Supporting Youth to Thrive

A Manual To Guide Compassionate Supports For Youth And Families Experiencing Trauma, Substance Use Or Mental Health Issues

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**Supporting Youth to Thrive Manual**

**TABLE OF CONTENTS**

*page numbers are active one-way links*

<p>| Health and Wellness from the Western Treatment Perspective © | 6 |
| Person Centered Perspective on Health &amp; Wellness © | 7 |
| <strong>OVERVIEW</strong> | 8 |
| Introduction <em>(NEW)</em> | 9 |
| Statement of Approach <em>(NEW)</em> | 13 |
| Purpose of the Supporting Youth to Thrive Manual <em>(NEW)</em> | 15 |
| <strong>FUNDAMENTAL UNDERSTANDINGS</strong> | 16 |
| Executive Function <em>(Who's in Charge?)</em> | 18 |
| Trauma and Adverse Childhood Experiences (ACEs) | 23 |
| Mental, Emotional, &amp; Behavioral Disorders | 25 |
| What are Substance Use Disorders? | 28 |
| Co-occurring Disorders | 35 |
| Ten Principles of COD Implementation | 37 |
| Intensive Outpatient Programs | 38 |
| What is High Fidelity Wraparound? <em>(NEW)</em> | 40 |
| Role of Family | 43 |
| What is the Neuroscience of Thrill and Risk? | 47 |
| The Power of Challenge | 53 |
| <strong>SERVICES AND APPROACHES CRITICAL TO WELLNESS</strong> | 60 |
| Habilitation and Rehabilitation | 61 |
| Life Skills and Positive Youth Development | 62 |
| Youth Support Services <em>(NEW)</em> | 66 |
| Youth Leadership <em>(NEW)</em> | 68 |
| Theoretical and Philosophical Foundations of Therapeutic Adventure | 70 |
| Prevention Services for Substance and Mental/Emotional Problems | 77 |
| Pharmacotherapy Related to Opioid Treatment | 81 |
| Traditional, Indigenous, Curanderismo, &amp; Alternative Healing | 85 |
| Spiritual &amp; Religious Beliefs &amp; Practices | 88 |
| Exercise and Mental Health | 93 |
| <strong>INTERRELATED FACTORS, PRINCIPLES, VALUES AND EVALUATIVE MEASURES</strong> | 97 |
| Organization Competencies &amp; Communities of Care | 98 |
| Program Evaluation | 101 |
| Performance Measures | 102 |
| Systems Assessment | 103 |
| Discussion of Medical Marijuana | 106 |
| Ethics | 112 |
| <strong>EIGHT GOVERNING ELEMENTS THAT ORGANIZE EFFECTIVE SERVICES</strong> | 114 |</p>
<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement, Alliance, &amp; Rapport</td>
<td>115</td>
</tr>
<tr>
<td>Youth Voice and Engagement <em>(NEW)</em></td>
<td>117</td>
</tr>
<tr>
<td>Supporting Youth to Thrive - Reframing Recovery <em>(NEW)</em></td>
<td>119</td>
</tr>
<tr>
<td>Cultural Competency <em>(edited- NEW)</em></td>
<td>125</td>
</tr>
<tr>
<td>Understanding Sexual Orientation And Gender Identity <em>(edited- NEW)</em></td>
<td>128</td>
</tr>
<tr>
<td>Stage-Wise Interventions</td>
<td>133</td>
</tr>
<tr>
<td>Motivational Approaches</td>
<td>136</td>
</tr>
<tr>
<td>Trauma Informed Systems of Care &amp; Support</td>
<td>140</td>
</tr>
<tr>
<td>INITIAL PROCEDURES OF CARE &amp; PLANNING</td>
<td>145</td>
</tr>
<tr>
<td>Initiation &amp; Retention in Behavioral Health Services</td>
<td>146</td>
</tr>
<tr>
<td>Intake Process</td>
<td>147</td>
</tr>
<tr>
<td>Screening &amp; Assessment</td>
<td>149</td>
</tr>
<tr>
<td>Individualized, Comprehensive, Integrated Service Plan</td>
<td>154</td>
</tr>
<tr>
<td>PERSONNEL, TEAM, AND SYSTEM COMPETENCIES</td>
<td>159</td>
</tr>
<tr>
<td>Staff Competencies</td>
<td>160</td>
</tr>
<tr>
<td>Supervision</td>
<td>161</td>
</tr>
<tr>
<td>Service Team/Multi-Disciplinary Team</td>
<td>163</td>
</tr>
<tr>
<td>Quality Management</td>
<td>167</td>
</tr>
<tr>
<td>TREATMENT IMPLEMENTATION PRACTICE STANDARDS</td>
<td>175</td>
</tr>
<tr>
<td>Research &amp; Evidence-Based Treatment Approaches</td>
<td>176</td>
</tr>
<tr>
<td>Eleven Fundamentals of Substance Use Disorder Treatment</td>
<td>181</td>
</tr>
<tr>
<td>System Adaptations for Particular Populations</td>
<td>185</td>
</tr>
<tr>
<td>Pharmacotherapy &amp; Medication Management</td>
<td>187</td>
</tr>
<tr>
<td>Medication Assisted Treatment (MAT)</td>
<td>189</td>
</tr>
<tr>
<td>Encouraging &amp; Monitoring Abstinence</td>
<td>190</td>
</tr>
<tr>
<td>Multifamily Group Engagement Practices</td>
<td>191</td>
</tr>
<tr>
<td>Service Integration</td>
<td>193</td>
</tr>
<tr>
<td>AFTERWORD</td>
<td>197</td>
</tr>
<tr>
<td>CONTRIBUTING AUTHOR BIOS</td>
<td>198</td>
</tr>
<tr>
<td>RESEARCH BIBLIOGRAPHY</td>
<td>202</td>
</tr>
<tr>
<td>ONLINE RESOURCES</td>
<td>210</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>212</td>
</tr>
<tr>
<td>Appendix A: Stages of Adolescent Development</td>
<td>213</td>
</tr>
<tr>
<td>Appendix B: 41 Developmental Assets® for Adolescents</td>
<td>214</td>
</tr>
<tr>
<td>Appendix C: Policy and Procedure Manual <em>(edited)</em></td>
<td>215</td>
</tr>
</tbody>
</table>
Supporting Youth to Thrive Manual

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**Natalie Skogerboe**, author, editor, and format designer for this manual. Natalie provided deep insight about continuity, nuances of language and expression, and support and encouragement to bring the manual to completion, and did so with playfulness and wit.

**Jenn Jevertson**, author, editor, and format re-designer for this version of manual. Jenn’s keen eye for detail brought this version of the manual to life.
This 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.
This is a depiction of 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.
OVERVIEW

What you will find:

- **Introduction**  
  *Michael Morton*

- **Statement of Approach**  
  *Michael Morton & Michael Hock*  
  The manual describes an integrated support based philosophy to adolescent treatment, shifting the locus of control to the adolescent and their family/support system.

- **Purpose of the Manual**  
  *Michael Morton & Michael Hock*  
  The Supporting Youth to Thrive 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

The New Mexico CYFD Adolescent Substance Use Reduction Effort (ASURE) is founded in the vision that “New Mexico will lead the nation in reducing youth and family substance use and co-occurring mental health issues and disorders” which under any circumstances is a bold statement. However, our State has many challenges that must be addressed to accomplish such a vision. To achieve this, the ASURE is tasked with accurately assessing and effectively responding to New Mexico’s statewide youth substance use crisis. Given the current statistics the onslaught of substance use on our state cannot be overstated and our effort must outmatch the challenges we are facing. The ASURE is a conceptual framework described fully by this manual, which is the distillation of the concentrated work of many individuals that are contributing to addressing substance use issues and disorders and related co-occurring mental/emotional (COD) and familial issues in our State.

This Manual is Designed for New Mexico

The New Mexico Children, Youth and Families Department Supporting Youth to Thrive (SytT) is a manual to aid understanding, improving, and implementing both individual and systems level competencies in the services provided to youth persons experiencing COD inclusive of trauma. It is a roadmap that can guide New Mexico in competently and successfully helping youth to thrive through the application of supports and treatments that are founded in knowledge, skillful implementation and resourcefulness, while meeting youth and families wherever they are at with the compassionate expectation of change for the better.

Over the past several years, New Mexico has seen profound change within the behavioral healthcare system statewide. Much of this change has been driven by the increasing numbers of individuals and families impacted by behavioral health and/or substance use disorders, as well as the many related co-occurring issues that limit a person’s ability to live a fulfilling self-directed life. Add to this the on-going limitations in needed funding, the increased costs of service delivery, ongoing workforce attrition, the need for substance related capability training and supervision, and it becomes clear that this is a complex set of systems issues that our state must address now and over the next many years.

There have been changes made, including efforts at increasing the effectiveness of services while controlling costs associated with those services. Yet, even with the past efforts and initiatives that have been attempted, implementation and access problems still remain. In part, the SytT has been developed to improve how the State will address this for our youth.

Why Thrive?

Over the years, some measures of thriving have included (but are not limited to): academic success, caring for others, optimal development, integrated and whole person development, community engagement, as well as engagement of one’s unique talents, interests and/or aspirations.

No doubt these definitions and others have helped to further the conversation on thriving among professionals and scholars alike. Yet we are faced with a stark reality: Not one of these
aforementioned ‘vital signs’ for thriving are words or phrases that a youth would most likely use to describe what it is they wanted most for and their life in a positive frame of reference (i.e., “positively developing”).

Given this, the question becomes, “How do we engage our youth in need in a conversation about “thriving” in a way that allows them to voice what “thriving” means to them in their own words and phrases?”

To answer this, I would suggest that we practice “sensitive questioning and understanding” as an entry point for an authentic conversation, a genuine dialogue, with the youth we serve.

Communication Between Youth and Treatment and/or Support Workers

Historically there has been a pervasive disconnect between how treatment and support workers view and discuss SUD or COD related issues in youth and how the youth themselves view and communicate these issues.

For example, an ongoing National Institute of Mental Health study that conducted in-depth interviews with 369 youth considered at risk for depression found that youth described their mental health conditions differently than adults would:

"Teens rarely stated they were depressed, but described bursts of feeling stressed and sad that often came and went," according to Daniela DeFrino, one of the study’s researchers at the University of Illinois at Chicago College of Medicine and College of Nursing. “They used words such as “down” or “stressed”, the team found. The teens gave indirect clues to their state of mind, such as: "I always find somehow to go back to stressful mode", or, "I get really mad at people very easily. They don't understand why I'm upset. Sometimes I don’t either."

Rather than identifying with the word depressed, the youth reported feeling angry or irritable, a loss of interest in activities they used to enjoy, and either sleeping too much or having trouble sleeping. "Teens may be experiencing a lot of internal turmoil and difficult life stresses that we can easily overlook if we don't probe with sensitive questioning and understanding," DeFrino said.

The sensitive questioning and understanding DeFrino speaks of is key to not only clearly understanding what is going on with the youth we serve, but in also providing context and opportunity for a genuine, meaningful two-way conversation that allows for:

1. Recognizing how the youth perceive themselves and their emotions by understanding the words and phrases THEY use to express empathy and rapport with other youth.

2. Providing an opportunity to share with the youth what their words and phrases mean in the world of the behavioral health worker and the world at large, i.e., depression.

Perhaps by simply asking the youth we serve what they want “more of”, and want “less of” in their lives we can guide the development of a personalized, youth-driven vision of what they want most in and from life. With such a vision, our job as their allies and supporters is to assist them in developing pathways to living their own inner voice driven life vision. In this
way we begin to understand more clearly and genuinely appreciate what it is that our teens would envision for themselves with regard to their “unique talents, interest and/or aspirations”, in other words, “thriving”.

Such a process fosters an understanding of the research on what it means for a youth to thrive and the personal world and language of the youth we serve. This not only facilitates ways for us to more accurately gauge how our youth are “positively developing”, but more importantly assures that our benchmarks are meaningful and relevant to those youth we serve.

**Context is Everything**

The context of this manual has to do with systems change of services for substance using youth in New Mexico. However, services look different depending on what services you may be providing or receiving, and on your training, your engagement, and your understanding of what you’re trying to accomplish.

Exactly what are some of these strands? They include, but are not limited to: the culture, ethnicity, developmental stage of who we are serving, gender, attitudes and relationships, access to treatment, formal and informal community supports, workforce capabilities, provider readiness, poverty and trauma, regulatory issues, funding, personal purpose, education, as well as issues unique to each youth and family. Each of these strands are inextricably interwoven with each other, and in order to shift the system to provide better support, they all must be taken into account while looking at the overall picture of co-occurring and substance use treatment and support. The *SYtT* addresses all of these subjects to aid understanding of the extremely complex issues that youth and families must address every day, and the same issues that services provider must address every day.

This is particularly so when it comes to strategically supporting youth to thrive. In order for us to have an accurate, complete picture of just what the problem is, we must be able to identify all the relevant issues that are essential to our long term objectives. Many of the people providing services see themselves as singular and separate from a more inclusive effort. We must often operate independently of other resources due to either scarcity, time related boundaries, of lack of knowledge of other services that could support our work and the youth of family we are serving.
Is This Doable? Is This Realistic?

Systems change often requires years and decades to happen, but we have dedicated significant resources to improve our systems and provide the resources you need every day. To support this effort CYFD has published this manual.

So, please, take some of your valuable time to genuinely look through and study the SYtT. Then, allow yourself to take one further step. Find something in the SYtT that:

1. You are already doing and can do more of the same
2. You are not doing and you can begin to implement
3. You can share with another clinician or agency for them to consider reading about and implementing

If you just do these three actions, you will be acting as champions by supporting our youth to thrive and in furthering our shared vision:

“New Mexico will lead the nation in reducing youth and family substance use and co-occurring mental health issues and disorders”

Michael A. Morton, PhD is respected visionary and innovator with four decades of success in the non-profit, business and government sectors. Michael’s expertise includes board development, vision and strategic planning, program design and implementation, as well as innovative collaborative social change initiatives that have positively impacted on legislative, regulatory and funding policy priorities in education, public health, behavioral health, substance use reduction initiatives. He served as a special advisor to the president of United Way of America.
Statement of Approach

Bite Size Pieces
Given the broad scope of the SYtT coupled with the complexity of the problems it addresses, much time and thought was given regarding the best way to format and present the information. The manual has been presented in 3 distinct sections:

Part A. [Overview, Fundamental Understandings, Services and Approaches Critical to Wellness, and Interrelated Factors, Principles, Values, and Evaluative Measures] Clarifies some of the challenges facing New Mexico's youth, including mental and emotional development in the context of mental health and substance use issues. Provides relevant definitions and descriptions of key issues and points that aid in understanding why and how youth experience their world, as well as what are some of the issues that are relevant to working with this population.

Part B. [Eight governing Elements that Organize Effective Services, Initial Procedures of Care and Planning, Personnel, team, and System Competencies, and Treatment implementation Practice Standards] Provides a description of the specific tools and practices needed to provide effective services. They are presented in sequence from initial engagement through discharge.

Part C. [Appendices] Provides a sample policy and procedure manual that can be adopted by provider agencies and mirrors Part B. Each policy statement has been written to support specific, measurable procedure statements. In this way policies and procedures are clearly linked as the administrative and service components, thus forming a foundational matrix for the implementation of continuous quality improvement methodologies. A Microsoft Word version these policies are available upon request.

Cornerstone Values
There are four foundational value cornerstones that are the essential to the intent, vision, and spirit of the SYtT. They are:
1. Compassion and respect
2. Inclusive of the person's life situation, conditions, and circumstances
3. Integrated
4. Youth and Family Centric

It is the consistent application of these four value cornerstones in all aspects of the SYtT that make it such a unique and timely document. Also, it is these values that assure that the envisioned systemic changes and improved services outcomes not only occur, but take deep root. In this way, we assure sustainability of this important work. Our success in doing this communicates much needed respect and valuing to the youth and families we serve and fosters more robust and sustained treatment outcomes. In other words, committed implementation of these values will result in an on-going positive systemic change for addressing youth substance use and related issues in New Mexico.
Compassion and Respect
It is one thing to say that we should all be compassionate to one another simply because it is the right thing to do. Still, as a moral axiom in and of itself, it does not prove that compassion is necessary or useful for enhancing successful outcomes in substance use reduction, clinical care, or support services. So, why then, is compassion so important in the SYtT manual’s systemic service paradigm? Given the many diverse and rich cultural overlays in New Mexico, it is compassion that is a shared universal value and language that all can understand and appreciate. This is also true when it comes to finding a shared vision and spirit of collaboration in addressing the deleterious effects and stigma associated with substance use and related behavioral issues.

Inclusive of the Whole Person
When looking at an individual, or even a family, it is important to see more than just their presenting symptoms and to attempt to see the whole person and as much as possible, the conditions and circumstances that affect them, both positive and negative.

Willingness to view a person this way makes it possible to fully appreciate who they are, what their issues and needs may be, as well as the resources and strengths they have that can be used to support them in their process of growth and healing. Viewing holistically affords a more accurate picture for making more discerning assessments and more accurate diagnoses.

Integrated
Integrated and seamless services for youth and their families acts as a failsafe assuring that those in need are receiving the full range of needed treatments, interventions, care and supports. This is likely to increase success and sustained outcomes. Services can include Youth Support Services (YSS), medically assisted treatments (MAT), intensive outpatient substance treatments, individual and family counseling services, physical care, transportation and childcare, food stamps, supported housing, medical and dental care, as well as a wide range of other services. Equally important is making sure there is access to and availability of those integrated services for youth in need and their families so they can thrive.

Youth and Family Centric
In substance use and related issues services, one of the most pressing questions is to support an individual in making a sustained positive behavioral change to a less destructive, more functional way of living, and, how we can support the youth and families we serve to thrive.

Simply put, we must make certain that the youth and families we assist are at the center of our vision of care and thriving. Youth, first and foremost, are unique human beings, and not a cluster of problems or diagnoses to be solved or barriers to a healthy family or society. Our job is not to fix them. Instead, we must assure that we are committed to supporting them in effectively navigating their way to a more functional healthy life. In order to do this, we must shift from an episodic care-taking model of service to one of self-care, self-management and self-efficacy that are youth and family centric. By placing the youth and their family at the center of how we treat and serve them, we move them from that of a consumer/object to that of a co-partner on equal ground with the services we provide.
Purpose of the Supporting Youth to Thrive Manual

Given the broad scope of this manual, there is a lot of information to be comprehended, appreciated and utilized. For example, just some of the foundational ideas and subject areas covered include services that are:

- Integrated, Comprehensive, and Holistic
- Effective and Engaging
- Dynamic and Evolving
- Measures to Improve Quality of Life
- Evaluated for both process and outcomes
- Informed by feedback between the provider and the youth and family

Discussing how to implement best practices that are:

- Evidence or Research Based
- Developed for Youth
- Co-occurring Disorder Focused
- Trauma Competent
- Supports for Youth and Families to Thrive

Equally important is the fact that the SYtT’s recommended policies and practices are not a substitute for the invaluable and essential commitment, creativity, and compassion that each stakeholder must bring to this systemic change process if it is to be successful. Given this, it is the authors’ desire and hope to inspire and encourage all who support this effort to advance policies and services in the directions outlined in the SYtT.

In summary, the SYtT is a manual of the best thinking and evidence-based research on effective ways to address New Mexico’s substance and opioid use crisis in the context of thriving. For those who are called and committed to help resolve New Mexico’s substance crisis, the New Mexico Children, Youth and Families Department Supporting Youth to Thrive manual provides knowledge that is useful and accessible.

The Adolescent Substance Use Reduction Effort is a statewide effort to provide services for youth experiencing trauma, substance and co-occurring mental health disorders. ASURE uses state and federal funds to establish comprehensive and sustainable services that are effective, develop workforce capabilities, serve adolescents, young adults and families, expand access to community services, and reduce the consequences related to unaddressed trauma, substance use and mental health issues or disorders.
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.
• **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 is High Fidelity Wraparound?**

• **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.
Executive Function (Who’s in Charge?)

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.¹ 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.² 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. Examples include aerobics, non-computerized games, martial arts, mindfulness training, and yoga.

It appears that children with poor executive function may benefit the most.³ 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.⁴

⁴ Diamond, A., Lee, K., (2011)
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. 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.

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.

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.

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5 [http://www.prearesourcecenter.org/sites/default/files/content/6._stages_of_adolescent_development.pdf](http://www.prearesourcecenter.org/sites/default/files/content/6._stages_of_adolescent_development.pdf)

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 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.

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7 Overview of the Neurosequential Model of Therapeutics,
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.⁸

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 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).

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⁸ See Appendix A for Stages of Adolescent Development
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. ⁹

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)


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Trauma and Adverse Childhood Experiences (ACEs)

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. 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. This cognitive impairment often carries into adulthood and findings suggest the more ACEs a child experiences the more likely they are to 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.

