supervisor, client and family will create a safety plan. The client and the family will be monitored to ensure they meet all the recommendations that are made by the therapist and the therapist's supervisor. Follow up calls and sessions will be made accordingly.

- If a client reports in a session or group that they are feeling suicidal, or if a friend, parent, teacher reports that the client has made suicidal comments, a suicide assessment will be conducted immediately as possible and appropriate to access to the identified client. The suicide assessment will be conducted by the therapist and reviewed by a clinical supervisor to develop an intervention plan.
- In the event of a medical emergency, the client will immediately be referred to one of the referring hospitals that <INSERT PROVIDER NAME> works with. If need be the client may be transported by an ambulance.
 - ✓ In all of the above situations, the client's parent or guardian will be made aware of the situation as soon as possible. If the therapist feels that a parent or guardian's response is negligent or damaging to the client, a CYFD report may be made.
 - ✓ If the client is 18 years or older, refuses help and is immediate danger, the police shall be contacted for referral to prevent <INSERT PROVIDER NAME> liability related to possible perceived or actual negligence such that any statement or threat, whether related to another person or to the clinician shall be construed as intent to self-harm. This is the most conservative and carries the least potential for acting out behavior.
 - ✓ The Clinical Supervisor or the CEO shall be contacted prior to referral to police, unless an emergency situation is occurring.
- In any situation where a client reports feeling suicidal, whether it is a low or high risk situation, the therapist will ask during the session or group if the client has any potentially lethal objects or substances on their person.
- The therapist will make a follow up call the next day to check in with the client and the family. Recommendations and the safety plan will be discussed and modified if needed.

- A release of information will need to be signed by the parents/guardians in order to discuss the intervention plan.

Protocol for After Hour Suicide Situations

<INSERT PROVIDER NAME> has a 24-hour on call number. If a client indicates a threat of suicide, the supervisor on call will notify the parent or guardian immediately.

- Crisis line contact info shall be made available to all persons identified with any risk level of suicide or self-harm.
- In the event that the family or guardian may not be available or helpful, the supervisor or therapist receiving the call will get as much information from the client as possible regarding the situation. Depending on the assessed seriousness of the case, local police may be called for immediate assistance.

e. Relapse Prevention Planning

Relapse planning and prevention must include the following:

1. A functional analysis of substance use behavior examining the past history and consequences of use. Results can be stated as either positive and/or negative consequences of use.
2. The relapse plan must address all substance related issues and take into account the interrelated mental health issues indicated by COD diagnoses.
3. Identify signs and symptoms of relapse.
4. Identify causes and contributing factors to relapse, including internal and external triggers.
6. Educate individuals and families regarding positive social activities and skills
7. Develop specific strategies to address each identified contributing factor of relapse.

Address each identified contributing factor of relapse, including:

- ✓ Potential safety concerns
- ✓ Medication management directive related to substance use
- ✓ Targeted behaviors
- ✓ Identification of signs and symptoms of relapse.
- ✓ Drop-out considerations
- ✓ Environmental precautions
- ✓ Coping strategies, e.g. relaxation, mindfulness, exercise, etc.
- ✓ Natural support planning
- ✓ Advanced determination of what signifies the resolution of the relapse
- ✓ Advance directives for loss of self-control related to substance use

f. Continuing care/discharge planning

1. <INSERT PROVIDER NAME> will explore suitable resources and make contact with the adolescent's other community service providers when appropriate. If the evidence-based program (such as the Matrix Model) does not specifically include transition from active treatment into aftercare, the provider will integrate aftercare planning into overall service planning.
2. The aftercare plan is developed sufficiently in advance of treatment discharge to minimize interruption to appropriate treatment services.

3. The <INSERT PROVIDER NAME> clinicians and the individual will collaborate to develop a plan that identifies services and supports needed or desired and specifies steps for obtaining these services.
4. <INSERT PROVIDER NAME> will follow up on the aftercare plan, as appropriate, when possible and with the permission of the service recipient, to ensure its commitment to the individual's continuing engagement in functional improvement and/or stabilization.
5. If <INSERT PROVIDER NAME> will not be the continuing support provider the individual will work with upon discharge from treatment, staff will contact the receiving community agency, if possible, to ensure relevant evaluation findings and assessment of unmet needs, is communicated in writing, as appropriate to the agreement and with the permission of the individual or parent/guardian.
6. Identify and initiate family and community supports, both formal and informal.



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12. Individual Case Files

Policy Number: III.12

I. Purpose

To maintain accurate and current records of all client's initial and ongoing assessments, goals, progress and discharge planning. These may be in paper or electronic format.

POLICY

1. An individual case file is established at the outset of services.
2. All intake documentation shall be kept in the individual case files.
3. Screens, assessments, diagnostic tools, psych-socials, GAIN, SASSI, ASAM, ASI, or other tools used to determine service need shall be maintained in individual case files.
4. All service plan documents will be kept in the individual case files.
5. Notes related to the process of mutual exploration of the client's issues and strengths, complemented by the staff's professional perspective and recommendations resulting in a jointly created plan with mutually agreed on goals will be maintained in individual case files.
6. Client rights and grievance policies are provided to each client or family/guardian and a signed copy of these is maintained in the file.
7. Relapse planning documentation shall be maintained in the individual case files.

PROCEDURES

1. A case file is established at the outset of services by intake staff.
2. Assessment will begin in the initial interview and builds on the information and presenting issues gathered by screening and during the intake interview. If there is a pre-existing screen or assessment, intake personnel will use this as a guideline for intake.

- a. The intake interview will gather basic information, to explore client strengths and issues and determine the client's desired outcomes and will be documented in the individual case files.
- b. The Client Contract/Consent for treatment with agency shall be signed by the individual and/or guardian and maintained in the individual case file.
3. Contextual information will be gathered and maintained in the case file, as relevant and appropriate to the nature of the issues and outcomes desired and shall include:
 - crisis or immediate need related to safety, shelter, food, etc.
 - safety issues (e.g., abuse, current risk of self-harm, previous suicide attempts)
 - the client's presenting issue
 - history of the issues
 - client's strengths and resources
 - physical, mental health and/or substance use issues
 - social and environmental context (e.g., social supports, work situation, income, living situation, neighborhood, family background)
 - formulation of the problem/issue
4. The documentation of referral to assessment will be maintained in the case file.
5. Assessment, psychosocial, ASI, ASAM, or other tools used to determine need and diagnoses, signed by the conducting clinician will be kept in the case file.
6. Assessment documents will be maintained in the individual case file.
7. The assessment will be documented for each client receiving service in the individual case file within five working days of the completion of the assessment interview.
8. Service goals, length of service and any potential interventions that may be required to achieve the stated goals will be documented in the service-planning document and maintained in the case file.
9. All client notes specific to each services session, as well as all treatment team and case-staffing notes shall be written and maintained in the individual case file.
10. Assessed safety issues shall be documented and kept in the case file.
11. If more than one service provider is involved in providing services, staff will clarify for the client who is ensuring service coordination and who is providing what service and this shall be clearly documented and kept in the case file.
 - a. Documented directives from the client and/or family about the nature of communication among service providers will be maintained. Consent for the release of information will be obtained and kept on record in the individual case file.
12. Progress notes for each treatment session will be kept in the case file for all services provided.
13. The Release of Information forms specific to treatment needs is signed and has been provided to the consumer and is kept in the individual case file.
14. A copy of the Client Bill of Rights is available to all clients and a signed copy is maintained in the individual case file.
15. A copy of the treatment schedule/attendance document is provided to the client and his/her family. This schedule will have the ability to track and match the recommended EBP service intensity specific to client needs and capability as documented in the Assessment (H0031-U8) or a Diagnostic/Evaluation (90801) or other diagnostic evaluation and shall be kept in the case file.

