

TREATMENT POLICY #14

SUBJECT: Adolescent Substance Use Treatment Services

ISSUED: June 1, 2018

EFFECTIVE: August 1, 2018

PURPOSE:

The purpose of this policy is to establish the philosophy and requirements for adolescent services (designated services and programs for youth ages 10 – 18). Ensure a full array of services for youth and supports for families and caregivers.

SCOPE:

This policy impacts the Prepaid Inpatient Health Plans (PIHP), their identified adolescent treatment programs and service provider network.

BACKGROUND:

The current system of care reflects poor penetration rates for the treatment of adolescents and transitional youth ages 16-21, with only approximately 8% of those with an identified need, receiving substance use disorder (SUD) treatment services. In addition, there is no mechanism for conducting effective outreach to this population, direction for collaboration with referral sources, or linking to resources from the Single State Authority.

The Office of Recovery Oriented Systems of Care (OROSC) was awarded a State Youth Treatment-Planning (SYT-P) grant for fiscal year (FY) 2016 – FY 2017. The purpose of the planning grant was to develop a structure to build an effective system that will increase access to and improve the quality of treatment and recovery support services for transitional aged youth ages 16-21, including those transitioning out of foster care, and their caregivers. An estimated 127,000 (14%) of youth 16-21 had a substance use disorder (SUD). Thirty-seven percent of those youth also had identified mental health (MH) concerns. In 2013, a total of 6,749 substance abuse treatment admissions for transitional youth aged 16-21 were reported by publicly funded SUD programs.

For FY18-FY22, OROSC was awarded a State Youth Treatment Implementation grant. This funding will support continuing the goals of the SYT-P grant including policy development, development of a support network, and youth peer curriculum. The purpose of the Michigan Youth Treatment Improvement and Enhancement (MYTIE) grant project is to: 1) Establish state infrastructure that will increase service access, treatment and recovery support service use, and quality for transitional youth aged 16-21; 2) Establish partnerships with key stakeholders for the purpose of developing policies, expanding workforce capacity, disseminating evidence-based practices, and implementing financial mechanisms; 3) Identify issues and barriers that affect access and treatment of SUD and co-occurring disorders; 4) Identify disparities that effect access to treatment; 5) Promote the development of statewide family and youth support organizations; 6) Develop a strategic plan to guide needed changes to the service delivery system.

DEFINITIONS

Adverse Childhood Experiences (ACEs): stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence

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of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

American Society of Addiction Medicine (ASAM): refers to the 6 dimensions used to evaluate an individual to establish most appropriate, least restrictive, level of care needed for treatment to alcohol or drug use disorder.

Case Management/Care Management/Care Coordination: a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes (per CMSA/org).

Co-Occurring Disorder: the existence of both a mental health and substance use disorder.

Developmentally Competent: capacity to identify where the difference is based on development is significant and to provide services that appropriately address developmental differences and enhance positive outcomes for the population.

Eligible Client: individuals aged 10-17 who have an identified substance use disorder.

Evidence Based Practices (EBP): treatment models that have been identified by national or state requirements as best practices based on evidence regarding best treatment options for client care and are approved by the Substance Abuse and Mental Health Services Administration (SAMHSA). They focus on continual learning, education, and development of best practice.

Medication Assisted Treatment (MAT): commonly uses one of three medications: methadone, buprenorphine (both deceive the body into thinking it is still getting the substance of use/abuse without getting the individual high or put into an altered state) and naltrexone (blocks the effect of opioids).

- Methadone: comes in pill, wafer, and liquid form. Taken daily and dispensed from a licensed treatment facility.
- Buprenorphine: comes in pill form. Taken daily or every other day from a treatment center or as prescribed by a specially licensed physician.
- Naltrexone: comes in pill form. Taken daily at first; can taper to once every three days. Taken at a treatment facility or as prescribed by a specially licensed physician.
- Naltrexone (brand names – Vivitrol and Revia): once monthly shot administered by a licensed physician. Used as treatment for opioid and alcohol dependence.

Outpatient Treatment (OP): treatment that is provided while an individual is living outside of a hospital or residential setting (i.e. in their home).

Intensive Outpatient Treatment (IOP): provides a higher level of intensity and structure than other outpatient treatment programs; still providing treatment while an individual is living outside of a hospital or residential setting (i.e. in their home).

Opioid Treatment Programs (OTPs): medications (*see MAT above*) and behavioral treatment modalities are blended to treat opioid use disorders.