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.

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**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.
Mental, Emotional, & Behavioral Disorders

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.\(^{13}\)

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 treatment acknowledge 5+ major problems including depression, anxiety, suicide attempts, ADHD, conduct disorders, etc.)\(^{14}\)

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.”\(^{15}\)

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

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\(^{14}\) Center for Substance Abuse Treatment, Adolescent Treatment Common GAIN Data set. Randolph Muck.

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.
- Recycling into and out of treatment and continued problems are the norm among adolescents who receive treatment for co-occurring disorders.¹⁶

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.
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.
<table>
<thead>
<tr>
<th>Definitions from the DSM 5 ¹⁷</th>
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<tbody>
<tr>
<td><strong>Addict/Addiction</strong></td>
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<tr>
<td>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. <em>(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.)</em></td>
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<tr>
<td><strong>Substance Use Disorder (from mild to severe)</strong></td>
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<tr>
<td>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:</td>
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<tr>
<td>1. The substance must be taken in large amounts or over a longer period than was intended</td>
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<tr>
<td>2. There is a persistent desire or unsuccessful efforts to cut down or control use</td>
</tr>
<tr>
<td>3. A great deal of time is spent in activities necessary to obtain, use, or recover from the substance</td>
</tr>
<tr>
<td>4. Craving or a strong desire/urge to use</td>
</tr>
<tr>
<td>5. Recurrent use resulting in a failure to fulfill major role obligations at work, school, or home.</td>
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<tr>
<td>6. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by its effects</td>
</tr>
<tr>
<td>7. Important social, occupational, or recreational activities are given up or reduced because of use</td>
</tr>
<tr>
<td>8. Recurrent use in situations that are physically hazardous</td>
</tr>
<tr>
<td>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</td>
</tr>
<tr>
<td>10. Tolerance as defined by either of the following:</td>
</tr>
<tr>
<td>a. A need for markedly increased amounts in order to achieve intoxication or desired effect</td>
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<tr>
<td>b. A markedly diminished effect with continued use of the same amount</td>
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<tr>
<td>11. Withdrawal, as manifested by either of the following:</td>
</tr>
<tr>
<td>a. Characteristic withdrawal syndrome as defined in the DSM 5 for each substance</td>
</tr>
<tr>
<td>b. Substance is taken to relieve or avoid withdrawal symptoms</td>
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</tbody>
</table>

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.\textsuperscript{18} 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.\textsuperscript{19}

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.


\textsuperscript{19} New Mexico House Joint Memorial-21 (2012) Recommendations: http://legiscan.com/NM/text/HJM21/id/619977
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.

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.

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. 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.

<table>
<thead>
<tr>
<th>The Current Renaissance of Adolescent Treatment Research</th>
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<tbody>
<tr>
<td>Feature</td>
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<tr>
<td>Treatment Studies*</td>
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<tr>
<td>Random/Quasi</td>
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<tr>
<td>Treatment Manuals*</td>
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<tr>
<td>QA/Adherence</td>
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<tr>
<td>Standard Assessment</td>
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<tr>
<td>Participation Rates</td>
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<td>Follow-up Rates</td>
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<td>Methods</td>
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</tbody>
</table>

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.

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Supporting Youth to Thrive Manual
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.

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.\(^{21}\) 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.\(^{22}\) 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

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\(^{21}\) Kash et. al. (2008) [http://www.jneurosci.org/content/28/51/13856.full.pdf](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

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 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.²³

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.

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²³ Behavioral Theories and the Neurophysiology of Reward, Wolfram Schultz; Annual Review of Psychology Vol. 57
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.
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.

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.

25 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.
Ten Principles of COD Implementation

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<tr>
<th>Ten Principles of COD Implementation from the SAMHSA Co-Occurring Center of Excellence</th>
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<tr>
<td>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.</td>
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<tr>
<td>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.</td>
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<td>3. The integrated system of care must be accessible from multiple points of entry (i.e., &quot;no wrong door&quot;) and be perceived as caring and accepting by the adolescent client and their family.</td>
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<td>4. The system of care for COD should not be limited to a single correct model or approach.</td>
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<td>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.</td>
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<tr>
<td>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.</td>
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<td>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.</td>
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<td>8. Within the treatment context, all co-occurring disorders are considered primary and treatment should be simultaneous and integrated.</td>
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<td>9. Empathy, respect, and belief in the individual’s capacity for recovery are fundamental provider attitudes.</td>
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<td>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.</td>
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**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.

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<th>The State of NM IOP Service Definition</th>
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<tr>
<td>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.</td>
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<td>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.</td>
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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.
What is High Fidelity Wraparound?

I had just finished my initial Wraparound training when I received a phone call from a parent whose family I had worked with as a service provider. Her son, who had been my identified “Client,” had been arrested and was in detention. This parent was scared and called asking for help. It was through the journey of working with this family that I came to understand the value and uniqueness of Wraparound.

Let’s start by defining Wraparound. The National Wraparound Institute defines Wraparound as follows:

“Wraparound is an intensive holistic method of engaging with individuals with complex needs so that they can live in their homes and communities and realize their hopes and dreams.”

First of all, it is important to emphasize that it is not a service, rather it is an approach or process of working with families that makes their existing services more effective. The Wraparound approach has a foundation composed of a set of 10 values:

1. The prioritization of family voice and choice
2. The incorporation of natural supports
3. The crafting of individualized plans
4. An intent to keep youth at home while using resources their local community offers
5. A strength based approach
6. Unconditional support through perseverance
7. The intent to yield outcomes
8. The consistent practice of cultural humility
9. A team based approach to seeking solutions and managing crisis
10. The intent to form collaboration between all parties and systems involved

In Wraparound these values are the heart of the process. A Wraparound facilitator is not only encouraged, but expected, to work with a family, providers, and system partners while consistently applying these values. When these values are practiced by a Wraparound facilitator, a youth and family starts to believe that their voice matters and that there is hope for change. At the same time providers and system partners experience the power of collaboration and validation.

Equipped with my recent Wraparound training, I offered to help the worried parent who called me for help. I was the first dedicated Wraparound facilitator in my agency and they were to become my first Wraparound family. To be honest, I was intimidated because I only knew Wraparound in theory and now it was time to start practicing. So I gathered all my training material, reviewed it as needed, and started down the road of Wraparound with a family who I had asked to give this new process a chance. Now that I reflect on it,
this family took a leap of faith because they had already experienced all the services available to them without lasting success.

My prior training had taught me that when I worked with a family I needed two things, a mental health diagnosis in one hand and set of services on the other hand. However, as was the case of my first Wraparound family, this approach often does not work. When a youth and family’s problems are enduring and complex in nature, addressing the behavior through isolated services may not be enough. It is like giving someone Tylenol for the pain when their appendix has ruptured. At the point when the family and the systems are feeling hopeless, their deeper needs are affecting multiple life domains and have gone inadequately addressed for a significant amount of time. This is where Wraparound works best: It supports the services and systems a youth and family already have in place, and helps identify new ones that may be necessary. It works best at this stage because it seeks to go to the center of the difficulties and meet the youth and family at the most essential place possible. It does this by employing the Wraparound five core elements:

**Wraparound Five Core Elements:**

1. **Holistic**, looking at the entire context of a family instead of only focusing on behavior
2. **Strengths Based**, integrating the qualities, interests, talents of a family into solutions
3. **Vision**, defining what hope looks like for a family to serve as a motivator
4. **Needs Driven**, asking why is a behavior happening, what is driving it?
5. **Teaming**, building a team that agrees to work together to help a family reach their vision.

The core elements in Wraparound are the framework for the implementation of the Wraparound model. The **Holistic** element holds the premise that individuals are influenced by several life domains, and it is this complexity that yields the critical factor(s) in their current difficulties. Wraparound rationale asserts that, in order to understand the complexity of a youth/family’s problems, one must seek to understand them across all of life’s domains. The **Strengths Based** element emphasizes that individuals, given the proper support, have, and will use, their strengths to get better. It also helps to individualize the approach as unique, with strength based strategies over cookie-cutter ones. The element of **Vision** premises that everyone has hopes and dreams, even if they have never been seen as possible, and hopes to reach a point in their lives where they can live out what is important to them. Defining a family’s vision sets a direction for a Wraparound team and also serves as inspiration to persevere when things get tough. The **Needs Driven** element affirms that behavior is a way in which individuals seek to get their needs met. Consequently, if we truly want to change behavior and help people reach their goals, these unmet needs must be addressed. Finally, the element of **Teaming** holds the premise that
many minds, working in collaboration, can be uniquely creative in their ideas. When the team is made up of members of a family’s natural community, that very community can eventually take over the support and formal systems and services can withdraw from family’s life.

My first Wraparound youth was released from detention and we went to work for almost a year. This second time around working with this youth and family I used Wraparound values to engage the youth, the family and others working with them. I spoke to everyone who was significant to them and could provide insight and support. I dedicated more time to discovering their strengths than focusing on deficits. I asked the providers and systems involved to slow down the deluge of solutions and consider why they have not worked in the past. I asked what was important to the youth and family and prioritized those items. I sought to understand the youth’s responsibilities to the systems involved. When confronted with a negative behavior I asked why was that behavior there, what was driving it? Finally, I kept showing up and supporting the youth and family.

I also utilized the Wraparound core elements to guide the process. As I facilitated their care using the Wraparound process, I came to appreciate Wraparound for several reasons. It provided a model that I could reflect back on to help me understand what to do when things stagnated or did not work. It built a team who was willing to help, think out of the box and believed in the vision of the family. It gave me a range of people to delegate tasks to that I would normally have to do myself. Most importantly, it allowed me to enter into a real relationship with the family at a deep enough level to name and address the hurts/unmet needs that kept them stuck, thus freeing them to discover their own hope for their own future.

Wraparound is not a short term approach, it takes time to address deep and complex hurts in people’s lives. Over a year went by before I discharged my first Wraparound family. Being my first family I was not sure when to end my time with them, lucky for me they told me when it was time. They were in a different place than when we started, with less services and no formal system involvement. They were within grasp of their vision and felt they could take it from there.

Earlier in this document I provided a formal definition for Wraparound. It is a definition that we often use in formal trainings and presentations. However, my favorite definition is how I’ve heard a number of young people describe Wraparound:

“Wraparound is where they listen to you.....Wraparound is when they bring people around you to help...Wraparound is where everyone agrees to work together to help us...Wraparound is when we all know what to do next...Wraparound is where no one quits on you.”
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. 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.” 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.”

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

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28 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).  

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.”

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 that recovery from substance use disorders is possible. They and their families know of no

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29 The Family Recovery and Research Project. [www.psychotherapy.net](http://www.psychotherapy.net)
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.31

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.

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.”

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” 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.

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 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.

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32 White, W. Unraveling the Mystery of Personal and Family Recovery. An Interview with Stephanie Brown, Ph.D. 2011. [www.williamwhitepapers.com](http://www.williamwhitepapers.com)
33 40 Developmental Assets for Adolescents. [www.search-institute.org](http://www.search-institute.org) See Appendix B
34 Smart Recovery Family and Friends. [www.smartrecovery.org](http://www.smartrecovery.org)
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 their 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

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Why Risk-Taking May Increase Teen Happiness

The Teen Brain Craves Risk-Taking -- Marilyn Price-Mitchell PhD

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.36

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...” 37

The Teen Brain: Still under Construction
National Institute of Mental Health

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. 38

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.39

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.

39 http://www.multiplyingconnections.org/sites/default/files/Teen%20Provider%20article%20%282%29_0.pdf
The Power of Challenge

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. DRD4-7 R, 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
Fundamental Understandings

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 deconstructed 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 lineup 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 ourselves.

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 dubbing 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.
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.

- **Youth Support Services**  
  Youth Support Services (YSS) are designed to promote resiliency and enhance wellness for all of New Mexico’s youth and young adults, especially for those with substance use issues. It is specifically targeted as a youth oriented recovery support for young people experiencing substance use issues, operationalized through life skills development.

- **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.
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.
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).

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.”

<table>
<thead>
<tr>
<th>The World Health Organization (WHO) categorizes life skills into the following three components:</th>
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<tbody>
<tr>
<td><strong>Critical Thinking Skills/Decision-Making Skills</strong></td>
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<tr>
<td>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.</td>
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<tr>
<td><strong>Interpersonal/Communication Skills</strong></td>
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<tr>
<td>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 for those around us.</td>
</tr>
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</table>
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.40

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.41

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 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).

<table>
<thead>
<tr>
<th>Factors of Success</th>
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</thead>
<tbody>
<tr>
<td>Long-term programs</td>
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<tr>
<td>Trained educators or providers</td>
</tr>
<tr>
<td>A focus on both generic and specific skill</td>
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<tr>
<td>Developmentally appropriate inputs</td>
</tr>
<tr>
<td>Active student involvement</td>
</tr>
<tr>
<td>Links to other subjects</td>
</tr>
<tr>
<td>User-friendly materials</td>
</tr>
<tr>
<td>Peer leadership components</td>
</tr>
</tbody>
</table>

Where these factors have been implemented, life skills programs contributed to a decrease in alcohol use, drug use, 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).  

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 youth. This gave birth to Positive Youth Development programs that advanced a set of principles, coming to many of the same conclusions as prevention scientists and those who now are the proponents of life skills education. The work in these three areas has

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converged over the years with 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 section).

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.
Youth Support Services

What are 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 use disorders or unrecognized and untreated mental health disorders. YSS provides 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.

Youth Support Services include:
1. **Life Skills:** Life skills, both classroom and individual, 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. All life-skills are curriculum-based, although individual need and individual coaching skills may enable access to skills not included in curricula;
2. **Life Skills Coach:** All services are delivered by a trained and approved Life Skills Coach (LSC):
   - The Coach will provide curriculum-based classes in all listed subjects, as well as arrange for experts in various living skills to provide classroom skills-based instruction. Although coaching partakes somewhat of both mentoring and case management, coaching is targeted to develop specific skills and generalized abilities that will enable the client to have more successful life experiences;
   - **Individual coaching sessions** are provided based on an in-depth assessment that identifies life skills deficits. A mix of both individual and classroom sessions is expected and encouraged. Variations from a mix of 2 or 3 classroom to 1 individual must be carefully documented and justified. Individual coaching must be driven by skills-based learning and all individual session must be documented and kept in an individual YSS case file.

YSS Curriculum consist of the following:
1. **Foundational Life Skills:** Address activities of daily living, nutrition, cooking, cleaning, personal hygiene, budgeting, overall organization and time management, household management, anger management strategies, and all issues appropriate to functioning in New Mexico society not covered under more advanced skills.
2. **Vocational Skills:** Develop the age-appropriate knowledge and skills for youth to gain and maintain employment:
   a. The program shall recognize that short-term job goal development is most appropriate for youth.
   b. Include and are not limited to providing instruction in the areas of resume writing, completing job applications and appropriate job interview responses, and career planning;
i. Career planning is based on selecting realistic career goals that match the selected career with personal skills, abilities and personal goals and aspirations and planning a pathway to accomplish identified goals.

ii. Potential career exploration and future development planning shall be conducted using this component of life skills. Link to http://www.mynextmove.org/explore/ip for help with career planning and development.

c. Emphasize the importance of being ready to seek and hold employment, proper nutrition, cleanliness and physical appearance and work ethic.

5. Education Success Skills: Enhance youth functioning and knowledge by developing learning and study skills that reinforce strengths and assist the youth to receive a High School Diploma, GED, or completion of vocational training, etc., and by exploring and planning for future educational needs by creating a career pathway.

6. Parent Education and Child Development: Assist youth and/or their family as appropriate 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.

7. Relational and Social Skills: Guide the youth and/or their family to address interpersonal communication, conflict management, relational issues and concerns, age appropriate sex education, appropriate use of technology in social situations, other subjects/issues pertaining to relational and social skills. Transition Planning:

8. Medical, Legal and Behavioral Health System Coaching, Referral, and Advocacy: Facilitate access to services and navigation of medical systems, and provide support and advocacy for youth identified with chronic or acute medical, vision or dental needs.

a. The LSC must have direct presence on a team for this service to be considered a YSS coaching activity. Clients served within this element must be receiving YSS Life Skills Coaching and have a completed YSA on file. This element of service is not intended to be used by any person not trained and providing YSS Life Skills Coaching to the client being served.

b. Receipt of only Transportation services are insufficient to qualify for this service:

c. A warm hand off from the LSC to a new service provider can be provided at the client’s request;

9. Administrative Services include all regularly performed staff duties inclusive of staff meetings and trainings, data entry, and duties associated with maintaining contractual obligations that are not specific to Outreach or LSC duties.
Youth Leadership

How does youth leadership/advocacy support a youth’s ability to thrive?

When young people have access to appropriate supports and opportunities they're more likely to achieve a healthy lifestyle, a positive identity, and achieve their goals. In developing youth advocacy groups youth will be able to be involved in each level of systems transformation and this creates opportunities for positive and meaningful change. Youth leaders and adult supports must have an understanding of both the benefits and challenges of changing negative views of youth. It is a responsibility of these change agents to show providers, caregivers, policy makers and community members the importance of youth advocacy and involvement.

Young people need to be given opportunities to advocate in ways that support their social, intellectual, psychological, physical, and developmental needs. Youth benefit from hands-on experiences from belonging to a group while keeping their individuality. Youth also need to develop critical-thinking skills where they learn to express their opinions, challenge assumptions of adults, and make sound decisions. When young people are not given these opportunities to grow and develop in a positive way, they're more likely to find harmful alternatives. When young people have access to appropriate supports and opportunities they are more able to avoid unhealthy lifestyles. Youth, families and professionals need to be valued as equal partners in creating systemic change. In order to achieve authentic youth involvement, community and professional partners must accept that they are need more than just youth feedback and that young people must be actively engaged in the decision-making processes.

There are countless benefits to involving youth and opportunities where they are able to advocate. Young people benefit by creating natural supports who “get” them. They develop confidence and strength in their sense of pride, identity and self-esteem, by having their voices heard and utilized to make positive change. Families benefit when their young people are able to have opportunities to advocate. Family members can see that their children are resilient and their youth has the ability to connect with peers and have sustained relationships. Adults benefit from the experiences of young people’s ideas. It helps adults to view youth as legitimate and essential contributors to the organizational decision-making process and to feel more effective, confident, and competent in their work with youth. Adults also gain a stronger sense of community connectedness. Organizations also benefit from having youth involved in decision-making opportunities. Young people can bring clarity to the mission, improve adult staff involvement and a hence their responsiveness to the community.

When young people feel heard and engaged it will help the community as well. It will help community members interact with young people and overcome youth cultural stereotypes. It will increase the community’s understanding of how young people view the world and increase community relationships. Involving young people to enhance our systems for their lives and organizations creates authentic youth involvement. Young people are engaged and have the opportunity to have their voice heard and utilized and adults and youth share...
power in decision-making. It also means the process should be meaningful and fun. Below is the Harts Ladder diagrams that shows what authentic youth involvement looks like:

<table>
<thead>
<tr>
<th>Quality of Participation</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young people and adults share decision-making</td>
<td>Young people need a role in decision-making throughout the project. They are involved in the planning and implementation of the project.</td>
</tr>
<tr>
<td>Adult-initiated, shared decision-making</td>
<td>Adult-designed and facilitated the project, and young people are given an equal voice and are involved in decision-making.</td>
</tr>
<tr>
<td>Young people are consulted and informed</td>
<td>Young people decide on the project and young people are informed about their options.</td>
</tr>
<tr>
<td>Young people are assigned but informed</td>
<td>Young people are assigned to the project and are informed about their options.</td>
</tr>
</tbody>
</table>

**Hart’s Ladder**

**Key Questions**

Which level of Hart’s Ladder is our project on? Which level of Hart’s Ladder should our project be on? What do we need to do to move to the right level on the ladder for our project?
Theoretical and Philosophical Foundations of Therapeutic Adventure

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.”

Social competency, problem solving skills, a strong sense of identity, 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.

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,

44 Benard, Bonnie; Fostering Resiliency in Kids: Protective Factors in the Family, School and Community; National Resilience Resource Center, University of Minnesota; Minneapolis, MN.
belonging, and power must become the primary focus of any prevention or education intervention with children and youth."

**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." 45

**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.

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:**
- a. 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,
- b. Active and direct use of clients’ participation and responsibility in their therapeutic process,
- c. Continuous group-living and regular formal group therapy sessions to foster teamwork and social interactions (excluding solo experiences),

45 [http://www.aee.org/about/whatIsEE](http://www.aee.org/about/whatIsEE)
d. Individual therapy sessions, which may be supported by the inclusion of family therapy,

e. 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,

f. The use of nature in reality as well as a metaphor within the therapeutic process, and

g. 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.46

**The Adventure Integrated Model,** developed by Project Adventure47 (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

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47 Project Adventure Inc., 719 Cabot Street, Beverly, MA 01915, info@pa.org - www.pa.org
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 functioning. Creating an environment that fosters this mental state must be a primary goal for teachers, therapists, and educators. 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.