16. All referrals to all other providers of any type are documented in the individual case files.
17. Client rights and grievance procedures that include the MCO and State Authority rights for fair hearings is provided to the client and his/her family and a signed copy of this is kept in the individual case files.
18. Exit criteria related to completion of service plan goals and objectives, or successful graduation from a treatment program shall construe referral into aftercare or other level of care treatment (such as from outpatient to community supports) as determined by treatment staff in collaboration with the individual client and/or his/her family and shall be documented and kept in the case file.
19. Discharge planning documents shall be established at the outset of services and shall be maintained and updated as necessary to reflect growth and needs of the consumer such that the treatment plan and discharge plan are consistent and cohesive. Discharge planning documentation maintained in individual case files shall include the following:
 - a. Recovery planning
 - b. Relapse prevention planning
 - c. Family and community supports and collaboration available and accessible
 - d. The stage of readiness to change, on-going recovery goals and challenges to be addressed for the individual to continue a successful path to recovery.
 - e. Concrete steps that can be taken that support the individual and his/her family in recovery and resiliency.

Part IV: Personnel, Team and Systems Competencies
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IV. Personnel, Team and Systems Competencies

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Policy and Procedure: Part IV: Personnel, Team and Systems Competencies
13. Staff Competencies
Policy Number: IV.13

I. Purpose

To deliver effective recovery-focused integrated services.

II. Policy

1. Clinical staff must be licensed in the State of New Mexico. Staff core-competencies can be developed over time and include but are not limited to the following:

- ✓ Recovery/resiliency philosophical orientation and recovery skills.
 - ✓ Cultural competency.
 - ✓ Stage-wise interventions.
 - ✓ Knowledge of developmental stages and how these pertain to individual youth.
 - ✓ Motivational interventions.
 - ✓ Trauma-sensitive care.
 - ✓ Development and maintenance of comprehensive service plans.
 - ✓ Adolescent development.
 - ✓ Initial training or opportunity for training in Evidence-Based Practices (EBP's) used within the agency specific services as identified on a case-by-case basis by the Clinical Supervisor or Executive Management shall be made available.
 - ✓ Refresher training or opportunity for training as appropriate to assigned duties.
 - ✓ Group facilitation, family interventions, use of natural supports, effective team interaction, facility in service continuum and referral to community supports and Comprehensive Community Support Services (CCSS), as appropriate.
 - ✓ Identification of clinical and psychosocial needs of client population, especially regarding co-occurring disorders (COD) and interactions of the various disorders.
 - ✓ Psychopharmacology and its effects on substance, mental and emotional health issues and COD.
 - ✓ Drugs of abuse, related symptoms and possible interventions related to adolescent development, stages of treatment and specific to COD.
 - ✓ Severe emotional disturbances and mental health diagnoses and related symptoms and effects exacerbating substance use and/or substance effects.
 - ✓ Working with behaviorally disruptive, unruly, violent and/or suicidal clients or family members of clients.
2. Staff will receive training within 90 days of hiring/contract and as needed based on a supervisory assessment particular to the staff member and his/her role in the treatment program.
 3. Clinical staff training will be guided by required competencies in support of the program's use of primary EBP and subsidiary services.
 4. Records of trainings attended, certificates of completion, or other evidence of completed trainings shall be kept in the individual personnel file, or, if the training is in-house, a training log listing the specific training topic, name of attendees and hours for each person attending shall be kept by the clinical supervisor and/or human Resources Manager.
 5. Additional, in-depth and training for specific client populations, such as COD, is conducted with staff as appropriate to need assessed by the Clinical Supervisor or at the time of hire.
 6. Supervision of staff competencies related to core competencies is specifically documented. The Supervisor shall provide and document supervision of staff competencies related to COD issues. Records of trainings attended, certificates of completion, or other evidence of completed trainings shall be kept in the individual personnel file, or, if the training is in-house, a training log listing the specific training topic, name of attendees and hours for each person attending shall be kept by the clinical supervisor and/or human Resources Manager.

III. Staff Responsible for Implementation

Clinical Supervisor and Executive Management

IV. Procedure

1. Agency policies and procedures support appropriate core competency training for all staff having contact with the adolescent client and family.
2. The supervisory assessment of staff will measure clinical skills pertaining to core competencies listed at time of hire/contract and as needed for currently employed/contracted staff.
3. Within 90 days of hire/contract, staff completes initial assigned training.
4. A staff development plan shall be utilized to determine specific education and training needs. The plan will be maintained in the personnel files. Individual need for supplementary training in support of program needs will be determined by the clinical supervisor on a case-by-case basis.
5. As possible and appropriate to need and capacity, provide regular, on-going training for staff providing services to adolescent clients and their families.
6. All staff are provided training or opportunity for training in previously listed core competencies, as appropriate to need and assigned work duties. Staff training may also include non-clinical agency staff with adolescent client and family contact, including administrative support staff.



Policy and Procedure: Part IV. Personnel, Team and Systems Competencies

14. Supervision

I. Purpose

<INSERT PROVIDER NAME> assures that appropriate, effective, compassionate and trained supervision is delivered to all staff that provides any level of clinical interface with clients and their caretakers or identified families. Supervision is critical to the successful treatment and provision of services to adolescent clients and families. The internal capacity to train and supervise staff is critical to maintaining skilled workers providing integrated services to clients and their families.

II. Policy

1. <INSERT PROVIDER NAME> will maintain the position of an active Clinical Director/Supervisor (hereinafter referred to as the supervisor) through direct employment or contract, through either direct employment or contract agreement, whether permanent or temporary, <INSERT PROVIDER NAME> clinical supervisors must adhere to all conditions of this Policy and Procedure as listed herein.
2. <INSERT PROVIDER NAME> shall maintain a supervisor position(s) job description that shall include all applicable policy statement conditions recorded in the Policy and Procedures (P&P) Sections of the various programs implementing clinical practices.
3. The currently employed or contracted supervisor will:

- ✓ Have active New Mexico licensure as an independent clinical practitioner.
 - ✓ Have one year documented supervisory experience.
 - ✓ Have documented education, formal training, or staff development training and experience in mental health treatment, including and as appropriate substance abuse treatment and co-occurring disorders treatment (Work history shall be determined through resumes and documented job references).
 - ✓ Meet program specific training requirements.
 - ✓ Have documented training and certification in relevant evidence-based programs used by the agency copies of which shall be kept in the individuals personnel file.
 - ✓ All geographic treatment sites that provide treatment services shall meet these supervisory standards set forth in this P&P.
4. Supervisors perform the critically important role of educating, encouraging, guiding, supporting and monitoring clinical staff as assigned and appropriate to need. Supervisors may maintain a client caseload as well as provide clinical supervision and oversight.
 - ✓ Supervisors' primary concerns should be as follows:
 - ✓ Relationship between all agency staff and the adolescent client and their family.
 - ✓ Professional credibility and capability of staff and organization.
 - ✓ Recovery and resiliency issues, concerns, approaches and how to support both the service level of recovery/resiliency and the individual or family recovery processes.
 - ✓ Cultural bias and/or unfair treatment as well as cultural competency.
 - ✓ Staff performance evaluations.
 - ✓ Professional and clinical liability matters.
 - ✓ Impairment of staff due to physical or mental illness, substance abuse, negative attitudes, or other condition that affects interaction with clients and families or other agency staff.
 5. Conduct documented training and certification in relevant or required evidence-based programs used by the agency for all appropriate staff and verify that accurate records are maintained in training logs and personnel files.
 6. Oversight and maintenance of fidelity to evidence-based practices and programs.
 7. Specific supervision related to mental/emotional disorders and/or co-occurring substance related issues in all domains identified in screening and assessment practice.
 8. Specific training and supervision of all crises, critical incidents, or other staff or client safety concerns and all issues that may affect client, staff, or agency well-being and security.
 9. Initial and on-going staff training to support and maintain the adolescent client and their families' recovery outcomes for both staff and self.
 10. Maintenance of confidentiality of all the adolescent client and family interactions and PHI, per HIPAA and CFR Part 2 regulations.
 11. All assessment and service planning documents are reviewed, dated and signed by a licensed independent clinician, or by a clinician receiving supervision by a licensed independent clinician.
 12. Quarterly reviews of their supervisees' client charts.

13. Streamlining and clarifying required paperwork and documentation to reduce time burden on staff and maintain accurate and precise clinical and administrative records.
14. Oversight of assigned and/or required team meetings specific to practice standard application and implementation.
15. Accountability to Quality Management oversight for tracking client outcomes as specified in the Quality Management Policy and Procedure.
16. Responsibility to provide supervision as described in Policy and Procedure for the following specific programs: <LIST PROGRAMS>
17. Supervisors shall meet the following three competencies:
 - a. Clinical supervisor is a NM licensed independent practitioner with one year demonstrated supervisory experience.
 - b. The Supervisor holds the educational degree appropriate to statute and New Mexico Service Definitions and Regulations and both State and Federal requirements.
 - c. All clinical staff receives regular and ongoing clinical supervision from the Clinical Supervisor. These sessions are arranged on a one-to-one basis between the Clinical Director and the individual supervisor on a monthly schedule; (An assigned Clinical Supervisor shall be available 24/7 for clinicians as needed and/or required for crisis and emergencies management.

III. Procedures

Supervision of clinical staff:

1. Each client's goals, progress and referrals must be discussed a minimum of every other week.
2. Clinical and administrative supervision are clearly delineated and structured as separate functions.
3. This formalized process is documented and available for quality management review. <INSERT PROVIDER NAME> also has a routine, formalized protocol that consistently reviews and focuses on co-occurring substance and mental health disorders (COD).
4. The supervisor shall monitor, assess and document fidelity to evidence-based practices and programs using appropriate fidelity tools, as appropriate and available to specific practice.
5. Clinical supervisors must be trained regarding how to manage and maintain service teams and shall be responsible to lead all service teams for any person, to include those diagnosed with COD as dictated by program requirements.
6. All assessment and service planning documents are reviewed, dated and signed by a licensed independent clinician, or by a clinician receiving supervision by a licensed independent clinician.
7. Supervision will focus on the client and/or family related to treatment issues as specified in the treatment plan, or as identified by the treating clinician as appropriate.

8. All clinical supervision/consultation is documented and documentation includes the content, date and length of time of supervision. Signatures will be captured as mandated by NM State Regulation or Statute, or as required by other certifying bodies
9. Supervision may be direct, or may occur through an assigned licensed clinician who is directly supervised by the <INSERT PROVIDER NAME> Clinical Supervisor.
10. Critical incidents, crises and emergencies (see Service Planning):
 - a. The Clinical Supervisor shall be informed of all occurrences and shall maintain direct supervision and oversight whenever time and circumstances permit.
 - b. Staff must always act to maintain the safety and wellbeing of themselves, their clients and families, other staff and the public as a primary responsibility.
 - c. All critical incidents, crises and emergencies shall be meticulously documented in compliance with NM laws and regulations, <INSERT PROVIDER NAME> P&P and shall be debriefed as appropriate by the Clinical Supervisor.
 - d. The Chief Executive Officer, <INSERT PROVIDER NAME> management level staff and other staff will be informed as appropriate and necessary.
 - e. The CEO, Clinical Supervisor, parents and guardians, law enforcement, JPO, CYFD and/or all other parties with jurisdiction shall be notified as appropriate to rules, regulations and all other guidelines to maintain health and safety of the persons involved in the incident and to maintain legal accord.
11. Clinical supervision documentation is included in the personnel record and in the Supervisor's supervision log.
12. Non-Independently Licensed clinicians/therapists are required, as part of licensure, to provide documentation of supervision on a yearly basis. Supervision to this junior clinical staff will be provided by a Licensed Independent Practitioner.
 - a. Supervision of non-credentialed, non-independently licensed State of New Mexico clinicians (statutory license awarded by the State of New Mexico), Mental Health Services Act (MHSA) clinicians, or other temporary or interim licensees will follow these guidelines:
 - 1) Supervising clinicians, who are independently licensed and in good standing in the State of New Mexico and with the OptumHealth New Mexico (OHNM) Network, will provide supervision to non-credentialed, non-independently licensed clinicians.
 - 2) The supervising clinician must have weekly one-on-one supervision with the non-credentialed clinician to review treatment provided to clients and their families on an ongoing basis. Supervision must be documented in a manner that permits auditors (State and OHNM) access to supervision records and documentation electronically, manually or via direct audit of the client's chart.

- 3) A supervision log of dates, times, persons attending and general issues addressed shall be maintained by the Clinical Supervisor and the supervisee; signatures will be captured at appropriate intervals.
 - 4) Supervising clinicians will review and co-sign treatment plans generated by non-credentialed, non-independently licensed clinicians.
 - 5) Non-credentialed, non-independently licensed clinicians will be introduced and trained to school officials and policies. There will be monthly random observations performed on their therapy sessions for training and appropriateness of care.
13. All Supervision Policies and Procedures shall be reviewed and may be updated at appropriate intervals through <INSERT PROVIDER NAME>'s quarterly quality review processes by the Quality Management Team, or more often to meet changes in <INSERT PROVIDER NAME> Mission, service capability or capacity and/or Federal or State directives that may affect application and implementation of clinical supervision.



Policy and Procedure: Part IV: Personnel, Team and Systems Competencies

15. Service Teams/Multi-Disciplinary Teams

Policy Number: IV.15

I. Purpose

Integrated service teams are a cornerstone of competent behavioral health service implementation. The team meeting follows a specific form with one of its primary goals being the development of new strategies to assist the client (and family, as appropriate) to move toward goal attainment from a multidisciplinary approach. Goals of treatment are more effectively met when other domains of functioning in which clients are typically impaired are also addressed. <INSERT PROVIDER NAME> coordinates all elements of treatment and rehabilitation to ensure that everyone is working toward the same goals in a collaborative manner.

II. Policy

All clients identified for care receive care from a team.