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Office Based Opioid Treatment (OBOT): combines medically assisted recovery services (*see MAT above*) with other services such as outpatient, medical or other enhanced services.

Residential Treatment: a facility in which individuals live for short or long term that is staffed 24 hours a day by therapists or other treatment staff. Intensive treatment (i.e. groups, individual counseling) is administered, as well as medication, as needed.

Peer Recovery: a one-on-one relationship in which a peer leader with more recovery experience than the person served encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery.¹

Trauma: a deeply distressing or disturbing experience. The event or experience itself does not make a traumatic event; rather the internalization, and the way in which a person experiences an event or experience make an event traumatic.

Withdrawal Management: Provision of medical and psychological care of individuals who are reducing or eliminating substances from their system (i.e. opioids, alcohol).

VISION:

To promote a systematic transformation with Michigan's adolescent SUD services through identified best practice model(s) and intervention practices. This will be accomplished by having a strength-based coordinated system of care, a state-wide assessment to drive an appropriate level of treatment, evidenced based practice treatment modalities, fidelity monitoring of evidence-based practices and a continuum of care to guide treatment beginning at the earliest identified intervention point.

CORE VALUES:

- Continuation of Care
 - From the onset of care, termination and recovery supports are identified and worked on. Identified outcomes are understood and shared among all members of the treated family and treatment system and are signed off on the treatment plan. Legal, education, employment, child safety and other applicable mandates are considered in developing and setting up recovery support networks. Progress is monitored, and each team member participates in defining success. Selected outcomes are standardized, measurable and individually developed and tracked.
- Cultural and Gender Competence
 - Services, programs, and treatment modalities reflect and respect an understanding and support of issues specific to gender, age, ability level, race, ethnicity, sexual orientation, and lifestyle diversity. This includes continuing education of providers and creation and distribution of culturally appropriate information.
- Developmentally Appropriate Care
 - Services, programs, and treatment modalities reflect and respect the emotional, developmental, physical, physiological, and social uniqueness of this population.
- Evidence Based Treatment
 - Use of Evidence-Based Programs specifically designed, tested, and validated for adolescents aged 10-18 for the treatment of substance use disorders. Continued training regarding best practices of

¹ <https://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf>

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the field as programs are developed and proven effective. Evidence based practices will be monitored periodically for fidelity as well as a review of the clinicians delivering the model to confirm proper delivery of the model.

- Family Inclusive
 - Family inclusion in the treatment process is empowering, impactful and increases the likelihood of cooperation, ownership, and success. Families are viewed as full and meaningful partners in all aspects of the decision-making process affecting their lives, including decisions about treatment plans. They are viewed as resources to an individual's history and can provide a scope or lens separate from the individual. Autonomy and individualized, respectful treatment plans are developed to increase acceptance and adherence to the plan, as well as assistance with following up services within the continuum of care and potential relapse episodes through a statewide network of partner agencies. This continuation of support will be available for youth as they return to their community and family as needed.
- Harm Reduction and Safety
 - Best practices will be implemented for treatment of the individual to minimize negative consequences associated with drug use. These include but are not limited to: medically assisted treatment and sexually transmitted infection education and prevention.
 - Individual safety is a priority of treatment, including collaboration with (and notification of, if needed) child protective services, foster care services, domestic violence shelters or suicide prevention services. Consideration will be given to whether the identified threats to safety are still in effect, whether individuals are being kept safe by the least intrusive means possible and whether the safety services in place are effectively mitigating those threats. Safety planning is developed and maintained where applicable.
- Holistic Treatment
 - Inclusion of an individual's physical, mental, spiritual, and emotional health to develop and deliver the most appropriate treatment; treatment of the entire body and its systems to discover and treat all effected parts within the individual. Treatment will include family inclusion and support, where appropriate.
- Individualized Care
 - Individuals will be provided with an individualized treatment plan specific to their needs, history, culture, and individuality. Family will be included when it is in the best interest of the individual being treated. Treatment plans will be updated regularly to communicate effectively current treatment objectives and progress throughout treatment. Treatment staff will meet the client where they are; this means physically, emotionally, spiritually, and mentally and develop treatment goals to reflect these aspects of the individual. Client's skills will be developed throughout the treatment plan and continuum of care.
- Strength-Based
 - An individual's unique qualities and identified strengths are identified and used to support strategies to meet their needs. Strengths must also be found and developed in the family's environment through their informal and formal support networks as well as in attitudes, values, skills, abilities, preferences, and aspirations. Strengths are expected to emerge, be clarified and change over time as the family's initial needs are met and new needs and strengths emerge, with strategies discussed and implemented. Barriers to success are countered with strengths and skills the family currently possesses and can be transferred to other areas within the family system.