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 Environment

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

48 http://www.cainelearning.com/
49 Caine & Caine; Making Connections: Learning and the Human Brain; 1994; Addison-Wesley
50 Glenn, H. Stephen & Brock, Michael L; Seven Strategies for Developing Capable Students; 1998; Prima Publishing, Roseville, CA; pp 10-25
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.

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.”

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.

51 Frank, Laurie; The Caring Classroom; Project Adventure, Inc; 2001
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. 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.

If we can delay the onset of use even by a little, we will spare our communities’ untold costs and consequences. 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. 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.

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 detectible, 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
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.

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

<table>
<thead>
<tr>
<th>Data Source</th>
<th>URL</th>
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<tbody>
<tr>
<td>New Mexico Youth Risk and Resiliency Survey</td>
<td><a href="http://www.youthrisk.org">www.youthrisk.org</a></td>
</tr>
</tbody>
</table>
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 users 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 use 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 use 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.  

**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 use 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.

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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 use 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.  

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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 Systems

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

*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
who 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.59

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.60

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.

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.61

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61 New Mexico Human Services Department Access to Recovery (ATR) Handbook service definition for Traditional Healing was written by Michael Hock and Gus Abeyta (2007)
**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 use treatment. Spirituality is entirely possible with or without a belief in a supreme being. During substance use 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.  

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.  

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62 Religion and Spirituality in Adolescent Development, Pamela Ebstyne King and Robert W. Roeser  
63 Excerpted from: The Spiritual Journey for Youth, by Fred J. Dyer, PhD, CADAC; Published on-line in The Addiction Professional, © 2011, Vendome Group, LLC
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 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.
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, 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).

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. More impressive was the facts 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 and efficacious method of increasing positive emotions. Sadly this possibility has not been investigated but we eagerly await research, which attempts to test this possibility. 65

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 use 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

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 use. 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.”66

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.

“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.”67

Vanderbilt co-investigators for this study are Evonne 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.
INTERRELATED FACTORS, PRINCIPLES, VALUES AND EVALUATIVE MEASURES

What you will find:

- **Organization Competencies & Communities of Care**  
  *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.

- **Discussion of Medical Marijuana**  
  *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.
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 evaluation.

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.

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.
Program Evaluation

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 ongoing 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.

<table>
<thead>
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<th>Most evaluations fall into one of three categories:</th>
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<tr>
<td>Process - Outcome - Impact</td>
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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.

<table>
<thead>
<tr>
<th>Types of Data</th>
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<tbody>
<tr>
<td><strong>Quantitative</strong></td>
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<tr>
<td>Descriptive and subjective: e.g., counting the number of drunk-driving fatalities or the percentage awareness of a risk</td>
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<tr>
<td><strong>Qualitative</strong></td>
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<tr>
<td>Measurable and definable in absolute numerical terms: e.g., recording subjective views on whether a program has changed perceptions</td>
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The following two sections; Performance Measures, and Systems Assessments, are descriptive of evaluative measurements, as well as evaluation processes.

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.
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).\(^6^9\)

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.)

Systems Assessment

Overview
The Supporting Youth to Thrive 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 SYtT, 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 SYtTAessment 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).⁷⁰

**Fidelity and the ATAT Assessment Tool**

The ATAT assessment tool measures fidelity related to the level of service implementation for each of the Elements in Part B of this SYtT. 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:

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.

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

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).73

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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 muddied. 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.

<table>
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<th>Question of Causation</th>
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<td>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.</td>
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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.
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. 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.

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74 [http://www.hhs.gov/ocr/privacy/hipaa/administrative/enforcementrule/hitechenforcementifr.html](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.
EIGHT GOVERNING ELEMENTS THAT ORGANIZE EFFECTIVE SERVICES

What you will find:

Philosophy of Approach & Principles of Practice:
Eight Governing Elements that Organize Effective Services

- Engagement, Alliance, & Rapport
- Youth Voice and Engagement
- Supporting Youth to Thrive
- Cultural Competency
- Understanding Sexual Orientation And Gender Identity
- Stage-Wise Interventions
- Motivational Approaches
- Trauma Sensitive Systems of Care & Support

These eight 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 eight 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.
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 and support services. 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 treatments and other integrated services, from the waiting room staff through intake and all types of interaction. Creating an alliance could be briefly stated as the qualities and expertise which the client perceives as potential for help in the person providing services, and therefore becomes willing to engage into a healthy 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 services provider consciously aligns all levels communication to the client; in tone, posture, expression, and complexity of verbal communication.75

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!

75 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 engagement:

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.

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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.

Youth Voice and Engagement

When it comes to youth voice and engagement, it is of utmost importance that the youth is a part of the decision making process. Not just present at the table, so-to speak, or meetings, conferences or anything of that sort, but actually empowering youth to take the lead and take action when it comes to things that not only impact their lives, but the lives of other youth as well. It is one thing to acknowledge their presence among stakeholders and service providers, but true youth engagement involves also acting on the ideas that they present: in their communities gathering other youth and taking initiative in events, in programs, and especially in anything that can be youth lead like youth groups. This should carry over into creating programs based on what the youth's needs and wants are. In order to be able to carry out any youth initiatives, it must be youth-driven, incorporate youth voice and be youth-engaged. Youth driven is defined as: getting youth to be present at events, conferences, and programs, which, then becomes youth voice: empowering them to present ideas, alternatives, and even solutions and then transitioning into youth engagement – partnering up with stakeholders, service providers, etc. and then empowering them to act on these decisions to make it become applicable to whatever situation or problem that they are “trying to tackle.” When the idea originates with youth stakeholders and they are able to make it become a reality and not just an idea, powerful things happen. It is like a chain-reaction, one or more youth will see a way to approach an idea, issue, or what have you and then it gives them motivation.

With the work that I do, at conferences, events, and programs, I know that I personally have come across certain issues within our system that neglect or underplay the importance of youth-voice. Because I have not been given enough credibility at times, it has only pushed me to assert my ideas and make sure that I equally represent youth as well as myself. Having had my own trust broken with adults and other officials who were not transparent and who did not honor their word has made me see what I could do to correct future instances of this from happening to not only me, but other youth as well. I have learned to take action by speaking up when someone's ideas may have not been so youth-driven in areas that I was negatively affected. But most importantly, I am making a change within the system by asking stakeholders to allocate funds to programs that do not just serve to help foster youth, etc., but ALL youth because between 14-26 of age are some of the most transition periods in life. Creating outlets for support within the community are vital, along with creating applicable skills, such as various life skills for going to college, getting financial aid, or anything a youth may need in order to succeed. I had to learn many of these skills on my own, and I became aware of just how hard it really is to get your career or any aspirations of that sort started. I understand just how important it is for other youth to get more formal support in these areas, which many presume will be easy or that
they will have the given assistance. Being a youth that went through these experiences
helped me to better understand how to serve other youth and then advocate for all youth
to get the support that they need not just from each other and their families, but the
community as well. Not all of us have families or programs that we are in to guide us, so
creating incentive for all youth to support each other is essential, along with the support of
the community stakeholders who can help make it happen.

When the youth and stakeholders are on the same page, it creates a more open
environment that is truly youth driven. The youth may create ideas and/or solutions to
some of the issues at hand, and with the support of stakeholders, service providers, and
other professionals, they are then able to create options and resources to accomplish what
it is that they envision. Youth will become more engaged when they are able to be
accountable for things that not only pertain to them, but are also important to them. People
in general can relate to the fact that you will have more incentive to accomplish a goal or
create solutions to things that either directly impact you and/or that you are passionate
about. This is particularly the case when engaging youth. That is why youth voice is the first
step to creating a youth engagement initiative. Empowering the youth to speak on behalf of
things that pertain to them is key, being that they are the only true expert in their life, and
then building off of that. This then segues into positive youth development. It gives youth
the opportunity to develop skills such as accountability, resource networking and overall to
be a part of the decision making process.

Many times youth are put into this box that doesn’t allow them to move around much when
involved in the decision making process. Self-directed action and accountability are what
creates incentive. It also empowers youth to openly develop ideas and solutions that, in
turn, create self-advocacy. Many youth struggle, especially in the transitioning periods in
their life, with self-advocacy, so when they are brought to the table and take that chance to
voice their opinions and ideas, they are not only self-advocating, but becoming involved.
Empowering youth voice creates a community of youth who are willing to engage in
collaborations that involve both input from adult professionals and youth.
Supporting Youth to Thrive

**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. This statement is a simple description of how we support substance affected youth and families: however many times youth stumble or trip, we must still support them. If we can help youth and families to stand one more time, to take even a single step towards health before they fall again, we must do so, as long as we are able.

We can build our systems, improve our skills, and know the best practices thus far developed trying our best to make a difference. Yet, 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. If our youth and children need life-long support due to the damage of substance use disorders 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 strained 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 person, must unite and work together to address this challenge to our social health and by extension our public safety. When youth are incarcerated, 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. We must work to 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 becomes more difficult and costly. Providing supports that aid youth to thrive is a simple and effective response, and everyone will benefit.

Recovery is a word that is defined as the regaining of something lost, or a return to a previous state of health or well-being. It is not an adequate term for youth that have been affected by substance use. The youth or young adults we are likely to serve most often have not had enough support in their lives to develop much of anything that can be recovered, so our duty is to support them in the development of skills and capabilities that will enable movement into health and wellbeing. Support is the operational word that has to replace recovery. Many of us cannot relate to having few or no inner or external resources. By the time we have negotiated life to the age of 25 or 30; many of the challenges that youth must meet successfully have been met and then forgotten. Add to that the almost incomprehensible rapidity of changing technology and the contemporary variations occurring in family structures, and those over 30 are often at a loss to understand those we
serve. This Element of the SYtT is about listening carefully to what our children and youth are telling us about this subject, sometimes loudly, if we will listen to them.

Moving Mountains
It is important to begin our discussion by examining our frame of reference about working with youth, even though this may seem like moving mountains. Outmoded beliefs tell us that as adults we are in the position to know what is best for the youth we serve. Recognizing that youth should be collaboratively engaged in deciding what services they need is key to changing our belief that we are the expert or authority on what is right for the youth. If we are focused only on holding youth accountable for their behaviors we can easily miss the significant opportunities to help youth to develop into responsible adults through coaching and support.

A Seat at the Table
Up until recently, services for youth were based on an authoritarian model. Adults made the choices, decided what was best for the youth, and implemented services based on their adult judgments. More and more, providers of youth services are giving youth a seat at the table, and giving youth a voice on what they need and what services will help them. This is a massive paradigm shift, and systemically can feel like moving a mountain, but it doesn’t have to be that way. Encouraging youth to direct the language adults’ use when discussing support services is a huge, and necessary, part of that paradigm shift. The following is a framework to support the growing trend of encouraging youth to have a much greater voice in all aspects of the services provided to them.

Changing Recovery into Thriving
This section begins with the premise that the word recovery is inappropriate as it is applied to adolescents, youth and young adults ("youth" will be used throughout this element inclusively). The field of adolescent treatment and supports 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 in some cases harmful. This same dynamic has plagued the recovery movement where adults in authority have made the assumption that these same behaviors, attitudes and assumptions of recovery or wellness would automatically translate to youth. There has been little to no research on how youth engage in healing processes related to substance use. Add to that trauma and mental health issues and disorders, developmental stages, lack of safety factors, neurological impairments caused by substance use and the subject can seem complex.

The notion of recovery implies that one is comparing their current undesirable state of substance use with a former state of wellness that they are attempting to return to. For adults experiencing disorders related to substance use this may be an accurate assessment of their path to wellness, but this is not generally the case with youth who use substances. This must be tempered with the understanding that recovery may not be an accurate term for many adults, especially those who are part of a cycle of multi-generational substance use disorders. For these adults, recovery supports may not be the most appropriate either.
The man or woman who becomes an alcoholic at the age of 36 can at least have a reference point to an earlier time when they were able to function without the use of alcohol. Persons that previously had familial and social connections may have enjoyed a balanced and satisfying life. For example, the man or woman who experienced a tragic loss and then developed a substance use disorder will have significant inner resources that will enable them to recover. Youth that have experienced similar sorts of trauma or have been exposed to substance use for any extended period will not have sufficient inner resources to effectively drive recovery, and will likely only be successful when they are adequately supported to thrive.

The words habilitation and rehabilitation are often presented as options. This are words that tend to be used in clinical or scholastic settings and as descriptions may be misunderstood and stigmatizing to youth. Thus, going to a facility with the word “rehab” embedded in its name is simultaneously stigmatizing and confusing. A youth may try to apply rehabilitation to themselves, but they are likely to attempt to take on adult definitions that will further stigmatize them as a result.

There have been efforts to discuss a definition of recovery with youth of that is youth focused. There is information from focus groups with youth that have experience with substance use and co-occurring disorders. Many youth choose not to use the term recovery to describe their own processes of growth and learning about how they regain balance from substance use. As has been done in other states, CYFD Behavioral Health Services has discussed this with youth in local community settings who have lived experience with substance use and misuse issues, and the answer is much the same—recovery is not the word most youth prefer to describe the processes they go through to thrive:

During a focus group conducted at the facilities of a local juvenile justice center a group of about fourteen youth (ages 16 to 21) were asked to close their eyes for a few moments and think about the word recovery. The youth were asked to keep their eyes closed until they came up with an idea of their definition of the word. After 30 seconds elapsed, they shared their responses to the word. Youth shared some alternative descriptive terms such as “bettering of life,” “to find happiness again” or “to come from nothing.” A follow-up question was posed, when youth suggested replacing the term.

The words recommended were, “strive,” “become,” “overcome”, “reborn” or “thrive.”

It is the last term, thrive, that is the most appealing to the youth that discussed this. It also demonstrates that the youth’s focus is on positive ideas and thoughts rather than negative, stereotypical jargon being used. The word thrive comes-up frequently at meetings, in vision statements, and during conversations where youth are involved, both as part of the open dialogue with them, or in reference to them when not present and particularly when the focus is on supporting youth that are transitioning into adulthood (approximate ages 16-26). Within this context, thrive is used more frequently and with deeper meaning. For many youth, the adoption of the word thrive also has a hopeful and open-ended meaning. Thriving can be easily defined by the person who is experiencing it and not by an external definition or standard. “I am thriving,” or “I am meeting the goals I set for myself” is self-empowering and tells us a great deal about self-efficacy for the person making the
Eight Governing Elements that Organize Effective Services

statement. It serves youth well to be empowered to define their own meaning to \textit{thrive} in that it allows for a wide-range of possibilities. It’s adaptable, practical and leaves little room for external judgments. Thriving can indicate relief at the lessening of daily drug use, or extended periods of sobriety and the resulting growing sense of well-being. For another youth it could mean fulfilling some dream or goal they set for themselves, such as an educational of vocational attainment. The word \textit{thrive} suggests that youth are having a hopeful expectancy about their future. They see themselves as being capable of functioning in an expanded capacity not experienced previously. Despite the fact that the word does not have a one size fits all approach, the concept of thriving brings hope to the person who strives for it.

The Choice to Thrive
In order to thrive, one must learn to make healthy choices, be willing to change, and engage in personal growth and development. This is becoming responsible, and is a completely different experience than being held accountable. The person who chooses to thrive has decided to connect to necessary supports and help and must admit that the issues they are facing need to be addressed. Without adequate and timely treatments and supports for many of the youth we serve this process or transitioning will be difficult and may not be successful.

Skills and Tools for Thriving
The process may be imperfect, because youth often face external barriers which may slow down their progress, and every life situation is unique. A few of the better known risk factors include: lack of access to services, returning to unhealthy, non-supportive peers, unhealthy or unsupportive family members or environments, not addressing trauma issues, and not engaging the youth into a hopeful future. However, rather than focus on what causes a lack of success, it is a better discuss critical factors which support a youth’s success during their thriving process that service providers can help with. These include the following:

- Develop foundational and advanced life skills utilizing Youth Support Services
- Maintain a supportive treatment environment amongst peers
- Develop responsibility and self-worth through directed learning processes
- Provide support and safety for youth transitioning to their next phase of development
- Provide services to the youth's family that are strengths based and aid the process of youth development and successful thriving

What does Thriving Look Like in New Mexico?
The basic tenet of thriving is that it is based on the person’s perception of what thriving means to them personally. Based on the Seven Challenges evidence-based practice and the intended responses that the Seven Challenges champions, it is clear that we must ask hard questions that support development rather than demand a hoped-for response that we have conditioned the youth to echo back to us. This refers back to the difference between holding youth accountable.
vs. supporting responsibility, while in fact we must balance both of these. The published Seven Challenges and goals of the responses are:

Youth Guided, Youth Directed, and Youth Driven—More than Tokenism

The next level of supporting thriving with youth is specific to positive youth development and the inclusion of youth in as many ways as possible in services that affect them.

Youth Guided/Directed/Driven means that young people have the right to be empowered, educated, and given a decision making role in the care of their own lives as well as the policies and procedures governing care for all youth in the community, state and nation. This includes giving young people a sustainable voice and the focus should be towards creating a safe environment enabling a young person to gain self-sustainability in accordance to their culture and beliefs. Through the eyes of a youth guided/driven approach we are aware that there is a continuum of power and choice that young people should have based on their understanding and maturity in this strength based change process. Youth guided also means that this process should be fun and worthwhile.

New Mexico is currently working on projects and practices which are youth guided and rest on the belief that it is the youth, and not adults, who are the voice of the project. This means from inception to completion, there must always be a place for youth to be given opportunities to inform decisions, advocate for their needs, make determinations, and provide direction to those who are responsible for implementing the project. These opportunities cannot be mere token gestures, or empty promises, but genuine

\section*{Challenges and goals of the responses are:}

1. Perceptions of personal capabilities—the youth is capable of facing problems and learning through challenges and experiences. We looked at what we liked about alcohol and other drugs, and why we were using them.

2. Perceptions of personal significance—the young person is capable of contributing in meaningful ways and believing that life has meaning and purpose. We decided to open up and talk honestly about ourselves and about alcohol and other drugs.

3. Perceptions of personal influence over life—the young person has the capacity to understand that one’s actions and choices influence one’s life and is able to be held accountable to such. We looked at our use of alcohol or other drugs to see if it has caused harm or could cause harm.

4. Intrapersonal skills—the young person has the capacity to manage emotions through self-assessment, self-control and self-discipline. We thought about where we seemed to be headed, where we wanted to go, and what we wanted to accomplish.

5. Interpersonal skills—the young person has the capacities necessary to deal effectively with others through communication, cooperation, negotiation, sharing, empathizing and listening. We looked at our responsibility and the responsibility of others for our problems.

6. Systemic skills—the young person has the capacity for responding to the limits, consequences and interrelatedness of human and natural systems with responsibility, adaptability, flexibility and integrity. We made thoughtful decisions about our lives and about our use of alcohol and other drugs.

7. Judgment skills—the young person has the capacity for making decisions and choices that reflect moral and ethical principles, wisdom and values. We followed through on our decisions about our lives and drug use. If we saw problems, we went back to earlier challenges and mastered them.
engagement of youth voice and choice in all matters which will impact upon them or their families.

Finally, we need to support youth to be successful and aid them having manageable and satisfactory lives as far as we are able. Our efforts can change a life for the better and make our future and the youth’s future more satisfying.
Cultural Competency

**A workable definition of culture:** Culture is the glue which keeps communities together, it’s a set of shared system of beliefs, attitudes, values, expectations, and norms of behavior and sometimes symbols, spiritual practices which add context and guidance.

**Cultural Competence is defined as:**
The term cultural competency is intended to remind us that our work can only be meaningful if we deliver services with a set of congruent practice skills, behaviors, attitudes and policies that support personal identities and respect the natural diversity of the human experience. Cultural competency is NOT a destination, it’s an expression of compassion and a celebration of the human condition.

**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.  

Cultural competency considerations must extend to race, color, gender (and gender identity), language, religion, political or other opinion, national or social origin, property, birth, ethnicity, national origin, age, developmental stage, mental or physical ability or medical condition, sexual orientation, medical history, evidence of insurability (including non-documented residents), and physical and intellectual ability.

Service providers are required to become familiar with the National Standards for Culturally Linguistically Appropriate Services (CLAS) in Health and Health Care. The National CLAS standards are the blueprint 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 knowledge and understanding of cultural expression
- 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
- This program is built on unique values, preferences, and strengths of adolescents, the adolescent client and their family, and their communities.