1. The integrated service team schedules and conducts team meetings regularly or as needed, but not less than once a week.
2. Structured lines of communication are present with team members, the client (and family) and other service providers.
3. The service team monitors stages of change for each disorder and responds to each disorder with the appropriate stage-wise intervention.
4. The service team monitors the care provided to persons with COD specifically to guide services that are provided within the various elements of treatment including: IOP, outpatient, PSR, BMS, CCSS, inpatient treatment, etc., as appropriate.

5. The expertise and skills of staff, clinicians, prescribers, supervisory staff and other members of the team represents both substance abuse and mental health disorders and specifically addresses COD as needed.
6. Documentation of service team meetings and roster, cases reviewed and decisions adopted by the team are recorded in logs or in the service plan, as appropriate.
7. Staff, regardless of position, provides information about the adolescent client and their family, which needs to be received as both valuable and pertinent to the client's recovery process.

Specific practices that enhance information sharing include:

1. Formal case presentation format.
2. Regular scheduled team meetings.
3. Structured lines of communication with all members and service providers with one another and with the adolescent client and family.
4. Team leader monitoring team interaction and maintaining recovery strength-based service approach.
5. Keeping clear records of cases reviewed and decisions adopted by the team.
6. Staff, regardless of position, provide information about the client, which needs to be received as both valuable and pertinent to the recovery process
7. Expertise and skills of clinicians represents both substance abuse and mental health disorders

III. Staff Responsible for Implementation

Administrative Management Staff and Clinical Director/Supervisor

IV. Procedure

1. The primary individual who will guide the recovery effort will be the individual (and family member as appropriate to age and functioning) served by the team.
2. The second person guiding the recovery effort of the individual is likely to be the clinician assigned primary responsibility for the client.
3. The clinician's efforts are informed by the integrated service team considering what course of action must be followed, what goals to focus on in specific order, etc.
4. Whenever possible, all parties that have service interaction will meet regularly to discuss the client's needs, goals of service and how needs and goals are being met, along with the specific administrative goal of maintaining the most highly integrated services possible. The integrated service team will schedule and conduct team meetings regularly or as needed.
5. Staff provides information about the client, which will contribute to the recovery process.
6. The service team shall monitor stages of change for each disorder and respond to each disorder with the appropriate stage-wise intervention. All interactions of the clinician and team with the client or family are guided by recovery principles and a strengths-based approach.
7. The service team acts to ensure that services are integrated as far as possible. This means that <INSERT PROVIDER NAME> shall employ appropriate resources to ensure that all co-occurring disorder-functional impairments, or co-morbid disorders, are addressed in an integrated and comprehensive manner.

8. Supervisory staff shall maintain positive working relationships within the team environment, so that contributions from all members are utilized to develop the integrated practice being described.
9. Decisions as to participation in the integrated service team shall be determined by senior staff.
 - ✓ The expertise and skills of CCSS staff, clinicians, prescribers, supervisory staff and other members of the team represents substance abuse and mental health disorders, as well as COD as needed.
 - ✓ If CCSS is referred, as far as possible, <INSERT PROVIDER NAME> will seek input regarding the client being served within their program with careful observance of all Protected Health Information (PHI) related law and regulation.
10. The integrated service team ensures that comprehensive and integrated care is provided to the client as possible and appropriate, specifically addressing the issues identified by the service plan.
 - ✓ Documentation of service team meetings and roster, cases reviewed and decisions adopted by the team are recorded in logs or in the service plan, as appropriate.



Policy and Procedure: Part IV: Personnel, Team and Systems Competencies

16. Quality Management

Policy Number: IV.16

I. Purpose

Provides systematic monitoring, assessment and evaluation of the various aspects of the <INSERT PROVIDER NAME> services, physical facility, changes in the healthcare system, attention to funding source directives, funding opportunities, cultural competency, recovery orientation, shifting needs for services based on accurate community needs assessments, outcomes, best practices, etc.

The following are key considerations in quality management (QM) processes and procedures:

- **Outcomes and evaluation:** In order to clearly determine practice efficacy and develop strategies that enhance services, it is imperative that agencies measure benchmarks and outcomes resulting from their services. Key client and family process and outcome measures relevant to services and implemented best practices should be tracked to inform provider goals and objectives and quality improvement to services. Key outcomes include: reduced use/abstinence, decreased mental health symptomatology, employment/school, criminal justice involvement, housing, social support/connectedness, access to services, increased engagement in primary care and hospitalization.
- **Organization Fluidity/adaptability:** In the context of QM, organization fluidity refers to the ability of the organization to utilize quality assurance (QA) principles and practices to steer the course of the agency towards the continuous quality improvement (CQI) of services while maintaining the most fluid and adaptable stance related to: change in the overall fiscal environment, community needs, the behavioral

healthcare system, the overall healthcare system. Such changes may include technological changes and advances, systemic changes within the agency, funding opportunities, emerging practices and rapid response to key staff turnover.

- **Best practices:** Techniques, methods, processes, activities, incentives, or rewards that are believed to be more effective at delivering a particular outcome than any other technique, method, process, etc. when applied to a particular condition or circumstance. The idea is that with proper processes, checks and testing, a desired outcome can be delivered with fewer problems and unforeseen complications. Best practices can also be defined as the most efficient and effective way of accomplishing a task, based on repeatable procedures that have proven themselves over time for large numbers of people. A given best practice is only applicable to particular condition or circumstance and may have to be modified or adapted for similar circumstances. In addition, a "best" practice can evolve to become better as improvements are discovered.

II. Policy

Governance of Quality Management Processes & Timelines:

16. <INSERT PROVIDER NAME> QA and CQI processes ensure that the review, evaluation, editing, changes or adaptations of all policies and procedures, Standard Operating Procedures, etc., occur on an annual or as needed basis to ensure that they are current with all other applicable change and modifications to the organization business stance, funding changes, service implementation changes, staff changes, etc.
17. Professional and clinical supervision processes are reviewed and evaluated to ensure that all required supervisory practices are adequately accomplished and implemented.
18. The QA officer and committee review records and record keeping processes to assess that satisfactory records and documentation are maintained and protected adequately both electronically and physically.
19. QA evaluates and confirms or denies that staff are monitored and that competencies are maintained.
20. Assessment of organization issues occurs semi-annually to assure organization success.
21. The QA committee interviews the supervisor and reviews and evaluates team meeting logs to provide oversight and feedback to the organization.
22. The QA committee assesses that interpersonal relationships among staff are of high quality.
23. The QA officer or committee evaluates fidelity to implemented research or evidence-based practices through review of internal and external fidelity assessments.
24. The QA officer or committee monitors and documents alignment with all applicable law, regulations, etc.
25. The QA officer or committee provides review and oversight of supervisory monitoring, assessment and documentation of fidelity to evidence-based practices and programs using appropriate fidelity tools, as appropriate and available to specific practice.
26. The QA officer or committee provides review and oversight of fiscal compliance with funding source and state entity regulations and reporting responsibilities.
27. The QA officer or committee monitors engagement rate and evaluates best practices for increasing or sustaining high engagement to initial service rates. Report findings to agency administration.

28. The QA officer or committee monitors, evaluates and reports on retention to service, service duration, drop-outs and no-shows and discharge data.
29. The QA officer or committee monitors, evaluates and assesses outcome measures identified by the adolescent client and their family, the provider or by the purchaser of services
30. The QA officer or committee monitors, assesses and evaluates all training efforts to assure alignment with all applicable quality controls and to the mission and values of the organization..
31. The QA officer or committee shall assess, evaluate, report and develop CQI work plans to address needed changes or sustain current quality management processes and protocols for fit to agency/program need and effectiveness.
32. The QA officer or committee shall assess, evaluate, report and develop CQI work plans to address needed changes or sustain quality management related to controls and standards.