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- System of Care Philosophy
 - An individual is best prepared and equipped to work towards recovery when his/her community supports them. These systems include medical providers, juvenile justice, department of corrections, educational system, Department of Health and Human Services and mental health. When these systems of care commit to deliver services in a way in which their services are braided and blended to support and strengthen one another instead of burdening and weakening the individual. When an individual's recovery is seen as a lifetime of services instead of an episodic event, individuals, with the support of their systems, are better equipped to remain free from substances.

REQUIREMENTS AND PROCEDURE

The Michigan Department of Health and Human Services (MDHHS) is dedicated to the following fundamental principles as the foundation for integrating age-specific substance use disorder treatment services while focusing on effective and comprehensive treatment of adolescents.

Developing a Philosophy of working with Adolescents who have a Substance Use Disorder

Program Structure

1. Treatment revolves around the development of the adolescent brain; therefore, treatment services must be developmentally appropriate.
 - a. Age-responsive programs are not adult substance abuse programs that only accept or treat adolescents.
 - b. Due to the uniqueness of adolescent needs, educational opportunities must be offered for individuals still enrolled in school or who have aged out or left the traditional school atmosphere without obtaining their GED or diploma.
 - c. Recreation and hobby building as alternative coping skills must be included in treatment modalities.
 - d. Life skills (develop mind and ready client for future life stages), focusing on self-sufficiency and independent living skills must be considered and implemented where appropriate.
 - e. Equality does not mean sameness; in other words, equality of service delivery is not simply about allowing adolescents access to services traditionally reserved for adults. Equality must be defined in terms of providing opportunities that are relevant to each age, culture, identity, ethnicity, or other group. Treatment services may appear very different depending on to whom the service is being delivered.
 - f. The unique needs and issues of adolescents must be addressed in a safe, trusting, and supportive environment.
 - g. Treatment and services shall be built on adolescent's strengths, competencies and resiliency and promote independence, self-reliance, and growth.
 - h. Treatment and services must be supportive and inclusive of lesbian, gay, bisexual, and transgender (LGBT) issues and development of self.
2. An assessment and an evidence-based practice model will be implemented for the program.
 - a. Utilization of an assessment specifically designed for adolescents with substance use disorders.
 - b. Treatment plans will be formulated from the assessment, using the ASAM criteria for proper placement and designed from a holistic approach to treatment.

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- c. Service delivery models will utilize current EBP models for SUD treatment with a focus on continual learning, education and development of best practices that have been identified by national or state requirements as an approved EBP
- d. Focus on specific issues related to psychological, developmental, social, educational, and physical growth/development of adolescents, ensuring EBP are validated for this population. Recognition of the influence of social and peer groups must be included and regarded when administering treatment.
- e. Providers will assure clinical staff are properly trained or moving towards certification to deliver services through EBP models appropriate for population.

Education and Training of Staff

In addition to current credentialing standards, individuals working and providing direct service within an identified adolescent program must have completed a minimum of 12 semester hours (or the equivalent) or 64 workshop-based hours of age and content-specific substance use disorder training or 2,080 hours of supervised adolescent-specific SUD training/work experience within an identified adolescent program. Those not meeting the requirements must be supervised by another individual working within the program and be working towards meeting the requirements. Documentation is required to be kept in personnel files.

Appropriate topics for adolescent specific substance use disorder training include, but are not limited to:

- Adolescents and addiction
- Child/Human development
- Communication
- Family dynamics
- Grief and loss
- Group facilitation
- Juvenile justice
- Relational aggression
- Self-esteem/empowerment
- Trauma
- Mental Health/Co-occurring Disorders
- Education and Vocational
- Conflict Resolution, Problems Solving
- Adaptation, Competency and Resiliency
- Prevention
- Communicable Disease (HIV/AIDS/Hepatitis/STI)
- Medication Assisted Treatment
- Sexuality/LGBT
- Adverse Childhood Experiences
- Intergenerational Trauma
- Cultural competency
- Prosocial Behavior

Admissions

PIHPs and treatment providers must follow the priority population guidelines identified in the MDHHS/BHDDA contract with PIHPs, listed below, for admitting youth to treatment:

Population	Admission Requirement	Interim Service Requirement
Pregnant Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	Begin within 48 hours: Counseling and education on: HIV and TB; Risks of needle sharing; Risks of transmission to sexual partners and infants;