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78 [http://clas.uiuc.edu/](http://clas.uiuc.edu/)
• Cultural considerations are essential for effective treatment practices to promote traditions and cultural strengths, including racial, ethnic, age and language preferences, and should include natural and informal supports.
• The service location must meet minimum compliance requirements for access per the American’s with Disabilities’ Act (ADA).
• The provider agency shall 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 result in inappropriate 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.

<table>
<thead>
<tr>
<th>The following categories are appropriate to address within cultural competency (SAMSHA/CMHS 1997)</th>
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</thead>
<tbody>
<tr>
<td>• Age</td>
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<tr>
<td>• Sex (male/female)</td>
</tr>
<tr>
<td>• Race</td>
</tr>
<tr>
<td>• Culture</td>
</tr>
<tr>
<td>• Socio-economic level</td>
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<tr>
<td>• Disability</td>
</tr>
<tr>
<td>• Corporate/employer culture</td>
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<tr>
<td>• Religion/Spirituality</td>
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<tr>
<td>• Gender (See Gender Competency, Part B Element 4)</td>
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<tr>
<td>• Justice and Provider agency culture, including Courts, Juvenile Justice System, all related service agencies, and medical and prescribing practitioners</td>
</tr>
<tr>
<td>• Personal beliefs and self-concepts and how these affect interactions with individuals and families</td>
</tr>
<tr>
<td>• Access to services related to any of the above</td>
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</tbody>
</table>
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).
Understanding Sexual Orientation And Gender Identity

Challenges Faced By LGBTQ+ Youth

In New Mexico, half of our LGBTQ students are feeling **unsafe at school**; each month; 15% of our lesbian, gay and bisexual students are missing school.

LGB students are bullied twice as much as straight students. 

In the **juvenile justice system**, LGBTQ youth are represented at a rate close to three times higher than their percentage in the general population.

**Suicide** is the 2nd leading cause of death among young people ages 10 to 24. LGB youth are 4 times more likely to attempt suicide compared to their straight peers. Nearly half of young transgender people have seriously thought about taking their lives, and a quarter report having made a suicide attempt.

In New Mexico, 8% of straight youth have attempted suicide, and 32% of lesbian, gay, and bisexual youth have attempted. This means 1 in 3 of our lesbian, gay and bisexual youth in NM have attempted suicide.

LGBTQ youth represent up to 40% of all young people **experiencing homelessness**. Considering that LGBTQ youth represent an estimated 7% of the total youth population, these numbers are disproportionately high.

LGBT young adults who reported high levels of **family rejection** were also:

- 8.4 times as likely to have attempted suicide
- 5.9 times as likely to experience significant depression
- 3.4 times as likely to use illegal drugs
- 3.4 times as likely to have engaged in unprotected sexual intercourse.

Sources (This section is adapted from CYFD’s LGBTQ+ Resource Guide):
Eight Governing Elements that Organize Effective Services


Terminology

General Terms:

LGBTQ+ = Lesbian, Gay, Bisexual, Transgender, Queer (the + stands for all the additional identity terms)

Gender identity refers to a person’s deeply felt identification as a man, woman or some other gender. This may or may not correspond to the sex assigned to them at birth.

Gender expression refers to all of the external characteristics and behaviors that are defined in society as either masculine or feminine, such as dress, grooming, mannerisms, speech patterns and social interactions. This is what an individual chooses to show the world.

Sexual orientation refers to a person’s physical or emotional attraction to someone. This can be toward the same and/or different gender.

Queer: 1) An umbrella term sometimes used to refer to the entire LGBTQ community. 2) An alternative that some people use to the labels and categories such as lesbian, gay, bisexual, etc. Historically, this was a derogatory slang term used to identify LGBTQ people, but more recently this term has been embraced and reclaimed by parts of the LGBTQ community as a symbol of pride, though not everyone in the LGBTQ community is comfortable with this term.

Two-Spirit: A contemporary term used to describe some North American Indigenous LGBT individuals, often meaning having both female and male spirits within one person. This term was coined in 1990 at a conference with men, women and transgender people from various tribes. The term is not universally accepted among Native communities and nations; some also use terms from their own nations, tribes, and pueblos.

Sexual Identity/Sexual Orientation Terms:

Lesbian: A female identified person who has emotional, physical, spiritual, and sexual attractions to other women and/or female bodied/identified individuals.

Gay: A male identified person who has emotional, physical, spiritual, and sexual attractions to other men and/or male bodied/identified individuals. Gay is also sometimes used as an umbrella term for the LGBT community.
Bisexual: A person who is emotionally, physically, spiritually, and sexually attracted to members of both male and female genders.

Pansexual: A person who is attracted to all people, regardless of gender identity or sexual orientation. Because many pansexual people are open to relationships with people who do not identify as strictly cisgender male or female, pansexuality therefore rejects the gender binary and it is often considered a more inclusive term than bisexual.

Asexual: A term used to describe a person who is not sexually attracted to anyone.

Gender Identity Terms:

Transgender/Trans: A term for people whose gender identity, expression or behavior is different from those typically associated with their assigned sex at birth. Transgender is a broad term and is good for non-transgender people to use. (Note: Transgender is correctly used as an adjective, not a noun, thus "transgender people" is appropriate but “transgendered” or "transgenders" is often viewed as disrespectful.) Often, the term Trans is used as an abbreviated umbrella term to refer to all of the identities within the gender identity spectrum.

Cisgender: A term used to describe someone whose gender identity is the same as the sex that they were assigned at birth.

Genderqueer: A term used to describe a person who does not identify as completely male or female. Genderqueer people may or may not identify as transgender.

Gender Non-Conforming: A term used to describe a person who is, or is perceived to have, gender characteristics and/or behaviors and/or gender expression that do not conform to traditional or societal expectations.

Intersex: Refers to a series of medical conditions in which a child’s sex (chromosomes) and phenotypic sex (genital appearance) do not match, or are somehow different from the ‘standard’ of male or female.

Terms To Avoid:

There are terms to avoid. While these terms are simply better, there are simply better appropriate and respectful terms.

homosexual lifestyle
hermaphrodite
fag faggot

dyke homo tranny

“he-she”/“she-he”
joto maricón

That are best to avoid. While terms are derogatory, others replaced with more appropriate and respectful terms.

Note an exception: some individuals may choose to embrace these terms as their own identity; however, if you are not part of that group, it is typically not appropriate to use that term. Example: It would be okay for a lesbian woman to refer to herself as a dyke, but it would not be appropriate for others to refer to lesbian woman as dykes.
Gender Pronouns
Pronouns are the words we use when talking about people without using their names. The most common pronouns are she/her/hers, he/him/his, and they/them/their. We are usually taught that there are only two kinds of pronouns that we can use when talking about people – feminine or masculine – however more and more people (especially young people) are using the gender-neutral they/them/their. It is best to make it practice to ask people “What pronouns do you use?”. This takes the guesswork and assumptions off of you, and gives individuals the power to self-identify.

Educational Training Videos

“I Am Me: Understanding the Intersections of Gender, Sexuality, and Identity” is an educational training video that explores the challenges lesbian, gay, bisexual, transgender, queer, etc. (LGBTQ+) young people face and how adults can be supportive allies. The 45-minute video defines the concepts of gender identity, gender expression, and sexual orientation, and provides an in-depth picture of how LGBTQ+ young people are marginalized in their everyday lives and the serious outcomes they face as a result. With personal stories from LGBTQ+ young people and adult advocates woven throughout, the main theme of adult allyship is exemplified through LGBTQ+ youth sharing how they need to be supported, as well as a helpful checklist at the end of the video on how to participate in acts of allyship for LGBTQ+ youth.

“Allyship in Action: Creating a Welcoming Environment for LGBTQ+ Youth in Your Organization” explores how you can make your organization more supportive of LGBTQ+ youth and families who utilize your services through conducting organizational assessments, implementing best practices and model policies, challenging your own and others’ personal biases, and maintaining a constant conversation about organizational culture. Now more than ever, it’s important that our organizations are educated and able to provide effective services that respect, support, and welcome all individuals.

Resource Guide
The LGBTQ+ Resource Guide is a companion to the I Am Me and Allyship in Action videos. It is meant to provide further information for concepts covered in the video as well as provide resources to help you be a stronger ally and continue to educate yourself. Please note that this is by no means a comprehensive resource, but is meant to be a starting place.

- Local, National, and Online Resources & Helplines
- Challenges Faced by LGBTQ+ Youth
- Terminology
- Ways to Engage in Acts of Allyship
Eight Governing Elements that Organize Effective Services

- Gender Pronouns & Gender Neutral Language
- Online Educational Resources (incl. model policies)
- School Pushout
- Two-Spirit/Indigenous
- Undocumented/Immigrant
- Disability Justice

I Am Me, Allyship in Action, and the LGBTQ+ Resource Guide can be accessed at: www.nmcoe.org/coevideos
**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. 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, 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.

<table>
<thead>
<tr>
<th><strong>Relationship between Stages of Change and Stages of Treatment</strong></th>
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<tbody>
<tr>
<td><strong>Stage of Change</strong></td>
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<tr>
<td>Subjective, internal stage of readiness experienced by the adolescent client and their family(s)</td>
</tr>
<tr>
<td>Pre-contemplation</td>
</tr>
<tr>
<td>No intent to change behavior in the near future</td>
</tr>
<tr>
<td>Contemplation</td>
</tr>
<tr>
<td>Openly state their intent to change, but remain ambivalent</td>
</tr>
<tr>
<td>Preparation</td>
</tr>
<tr>
<td>Intend to change, transition rather than stable</td>
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<td></td>
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</tbody>
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70 Toward a Comprehensive Model of Change: James O. Prochaska, Carlo C. Diclemente (1986). Treating Addictive Behaviors, Applied Clinical Psychology

80 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.
Help the adolescent client and their family recognize and take pride in their own strengths and successes

**Action**
Has made overt, perceptible lifestyle modifications

**Active Treatment**
Substance use counseling, medication treatments, skills training, self-help groups

**Maintenance, Relapse, and Recycling**
Working to prevent relapse and consolidate gains secured

**Relapse Prevention**
Relapse prevention plan, continue skill building in active treatment.

**Measurement tools could include:**

- University of Rhode Island Change Assessment (URICA): [http://www.uri.edu/research/cprc/Measures/urica.htm](http://www.uri.edu/research/cprc/Measures/urica.htm)
- *Stages of Change, Readiness and Treatment Eagerness Scale (SCORTES).* Available from: [casaa.unm.edu/inst.html](http://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.

<table>
<thead>
<tr>
<th>Stage of Readiness</th>
<th>Implementation Strategy</th>
</tr>
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<tbody>
<tr>
<td><strong>1. Pre-contemplation:</strong> 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.”</td>
<td><strong>Engagement:</strong> 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.</td>
</tr>
</tbody>
</table>
| **2. Contemplation:** Consumer openly states their intent to change, but remains ambivalent; and in **Preparation** 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 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.” | **Persuasion:** The goal in this stage shifts to helping consumers develop motivation to change their substance use and mental illness management behaviors. Strategies include:
- Commit yourself to understanding consumers’ goals
- Help consumers understand the pros and cons of personal change |
Eight Governing Elements that Organize Effective Services

<table>
<thead>
<tr>
<th>3. <strong>Action:</strong></th>
<th>4. <strong>Maintenance, Relapse, and Recycling:</strong></th>
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</thead>
<tbody>
<tr>
<td>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.”</td>
<td>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.</td>
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<table>
<thead>
<tr>
<th><strong>Active Treatment:</strong></th>
<th><strong>Relapse Prevention:</strong></th>
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<tbody>
<tr>
<td>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:</td>
<td>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:</td>
</tr>
<tr>
<td>• Provide or refer to substance use disorder counseling, medication treatments, skills training and self-help groups.</td>
<td>• Develop relapse prevention plan, continue skills building in active treatment. • Support consumer in developing and maintaining a healthy lifestyle.</td>
</tr>
</tbody>
</table>

- 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
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.  

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.

<table>
<thead>
<tr>
<th>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.</th>
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</thead>
<tbody>
<tr>
<td>Implementation strategies include:</td>
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<tr>
<td>- 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”)</td>
</tr>
<tr>
<td>- Use reflective listening</td>
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<tr>
<td>- Ask clarifying questions</td>
</tr>
<tr>
<td>- Avoid challenging the client, expressing doubt, passing judgment, giving unsolicited advice</td>
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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 Management82 – 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).83 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 use 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.84

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82 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
83 Fishbowls and Candy Bars: Using Low-Cost Incentives to Increase Treatment Retention, Nancy M. Petry, Ph.D. and Michael J. Bohn, M.D


Trauma Informed Systems of Care & Support

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.\(^{85}\)

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 the Fundamental Understandings Section.

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


Supporting Youth to Thrive Manual
Eight Governing Elements that Organize Effective Services

providing support to the various persons on this list, can all experience various levels of traumatic impact.

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.nctsnn.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.
Eight Governing Elements that Organize Effective Services

- 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.  

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

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86 National Childhood Traumatic Stress Network and the National Center for PTSD
http://www.nctsn.org/content/psychological-first-aid
• Disruptive Behavior Disorders
• Substance use disorders
• Co-occurring disorders
• Dissociative Identity Disorder

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). In

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87 The David Mulhall Centre, 31 Webbs Road, London: [http://www.davidmulhall.co.uk/why-are-reflexes-retained](http://www.davidmulhall.co.uk/why-are-reflexes-retained)
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 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.
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
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.
**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 or 855-662-7474 or 855-227-5485 (TTY)
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-SS\(^88\) 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 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).

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\(^88\) http://gaincc.org/GAINSS
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.


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. 89

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 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.\textsuperscript{90}

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 \textbf{seventh 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.

\textbf{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) \textit{current} need for services.

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 it 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.91

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 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.

91 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
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.
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.
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

<table>
<thead>
<tr>
<th>Key Components for COD Supervision</th>
<th>Implementation Strategy</th>
</tr>
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<tbody>
<tr>
<td>1. Supervisory training regarding how to manage and maintain rapid response and integrated service teams is incorporated in supervisor and clinical training.</td>
<td>In addition to being trained in supervision models, clinical supervisors must be trained regarding how to manage and maintain service teams.</td>
</tr>
<tr>
<td>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.</td>
<td>Supervisors are trained and experienced in practices and programs in use and have expertise in substance use disorders, mental health, and co-occurring disorders.</td>
</tr>
<tr>
<td>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.</td>
<td>Supervision sessions for COD clients are client and family centered.</td>
</tr>
<tr>
<td>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.</td>
<td>Supervision specifically addresses both the level of care and the specific implementation of practices towards ensuring fidelity.</td>
</tr>
<tr>
<td>5. Each client and the implementation goals, progress, and referrals must be discussed a minimum of every other week.</td>
<td>Either in a group or individual supervisory session, each client and his/her progress/issues should be staffed a minimum of every other week.</td>
</tr>
<tr>
<td>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 not clinical supervision.</td>
<td>Professional and administrative supervision are clearly delineated and structured as separate functions.</td>
</tr>
</tbody>
</table>
**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.

<table>
<thead>
<tr>
<th>Service Team Structure</th>
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<tbody>
<tr>
<td><strong>Team Structure: Integrated service team</strong></td>
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<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Implementation Strategy</strong></td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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.

### Stages of Development and Change

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<tr>
<th>Team Structure</th>
<th>Implementation Strategy</th>
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<tr>
<td>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 different diagnoses, and that many factors influence readiness and motivation to engage in learning about personal change and self-management.</td>
<td>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 use must be worked with using distinctly different approaches.</td>
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</table>
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.

<table>
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<tr>
<th>Service Integration</th>
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<tr>
<td><strong>Team Structure</strong></td>
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<tr>
<td>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.</td>
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</table>

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.

<table>
<thead>
<tr>
<th>Service Team Documentation and Planning</th>
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<tbody>
<tr>
<td><strong>Team Structure</strong></td>
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<tr>
<td>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.</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Quality Management has three major components</th>
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<tbody>
<tr>
<td>Quality Assurance</td>
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<tr>
<td>Quality Control</td>
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<tr>
<td>Continuous Quality Improvement</td>
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*Supporting Youth to Thrive Manual*
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.

<table>
<thead>
<tr>
<th>Quality Control Area</th>
<th>Quality Assurance Process</th>
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<tbody>
<tr>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>2. Supervisory practices, internal and external review processes, performance and integrity criteria.</td>
<td>Professional and clinical supervision processes are reviewed and evaluated to ensure that all required supervisory practices and targets are adequately accomplished and implemented.</td>
</tr>
<tr>
<td>3. Record keeping and data management, HIPAA, CFR 42, etc.</td>
<td>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.</td>
</tr>
<tr>
<td>4. Staff competencies, such as knowledge, skill, experience, licensures, certifications, integrity, individual alignment with the organizational mission, individual motivation, and related qualifications.</td>
<td>QA processes evaluate and confirm (or deny) that staff are monitored and that competencies are maintained.</td>
</tr>
<tr>
<td>5. Organizational issues, including integrity, overall competence of service implementation, internal culture, and alignment with stated mission.</td>
<td>Assessment of organization issues occurs semi-annually to assure organization success.</td>
</tr>
<tr>
<td>6. Team quality, training agendas, and regular meeting schedule.</td>
<td>The QA committee interviews the supervisor and reviews and evaluates team meeting logs to provide oversight and feedback to the organization.</td>
</tr>
<tr>
<td>Quality Control Area</td>
<td>Quality Assurance Process</td>
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<tr>
<td>7. Adaptation and implementation of research or evidence-based practices.</td>
<td>The QA officer or committee evaluates fidelity to implemented research or evidence-based practices through review of internal and external fidelity assessments.</td>
</tr>
<tr>
<td>8. External Controls: laws, regulations, service definitions, licensure requirements, professional standards and ethics.</td>
<td>Monitors and documents alignment with all applicable law, regulations, professional standards, etc.</td>
</tr>
<tr>
<td>9. Fiscal compliance with funding sources and state entity regulations and reporting responsibilities.</td>
<td>Assesses fiscal compliance based on audits and reports.</td>
</tr>
<tr>
<td>10. Engagement rate: Must include initial engagement and re-engagement following discharge or service interruption.</td>
<td>Monitors engagement rate and evaluates best practices for increasing or sustaining high engagement to initial service rates. Report findings to agency administration.</td>
</tr>
<tr>
<td>11. Retention in service rate and duration up to discharge, and drop-out or no-show rate.</td>
<td>Monitors, evaluates and reports on retention to service, service duration, drop-outs and no-shows, and discharge data.</td>
</tr>
<tr>
<td>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.</td>
<td>Monitors, evaluates and assesses outcome measures identified by the adolescent client and their family, the provider or by the purchaser of services.</td>
</tr>
<tr>
<td>13. Comprehensive and appropriate training related to the mission and values of the organization.</td>
<td>Monitors, assesses, and evaluates all training efforts to assure alignment with all applicable quality controls.</td>
</tr>
<tr>
<td>14. Current quality management processes and protocols.</td>
<td>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.</td>
</tr>
<tr>
<td>15. Internal controls and standards as identified by the organization.</td>
<td>Assess, evaluate, report, and develop workplans to address needed changes or sustain quality management related to controls and standards.</td>
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</table>
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.\textsuperscript{92}

<table>
<thead>
<tr>
<th>Quality Management Component</th>
<th>Implementation Strategy</th>
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<tbody>
<tr>
<td>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.</td>
<td>Develop and maintain a QA steering committee that meets at least every six months and specifically addresses COD-competent service delivery issues.</td>
</tr>
<tr>
<td>2. A thorough assessment of COD competent IOP services should be conducted, preferably by an external reviewer, using the IOP AFT.</td>
<td>Review fidelity to COD competent IOP, preferably by an external reviewer with knowledge of COD-competent IOP and the use of the IOP AFT.</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
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</table>

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?

<table>
<thead>
<tr>
<th>Quality Management Component</th>
<th>Implementation Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Make recommendations to steering committee for improvement to services for individuals with COD.</td>
</tr>
<tr>
<td>5. The agency actively develops a culture among providers and the community that promotes COD-competent service practices.</td>
<td>Advocate and promote COD-competent service practices within the agency and in the community.</td>
</tr>
<tr>
<td>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.</td>
<td>Collect and track adolescent client and family process and outcome measures relevant to the program model in areas described above.</td>
</tr>
</tbody>
</table>
What you will find:

- **Research and Evidence-Based Treatment Approaches**
  Interventions that are based on solid scientific evidence.

- **Eleven 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.

- **Medication-Assisted Treatment, Pharmacotherapy, and Medication Management**
  Medication-assisted treatment (MAT) is the use of medications with counseling and behavioral therapies to treat substance use disorders and prevent opioid overdose.

- **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.
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.93

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

93 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:


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.)