III. Staff Responsible for Implementation

Purview of Quality Management Responsibility & Team (QMT) Members

The QA officer or committee

IV. Procedure

1. The QM steering committee shall meet SPECIFY TIME HERE and specifically addresses COD-competent service delivery issues critical in developing and sustaining all behavioral health practices.
2. The QA officer or committee shall verify through regular chart reviews that service plans address, with separate goals and objectives, all assessed functional impairment, substance abuse, mental health and COD issues and how interventions are appropriately integrated.
3. The QA officer or committee shall make recommendations to steering committee for improvement to services for individuals with COD.
4. Historical documentation of the QMT Meetings (AKA QA/QM/QI Team) shall be maintained in the <INSERT PROVIDER NAME> and <LOCATIONS>.
5. The QA officer or committee shall evaluate all agency processes during its quarterly meetings. All processes are then updated through CQI work plans and communicated back to all members to share and disperse the new policy, procedure, or other changes to appropriate persons.
6. The CQI work plan shall be used for the purpose of reviewing policy, systems and process changes for effective adoption and implementation. At the next QMT meeting full approval or changes to the CQI will be reviewed and formally adopted into Policy and Procedure as appropriate.
7. The QA officer or committee shall evaluate all agency processes during its quarterly meetings. All processes will be updated through CQI work plans and communicated back to all members to share and disperse the new policy, procedure, or other changes to appropriate persons.
8. The CQI work plan shall be used for the purpose of reviewing policy, systems and process changes for effective adoption and implementation. At the next QMT

meeting full approval or changes to the CQI will be reviewed and formally adopted into Policy and Procedure as appropriate.

9. The QA officer or committee shall monitor that key adolescent client and family process and outcome measures relevant to the program model are tracked, inform provider goals and objectives and quality improvement to services. Key outcomes include: <LIST ALL HERE> reduced use/abstinence, decreased mental health symptomatology, employment/school, criminal justice involvement, housing, social support/connectedness, access to services, increased engagement in primary care and hospitalization.



Policy and Procedure: Part IV: Personnel, Team and Systems Competencies

17. Electronic Systems Competencies

Policy Number: IV.17

I. Purpose

The effective and efficient administration of the electronic data-management systems of <INSERT PROVIDER NAME>.

II. Policy

1. <THE EHR PROVIDER> is a secure, high-level email-based database, communication, tracking and reporting system implemented at <INSERT PROVIDER NAME>. The database meets all standards set forth by HITECH, HIPAA, CFR 42, etc. requirements for security. In addition, ONC EHR Certification has been applied for.
2. <THE EHR PROVIDER> server is a dedicated electronic record storage system used for both active administrative and clinical files storage and active access. The server is kept in a physically secure, HIPAA compliant environment.

III. Staff Responsible for Implementation

<THE EHR PROVIDER> is overseen by?

IV. Procedures

- a. <THE EHR PROVIDER> will be monitored and maintained by <ASSIGNED STAFF>
- b. <THE EHR PROVIDER> server will be monitored and maintained by?



Policy and Procedure: Part IV: Personnel, Team and Systems Competencies

18. Co-Occurring Disorders

Policy Number: IV.18

I. Purpose

The purpose of the Co-Occurring Disorders Policy and Procedure is to state the provider's commitment to treating individuals with co-occurring disorders.

II. Policy

1. The provider will provide a welcoming, empathic, integrated, continuous, comprehensive, appropriate "best practices" approach to the treatment of individuals with co-occurring disorders.
2. As used in this policy, the term *co-occurring disorders* (COD), will refer to co-occurring substance-related and mental disorders. Persons said to have COD have one or more substance related disorders as well as one or more mental disorders.
3. Interrelated medical, cognitive and/or developmental disorders and conditions shall be defined as co-morbid disorders.
4. No person shall be discharged from services due to determination of a co-occurring mental, emotional, or substance use disorder. Referrals with appropriate follow-up to assure care may be made due to capacity of capability issues, but *never* due to presence of one or more co-occurring disorders.
5. No person shall be refused admission into treatment due to a co-occurring disorder, although referrals with appropriate follow-up to assure care may be made due to capacity of capability issues.

III. Staff Responsible:

Director, quality management officers, intake coordinator, licensed clinicians, program manager, Clinical Director/Supervisor, site director, behavioral health director, licensed clinicians

IV. Procedure

A. Welcoming

1. Program descriptions, orientation materials, education materials, program policies and procedures shall be written with the expectation that individuals with co-occurring disorders will be welcomed and routinely accepted for treatment.
2. Individuals with active co-occurring disorders shall be accepted for admission without barrier (e.g. exclusion based on **current* alcohol or drug use and/or intoxication, urine screen, psychiatric diagnosis, type of medication, etc.) provided level of care criteria are met.

*Detox needs must be assessed at admission and referral to appropriate care made if need is determined. In such cases the health and safety of the potential client shall be a priority.

B. Treating / Coordination

1. Service/Treatment plans shall identify co-occurring disorders as a primary problem; and specific goals, objectives and interventions shall be identified for each primary co-occurring disorder. Service planning will develop a comprehensive set of staged, integrated program placements and treatment interventions for each disorder that is adjusted as needed to take into account issues related to the other disorder.

2. Each client has access to a primary integrated relationship with an individual clinician or treatment team (see Staff Competencies P&P) and other individuals involved in the overall treatment program as possible and appropriate, that integrates intervention for both disorders throughout the course of care in the program. If the individual attends IOP, or receives other services, the primary clinician will stay informed of conditions, progress and other aspects of services that may impact the client.
3. Clients receive specific education regarding participation in treatment for the co-occurring disorder. The team members shall identify both the target of the interventions (e.g., specific symptoms, social problems, substance abuse behaviors, etc.) and the interventions identified to address both the substance abuse and mental health issues and how the interventions will bring about positive change. One example of such integration is helping clients to cope with psychiatric symptoms that appear to contribute to their substance use. Another example is providing psycho-education to clients to help them understand how substance abuse worsens their psychiatric illness, along with referral to IOP, CCSS, BMS, or other services, as appropriate to the individual and available in the treatment setting, or as determined as needed by assessment or treatment planning. Services not available at <INSERT PROVIDER NAME> may be referred as appropriate and/or available in the community.
4. Continuous treatment relationship providers may participate in integrated treatment planning with providers of episodic interventions for either disorder (inpatient, detox, residential) as appropriate to provider capacity and availability of staff. Service plans for COD consumers shall address multiple domains of functioning, as informed by the assessment findings and specifically address functional impairment related to mental health, substance abuse, co-occurring and other co-morbid disorders. All issues identified through the assessment, interaction with the consumer, or by the consumer will be specifically addressed in an integrated service plan, as possible and appropriate to capacity, service capability and resources available to the provider at the time that services are delivered.
5. The <INSERT PROVIDER NAME> Service Team shall be comprised of assigned staff and is led by the Clinical Director/Supervisor as appropriate and in all cases for IOP team staffing is led by the Clinical Supervisor/Director. Team members maintain documented communication linkages with the consumer's primary mental health providers and other critical service linkages as identified in the assessment and treatment plan (e.g. HIV health care; criminal justice, courts, PO's, etc.). The teams serve individuals or families that have service needs identified in multiple domains, such as co-occurring substance and mental health disorders and specifically assure that services are coordinated and consistent across domains. The Clinical Director/Supervisor shall be responsible that staffing for all individuals meets requirements and addresses the needs identified by assessment and service planning on a case-by-case basis during regularly scheduled staffing meetings.
6. The <INSERT PROVIDER NAME> shall determine appropriate clinical or other care based on level of care criteria and assessment and service planning. No person shall be refused services based on substance use disorders, mental, behavioral, or emotional disorders, although staff must refer to needed services and conduct

appropriate follow-up to assure care based on <INSERT PROVIDER NAME> treatment capability and current capacity.