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Population	Admission Requirement	Interim Service Requirement
		effects of alcohol and drug use on the fetus. Referral for prenatal care. Early Intervention Clinical Services.
Pregnant with Substance Use Disorder	Screened and referred within 24 hours. Withdrawal Management, methadone or residential – offer admission within 24 business hours. Other Levels of Care – offer admission within 48 business hours.	Begin within 48 hours: Counseling and education on: HIV and TB; Risks of transmission to sexual partners and infants; effects of alcohol and drug use on the fetus. Referral for prenatal care. Early Intervention Clinical Services.
Injecting Drug User	Screened and referred within 24 hours. Offer admission within 14 days.	Begin within 48 hours – maximum waiting time 120 days: Counseling and education on: HIV and TB; Risks of needle sharing; Risks of transmission to sexual partners. Early Intervention Clinical Services
Parent at Risk of Losing Children	Screened and referred within 24 hours. Offer admission within 14 days.	Begin within 48 business hours: Early Intervention Clinical Services.
All other substances	Screened and referred within 7 calendar days. Capacity to offer admission within 14 days.	Not required

The admission standards listed above are minimum standards. PIHPs and programs interested in providing the best possible treatment to families and youth should be meeting a higher standard for admission and interim service provision.

Treatment

Programs that are designed to support and meet the unique dynamic needs of an adolescent drug or alcohol user tend to be more successful in retaining clients. For a provider to be able to offer age-specific treatment, its programs shall include the following criteria:

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1. Screening

Screening will identify if a client meets minimum eligibility requirements of the program (i.e. age, gender), need for medical services, withdrawal management or MAT services, and admission date. These can be reviewed over the phone when a client is seeking services.

2. Intake

Intake procedures will include, at a minimum, identification of the goals of the program, administering of a drug screen to create baseline data and evaluate for additional immediate services (i.e. medically assisted withdrawal management), signing of paperwork, an inventory of personal belongings and a tour of the program grounds.

3. Assessment

Assessment shall be a continuous process that evaluates the client's psychosocial needs and strengths within the family context and through which progress is measured in terms of increased stabilization/functionality of the individual/family.

4. Privacy Issues

- a. HIPAA laws (<https://www.hhs.gov/hipaa/for-professionals/index.html>)
- b. 42 CFR Part 2 (https://www.integration.samhsa.gov/operations-administration/the_confidentiality_of_alcohol_and_drug_abuse.pdf)
- c. Insurance carriers (i.e. what can be disclosed to a parent if the youth is still on their insurance) (<https://www.hhs.gov/hipaa/for-professionals/special-topics/mental-health/index.html>)

5. Accessibility

PIHPs and providers must demonstrate a process to reduce barriers to treatment by ensuring that priority population requirements are met, as well as providing ancillary services or ensuring that appropriate referrals to other community agencies are made.

- a. There are many barriers that critically inhibit attendance and follow-through for youth in treatment. They may include school conflicts, housing, transportation, hours of operation and mental health concerns.
- b. Access will be provided to families; where appropriate.

6. Psychological Development

Providers shall demonstrate an understanding of the specific stages of psychological development adolescents are in, the acute and long-term effects and complications related to adolescent drug and alcohol use and modify therapeutic techniques according to client needs, especially to promote autonomy. Only treatment models that have been evaluated on youth shall be utilized.

- a. Need for comprehensive evaluation and assessment with complete biopsychosocial history and ongoing treatment to treat the entire client.

7. Abuse/Violence/Trauma

Providers must develop a process to identify and address abuse/violence/trauma issues. This includes human trafficking, ACEs (and post-traumatic stress disorder identification and awareness. Services will be delivered in a trauma-informed setting and provide safety and security from family or other participants.

- a. A history of abuse, violence and trauma often contributes to the behavior of substance abusing and dependent youth. A provider who does not take this history into consideration when treating the client is not fully addressing the addiction or resulting behaviors.
- b. Knowledge of and training on the ACEs should be made available to all individuals working with youth who have been diagnosed with a SUD.

8. Family Orientation

Clinical treatment, when available through reasonable accommodations (including telemedicine) and not detrimental to the individual, shall include the client's family during all levels of treatment when appropriate.

- a. Family can include family of origin, individuals cohabitating with the client, individuals identified as a resiliency factor.

9. Mental Health Conditions

- a. Providers must focus on any co-occurring disorders and treat each as a separate disorder while being mindful of the interaction between the two. Use of EBP that are validated for both SUD and MH conditions are encouraged.