In addition, the following short list of other complementary practices and EBPs 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)
- Functional Family Therapy (FFT)
- Adolescent Community Reinforcement Approach (ACRA)

94 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.
• Anger management
• Seeking Safety
• Family psycho-education and counseling
• 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). 95

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. 96

95 Contributed by Karan Northfield, LPCC, Manager of Quality Improvement, OptumHealth New Mexico
96 New Mexico Office of Substance Abuse Prevention Contracting Specifications 2014
More specifically, the actual activities during the adolescent IOP startup process that require funding will likely be:

- 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

<table>
<thead>
<tr>
<th>Federal Block Grants</th>
<th>NM State Grants</th>
<th>NM State General Funds</th>
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</thead>
<tbody>
<tr>
<td>• Substance Abuse and Mental Health Services Administration (SAMHSA)</td>
<td>• Communities of Care (SOC)</td>
<td>• BHSD</td>
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<tr>
<td>• Substance Abuse, Prevention, and Treatment (SAPT)</td>
<td>• Healthy Transitions</td>
<td>• CYFD</td>
</tr>
<tr>
<td>• Center for Mental Health Services (CMHS)</td>
<td>• Adolescent Substance Use Reduction Effort Treatment Implementation(ASURE TI)</td>
<td>• DOH</td>
</tr>
</tbody>
</table>

Current EBP funding sources in New Mexico include
City and county contracts, private foundation grants, and local, regional, and national foundations, may fund specific areas of behavioral health, but not all; check foundation guidelines for more detail.
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. 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.

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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.
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.”

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

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sustained sobriety following treatment and high treatment re-admission rates.”\footnote{White, W. & Godley, S. (2007) \textit{Adolescent recovery: What we need to know}. Student Assistance Journal, 19(2), 20-25.} 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 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.
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 Programatically 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.
Pharmacotherapy & Medication Management

For an in-depth discussion of Pharmacotherapy Related to Opioid Treatment, please refer to the section in this manual.

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)

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 Use Disorder**

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.

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*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*  Copyright © 2009 by Florian Birkmayer, M.D. 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

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100 The Interface of Multiculturalism and Psychopharmacology (2006) : Jose A. Rey, PharmD, BCPP

http://jpp.sagepub.com/content/19/6/379.abstract
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.
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.101 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.102 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.103

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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.

<table>
<thead>
<tr>
<th>Principles of Service</th>
<th>Implementation Strategy</th>
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<tr>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>
### Principles of Service

1. **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 conducted by supervisory staff ensures that integrated COD services are consistent with level of need and functional impairment.

2. **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).

3. 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.
IOP providers shall strive to provide individualized, integrated and effective services.

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<tr>
<th>Principles of Service</th>
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<tr>
<td>4. Service is provided primarily in a clinical setting.</td>
<td>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 building skills.</td>
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IOP providers shall strive to provide individualized, integrated and effective services.

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<tr>
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<tr>
<td>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.</td>
<td>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.</td>
</tr>
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</table>
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

<table>
<thead>
<tr>
<th>Author</th>
<th>Bio</th>
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<tbody>
<tr>
<td>Arturo R. Calderon</td>
<td>Arturo R. Calderon has a bachelor's degree in Psychology and Economics and a master's degree in clinical social work. He has been working with New Mexico families for 8 years as a service provider and Wraparound practitioner. He currently works with CYFD as a state-wide Wraparound coordinator with the Communities of Care grant.</td>
</tr>
<tr>
<td>Craig Pierce</td>
<td>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 use 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.</td>
</tr>
</tbody>
</table>
| Doug Robinson | 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.”  

**WRITING:** Doug’s long-awaited book, *The Alchemy of Action*, 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.  


Recipient of the American Alpine Club’s Literary Award, 2010.  

**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.  

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.  

**VIDEO:** Produced, wrote and hosted Moving Over Stone (1988), which was groundbreaking in its fusion of instruction and entertainment, basics to cutting-edge. |
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<tr>
<th>Name</th>
<th>Description</th>
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<tr>
<td>Guiding</td>
<td>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.</td>
</tr>
<tr>
<td>Erica Padilla</td>
<td>Erica Padilla is the State Wide Youth Coordinator for New Mexico Behavioral Health Services with Children Youth and Families Department. She supports and coaches Local Youth Coordinators, Communities of Care Sites and Youth Outreach Workers for the Healthy Transition Grant by providing ongoing training and one on one support through Youth Voice and Choice through advocacy and positive peer relationships. She has created and supported youth involvement and participation both locally and statewide. As someone with first hand experience in foster care as a young person, she has advocated for foster youth rights and choice since she was 15 and is honored to continue those efforts. She believes that a young person is capable of living their life to the fullest, with love and support from friends, family and the community; and that youth have a responsibility to themselves and their communities to live a happy and meaningful life.</td>
</tr>
<tr>
<td>Jenn Jevertson</td>
<td>Jenn has a Master’s Degree in Adventure Education and has eighteen years experience working with individuals in wilderness and adventure settings. As a queer identified activist, she combines her passions for social justice, nature, and teaching through therapeutic adventure. Through her company, Prevention at Play, she provides custom-designed consultation, trainings and programs to both youth and adults on topics such as community building, life skills development, bullying, gender identity/sexual orientation, and anti-oppression.</td>
</tr>
<tr>
<td>Kerry Moriarty</td>
<td>Kerry Moriarty is currently the Clinical Specialist working on the ASURE team at CYFD, Behavioral Health Services. She is an LPCC, with a master’s degree in Art Therapy and Counseling, as well as a bachelor’s degree in Art Therapy. She has worked in various capacities with the mentally ill and developmentally disabled for the past 14 years. 7 of those years were spent as an advocate, counselor, and evaluator for those incarcerated in jails and prisons.</td>
</tr>
<tr>
<td>Michael Gass</td>
<td>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 Journal of Therapeutic Schools and Programs, 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.</td>
</tr>
<tr>
<td>Michael Hock</td>
<td>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. 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.</td>
</tr>
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</table>
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.

**Michael Morton**

Michael A. Morton, PhD, LMFT, Individual and Family Therapist, Author, Consultant and Trainer, holds a Doctorate in Psychology and is a California and New Mexico licensed marriage, family and child counselor as well as a trained mediator. He taught at the Masters level in psychology and counseling at several colleges. Michael also served on the *Crime, Substance Abuse, and Terrorism Task Force* of the National Foundation of Women Legislators as a delegate in the hemispheric dialogues between the United States, Canada and Mexico addressing related policy issues and legislative priorities. As an author, his book *Five Steps to Selecting the Best Alternative Medicine* (New World Library, 1997) a Double Day Book Club Selection receiving praise and endorsements from the professional health care community as a major contribution to the field. He was the founding president of the American Holistic Health Association.

**Michael Ruble**

Twenty-years ago, Michael began working in a large non-profit organization supporting people with HIV/AIDS. From that point forward, he has created, implemented and managed programs and community-based agencies throughout the Southwest. The populations he serves includes people with the following issues and/or conditions: homelessness, substance use, incarceration, and at risk or transitioning youth and young adults. Now, as project director of Healthy Transitions – New Mexico, he has been able to call upon his life experiences, education, and compassion to help create an innovative program to support youth and young adults as they transition into adulthood. Michael has over seventeen years’ experience with the adult recovery community.

**Natalie Skogerboe**

Natalie has worked as a program coordinator and consultant in the substance use 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 use prevention grants for the State and local community programs.

**Olin Dodson**

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.

**Porfirio “Pilo” Bueno**

Pilo has decades of experience in prevention, treatment, and recovery services. Mr. Bueno began his career in the 1980s when New Mexico saw its first cases of HIV AIDS. Initially Mr. Bueno provided emotional support to men and women living with AIDS. Soon Mr. Bueno was hired by New Mexico AIDS Services to serve as the Director of the Gay Men’s Health Project where he began his work in prevention and in public health. Mr. Bueno is currently serving as the Director of Recovery for Presbyterian Health Plan and Magellan Healthcare. Mr. Bueno started with Magellan Health in 2013 after serving as the Director of Cultural Competency for OptumHealth New Mexico. Mr. Bueno served as the Director of Substance Abuse Prevention for Value Options New Mexico, the Executive Director for the Santa Fe Mountain Center and in
leadership roles with the State of New Mexico, Department of Health where he was instrumental in developing the evaluation and delivery systems for the Strategic Prevention Framework initiatives. Mr. Bueno is passionate about developing capacity and resources to mitigate disparities and promote social justice efforts. Mr. Bueno studied art in Aix-en-Provence, France at the Leo Marchutz School of Drawing and Painting, Accounting at the Santa Fe Business College, and evaluation at the University of New Mexico School of Medicine.

| Shannon Morrison | 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. |
| Sky Gray | 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, and was the Executive Director of the Santa Fe Mountain Center. Sky is deeply engaged in social justice and social change work. 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 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. |
| Victoria Cantwell | Victoria Cantwell is a member of Youth M.O.V.E and is Youth Engagement trainer for northern New Mexico. She is currently an undergraduate at UNM and is dual-majoring in human resources and policy reform and environmental sociology with a dual minor in economics and demographics. She started out while in high-school volunteering and attending conferences with CYFD and then progressed to becoming a youth intern with the behavioral and mental division of CYFD. She advocates not only for youth driven initiatives but for the youth engagement in her community as well as others. |


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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)

Adverse Childhood Experiences (ACE) Study, www.acestudy.org
http://aip.psychiatryonline.org/cgi/content/full/164/3/402

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


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.bhrm.org/guidelines/Minkoff.pdf

CDC Positive Parenting Tips for Healthy Child Development;

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


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

http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

http://www.ihi.org/resources/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx


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

http://mentalhealth.samhsa.gov/nctic/default.asp - Trauma-informed care
http://ncadi.samhsa.gov/
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.preareresourcemanagercenter.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
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
APPENDICES

Appendix A: Stages of Adolescent Development

Appendix B: 41 Developmental Assets

Appendix C: CYFD Policy & Procedure Manual
Appendix A: Stages of Adolescent Development

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<thead>
<tr>
<th>Stages of Adolescence</th>
<th>Physical Development</th>
<th>Cognitive Development</th>
<th>Social-Emotional Development</th>
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<tbody>
<tr>
<td>Early Adolescence</td>
<td>Puberty: grow body hair, increase perspiration and oil production in hair and skin&lt;br&gt;Girls – breast and hip development, onset of menstruation&lt;br&gt;Boys – growth in testicles and penis, wet dreams, deepening of voice&lt;br&gt;Tremendous physical growth: gain height and weight&lt;br&gt;Greater sexual interest</td>
<td>Growing capacity for abstract thought&lt;br&gt;Mostly interested in present with limited thought to the future&lt;br&gt;Intellectual interests expand and become more important&lt;br&gt;Deeper moral thinking</td>
<td>Struggle with sense of identity&lt;br&gt;Feel awkward about one’s self and one’s body; worry about being normal&lt;br&gt;Realize that parents are not perfect; increased conflict with parents&lt;br&gt;Increased influence of peer group&lt;br&gt;Desire for independence&lt;br&gt;Tendency to return to “childish” behavior, particularly when stressed&lt;br&gt;Moodiness&lt;br&gt;Rule- and limit-testing&lt;br&gt;Greater interest in privacy</td>
</tr>
<tr>
<td>Middle Adolescence</td>
<td>Puberty is completed&lt;br&gt;Physical growth slows for girls, continues for boys</td>
<td>Continued growth of capacity for abstract thought&lt;br&gt;Greater capacity for setting goals&lt;br&gt;Interest in moral reasoning&lt;br&gt;Thinking about the meaning of life</td>
<td>Intense self-involvement, changing between high expectations and poor self-concept&lt;br&gt;Continued adjustment to changing body, worries about being normal&lt;br&gt;Tendency to distance selves from parents, continued drive for independence&lt;br&gt;Driven to make friends and greater reliance on them, popularity can be an important issue&lt;br&gt;Feelings of love and passion</td>
</tr>
<tr>
<td>Late Adolescence</td>
<td>Young women, typically, are fully developed&lt;br&gt;Young men continue to gain height, weight, muscle mass, and body hair</td>
<td>Ability to think ideas through&lt;br&gt;Ability to delay gratification&lt;br&gt;Examination of inner experiences&lt;br&gt;Increased concern for future&lt;br&gt;Continued interest in moral reasoning</td>
<td>Firmer sense of identity&lt;br&gt;Increased emotional stability&lt;br&gt;Increased concern for others&lt;br&gt;Increased independence and self-reliance&lt;br&gt;Peer relationships remain important&lt;br&gt;Development of more serious relationships&lt;br&gt;Social and cultural traditions regain some of their importance</td>
</tr>
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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](http://www.prearesourcecenter.org/sites/default/files/content/6_stages_of_adolescent_development.pdf)
Appendix B: 41 Developmental Assets® for Adolescents

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<tr>
<th>41 Developmental Assets® for Adolescents ages 12-18&lt;sup&gt;104&lt;/sup&gt;</th>
</tr>
</thead>
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### Support

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<tr>
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<tbody>
<tr>
<td>1.</td>
<td><strong>Family Support:</strong> Family life provides high levels of love and support</td>
</tr>
<tr>
<td>2.</td>
<td><strong>Positive Family Communication:</strong> Young person and her/his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents</td>
</tr>
<tr>
<td>3.</td>
<td><strong>Other adult relationships:</strong> Young person receives support from 3 or more nonparent adults</td>
</tr>
<tr>
<td>4.</td>
<td><strong>Caring Neighborhood:</strong> Young person experiences caring neighbors</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Caring School Climate:</strong> School provides a caring, encouraging environment</td>
</tr>
<tr>
<td>6.</td>
<td><strong>Parent Involvement in Schooling:</strong> Parent(s) are actively involved in helping young people succeed in school</td>
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### Empowerment

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<tbody>
<tr>
<td>7.</td>
<td><strong>Community Values Youth:</strong> Young person perceives that adults in the community value youth</td>
</tr>
<tr>
<td>8.</td>
<td><strong>Youth as Resources:</strong> Young people are given useful roles in the community</td>
</tr>
<tr>
<td>9.</td>
<td><strong>Service to Others:</strong> Young person serves in the community 1 hour per week</td>
</tr>
<tr>
<td>10.</td>
<td><strong>Safety:</strong> Young person feels safe at home, school and in the neighborhood</td>
</tr>
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### Boundaries & Expectations

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<tbody>
<tr>
<td>11.</td>
<td><strong>Family Boundaries:</strong> Family has clear rules and consequences and monitors the young person’s whereabouts</td>
</tr>
<tr>
<td>12.</td>
<td><strong>School Boundaries:</strong> School provides clear rules and consequences</td>
</tr>
<tr>
<td>13.</td>
<td><strong>Neighborhood Boundaries:</strong> Neighbors take responsibility for monitoring young person’s behavior</td>
</tr>
<tr>
<td>14.</td>
<td><strong>Adult Role Models:</strong> Parent(s) and other adults model positive, responsible behavior</td>
</tr>
<tr>
<td>15.</td>
<td><strong>Positive Peer Influence:</strong> Young person’s best friends model responsible behavior</td>
</tr>
<tr>
<td>16.</td>
<td><strong>High Expectations:</strong> Both parent(s) and teachers encourage the young person to do well</td>
</tr>
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### Constructive Use of Time

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<tbody>
<tr>
<td>17.</td>
<td><strong>Creative Activities:</strong> Young person spends three or more hours per week in lessons or practice in music, theater, or other arts</td>
</tr>
<tr>
<td>18.</td>
<td><strong>Youth Programs:</strong> Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community</td>
</tr>
<tr>
<td>19.</td>
<td><strong>Religious Community:</strong> Young person spends one or more hours per week in activities in a religious institution</td>
</tr>
<tr>
<td>20.</td>
<td><strong>Time at Home:</strong> Young person is out with friends “with nothing special to do” two or fewer nights per week</td>
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### Commitment to Learning

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<tbody>
<tr>
<td>21.</td>
<td><strong>Achievement Motivation:</strong> Young person is motivated to do well in school</td>
</tr>
<tr>
<td>22.</td>
<td><strong>School Engagement:</strong> Young person is actively engaged in learning</td>
</tr>
<tr>
<td>23.</td>
<td><strong>Homework:</strong> Young person reports doing at least one hour of homework every school day</td>
</tr>
<tr>
<td>24.</td>
<td><strong>Bonding to School:</strong> Young person cares about her/his school</td>
</tr>
<tr>
<td>25.</td>
<td><strong>Reading for Pleasure:</strong> Young person reads for pleasure three or more hours per week</td>
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### Positive Values

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<tr>
<td>26.</td>
<td><strong>Caring:</strong> Young person places high value on helping other people</td>
</tr>
<tr>
<td>27.</td>
<td><strong>Equality and Social Justice:</strong> Young person places high value on promoting equality and reducing hunger and poverty</td>
</tr>
<tr>
<td>28.</td>
<td><strong>Integrity:</strong> Young person acts on convictions and stands up for her/his beliefs</td>
</tr>
<tr>
<td>29.</td>
<td><strong>Honesty:</strong> Young person “tells the truth even when it is not easy”</td>
</tr>
<tr>
<td>30.</td>
<td><strong>Responsibility:</strong> Young person accepts and takes personal responsibility</td>
</tr>
<tr>
<td>31.</td>
<td><strong>Restraint:</strong> Young person believes it is not important to be sexually active or to use alcohol or other drugs</td>
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### Social Competence

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<tbody>
<tr>
<td>32.</td>
<td><strong>Planning and Decision Making:</strong> Young person knows how to plan ahead and make choices</td>
</tr>
<tr>
<td>33.</td>
<td><strong>Interpersonal Competence:</strong> Young person as empathy, sensitivity and friendship skills</td>
</tr>
<tr>
<td>34.</td>
<td><strong>Cultural Competence:</strong> Young person has knowledge of and comfort with people of difference cultural/ethnic backgrounds</td>
</tr>
<tr>
<td>35.</td>
<td><strong>Resistance Skills:</strong> Young person can resist negative peer pressure and dangerous situations</td>
</tr>
<tr>
<td>36.</td>
<td><strong>Peaceful Conflict Resolution:</strong> Young person seeks to resolve conflict nonviolently</td>
</tr>
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### Positive Identity

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<tbody>
<tr>
<td>37.</td>
<td><strong>Personal Power:</strong> Young person feels he or she has control over “things that happen to me”</td>
</tr>
<tr>
<td>38.</td>
<td><strong>Self-esteem:</strong> Young person reports having a high self-esteem</td>
</tr>
<tr>
<td>39.</td>
<td><strong>Sense of Purpose:</strong> Young person reports that “my life has a purpose”</td>
</tr>
<tr>
<td>40.</td>
<td><strong>Positive view of Personal Future:</strong> Young person is optimistic about her/his personal future</td>
</tr>
<tr>
<td>41.</td>
<td><strong>Positive Cultural Identity:</strong> Young person feels proud of her/his cultural background</td>
</tr>
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Appendix C: Policy and Procedure Manual

The New Mexico CYFD
Supporting Youth to Thrive Manual
Policies & Procedures ©

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Please use the following citation:
New Mexico Children, Youth and Families Department, Supporting Youth to Thrive Manual, September 2017.

<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 the following sections listed in this manual, and are used within the ASURE Supporting Youth to Thrive Manual web-based provider self-assessment:

- Eight Governing Elements that Organize Effective Services
- Initial Procedures of Care and Planning
- Personnel, Team, and System Competencies,
- Treatment implementation Practice Standards
General Table of Contents for PROVIDER NAME Manual

I. General Systems

II. Assuring Client Rights and Responsibilities

III. Hazard and Emergency Management

IV. Supervision of Behavioral Health Services

V. Philosophy of Approach and Principles of Practice

VI. Initiation of Services

VII. Treatment Implementation Practice Standards

VIII. Agency Quality Management

Appendix A: Federal Employment Protections Overview

Material in this document is current as of August, 2017
SECTION I - GENERAL SYSTEMS

TABLE OF CONTENTS

A. Overview

B. Mission Statement

C. Statement of Values, Principles, and Ethics

D. Organization Management and Governance
   - Insert an organizational chart and, if the agency has multiple sites, site specific organizational charts;
   - Describe the manner in which the agency is structured, such as a board of directors, an owner operated business;
   - Is the agency a non-profit or for-profit;
   - Is it a private or governmental agency;
   - Is the agency broken into separate service management (youth services, adult services, mental health illness, substance disorders, etc?)