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Policy and Procedure: Part V: Treatment Implementation Practice Standards
19. Research and Evidence-based Treatment Approaches
Policy Number: V.19

I. Purpose

<INSERT PROVIDER NAME> shall, at the program level preferentially deliver treatment interventions that are based on solid scientific evidence. This comprises a commitment to Evidence-based Practices (EBPs, which is also used to indicate evidence-based programs and evidence-based treatments) in general, as distinguished from the provision of particular EBPs.

Definition of EBP

Evidenced-based behavioral health practice (here abbreviated EBP) is a multidisciplinary field that promotes optimal mental and physical health by maximizing bio-psychosocial functioning. Evidence-based behavioral practice entails making decisions about how to promote healthful behaviors by integrating the best available evidence with practitioner expertise and other resources and with the characteristics, state, needs, values and preferences of those who will be affected. This is done in a manner that is compatible with the environmental and organizational context. Evidence is comprised of research findings derived from the systematic collection of data through observation and experiment and the formulation of questions and testing of hypotheses.¹²²

II. Policy

1. Clinical staff are trained in the EBPs that are appropriate for the population served
2. Clinical staff will modify/adapt the EBP to accommodate language, community specific issues, cultural differences, etc, as necessary with fidelity to the EBP in mind. Such adaptations are specific to the EBP and are documented carefully and fully.
3. Clinical staff self-monitor fidelity to the EBP

¹²² <http://ebbp.org/ebbp.html>

4. Clinical staff are responsible to represent with accuracy and fidelity the conceptual treatment model and treatment philosophy embraced by their employing agency
5. <INSERT PROVIDER NAME> maintains a strong commitment to delivering evidence based practices
6. <INSERT PROVIDER NAME> maintains knowledge of organizational and community demographic data
7. <INSERT PROVIDER NAME> selects EBPs that are appropriate for the population and/or specific group to be served and appropriate to NM State Service Definitions and Service Regulations
8. Staff time is allotted for initial training or refresher trainings in EBPs
9. Organizational flexibility to adopt or amend policies and procedures that support fidelity to the EBP's and complementary practices is maintained and reviewed by the QM team
10. <INSERT PROVIDER NAME> provides supervisory oversight and clinical supervision of the use of EBPs specifically in support of effective implementation and fidelity to the practice/program
11. Quality Management Team regularly reviews EBP service match and fidelity to populations served and organization capacity

III. Staff Responsible for Implementation

Executive management, Clinical Supervisors, clinical staff

IV. Procedure

1. Specific EBP shall be implemented in <INSERT PROVIDER NAME> programs as appropriate to need and population. These practices are supervised for fidelity to practice.
2. A list of EBPs in use at <INSERT PROVIDER NAME> follows, but is not exhaustive:
 - Motivational Interviewing
 - Multi-Systemic Therapies
 - Cognitive Behavioral Therapies
 - The Seven Challenges
 - The Matrix Model
 - The Next Step
 - Trauma -informed Care
 - Neuro-sequential Model of Therapeutics



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20. Eleven Fundamentals of Substance Use Treatment

Policy Number: V.20

I. Purpose

Substance use disorders are complex, chronic health conditions that require an array of treatment options. The fundamental principles of recovery described as long-term and mostly cooperative efforts are similar to the long-term support needed for chronic illness.

For some such support is required as a life-long engagement. Substance disorder treatment is intended to serve youth who may be actively using substances. More intensive levels of care, from outpatient through intensive outpatient up to and including hospitalization and detox are intended to treat increasingly severe levels of substance use, such that IOP will engage youth with more severe use issues than those receiving outpatient treatment.

II. Policy

1. <INSERT PROVIDER NAME> shall adopt, train staff, supervise and adhere to the elements and principles of the evidence-based program or practice.
2. Individuals are not refused services due to substance use, but may be referred to appropriate services providers based on capability and capacity issues.
3. Youth are always met where they “are at,” and are not expected to be in an active state of recovery, or abstinence, in order to receive treatment.
4. All youth are assessed for co-occurring mental health disorders, as well as possible health related issues.
5. Parents and youth are included in all service planning such that the service plan is a collaborative agreement with treatment goals and objectives agreed upon by all parties. This means that treatment goals are youth and family driven and are not simply determined by the clinician.
6. Discharge planning and continuing care planning is mandatory from the first day of treatment, such that any youth that does not complete treatment for any reason has some link to potential resources in the community should they choose to access them.
7. Pharmacological treatment is welcomed and NEVER discouraged by <INSERT PROVIDER NAME> staff. No person receiving substance use disorder treatment shall be stigmatized, punished, discharged, discouraged, etc. for complying with prescribed medication use related to either substance or mental health disorders.

III. Staff Responsible for Implementation

All <INSERT PROVIDER NAME> staff

IV. Procedure

1. Staff are trained and adequately supervised to maintain fidelity and effective use of the adopted evidence-based practice.
2. Individual not meeting the agencies treatment competencies and capabilities, or because of capacity issues, are referred to appropriate services elsewhere. Follow up to assure engagement, as far as is possible, into services at the referral provider is made by staff.
3. Adolescent services employ best-practice models that assure that youth are not stigmatized by expectations of abstinence. In the case of court or Juvenile Justice referred youth that requires abstinence, the youth will be engaged appropriately to actually thoughtfully and carefully make decisions that will support recovery over time.
4. The agency and clinical staff actively engages youth and families into all treatment and support services planning.

5. The clinician immediately address the potential for discontinuous care and long-term care such that if the youth does not return to services that there is a resource for future engagement. Continuing care or discharge planning begins in the first session.
6. All <INSERT PROVIDER NAME> staff support appropriate use of medications.

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21. EBP Adaptations for Particular Populations Served

Policy Number: V.21

I. Purpose

Programmatic adaptations describes systemic adaptations to work with whole populations, or distinct issues and is not a specific change to the evidence-based curriculum that takes place on a case-by-case basis, or as needed by differing needs within the treatment setting.

Systemic adaptations describes the systems-level adaptations required to address specific needs of discrete populations, which may include exclusive populations of individuals. These populations may include subsets of co-occurring substance and mentally/emotionally disordered persons based on race, ethnicity, spiritual values, sex, gender identity, developmental disability, sexual orientation, religion, age, adolescent in transition to adulthood, geographic location (e.g., rural vs. urban), military personnel, veterans, or other populations identified by <INSERT PROVIDER NAME> in need of discreet services.