10. Physical Health Considerations and Conditions

- a. Agencies will abide by all rules and regulations set forth by the Americans with Disabilities Act (ADA) of 1990 to ensure a client's medical needs are considered and accommodated appropriately. Coordination of care with the individual's primary care provider must occur as well. Visual and hearing impairments will be accommodated by the agency as needed.

11. Legal

- a. Youth come into treatment with specialized legal issues and language. Individuals working with youth must be well versed on these issues and language differences. Connecting youth and services to appropriate specialty, family, or juvenile courts (as appropriate) are encouraged. These include, but are not limited to:
 - i. Age of consent to treatment without parental or guardianship knowledge.
 - ii. Human trafficking.
 - iii. Limited or no state identification.
 - iv. Emancipation: legal separation from a minor's guardians/parents thereby granting the youth autonomy prior to the state legal age of 18.
 - v. Status offenses: offenses and crimes that youth can be charged with, solely based on age (i.e. minor in possession, truancy, and runaway).
 - vi. Foster care youth aging out of the system:
 - vii. Crossover youth: Youth who experience maltreatment and engage in delinquency and who may or may not be known to the child welfare and/or juvenile justice systems.
 - viii. Dually-involved youth: Crossover youth who have some level of concurrent involvement (diversionary, formal, or a combination of both) with both the child welfare and juvenile justice systems.
 - ix. Dually-adjudicated youth (aka dual wards): Dually-involved youth who are formally involved (sustained dependency court allegation) and are adjudicated by the delinquency court.
 - x. Act 150 public ward: A youth accepted for care by MDHHS who is at least 12 years of age when committed by the juvenile division of the probate court or the family division of circuit court under section 18(1)(e) of chapter XIIA of 1939 PA 288, MCL 712A.18, if the court acquired jurisdiction over the youth under section 2(a) or (d) of chapter XIIA of 1939 PA 288, MCL 712A.2, and the act for which the youth is committed occurred before his or her seventeenth birthday or a youth accepted for care by MDHHS who is at least 14 years of age when committed by a court of general criminal jurisdiction under section 1 of chapter IX of the code of criminal procedure, 1927 PA 175, MCL 769.1, if the act for which the youth is committed occurred before his or her seventeenth birthday.

- xi. Expungement opportunities of adjudicated offenses.
- xii. Legal guardianship verses or as opposed to biological parent(s).

12. Sexuality/Intimacy/Exploitation

- a. Human trafficking (including sex and labor trafficking)
 - i. Warning signs
 - ii. Access to help
- b. Homelessness
- c. Communicable Diseases
 - i. HIV/AIDS/STI/Hepatitis
- d. Survival sex
- e. Abuse
 - a. Physical
 - b. Emotional
 - c. Power and control wheel
(<http://www.ncdsv.org/images/PowerControlwheelNOSHADING.pdf>)
- f. LGBT specific issues

13. Survival and Life Skills

Goals, treatment objectives and training will be given to adolescents to assist them in leading a healthy, productive life following discharge from the program. This includes the teaching and practice of life skills and “soft” skills (attributes that allow individuals to work and interact effectively with others). These include, but are not limited to:

- a. Financial health, budgeting, identity theft and online safety
- b. Home upkeep
 - i. Laundry, cooking, cleaning
- c. Personal hygiene and upkeep
- d. Social skills
- e. Workforce skills and attributes
 - i. How to apply for a job
 - ii. Interviewing techniques
 - iii. Workplace etiquette
 - iv. Professionalism
 - v. Communication skills
 - 1. Non-verbal cues and expression of language
 - vi. Teamwork
 - vii. Networking
- f. Cyber security, cyber footprint, and identity theft

14. Continuum of Care/Recovery Support

- a. Planning for recovery and community reentry begins at first contact with the provider.
- b. Collaboration between all levels of support to increase seamless transition and continuation of treatment goals and objectives throughout duration of substance use treatment.
 - i. Including appropriate releases of information between providers, caregivers, guardians, and youth, where appropriate.
- c. Connection to a recovery support network in his/her area.
- d. System of care collaboration which includes all four (4) levels of case management services that are used collaboratively to enhance the level of care and recovery of an individual.

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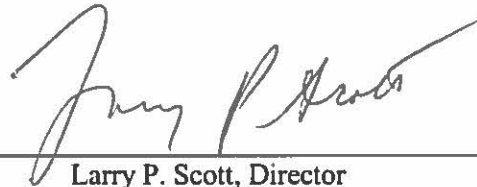
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