E. Funding and Financial Management
   - List each funding source and anything unique that the agency staff should know

F. Services Offered
   - List each service with a description

G. Organizational Operations

H. Record Management
   - List all record management P/Ps, including things like the need for an annual review to determine if the current software meets the needs of clinicians, administrative staff, human resources, and the quality team.
   - List P/Ps that inform or direct agency staff (clinical, HR, and administrative) how files are stored, accessed, returned, and destroyed; and what is included in personnel or contract files

I. Agency’s annual calendar of quality audit activities
   - The calendar provides at a glance the start and end dates for specific audit efforts, such as review of clinical staff personnel or contract files for specific information and such as adherence to the various supervision requirements.
   - Whenever the agency has set a date (quarterly, semi-annually, or weekly) in its procedures, it should be included in this calendar.
I. GENERAL SYSTEMS
A. Overview

Policy Number: 1
Approval Date:
Revision Date:

Purpose: In order to administer, implement, and evaluate the services rendered by PROVIDER NAME, it must develop and maintain its infrastructure and organizational capacity by providing:
A. Direction (policies and procedures);
B. Continuity (services consistently provided); and
C. Accountability (audits and reviews).

Overall Functions:
A. PROVIDER NAME policies and procedures provide clear and descriptive directions for each function to be accomplished, provides information to determine who provides the oversight for the implementation of the various clinical and administrative functions and responsibilities; and finally, has detailed procedures for PROVIDER NAME staff to conduct reviews and evaluations of staff, audit systems, and measure client and family outcomes.

B. PROVIDER NAME administrative and clinical systems are aligned, and there are mechanisms in place to support administrative and clinical management decisions concerning service delivery and staffing considerations. When PROVIDER NAME clients and their families, and collaborating agencies interact with PROVIDER NAME staff, they encounter coordinated and responsive services to provide clients and their families with consistent and competent services.

C. PROVIDER NAME maintains the accountability of its operations and services by conducting audits and reviews to determine whether its:
1. Systems are in compliance with best clinical practices, industry standards, and regulated funding sources requirements.
2. Fiscal operations are responsive to the needs of the agency and are tightly managed and controlled to support PROVIDER NAME mission, values, and goals for clients, families, and agency staff members.
3. PROVIDER NAME staff is supported with the training, tools, materials, and supervision necessary to provide high quality administrative and clinical services.
4. Clients, families, and community resources feel engaged and valued for what each brings to the agency in ideas, solutions, potential areas of agency growth, and a system-wide feeling of purposefulness is generated in each policy and procedure.

Refer to Appendix A for Federal Employment Protections Overview
I. GENERAL SYSTEMS
B. Mission Statement
Policy Number: 1
Approval Date:
Revision Date:

Purpose: PROVIDER NAME has a mission statement, developed with its staff, clients and their families, collaborating agencies, to guide the overarching principles of PROVIDER NAME beliefs, practices, and service delivery.

Policy: The Job Title works in a collaborative manner with the Board of Directors, executive, clinical and administrative staff, clients and their families, and with collaborating agencies to develop and maintain a mission statement to guide its staff recruiting efforts, to maintain its highly quality staff, to seek out highly effective evidence-based practices, and finally, to provide the internal mechanisms to implement, monitor, track and audit PROVIDER NAME policies and procedures.

Staff Responsible for Implementation:
Executive Director or whomever the Board of Directors appoints

- The agency’s organizational chart and job descriptions list the individual functions a staff member is to fulfill outside of his or her specific job duties. An example is Administrative Manager spearheads the process for annual review of the agency’s mission statement. The agency uses the job title of Administrative Manager, not the function of mission statement review lead.
- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The Job Title, during the first month of the last quarter of the operating year, arranges and attends separate meetings with the Board of Directors*, executive staff, clinical staff, administrative staff, its clients and families (current and past), and collaborating agencies to review PROVIDER NAME mission statement and recommend revisions as needed.
2. The Job Title presents to the Board of Directors his or her final recommendations.
3. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval.
4. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule administrative and clinical staff training as a refresher.

*If the agency does not have a governing board of directors, substitute the appropriate chain of command position title.
I. GENERAL SYSTEMS  
C. Statement of Values, Principles, Ethics  
Policy Number: 1  
Approval Date:  
Revision Date:  

**Purpose:** Ethics and ethical conduct are essential elements to all behavioral health services provided at PROVIDER NAME regardless of funding source. All PROVIDER NAME staff and all business or professional associates of PROVIDER NAME are expected to meet the highest standards of ethical conduct. Such conduct includes:  
1. Initiating and maintaining honest and principled client and family relations;  
2. Initiating and maintaining honest and respectful relations with collaborating agencies and stakeholders;  
3. Initiating and maintaining trustworthy and honest relations with its funding sources and other state-wide stakeholders;  
4. Initiating actions to support staff refrain from engaging in circumstances or conditions that could lead to dual relationships or conflicts of interest, either personal or professional; and  
5. Initiating and maintaining adherence to funding sources laws, rules, service standards, billing instructions, regulations requirements of specific types of ethical practices and guidelines. Specific care and attention to HIPAA and 42 CFR Part 2 must underscore all service ethics related to confidentiality and protected health information.  
6. Support and ensure all licensed and credentialed staff or contractors adhere to professional ethical standards as established by their practice boards or certifying bodies, and licensure and certification is rigorously maintained.  

**Policy:** The Job Title works in a collaborative manner with the Board of Directors, executive, clinical and administrative staff, clients and their families, and with collaborating agencies to develop and maintain its statement of values, principles and ethics that match its values and beliefs for recruiting, maintaining high quality staff, for rendering high quality evidence-based practices, for providing a mechanism to implement, monitor, track and audit its policies and procedures.  

**Staff Responsible for Implementation:**  
Executive Director or whomever the Board of Directors appoints  
- List the job title of the staff, not the function the staff person is fulfilling.  
- The agency’s organizational chart and job descriptions list the individual functions a staff member is to fulfill outside of his or her specific job duties. An example is Administrative Manager spearheads the process for annual review of the agency’s mission statement. The agency uses the job title of Administrative Manager, not the function of mission statement review lead.
Procedures:
1. The Job Title during the first month of the last quarter of the operating year arranges and attends separate meetings with the Board of Directors, the executive staff, clinical staff, administrative staff, its clients and families, and collaborating agencies to review PROVIDER NAME statement of values, principles and ethics and recommend revisions as needed.
2. The Job Title presents to the Board of Directors his or her final recommendation to update the statement of values, principles and ethics or to retain the current version.
3. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval.
4. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical and administrative staff training as a refresher.

I. GENERAL SYSTEMS
D. Organization Management and Governance
Policy Number: 1
Approval Date:
Revision Date:

Purpose: PROVIDER NAME has clear lines of communication, a chain of command in order to provide consistent and accurate information to its staff, client and their families, funding sources, and collaborating agencies as to who has direct responsibility for each function of PROVIDER NAME. Such information supports the mission of PROVIDER NAME to be accountable and responsive as it delivers high quality services.

Policy: PROVIDER NAME develops and maintains an organizational chart that details job titles with assigned functions.
- Example – Clinical Supervisor: quality assurance team lead, clinical staff supervisor, executive management team member, etc. If the agency operates multiple sites, it attaches site specific organizational charts and explains in writing how each site integrates into the central site.

Staff Responsible for Implementation:
- This is the job title the agency has determined monitors, tracks, and evaluates the agency’s implementation of the policies and procedures. There may be different titles listed.(Example: Clinical Supervisor reviews of the clinical files, the HR reviews the personnel files, and the overall Quality Team Lead is responsible for evaluating the effectiveness the policy and procedures.)
- Remember to list the Job Title, not the function he or she is fulfilling. The organizational chart and job descriptions will detail all the functions assigned to that one Job Title.
Procedures:
1. The Job Title, with the clinical supervisor and Human Resources Manager, during the last quarter of the operating year a review of PROVIDER NAME organizational structure to determine if the status remains accurate and, if not, to recommend revisions to the Board of Directors.
2. The Job Title presents within two weeks to the Board of Directors his or her final recommendation.
3. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval.
   - INSERT ORGANIZATIONAL CHART WITH JOB TITLES AND BROAD FUNCTIONS ASSIGNED – IF A NEW POSITION OR NEW STAFF MEMBER CHANGES ASSIGNED FUNCTIONS, THIS CHART SHOULD BE REVISED.
I. GENERAL SYSTEMS
E. Funding and Financial Management

Policy Number: 1
Approval Date: 
Revision Date: 

Purpose: PROVIDER NAME funding sources meet the needs of the agency and there are assigned functions and responsibilities:
1. To ensure PROVIDER NAME meets industry's standards for fiscal management;
2. To ensure PROVIDER NAME meets each funding source's unique fiscal requirements;
3. To ensure there is an annual audit to determine if PROVIDER NAME is meeting its fiscal responsibilities.

Policy: PROVIDER NAME conducts or arranges to have conducted annual audits of its fiscal accounting systems to determine if the policies and procedures are uniformly implemented.

Staff Responsible for Implementation:
Job Title for the staff person who is the lead for the fiscal operations of the agency.
- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The Job Title develops and maintains a schedule of monthly, quarterly, semi-annual, and annual dates for auditing activities that occur at different points in PROVIDER NAME operating year for the following operating year – name the month/quarter/semi-annual/annual dates and functions with assigned lead staff as an appendix. The annual calendar could address this procedure if the agency includes are a part of the calendar the functions and leads (by job title).
2. The Job Title presents to the Board of Directors his or her audit findings and recommendations within one month after the close of the audit.
3. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board's approval.
4. The Job Title responsible for the submission of claims to MAD or its MCOs, or other funding sources reviews the applicable New Mexico Administrative Code rules, service definitions, billing instructions, utilization requirements, MCO specific provider instructions, and other funding source requirements semi-annually.
5. The Job Title requests to be placed on the MAD Interested Parties List in order to receive copies of proposed and final NMAC rules related billing and claims submission.
6. If MAD amends the processes, Job Title reviews PROVIDER NAME internal processes for claim submission within 10 working days of receipt of approved amendments.
7. The Job Title submits within one week of a HSD's or MCO's or other funding sources' newly approved billing or claims submission changes his or her recommendations to Job Title.
8. The Job Title works with Job Title of the administrative staff to revise the internal processes and remove the previous version and replace it with the newly approved version and disseminate to staff with responsibilities of submitting billing information to PROVIDER NAME.

9. When the decision is made to retain the current version, the Job Title of trainer works with the Job Title of whoever makes the training calendar to schedule annual agency staff training as a refresher.
   - The agency must have established internal fiscal policies and procedures under which it operates.
   - If the agency already has its own financial manual policies and procedures, place it as an appendix.

I. GENERAL SYSTEMS
F. Services Offered
Policy Number: 1
Approval Date:
Revision Date:

**Purpose:** PROVIDER NAME requires all clinical and administrative staff to be knowledgeable of the services it renders to assist clients determine appropriate services for themselves and their families, and for collaborating agencies to be knowledgeable of the services available at PROVIDER NAME.

**Policy:** PROVIDER NAME develops and maintains a listing of current services it operates which details:
The identified population (age range, diagnosis if required)
Evidence-based practices (EBP) utilized in the delivery of a specific specialized behavioral health service.
Staff required to be trained in EBP

**Staff Responsible for Implementation:**
Job Title assigned (usually the Executive Director or Clinical Supervisor)
   - Remember to list the Job Title, not the function he or she is fulfilling.
I. GENERAL SYSTEMS

F. Services Offered

Policy Number: 2
Approval Date: 
Revision Date: 

Purpose: PROVIDER NAME requires all clinical and administrative staff to be knowledgeable of the services it renders to assist clients determine appropriate services for themselves and their families, and for collaborating agencies to be knowledgeable of the services available at PROVIDER NAME.

• Insert a list all services the agency offers or place it as an appendix.

Policy: PROVIDER NAME develops and maintains a process that describes how it determines when to add to or terminate a service.

Staff Responsible for Implementation:
Job Title assigned (usually the Executive Director or Clinical Supervisor)

• Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The Job Title who is responsible for this aspect of its quality team conducts an audit of the services offered by the agency during the first month of the second quarter of the operating year and recommends to the Job Title (executive director or possibility clinical supervisor) terminating a service or adding a new service.
2. The Job Title conducts a study to determine the feasibility of the recommendations within one month of the completion of the audit and presents to the Job Title.

Example: Intensive Outpatient Treatment Services

Identified Population:
13 years and older
Has a Substance Use Disorder or a substance use disorder with co-occurring mental illness diagnosis
Meets American Society of Addiction Medicine Level of Care 2.1 - Intensive Outpatient Services

Evidence-based Practices/Programs:
Name IOP EBP Model (Matrix, Seven Challenges, etc)
Motivational Interventions
Seeking Safety
Stage-wise Interventions

Staff Required to be trained in EBPs:
Clinical Supervisor over IOP services
All clinicians rendering IOP services
3. The Job Title, within two weeks of the completion of the feasibility study, makes his or her final recommendations to the Board of Directors for termination of an existing service or to seek additional funding to provide a new service.

4. The Job Title develops a schedule that is detailed in due dates, Job Titles to be involved, tasks, reporting, monitoring, tracking, and evaluating the progress towards completion of the project within two months of the Board's approval.

I. GENERAL SYSTEMS

G. Organization Operation

Policy Number: 1
Approval Date:
Revision Date:

Purpose: The PROVIDER NAME takes the necessary steps and measures to ensure its clinician meets his or her job requirements for licensure, certification, training, health and safety practices in order to render high quality and maintain high fidelity services to its clients

Remember:
List the Job Title of the individual staff positions, not the function he or she is fulfilling (the Clinical Supervisor is the Quality Team leader...use his or her job title – Clinical Supervisor, not Quality Team Lead.

Policies:
1. The PROVIDER NAME has an agency-wide non-discrimination policy to ensure employees, clinicians, clients and their families, and other stakeholders PROVIDER NAME enacts while conducting business and services are treated with respect and inclusion.
2. The PROVIDER NAME has systems in place to ensure clinician’s initial hire files contain documents to substantiate the clinician’s ability to render services.
3. The PROVIDER NAME conducts ongoing monitoring and tracking of each clinician’s status with his or her practice board’s licensure, required certifications to render specific services, ongoing required State or agency background or registry checks, any required trainings, CEUs to maintain licensure/certification, and other requirements to maintain employment with the agency, such as health and safety practices: random drug screenings, CPR, TB screens.

Procedures:
1. Each job description must include:
   a. Assigned job duties (functions of the position) an employee or contractor is to fulfill.
   b. The position’s supervision requirements, education, experience, licensure requirements, New Mexico and agency background checks.
   c. Specific PROVIDER NAME agency requirements such health and safety practice requirement for an initial UA screen and random screenings thereafter, TB test, etc).
2. Prior to the offer of employment, the Job Title must:
   a. Verify with the applicant’s practice board licensure;
   b. Have applicant complete a New Mexico background registry check; and
   c. Have in hand all CEUs and certifications required for the job position and the services he or she will render; and
   d. The clinical supervisor have reviewed all CEUs and certifications to verify they meet PROVIDER NAME requirements for specific services, i.e. IOP, MST, etc.

3. After the offer of employment has been made and accepted by the application and prior to rendering services, the Job Title:
   a. Holds the new hire complete the PROVIDER NAME new hire form;
   b. Holds verification the clinician is a currently enrolled MAD provider with his or her unique provider number
   c. Holds verification the agency has submitted a MAD 312 to MAD’s fiscal agent and appropriate MCO and been approved to submit claims for reimbursement on behalf of the clinician;
   d. The Job Title places the documents into the clinician’s personnel file.

4. The Job Title logs within 5 working days of each hire, the applicant’s license, certification, training and other compliance requirement (such as CPR/TB) renewal dates into the master annual calendar.

5. Sixty calendar days prior to the expiration date of the clinician’s license, certification and training, and agency’s requirements (TB, UA, etc), Job Title sends weekly reminders to the clinician.

6. Starting three weeks prior to the clinician’s license expiration, Job Title requests weekly status updates from the clinician.

7. Job Title verifies the practice board of the clinician’s the date of his or her license or certification expiration.

8. If the clinician has failed to renew non-licensure requirements, the PROVIDER NAME may initiate disciplinary measures.

9. If the clinician has failed to renew his or her license or certification, the clinician cannot render services until he or she presents to Job Title proof of current licensure.

10. If the clinician’s license is not renewed, PROVIDER NAME may initiate termination procedures.

I. GENERAL SYSTEMS
H. Record Management
Policy Number: 1
Approval Date:
Revision Date:

Purpose: In order to provide quality services and meet funding sources documentation requirements, PROVIDER NAME must have a process in place to ensure a staff member is adequately trained early in his or her tenure and then on an annual basis on how to navigate and update client and personnel information.
Policy:
1. PROVIDER NAME has a secure, high-level email-based database, communication, tracking, and reporting system implemented. The database meets all standards set forth by the Health Information Technology for Economic and Clinical Health (Hitech), HIPAA, CFR 42, etc. requirements for security.
   a. The server has a dedicated electronic record storage system used for administrative and clinical files storage and active access.
   b. The server is kept in a physically secure, HIPAA compliant environment.

Staff Responsible for Implementation:
Job Title of staff who is the Information Technology (IT) Quality Team Lead
   • Include who maintains the software and hardware for the Provider – by hire or contract.
   • Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
a. PROVIDER NAME contracts or employs an individual who has the knowledge and technical expertise to manage PROVIDER NAME information technology systems.
b. The IT software services are reviewed in the third month of the second quarter of the operating year by assigned the IT Quality Team members to determine the effectiveness and efficiency of the electronic data-management systems of PROVIDER NAME. The IT Quality Team members evaluate if the current software meets the needs of the clinicians, administrative staff, human resources, and quality leads.
c. The IT Quality Lead presents to Job Title a report that details: (a) the areas of compliance, (b) the areas of non-compliance, and (c) recommendations for IT quality improvement within one month of the completion of the audit.
d. The Job Title makes the determination of approving the plan or modifying the IT plan within one month of receiving the recommendations.
e. The Job Title develops a calendar to track and monitor the process towards completing the IT plan and assigns staff to oversee its implementation.
f. The IT Quality Improvement Team and Plan are developed.
g. The IT Lead works with the IT Quality Team to implement the Quality Improvement Plan (QIP).
h. The IT Lead provides the IT Quality Lead status reports as detailed in the QIP.
i. Based on the IT Quality Lead’s reports, the Job Title determines when the QIP has been successfully implemented and evaluated.
j. If the adopted recommendations require an expenditure of funds, Job Title insert here the process to requests funds within the agency or refer to the section of its fiscal policies and procedures this information is located.
I. GENERAL SYSTEMS
H. Record Management
Policy Number: 2

Approval Date:
Revision Date:

Policy:
PROVIDER NAME establishes an Information Technology (IT) training schedule for new hires or contractors, and provides annual refresher IT training to current staff.

Staff Responsible for Implementation
Training Lead
- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The Job Title of the Training Lead provides, within 10 working days of the start date of the new hire or contractor, IT training that includes how to utilize PROVIDER NAME software for reporting time, starting and maintaining client files, billing, and scheduling.
2. The Training Lead, during the first month of the first quarter the operating year, schedules current staff for a refresher IT training specific to administrative or clinical staff.
3. After each training session, staff completes an IT Quality Systems Survey. This information is collected and analyzed by the IT Quality Lead and then shared during PROVIDER NAME semi-annual Quality Audit insert the specific date this will occur.

I. GENERAL SYSTEMS
H. Record Management
Policy Number: 3

Approval Date:
Revision Date:

Purpose: Staff, clients and their families provide confidential information to be utilized to conduct business and to render services. PROVIDER NAME values the trust these individuals have placed in it and, in turn, has developed policies and procedures to safeguard information, while having that information readily available for service usage. Policies and procedures inform or direct PROVIDER NAME (clinical, human resources, administrative) how client and personnel files are managed.

Policy: PROVIDER NAME provides record management training to new staff and provides annual refresher Information Technology training to current staff.

Staff Responsible for Implementation
Job Title of the Human Resources and Administrative leads
- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. Storage
   a. PROVIDER NAME employee and contractor personnel files are stored in locked drawers located in name room which is kept locked.
   - List here the Job Titles that have access to keys and files.
   b. All client files are stored in locked files located in name room which is also kept locked.
2. Accessibility
   a. Employee and contractor personnel files are accessed by Job Title which is often the Human Resource Manager who in turn authorizes Job Title(s) to retrieve the requested file. The cover of each file has a sign out and in sheet detailing who accessed the file, for what purpose, and date checked out and checked back into the file room.
   b. The Job Title has access to retrieve client files. The Job Title completes the coversheet for check-outs and check-ins.
   c. A clinician must request a client file from Job Title the day before the client’s next appointment. Job Title personally delivers the file to the requesting clinician the morning required. If the appointment is scheduled before Job Title’s arrival time, Job Title provides the client file to the clinician at the close of business the day before. The clinician stores the client’s file in a locked drawer.
   d. If the clinician has multiple clients scheduled on one day, the clinician must have only the current client’s file outside his or her locked drawer.
   e. The Job Title of administrative lead arranges staff schedules so at least one staff person is available to check-in client files at the end of the day.
   f. The Job Title maintains a list of files checked-out and informs the clinical supervisor if a clinician fails to return a client’s file at the end of the day.
   g. The clinician must return all client files at least fifteen minutes before the close of business.
   - If the applying agency sees a high volume of clients each day, it may elect to allocate additional time to administrative staff to complete a file’s check-in.
   h. The Job Title checks the returned files to ensure the contents are intact. He or she then replaces the file.
3. Retention and Destruction Destroyed
   a. Personnel files are retained for at least six years after the last date of employment. Job Title arranges list semi-annual dates for personnel files to be picked up by insert name of the document disposal company or if done internally list the Job Title and the date (this could be general enough to say the first working day of the sixth month of the operating year) personally witnesses the destruction of personnel files by shredding.
   - MAD requires a provider to retain files for up to six year or additional time until any investigations are concluded.
   b. Client files are retained for up to six years after the last date of service. Job Title arranges – list semi-annual dates – for client files to be picked up by insert name of
document disposal company or if done internally the Job Title and dates personally witnesses the destruction of client files.