II. Policy

1. As far as possible, systemic adaptations to the EBP must be standardized and integrated into the clinical practice model at the systems level as appropriate (with fidelity to the EBP clearly maintained), to ensure that all associated staff can implement the adapted model in a uniform manner.
2. The administrative structure has the flexibility to make adaptations to EBP to include consultation with representative community members of the population to be served to gain insight into adaptation needs/requirements.
3. Executive Management support to make appropriate adaptations within <INSERT PROVIDER NAME> treatment system model.
4. The clinical Supervisor guidance to clinical staff to assure that systemic adaptations are understood and implemented while monitoring and maintaining fidelity to the EBP.
5. The Quality Management Team assures ongoing evaluation to ensure that adaptation results in improved client outcomes.

III. Staff Responsible for Implementation

All <INSERT PROVIDER NAME> staff

IV. Procedure

1. Clinicians respond fluidly and flexibly within the clinical setting while still maintaining fidelity as appropriate to issues regarding co-occurring disorders and the cultural context (translation, functional issues, traditional healing practices or

considerations/inclusions, religious or spiritual considerations) specific to the client and family need.

2. Systemic adaptations are recorded and used as new guidelines for implementation within the specific adaptation for the population served by that adaptation.



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22. Youth Support Services

Policy Number: V.23

I. Purpose

The purpose of youth support services is to promote wellness for all New Mexico children and to help NM youth steer a course towards a healthy adulthood, free of substance disorders or unrecognized untreated mental health disorders. Support services are experiential or social as opposed to cognitive. Support to achieve wellness can also be a community effort. Support services also assist healthy youth development.

II. Policy

1. **For service provision, the following three categories may receive support services:**
 - ✓ Youth supports for youth that do not need treatment but have need of support services based on a perceived lack of natural supports
 - ✓ Support services are provided concurrent to behavioral health treatment
 - ✓ Aftercare services/relapse prevention and reintegration for youth who have graduated from behavioral health treatment
2. All youth who are eligible for Youth Support Services shall be administered the Casey Life Skills assessment and a service plan shall be developed based on findings.
3. Transportation support is provided as described in the Transportation Service Description.

III. Staff Responsible for Implementation

Clinical Supervisor and clinical staff.

IV. Procedure

1. The support services coordinator shall strive to enable the individual, as appropriate to need and capacity, to access or acquire skills at evaluating the future consequences of their present actions and the actions of others through the use of the Casey Life Skills curriculum.
2. Development of interpersonal communication skills and life skills enables the client to be accepted as a functional member of the community in which they live. Staff shall strive for the development or access to such skills with the intent this will likely result in the individual's greater acceptance of social norms that provide the foundation for functional social behavior.

3. Life skills shall be taught to facilitate a decrease in alcohol misuse, drug abuse, smoking, delinquency, violence, suicide and to improve pro-social behaviors related to functional abilities and self-efficacy.
4. <INSERT PROVIDER NAME> staff shall actively include decision making/problem solving skills and information gathering skills within services as appropriate to individual need.
5. <INSERT PROVIDER NAME> staff shall use training, feedback, or other methods of skills building to include verbal and non-verbal communication, active listening and the ability to express feelings and give feedback.
6. <INSERT PROVIDER NAME> staff shall strive to impart coping and self-management skills to increase the internal locus of control, so that the individual believes that they can make a difference in the world and affect change, personally and globally.
7. Transportation support is provided based on assessed need of the youth an/or his or her family or transporter.



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23. Pharmacotherapy and Medication Management

Policy Number: V.24

I. Purpose

Access to Pharmacotherapy is an essential component of integrated treatment services. Pharmacotherapy and medication management includes the use of appropriate medications to manage substance, mental health or co-occurring disorders and use of a recovery-based approach including shared decision making, informed consent and an active role on multi-disciplinary teams.

II. Policy

1. Prescribe *psychiatric medications* despite active substance use as appropriate, with particular care regarding substance related conditions, cravings and effects of medications on substance use issues.
2. Prescribe *medications to support substance use recovery* and to manage urges and cravings.
3. Provide education and educational materials to consumers and families about medication's advantages and side effects.
4. Assure access to appropriate prescriber that understands adolescent development.
5. Utilize prescriber with COD training and/or prior COD experience.
6. Incorporate ethno-pharmacology as appropriate, which takes into account the study of the effect of ethnicity on responses to prescribed medication, especially drug absorption, metabolism, distribution and excretion (recommended, but not a required component).

III. Staff Responsible for Implementation

All <INSERT PROVIDER NAME> staff

IV. Procedure

1. Work closely with clinicians or multi-disciplinary team and consumer and maintain open communication regarding effects and/or side effects.
2. The prescriber maintains active participation on staff team multi-disciplinary clinical team (MDT). If this is not possible, some sort of reporting process is established to provide feedback to the prescriber.
3. Allocate time to prescriber, clinician and team for collaboration regarding pharmacotherapy for individuals and for education regarding overall issue of psychiatric and substance medication.



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24. Encouraging and Monitoring Abstinence

Policy Number: 22

I. Purpose

<INSERT PROVIDER NAME> utilizes monitoring methods as part of evidence-based program (currently, The Matrix Model and MST) implementation to recognize progress that a client makes towards substance related recovery and maintaining abstinence.

II. Policy

1. Recovery towards abstinence is actively supported and encouraged in the treatment setting with the recognition of the interrelated and reinforcing correlation of co-occurring disorders with one another.
2. The treatment team addresses all treatment and rehabilitative issues with the intent to reduce symptoms and improve function.
3. <INSERT PROVIDER NAME> policy is established for off-site/on-site testing <CHOOSE ONE IF APPLICABLE>
4. Testing can include:
 - a. Urine drug screens
 - b. Breathalyzer tests
 - c. Laboratory testing
 - d. Mouth swabs, etc., as appropriate
5. <INSERT PROVIDER NAME> policy supports immediate use of results in treatment intervention

6. <INSERT PROVIDER NAME> Quality Management Team processes ensure that abstinence protocols are regularly researched for most current effective use and appropriateness for in-house or referred testing

III. Staff Responsible for Implementation

Clinical Supervisor and Clinical Staff

IV. Procedure

1. Relapse and reduced use are part of the recovery process and the cyclical nature of addiction, relapse and recovery are recognized and thoughtfully addressed by <INSERT PROVIDER NAME> clinicians and treatment teams.
2. Treatment interventions are informed by recovery oriented principles including harm reduction as a significant step on the road to recovery
3. Clients diagnosed with either substance or co-occurring disorders will not be discharged or referred out by <INSERT PROVIDER NAME> for substance abuse relapses if case review determines that <INSERT PROVIDER NAME> has appropriate service capability to match the needs of the client
4. Staff are trained and supervised regarding encouraging and monitoring abstinence in a strengths-based recovery perspective in fidelity to the EBP being implemented
5. Monitoring abstinence may be mandated by an element of the NM Juvenile Justice System, courts, or other referring agencies and rules and protocols specified by such agencies will be adhered to as determined by contractual agreements; however, <INSERT PROVIDER NAME> will approach a failed drug or alcohol screen as an opportunity for applying recovery principles



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25. Multifamily Group Engagement Practices

Policy Number: V.23

I. Purpose

The therapeutic involvement of families throughout the recovery process is associated with improved treatment outcomes. Planning for family-based services involves defining the client's family in broad and flexible terms, setting essential goals and determining the desired outcomes.