- **MAD requires a provider to retain files for up to six year or additional time until any investigations are concluded.**

4. Human Resource director and clinical supervisor, during the third month of the first quarter of the operating year, review the methods utilized to destroy client and personnel files, assess if there are issues requiring resolution or contractual changes to be made, determine the number of files from the previous year requiring storage, and the number of files projected to require destruction during the current operating year.

   a. The Human Resources Manager determines whether PROVIDER NAME requires additional disposal days to its calendar based on the number of projected files, and prepares recommendations to move towards retention of electronic files instead of paper files, or seeks other options to safely and pragmatically manage client and personnel files.

   b. The Job Title provides Job Title, the final decision maker, recommendations.

   c. The Job Title (as necessary) seeks approval from the Board of Directors.

   d. The Job Title within one month of the final decision develops a schedule to implement the changes.

   e. The Job Title reports bi-weekly to Job Title the process towards completion of the implementation.

   f. The Job Title makes the determination when the changes have been successfully completed.

   g. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) schedule annual administrative staff training as a refresher.

### I. GENERAL SYSTEMS

#### J. Agency Annual Calendar

**Policy Number: 1**

**Approval Date:**

**Revision Date:**

**Purpose:** PROVIDER NAME has the mechanisms in place to ensure all trainings, all personnel and supervisor requirements, and quality audits and reviews are started and completed within a predetermined period to:

1. Support its efforts to maintain compliance with funding source requirements;
2. Support the initiation of and completion of audits and reviews of client and family outcomes, clinician competencies, training activities, supervision quality, and administrative functions to determine whether PROVIDER NAME systems and its delivery of services meet the needs of clients and their families, staff, and collaborating agencies.
**Policy:** The Job Title develops and maintains an agency-wide annual calendar of start and end dates for required quality reviews and audits, trainings, administrative functions, supervision requirements.

- *The calendar provides agency start and end dates for specific review, observation, and audit functions:*
  - such as review of clinical staff personnel or contract files for specific information;

**Staff Responsible for Implementation**

Job Title of whoever is the Training Lead

- *Remember to list the Job Title, not the function he or she is fulfilling.*

**Procedures:**

1. The Job Title reviews PROVIDER NAME Manual during the first month of the third quarter of the operating year to gather start/end dates of audit and review tasks and names the audit leads and team members for the various audited components/functions of PROVIDER NAME.

1. The Job Title inserts the information onto a master calendar that follows PROVIDER NAME operational and fiscal years no later than the first month of the fourth quarter of the operating year.

2. The Job Title emails the calendar at least two months prior to the start of the operating year to administrative and clinical staff.

3. The Job Title sends reminders to the quality team members two weeks before an audit or review task is to begin and two weeks before an audit task is due for completion.

4. The Job Title, during the first month of the third quarter of the operating year, interviews audit and review team staff to determine the effectiveness of the prior year’s annual calendar with audit task reminders, and seeks recommendations for the next year’s calendar.

5. The Job Title submits two weeks after he or she completes the interviews a report to Job title of the successes, areas of improvement, and recommendations for the upcoming operating year’s calendar.

6. The Job Title whoever makes the final decision on annual calendar approves or revises the recommendations for the coming year’s annual calendar.

7. The Job Title provides administrative and clinical staff with the next year’s calendar no later than the second month of the fourth quarter of the operating year.
SECTION II – ASSURING CLIENT RIGHTS AND RESPONSIBILITIES

Table of Contents

A. Client Rights

B. Client Responsibilities
   Please provide in detail how the agency informs a client of his or her rights and responsibilities within the agency, with his or her MCO, and with HSD.

Review the NMAC rules of how to file a MCO grievance or appeal:

How to request and participate in a HSD’s Administrative Hearing:

C. Internal Grievance Process

D. Client Grievance Against An Action The MCO Has Taken Or Plans To Take As An Organization

E. Client Appeal of an Adverse Action planned or has been taken by his or her HSD Managed Care Organization against the client’s services, goods or items.

F. HSD Administrative Hearing
II. ASSURING CLIENT RIGHTS AND RESPONSIBILITIES
A. Client Rights-Advance Directives and Psychiatric Advance Directives

Policy Number: 1
Approval Date:
Revision Date:

Purpose: PROVIDER NAME mission and value statements encourage clients and families to speak out and seek assistance when they are experiencing challenges from within PROVIDER NAME in accessing and receiving services. PROVIDER NAME has developed policies and procedures detailing how a client creates his or her advance directives or psychiatric advance directives.

Policy: PROVIDER NAME supports the empowerment of clients and their families by providing templates a client may utilize to complete his or her advance directives or psychiatric advance directives.

Staff Responsible for Implementation: Job Title of the lead for managing client rights and responsibilities.
- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The Job Title observes within the first 30 working days of a new hire or contractor to determine compliance in assisting a client complete as desired his or her advance directives and psychiatric advance directive in a suitable and appropriate manner to client. The Job Title meets to discuss. Thereafter the Job Title observes at least quarterly. Job Title provides as necessary additional training and monitoring. The Job Title utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the staff's personnel or contractor file.
   - The agency determines the turnaround.
2. The Job Title at least quarterly conducts a review of client files to determine the staff's adherence to completing advance directive and advance psychiatric directive with a client as requested by the client. The Job Title meets to discuss. The Job Title provides as necessary additional training and monitoring. The Job Title utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the staff's personnel or contractor file.
   - The applying agency determines a reasonable turnaround time.
3. The CEO or Quality Officer QO (use Job Titles) reviews its advance directive and psychiatric advance directive templates continuing compliance with state and federal requirements during the first month of the second quarter of the operating year to determine if PROVIDER NAME policies, procedures, and forms continue to meet requirements.
4. Job Title presents within two weeks of the review his or her recommendations to Job Title.
5. Job Title presents within two months to the Board of Directors his or her recommendations.

6. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working days of the Board’s approval.

7. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as a refresher.

II. CLIENT RIGHTS AND RESPONSIBILITIES

B. Client Responsibilities

Policy Number: 1
Approval Date:
Revision Date:

Purpose: PROVIDER NAME values the therapeutic partnership a client has with his or her clinicians. In order for this partnership to flourish, both the clinician and the client must uphold their responsibilities to further the client’s efforts towards his or her treatment goals. The clinician’s responsibilities are found in various sections of PROVIDER NAME Manual.

Policy: The client and his or her family have specific standards, expectations, and requirements to fulfill in order to further his or her treatment goals. In order for PROVIDER NAME to provide services, the client and his or her parent must agree by initializing the items listed in the Client or Parental Responsibilities Agreement. The term ‘parent’ is inclusive of individuals with legal custody of a minor-aged client or a client for whom the court has appointed a guardian, e.g. grandparent, foster care parent, older sibling. PROVIDER NAME Manual includes the client’s family in services only where required by law or with permission of the client.

Staff Responsible for Implementation:
- The assigned job title who the agency has determined will monitor, track, and evaluate the implementation various parts of this subsection’s policies and procedures.
- There may be different job positions listed: Clinical Supervisor for reviews of the clinical files, HR for personnel files, and the Quality Team Lead may do the evaluation of this entire section.
- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The Job Title of the staff conducting intakes reviews and assists a client complete the Client Responsibility Agreement or the client’s parent complete Parental Responsibilities Agreement prior to the start of client services.

2. If the parent or client refuses to agree to PROVIDER NAME responsibilities agreement, Job Title stops the intake process and refers the client or parent to the clinical
supervisor. If the clinical supervisor is available, a meeting occurs or it is scheduled for a time all are available.

3. If the parent or client continues to refuse to sign the responsibilities agreement, the clinical supervisor informs the parent or client PROVIDER NAME is unable to provide services to him or her, and the clinical supervisor provides the client or parent with alternative agencies in the community and PROVIDER NAME internal grievance form.

4. The Job Title observes within the first 30 working days of a new hire or contractor to determine compliance in completing the Client and Parental Responsibility Agreement and general adherence to completing client intake requirements in a suitable and appropriate manner to client. The Job Title meets to discuss. Thereafter the Job Title observes at least quarterly. Job Title provides as necessary additional training and monitoring. The Job Title utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the staff’s personnel or contractor file.
   - The agency determines the turnaround.

5. The Job Title at least quarterly conducts a review of client files to determine the staff’s adherence to completing client intake requirements. The Job Title meets to discuss. The Job Title provides as necessary additional training and monitoring. The Job Title utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the staff’s personnel or contractor file.
   - The agency determines a reasonable turnaround time.

6. The CEO or Quality Officer QO (use Job Titles) reviews funding sources’ client responsibility requirements during the first month of the second quarter of the operating year to determine if PROVIDER NAME policies, procedures, and forms continue to meet requirements.

7. Job Title presents within two weeks of the review his or her recommendations to Job Title.

8. Job Title presents within two months to the Board of Directors his or her recommendations.

9. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working days of the Board’s approval.

10. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as a refresher.

II. CLIENT RIGHTS AND RESPONSIBILITIES
C. Agency Client Grievance Process
Policy Number: 1
Approval Date: 
Revision Date: 

Purpose: PROVIDER NAME supports clients and their families acquire the skills to self-advocate. A client has the right and responsibility to inform his or her clinician, administrative staff of any concerns or issues with his or her delivery of services. In this
way, a client learns and refines his or her skills to continue self-advocacy throughout the times he or she utilizes services.

**Policies:**
1. Clients have the right to be treated ethically, professionally, and with respect by all PROVIDER NAME staff.
2. All clients have the legal right to:
   a. Refuse services;
   b. Seek alternative behavioral health services elsewhere; and
   c. Address complaints and grievances by following PROVIDER NAME internal grievance process.

**Staff Responsible for Implementation:**
CEO

- *Remember to list the Job Title, not the function he or she is fulfilling.*

**Procedures:**
1. If the client has concerns, complaints, or grievances about his or her PROVIDER NAME services, which are not related to a proposed adverse action by the Medical Assistance Division (MAD) or its contracted managed care organizations (MCO).
   - Insert the chain of command for handling complaints and issues or if the agency has a developed process, place as an appendix.
2. If the client is not satisfied with PROVIDER NAME response, he or she has other remedies:
   a. If the services are paid by the Children, Youth and families Department (CYFD) the number is 505-827-8008.
   b. If the services are paid by the Human Services Department (HSD) Behavioral Health Services Division the number is 505-476-9266.
   c. If the services are provided through a MCO call the client’s MCO member services number:
      i. Blue Cross Blue Shield 866-689-1523
      ii. Molina Health Care 877-373-8986
      iii. Presbyterian Health Plan 505-923-5200 or 888-977-2333
   d. If the services are paid through the MAD Fee-for-Service Plan (FFS), call at 888-997-2583, ext. 7-3118 or call 505-827-3118, ask to be connected to the Behavioral Health FFS Program Manager.

- *The agency may want to have the above contact phone numbers as an appendix as the numbers and titles do change over time.*
3. The Job Title provides the individual requesting services the approved written document of his or her rights and responsibilities while accessing services. Job Title secures the client signature acknowledging he or she has received a copy. The document must include the following information:
   a. Refusal of services
      - *Detail the agency’s process when a client refuses services; this most likely includes a form the client signs stating he or she is refusing an offered service.*
- Include this form as an appendix.

b. Alternative behavioral health services
   - List contact information of agencies providing behavioral health services. The agency may want the above contact phone numbers inserted as an appendix as phone numbers and titles change over time.

c. Complaints and grievances.
   - Detail the steps a client is to take if he or she wishes to file a complaint or grievance.

4. The Job Title observes within the first 30 working days of a new hire or contractor to determine the staff’s compliance in explaining the grievance and appeal process in a suitable and appropriate manner to the client. The Job Title meets to discuss. Thereafter, the clinical supervisor observes least quarterly. The clinical supervisor provides as necessary additional training and monitoring to a clinician. The clinical supervisor utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the clinician’s personnel or contractor file.
   - The agency determines a reasonable turnaround time.

5. The Job Title at least quarterly conducts a review of client files to determine the staff’s adherence to completing client intake requirements. The Job Title meets to discuss. The Job Title provides as necessary additional training and monitoring. The Job Title utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the staff’s personnel or contractor file.
   - The applying agency determines a reasonable turnaround time.

6. The Job Title includes in the staff’s or contractor’s annual performance evaluation compliance with intake requirements. The Job Title provides necessary training, monitoring or other forms of corrective action to the staff. The evaluation is filed in the staff’s personnel or contractor file.

7. The CEO or Quality Officer QO (use Job Titles) reviews funding sources’ client grievance and appeal requirements during the first month of the second quarter of the operating year to determine whether PROVIDER NAME policies, procedures, and forms continue to meet requirements.

8. The Job Title presents within two weeks of the review his or her recommendations to Job Title.

9. The Job Title presents within two months to the Board of Directors his or her recommendations.

10. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working days of the Board’s approval.

11. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as a refresher.
II. CLIENT RIGHTS AND RESPONSIBILITIES
D. Client Grievance Against An Action The MCO Has Taken or Plans To Take As An Organization

Policy Number: 1
Approval Date:
Revision Date:

Purpose: PROVIDER NAME believes in supporting client empowerment to seek a remedy when he or she believes the MCO has acted in a manner that is dissatisfactory to him or her concerning how the MCO conducts its business. A grievance is not the course of action a client takes when his or her MCO plans or has taken an adverse action against the client’s physical or behavioral health services. PROVIDER NAME assists a client learn the skills to self-advocate when he or she believes the MCOs organizational actions were dissatisfactory to him or her. An example is a client felt disrespected by a customer service representative.

Policies:
1. PROVIDER NAME requires key staff members to learn the client’s MCO process to file a grievance.
2. PROVIDER NAME requires key staff members to learn the process to file a request for a HSD Administrative Hearing.
3. PROVIDER NAME links a client to a trained key staff member to assist him or her navigate the MCO process to seek to remedy a concern of how the MCO conducts its business.

Staff Responsible for Implementation:
Job Title of who is responsible to assist a client request a HSD Administrative Hearing or a Managed Care Appeal

- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The Job Title becomes familiar with the MCOs client, the New Mexico Administrative Code (NMAC) rules governing how a MCO member grieves his or her MCO’s action. If a MCO has a written ‘checklist’ of client rights and responsibilities, the Job Title makes it available for client use.
2. If a MCO does not have a written "checklist" of client rights and responsibilities, Job Title creates one following the MCO’s and TPA’s process for client use.
3. The Job Title requests to be placed on the MAD Interested Parties List in order to receive copies of proposed and final NMAC rules related to grievances, appeals, and HSD Administrative Hearings.
4. If MAD amends the processes, Job Title reviews PROVIDER NAME ‘checklist’ to determine if revisions are necessary to its versions.
5. The Job Title submits within two weeks of a HSD or MCO newly approved grievance changes his or her recommendations to Job Title.
6. The Job Title works with Job Title of the administrative staff to revise the ‘checklist’ and remove the previous version and replace it with the newly approved version and disseminate to agency staff and clients.

7. When the decision is made to retain the current version, the Job Title of trainer works with the Job Title of whoever makes the training calendar to schedule annual agency staff training as a refresher.

II. Client Rights and Responsibilities

E. Client Appeal an Adverse Action the MCO has taken or plans to take against the Client’s Benefits and Services

Policy Number: 1
Approval Date:
Revision Date:

Purpose: PROVIDER NAME believes in supporting client empowerment to seek services he or she believes are medically necessary for his or her behavioral health care. PROVIDER NAME assists a client learn the skills to self-advocate when he or she believes his or her MAD managed care organization (MCO) has made an adverse determination effecting his or her requested or current or future benefits and services, or if a MCO is not fulfilling its stated responsibilities or adhering to its timelines.

Policies:
1. PROVIDER NAME requires key staff members to learn the client’s MCO appeal process to request or file an appeal,
2. PROVIDER NAME links a client to a trained key staff member to assist him or her navigate the MCO appeal process to seek to remedy a concern, to address a change in service delivery, or request a reversal of a denied requested for a service or benefit.

Staff Responsible for Implementation:
Job Title of who is responsible to assist a client request a HSD Administrative Hearing or a Managed Care Appeal
• Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The Job Title becomes familiar with the TPA and each MCOs client grievance and appeal processes, the New Mexico Administrative Code (NMAC) rules governing how a MCO member grieves and appeals his or her MCO’s adverse action, and NMAC rules governing how a recipient files a request for a HSD Administrative Hearing based on the TPA’s adverse action.
2. If a MCO or the TPA has a written ‘checklist’ of client rights and responsibilities, the Job Title makes it available for client use.
3. If a MCO or the TPA does not have a written “checklist” of client rights and responsibilities, Job Title creates one following the MCO’s and TPA’s process for client use.
4. The Job Title requests to be placed on the MAD Interested Parties List in order to receive copies of proposed and final NMAC rules related to grievances, appeals, and HSD Administrative Hearings.
5. If MAD amends the processes, Job Title reviews PROVIDER NAME ‘checklist’ to determine if revisions are necessary to its versions.
6. The Job Title submits within two weeks of a HSD, MCO or TPA newly approved grievance or appeal changes his or her recommendations to Job Title.
7. The Job Title works with Job Title of the administrative staff to revise the ‘checklist’ and remove the previous version and replace it with the newly approved version and disseminate to agency staff and clients.
8. When the decision is made to retain the current version, the Job Title of trainer works with the Job Title of whoever makes the training calendar to schedule annual agency staff training as a refresher.

II. CLIENT RIGHTS AND RESPONSIBILITIES
F. Client Appeal of an Adverse Action the MAD TPA Has Taken or Plans to Take Against the Client and MCO Member’s Right to Request HSD Administrative Hearing Rights
Policy Number: 1
Approval Date:
Revision Date:

Purpose: PROVIDER NAME believes in supporting client empowerment to seek services he or she believes are medically necessary for his or her behavioral health care. PROVIDER NAME assists a client learn the skills to self-advocate for a HSD Administrative Hearing when he or she disagrees with the MAD managed care organization (MCO) final internal appeal decision or the TPA’s decision to have taken or take an adverse action against the client’s current or future MAD benefits or services. A client who receives his or her MAD benefits or services through the Fee-for-Service benefit plan is not required to file an appeal with the MAD TPA prior to requesting a HSD Administrative Hearing.

Policies:
1. PROVIDER NAME requires key staff members to learn the client’s process to request a request a HSD Administrative Hearing.
2. PROVIDER NAME links a client to a trained key staff member to assist him or her navigate the MCO or TPA process and the HSD Administrative Hearing process to seek to remedy a concern, to address a change in service delivery, or request a reversal of a denied requested for a service or benefit.

Staff Responsible for Implementation:
Job Title of who is responsible to assist a client request a HSD Administrative Hearing or a Managed Care Appeal
• Remember to list the Job Title, not the function he or she is fulfilling.
Procedures:
1. The Job Title becomes familiar with each MCOs client appeal processes, the New Mexico Administrative Code (NMAC) rules governing how a MCO member appeals his or her MCO’s adverse action.
2. If a MCO has a written ‘checklist’ that provides step by step instructions how to file and participate in a MCO appeal process, the Job Title makes it available for client use.
3. The Job Title requests to be placed on the MAD Interested Parties List in order to receive copies of proposed and final NMAC rules related to grievances, appeals, and HSD Administrative Hearings.
4. If MAD amends the processes, Job Title reviews PROVIDER NAME ‘checklist’ to determine if revisions are necessary to its versions.
5. The Job Title submits within two weeks of a HSD or MCO newly approved grievance or appeal changes his or her recommendations to Job Title.
6. The Job Title works with Job Title of the administrative staff to revise the ‘checklist’ and remove the previous version and replace it with the newly approved version and disseminate to agency staff and clients.
8. When the decision is made to retain the current version, the Job Title of trainer works with the Job Title of whoever makes the training calendar to schedule annual agency staff training as a refresher.
SECTION III - HAZARD AND EMERGENCY MANAGEMENT

Table of Contents

A. Definitions

B. Hazard and Emergency Management

C. Quality Management of Hazard and Emergency Plan
   - The agency must individualize the plan to be representative of each of its sites or
     facilities: staffing patterns, available emergency responders, and chain of command.
   - Examples:
     o Agency T has directed each site to operate independently of the other sites and the
       central office. The site supervisor has the authority to declare a state of emergency,
       evacuate the facility, and to call emergency responders for assistance. As soon as
       possible he or she notifies the central office of the situation.
     o Agency R requires each site supervisor to call the central office before any steps are
       taken to evacuate the facility or call emergency responders, with the exception of a
       threat to life or limb to staff, clients, and others at the facility. The central office
       makes all decisions and communicates back to the site with directions.