II. Policy

1. <INSERT PROVIDER NAME> Policies and Procedures that reflect support of the provision of family interventions are reviewed regularly
2. <INSERT PROVIDER NAME> provides a welcoming environment to families of clients being served
3. Families are actively engaged by staff
4. If deemed appropriate, or as required by the age of client, the family will be included during intake and service planning

5. Provisions for childcare are not a formal function of <INSERT PROVIDER NAME>, but arrangements may be made as necessary and/or possible
6. <INSERT PROVIDER NAME> shall maintain a list of positive social and recreational resources appropriate for families for recreational referral

III. Staff Responsible for Implementation

Executive Management, Clinical Supervisor, Clinical staff and staff as assigned

IV. Procedure

Essential components included in the provision of family services consists of:

1. <INSERT PROVIDER NAME> staff will employ family engagement strategies, including alliance building, skills development and problem solving. Clinical staff will determine and emphasize the family strengths and supports to enhance them and will aid family members to recognize the barriers to change and help the family to work through these.
2. The clinical staff will attempt to determine roles, family and cultural values and norms of behavior within the family unit and develop the alliance that includes the clinician, the client and the family members, as appropriate within the treatment setting.
3. <INSERT PROVIDER NAME> clinical staff will endeavor to engage families into committing to significant change and to become significant partners in furthering the therapeutic progression of the client family member.
4. All <INSERT PROVIDER NAME> staff interacting with clients and/or families endeavor to instill hope and focus towards recovery in both the client and their family.
5. <INSERT PROVIDER NAME> clinical staff provides family related skills education and coaching, so that family members and the client recognize their common goals of recovery.
6. <INSERT PROVIDER NAME> clinical staff provides coaching for basic communication skills and attempt to resolve family conflict through application of structured problem solving techniques, setting boundaries, removing triggers and managing behaviors.
7. <INSERT PROVIDER NAME> clinical staff provides family oriented psycho-education related to the client's disorder(s), as appropriate to need and presence of family members in the treatment setting.
8. <INSERT PROVIDER NAME> clinical staff provides solution-oriented input for distress related to the client's condition. This distress may be of two types; practical distress related to finances, time, obtaining services and supervision of a youthful client and distress related to emotional and psychological responses and reactions to the clients condition.
9. <INSERT PROVIDER NAME> clinical staff encourages family participation in recreational activities with the client. This can be framed as cooperative and therapeutic whole-family activity.
10. <INSERT PROVIDER NAME> clinical staff provides referrals to individual family therapy, as appropriate.

11. <INSERT PROVIDER NAME> shall provide or post a referral list to crisis lines and other urgent services in case of crisis, relapse, or difficult behavior.



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26. Service Integration

Policy Number: V.24

I. Purpose

<INSERT PROVIDER NAME> employs an integrated treatment model utilizing multiple avenues of treatment interaction and with flexibility of service intensity according to client need. Client need is indicated by bio-psychosocial issues assessed and identified in service planning in collaboration with the client (and family, as appropriate). Integrated services serve to maximize <INSERT PROVIDER NAME> contribution to the client and the community when services provided assist the client to successfully address identified treatment needs.

The entire Policy & Procedure is a testament to integrated treatment, so this specific P&P is intended to wrap all the P&P into a cohesive whole, but it does not replicate what is already contained in other P&P.

II. Policy

1. <INSERT PROVIDER NAME> oversight processes assure that staff has the skill to identify level of care needs in collaboration with the client and/or families.
2. <INSERT PROVIDER NAME> oversight processes assure that staff have knowledge of existing service options for all clients across the continuum of care
3. <INSERT PROVIDER NAME> Policies and Procedures specify what services are available on the organizations' continuum of care and P&P are reviewed regularly (see the QMT P&P).
4. Additional services not provided at <INSERT PROVIDER NAME> will be referred out on a case-by-case basis as determined by need or client request.
5. <INSERT PROVIDER NAME> maintains discharge and referral processes so that individuals who require changes in service levels can move seamlessly between systems and/or services.
6. A quality review process shall be regularly conducted by supervisory staff to ensure that integrated services available are consistent with level of need and functional impairment of clients being served.
7. <INSERT PROVIDER NAME> clinical staff maintains the ability to provide integrated in-house mental and emotional, substance abuse, or co-occurring disorders services.
8. <INSERT PROVIDER NAME> staff conducts crisis and discharge planning from time of entry into services through discharge from the program for all clients and with particular attention for COD interactions and complexity.
9. <INSERT PROVIDER NAME> staff maintains collaborative relationships with all stakeholders to ensure the most effective services are delivered in partnership with the client, family and community.

III. Staff Responsible for Implementation

All <INSERT PROVIDER NAME> staff

IV. Procedure

Service integration will be uniformly applied to all eligible persons and will be faithful to the recovery and resiliency philosophy and cultural and gender competence as outlined in those P&P.

<INSERT PROVIDER NAME> shall strive to provide individualized, integrated and effective services based on the principles of:

1. Recognition of the need for concurrent approaches to both mental health and substance disorders where present and which are consistent with motivational and stage-wise intervention strategies. Concurrent approaches will identify the developmental stage and functional capability for change of the individual for each identified disorder. In the case of co-occurring disorders, clinical staff recognizes that individuals are not likely to be in the same stage of readiness to change for multiple disorders.
2. The client will be referred to outside services on a case-by-case basis as determined by need or client request.
3. Team integration and collaboration takes place across disciplines, agencies and locales, as needed by the persons providing services and with the client's permission within PHI regulations.
 - A quality review process conducted by supervisory staff shall ensure that integrated services are consistent with level of need as identified in assessment and service planning.
 - <INSERT PROVIDER NAME> service staff will strive to maintain contact with persons interacting with the client, including other in-house staff, staff of other agencies and providers, persons related to the client's medical, housing, education, employment, etc, as is appropriate to need, capacity and determination by the Clinical Supervisor.
4. <INSERT PROVIDER NAME> staff attempt to build a long-term service relationship with the client (and family as appropriate) that relies on the principles and practices of recovery and resiliency, cultural competency and alliance and rapport. All services are intended to engage the client to the highest level of developmental and functional capability possible for that person, in order to foster self-care, self-management and self-efficacy as appropriate to age and capability. Such interaction may entail multiple service approaches in multiple domains of functioning and may be characterized by slow pace and learning over extended periods of time as indicated by assessment and service planning and authorized by State or an agent of the State (MCO). The organization assures that staff has knowledge of existing service options for persons with co-occurring disorders across the continuum of care.
5. <INSERT PROVIDER NAME> recognizes that behavioral health treatment may require multiple integrated intervention strategies, may be life-long and is directed by the client (and family) for the client, requires a commitment to the long-term

principles of recovery and building self-efficacy, habilitation and rehabilitation and functional and developmentally appropriate skills, concepts and capabilities.

6. <INSERT PROVIDER NAME> staff have been trained and supervised to provide integrated services (see Staff Competencies and Supervision P&P)
7. <INSERT PROVIDER NAME> assures, as far as is practicable, through training and supervisory practices, that staff have the skill to identify functional, developmental and level of care needs in collaboration with the client and to provide integrated services.
8. Staff conducts crisis and discharge planning from time of entry into services through discharge from the program with particular emphasis for COD interactions and complexity, as they may exist at the time of most current services.