III. HAZARD AND EMERGENCY MANAGEMENT
A. Definitions

Policy Number: 1
Approval Date:
Revision Date:

Purpose: The integration of hazard and emergency management into the core
responsibilities of central and site management is intended to provide safe and
healthy conditions for employees, contractors, clients and their families, and visitors
to its facility. PROVIDER NAME has established a plan to safeguard individuals
working at, assessing or visiting its places of business and a plan to monitor the
effectiveness and responsiveness of the Hazard and Emergency Management
procedures.

Definitions:
1. Facility: The office, building, facility, and property PROVIDER NAME conducts
   business and renders services.
2. Hazard or Emergency: The potential to cause harm to a person, to property, or to
   the natural environment.
3. **Hazard and Emergency Management**: The structured process of hazard identification, risk assessment, and establishment of control aimed at providing a safe and healthy environment for employees, contractors, clients and their families, and visitors to the facility.

4. **Risk**: A combination of the potential frequency and severity of harm arising from a hazard.

5. **Risk Assessment**: The process of evaluating the likely frequency and severity of harm arising from a potential or active hazard or emergency.

6. **Risk control**: The process of implementing measures to reduce as far as *reasonably practicable* the risk associated with a hazard.

7. **Reasonably practicable**: Practicable means taking into consideration:
   a. the severity of the hazard or risk in question;
   b. the state of knowledge about that hazard or risk and the availability and suitability of ways of removing or mitigating it;
   c. the cost (financial and personal) of removing or mitigating that hazard or risk.

III. HAZARD AND EMERGENCY MANAGEMENT

B. Hazard and Emergency Management Plan and Hazard and Emergency Response Plan

*Policy Number: 1*

*Approval Date:*

*Revision Date:*

**Purpose:** PROVIDER NAME has developed a Hazard and Emergency Management Plan and a Hazard and Emergency Response Plan that defines responsibilities for staff in the event of a hazardous, emergency, or dangerous situation, incident, injury, or illness. These plans apply to all properties and facilities or offices owned, occupied, or managed by PROVIDER NAME.

**Policies:**
1. PROVIDER NAME has developed and implements a Hazard and Emergency Management Plan which determines the appropriate management of incidents, injuries, illnesses, and emergencies is an essential element of its health and safety responsibilities and also function to preserve its well-being and business viability.
2. PROVIDER NAME develops and disseminates its Hazard and Emergency Response Plan to all staff, clients and families, and displays the plan for visitor reference. Information must include the following.
   a. Staff is informed who has the authority to determine if a situation or event requires a hazardous or emergency response.
   b. Staff is informed who is assigned the agency role of “spokesperson” to authorities and to the media.
c. Staff is informed what the guidelines and restrictions they are to follow during an emergency situation related to the disclosure of client or staff PHI in cases of emergency or crisis.
d. Staff receives annual first aid and CPR training in order to provide appropriate treatment of on-site injuries and illnesses caused by a hazard.
e. Staff is trained in the use of Manufacturer Date Sheets (MDS) in order to respond to hazards related to housekeeping and janitorial supplies.
f. Designated staff is directed to contact the appropriate authority. Staff is to limit his or her investigation of incidents, injuries, and illnesses to only what the responding authority requests. These include but are not limited to:
   i. Executive supervisory staff
   ii. Medical authorities – such as the Department of Health, the Centers for Disease Control and Prevention (CDC)
   iii. New Mexico state authorities: Human Services Department (Behavior Health Services Division, Medical Assistance Division (MAD), their contracted managed care organizations, and the MAD Third Party Assessor), Children Youth and Families Department, Aging and Long-Term Services Department, Department of Health
   iv. Emergency or law enforcement authorities: New Mexico Department of Public Safety (DPS), federal departments of: Homeland Security, Interior-Bureau of Indian Affairs, and Federal Bureau of Investigations, etc., as appropriate to the nature of the incident

g. Designated staff is assigned the specific responsibilities to implement corrective actions following incidents, as appropriate.
h. Designated staff is assigned responsibly to review and report PROVIDER NAME implementation of the Hazard and Emergency Management Plan and Hazard and Emergency Response Plan policies and procedures.
i. Designated staff is assigned the responsibilities to develop responses to the report to update the processes or to retain the current processes.

**Staff Responsible for Hazard and Emergency Management**

**Quality Assurance Team Lead**

- The agency will list by title (not job function) individual positions responsible as the Quality Assurance Lead for this policy and procedures or a corresponding Team Member.

**Quality Assurance Team Members**

- 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.
Procedures: Hazard and Emergency Response Plan

- The agency must amend this template to reflect:
- The chain of command at the central office site and at individual sites
- The authorities present in its community (example, some areas only have sheriff or State Police access; others have local police departments; others operate on tribal land which may have tribal law enforcement or may have Bureau of Indian Affairs law enforcement)
- A designated staff member is the individual PROVIDER NAME has approved to respond to hazardous or emergencies.
- List the job titles with phone numbers if the agency elects to have a lead available whether he or she is onsite or offsite.

1. **The witnessing staff member assesses the situation** to gather information on the immediate need to act when critical or serious health and safety issues are present. Whenever possible, contact the designated staff before pursuing other actions.

2. **The designated staff gathers as much information** as he or she can to determine if a particular section of the facility or the entire facility requires immediately evacuation. If the hazard is related to a chemical spill, the janitorial supervisor accesses the Manufacturer Data Sheets (MDS) for response directions and warnings. He or she informs the designated staff of the spill, recovery, and MDS recommended actions. The designated staff may determine the safest action is to stay within the facility wherever persons are presently located or to gather persons to a specific location within the facility.

3. **The designated staff alerts list job titles, such as the clinical supervisor, administrative supervisor, do not use individual names unless the agency take the responsibility of changing this document whenever a staff member leaves or is hired to communicate the current situation, steps being taken, and next steps to be taken by others within the facility.**

4. **The designated staff determines when and if it is safe to assist** other persons in immediate danger.

5. **If witnessing the incident,** one staff member is to secure support and help before undertaking rescue actions. It is imperative the designated staff is made aware at the earliest moment what is occurring.

6. Any staff member who believes there is a need for immediate emergency services to a person or situation (fire) calls or directs another person to call the appropriate emergency number (if 911 is not available in the community, list the emergency number).

7. When safe, witnessing staff is to **follow his or her basic emergency responder training procedures to render appropriate levels of first aid, CPR, or other resuscitation efforts, or to follow the directions of the responding emergency personnel.**

8. **Designed staff takes command of the situation or incident.** He or she may direct immediate action if appropriate to contain or combat the situation only when safe to do so or directed by emergency responders.
9. When the designated staff determines an evacuation is required or when a staff member determines there is an immediate need to evacuate the facility to protect the health and safety of others these procedures are followed:
   a. The Administrative manager takes PROVIDER NAME sign-in log and employee roster whenever possible prior to evacuating the facility.
      - The agency is encouraged to utilize for visitors and especially for clients and their families a sign-in process that prevents a fellow client or visitor from knowing who is at the facility. Some agencies have labels the individual fills out, then the administrative staff peels the label off and places on an agency daily sign-in sheet.
   b. Staff and other persons go to the post-evacuation location of: NAME AGREED UPON POST-EVACUATION DESTINATION SPECIFIC LOCATION FOR EACH SITE.
   c. Designated staff immediately conducts a headcount of all persons known to be in the facility.
   d. Designated staff informs emergency responders of any person missing, his or her last known location, and provide a list of persons who have been accounted.
   e. Designated staff must attempt to have all persons assessed by appropriate emergency responders prior to their departure from the scene if they may have been exposed to a contamination, injured from exposure to smoke or chemical fumes, received burns or other physical harm that may be a result of the incident.
   f. Designated staff appoints a staff member to act as a witness when a person refuses such assessment. If possible, the person signs a statement refusing treatment.
   g. NO staff member is to lock any facility door when evacuating - this would delay emergency responders’ access to the facility to check on missing persons and to respond to the situation within the facility.
      - The agency is encouraged to have a centralized folder at each site that the administrative staff takes upon evacuating the facility. At a minimum it contains: client and staff log-in sheets, emergency numbers (staff and client), refusal to seek medical treatment forms, facility floor plan, MDS for each product. This information will assist emergency responders.

III. HAZARD AND EMERGENCY MANAGEMENT
C. Building or Office Physical Management Plan
Policy Number: 1
Approval Date:
Revision Date:

Purpose The PROVIDER NAME requires the physical spaces staff, clients and families, and visitors occupy meet federal and state health and safety requirements.
Policy:
1. The Building or Offices Physical Management Plan and the Hazard and Emergency Response Plan are specific to PROVIDER NAME sites or facilities.
2. The PROVIDER NAME building or offices meet federal and state requirements for the health and safety of all individuals occupying its physical location.
3. The PROVIDER NAME has intake and therapy rooms available that offer adjustable lighting, window covering, secure door closures, and other necessary physical accommodations to provide a ‘safe’ environment for clients and family members who have experienced trauma and express or demonstrate through actions a heightened negative awareness and response to the physical location and surrounds.

Staff Responsible for Implementation
Chief Executive Officer (CEO), Human Resources Manager, Quality Lead, Clinical Supervisor, Site Supervisor – the agency must make this determination that fits its organization and sites.
- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. Each geographic location maintains a printed copy of the Hazard and Emergency Response Plan, which is site specific in the listing of escape routes and job titles.
2. Each geographic location maintains a binder of all Manufacturer Data Sheets (MDS) of chemicals utilized by the facility. Each site janitorial supervisor reviews the MDS file monthly to add new products or remove products no longer stored at the site and provides the site administrative staff a copy for PROVIDER NAME evacuation folder.
3. The janitorial supervisor posts the location of the MDS binder throughout the facility. It is kept in an unlocked location at name the specific location for each site.
4. The site supervisor posts the escape routes and the Hazard and Emergency Response Plan in view of any person entering the facility, in each treatment room, and throughout the facility.
5. The site supervisor monthly conducts a check to ensure the escape routes, the Hazard and Emergency Response Plan (including the location of the MDS binder) are visible throughout the facility and posts updated routes and plans when revised.
6. The site supervisor sends updates of the facility evacuation information (routes, designated post evacuation site, etc.) to Job Title at the central business location-name location. The administrative Job Title maintains a specific folder for each site.
7. The Job Title at each site weekly conducts a health and safety inspection utilizing a standard checklist.
   a. If there are any concerns or issues, he or she presents to the Job Title who has the authority to remedy the concerns or issues.
   b. The Job Title prepares an action plan with specific dates, funding resources and the lead to monitor and track the project from the start to the completion of the project.
8. The site supervisor conducts an evacuation drill at least once a year when clients are present. He or she arranges for local first responders to participate in this drill and requests recommendations of the site’s responsiveness and areas in need of improvement.
9. The site supervisor works with Job Title and community’s first responders to develop and implement a work plan to address these issues.

10. The Job Title that acts as the Quality Lead evaluates the implementation of the work plan and determines if further action is required to correct the issues.

11. The clinician works with Job Title authorized to approve physical changes or adaptations to intake and therapy rooms that are supportive and appropriate to the needs of clients experiencing trauma-related sensitive concerns or issues.
   a. The site supervisor meets weekly with intake staff to access if the intake room remains welcoming and inviting to clients with trauma-related concerns or needs.
   b. Accommodations are made prior to the first date of service of a client’s utilization of a therapy room.

12. Agency selections one of these options:
   The Job Title meets with the owner of the building during the last quarter of the PROVIDER NAME operating year to discuss health and safety concerns, develops an action plan for the initiation of, concrete schedule of deliverables, and completion date.
   OR The Job Title meets with the Job Title during the last quarter of the PROVIDER NAME operating year to discuss health and safety concerns, develops an action plan for the initiation of, concrete schedule of deliverables, and completion date.
SECTION IV – SUPERVISION OF BEHAVIORAL HEALTH SERVICES

This section provides a listing of policies and procedures for the agency. If a particular service requires additional policies and procedures, those policies and procedures can be clearly noted in the appropriate policy and procedure.

Table of Contents

A. Clinical Supervisor
B. Clinical Supervision Standards
C. Core Competencies

IV. SUPERVISION OF BEHAVIORAL HEALTH SERVICES
A. Clinical Supervisor
Policy Number: 1
Approval Date:
Revision Date:

Purpose: The role of the clinical supervisor is to establish practice standards that are reflective of the services and population the agency serves. The overall clinical quality of PROVIDER NAME services are dependent upon the clinical supervisor’s ability to develop, implement, and evaluate clinical practices and behavioral health services offered, and then enact appropriate responses.

Policies:
1. The clinical supervisor must have:
   a. Knowledge of the evidence-based best practices (EBP) PROVIDER NAME utilizes and be able to train clinical staff on the EBPs.
   b. Professional expertise in the delivery of substance use, mental health, and co-occurring services to specific age populations PROVIDER NAME serves;
   c. Abilities to effectively and efficiently develop, monitor, evaluate or audit compliance to PROVIDER NAME clinical policies and procedures and recognized industry standards.
2. The clinical supervisor must ensure PROVIDER NAME EBPs fidelity standards are maintained throughout a client’s services.

Staff Responsible for Implementation
Chief Executive Officer (CEO), Human Resources Manager, Quality Lead – the agency must make a determination.
- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. A clinical supervisor must:
   a. Hold an active New Mexico license as an independent behavioral health clinical practitioner;
   b. Have completed the necessary coursework required by his or her practice board to supervise practitioners;
   c. Have documented education, formal substance use education and experience, experience in staff development training and monitoring, and have mental health and co-occurring disorders treatment (work history is determined through resumes and documented job references);
   d. Maintain a 24 hour and seven days per week availability when a clinician’s client is experiencing a crisis and requires immediate interventions; The Provider does not need have 24/7 coverage by its staff, it may utilize a community crisis line for clients to access.
   e. Hold (or obtain before clinical supervision services begin) documented training and certification in the evidence-based programs utilized PROVIDER NAME; copies of which are kept in the clinical supervisor’s personnel file;
   f. Be in compliance with his or her practice board’s requirements in order to supervise clinical staff.
2. The Quality Lead and the CEO (Evaluation Team) conducts an annual evaluation during the quarter of the clinical supervisor’s hiring anniversary date. The Evaluation Team takes into consideration the audits and reviews conducted by the clinical supervisor to measure clinical management and oversight compliance to PROVIDER NAME Manual. The results of success or areas of improvement are reflected in the clinical supervisor’s evaluation.
3. If the Evaluation Team determines it does not have the clinical knowledge to fairly evaluate the clinical supervisor, the Evaluation Team is authorized to secure by contract a professional knowledgeable and experienced in rendering and managing services. The consultant offers and provides assistance to the Evaluation Team in determining areas compliant and areas non-compliant, and recommends corrective action plan.
4. If a corrective action plan is necessary, the Job Title of who will be developing and monitoring develops and monitors the implementation of the plan.
5. Failure to fully comply with the corrective action plan may result in further disciplinary actions against the clinical supervisor.

IV. SUPERVISION OF BEHAVIORAL HEALTH SERVICES
B. Clinical Supervision
Policy Number: 1
Approval Date:
Revision Date:
**Purpose:** PROVIDER NAME assures that appropriate, effective, timely, and compassionate supervision is delivered to all clinical staff or non-clinical staff (administrative staff if he or she participates in the Intake Process) who provide any level of clinical interface with clients and their families. Supervision is critical to successful treatment and the provision of services to clients and their families. PROVIDER NAME internal capacity to train and supervise staff is critical to maintaining skilled clinicians rendering integrated services to its clients and their families.

**Staff Responsible for Implementation**

Clinical supervisor and the team that will evaluate adherence to supervision requirements

- *Remember to list the Job Title, not the function he or she is fulfilling.*

**Standards**

This subsection provides PROVIDER NAME's global view of the elements, areas, and general requirements of clinical supervision. Embedded within this manual's section are the details of specific requirements of clinical supervision pertaining to a set of tasks or responsibilities a clinical supervisor and clinician fulfills.

1. PROVIDER NAME maintains a clinical supervisor job description.
2. PROVIDER NAME maintains the position of a full time clinical supervisor through direct employment or contract, and whether through permanent or temporary status.
3. The clinical supervisor provides three distinct types of supervision:
   a. Clinical supervision is provided during the clinician’s Internal Service Team (IST) meeting to guide and support the clinician’s interventions with each client.
      Supervision may be both during the Internal Service Team meeting and during one-on-one supervision.
   b. Clinical oversight to monitor, track, and evaluate a clinician’s level of compliance with PROVIDER NAME philosophy, values, policies and procedures, as well as the fidelity compliance with name the EBP models.
   c. Each clinician’s practice board requires clinical supervisor. He or she must receive the required supervisor to retain his or her licensure. The individual providing supervision must be authorized by his or her practice board to supervise other clinicians. The two other types of supervisor listed above in large part meet the supervised clinician’s practice board supervision requirements.
4. The clinical supervisor performs the critically important role of educating, encouraging, guiding, supporting, monitoring, and evaluating assigned clinical staff.
5. The clinical supervisor provides oversight and maintenance of PROVIDER NAME various evidence-based fidelity practices.
6. The clinical supervisor provides specific supervision related to substance disorders, mental or emotional disorders, and co-occurring disorders in all domains identified in the client’s assessment, and interpretive summary inclusive of a diagnosis, Service Plan and Treatment Plan.
7. All assessments, interpretive summaries, Service Plans, and Treatment Plans are reviewed, dated and signed by the clinical supervisor, regardless if a non-independently licensed clinician is receiving supervision by another independently licensed clinician within the agency.
• If the agency hires independently licensed clinicians in addition to the clinical supervisor, it must decide:
  o Does the clinical supervisor review an independently licensed clinician’s work?
  o Does an independently licensed clinician have approval to sign on his or her work without the clinical supervisor’s review?
  o Is the clinical supervisor the only clinician approved to review a non-independent clinician’s work and sign on his or her behalf?
  o Are any or specific independently licensed clinicians approved to review and sign on behalf of a non-independent clinician’s work?

8. The clinical supervisor must review documents prior to presentation to the client and his or her family.
   • The agency must determine based on the above decisions, if this is to be a requirement.

9. The clinical supervisor provides or contracts for specific clinical staff training.

10. The clinical supervisor is the lead clinician for 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.
    • The agency must determine who fulfills each of these job functions. The clinical supervisor may only fulfill clinical functions and the CEO fulfills the general agency safety, well-being and security functions.

11. The clinical supervisor reviews all client files to determine if the documents meet funding source requirements and industry standards of clinical recordkeeping.

12. The clinical supervisor conducts quarterly reviews of client files to assess a variety of clinical skills, knowledge, expertise, and areas requiring additional training. See individual sections of this manual for detailed supervision requirements.

13. The clinical supervisor semi-annually (name months) reviews with the clinician his or her licensing practice board’s requirements for developing and maintaining therapeutic boundaries with client, and ethical standards of care to clients and the profession. The clinician signs a statement attesting to his or her agreement to comply with the clinician are licensing board’s standards. Any deviation from these standards by the clinician results in:
    a. Report to his or her licensing practice board; and
    b. Disciplinary action by the PROVIDER NAME.

14. The clinical supervisor streamlines and updates required paperwork and documentation to reduce time burden on clinical staff and maintain accurate and precise clinical and administrative records. See individual sections of this manual for detailed review and audit requirements.

15. The clinical supervisor provides the oversight of Multi-disciplinary Team (MDT) meetings and Internal Service Team (IST) meetings with documentation of follow-up from previous meetings, current information, and recommendations for future services. See individual sections of this manual for detailed review and audit requirements.

16. The clinical supervisor provides the oversight tracking, monitoring of client and family outcomes to determine if service policies and procedures support positive outcomes or require amendments. See individual sections of this manual for detailed review and audit requirements.
17. The clinical supervisor utilizes PROVIDER NAME standardized observation and feedback form when conducting clinical supervision. See individual sections of this manual for detailed supervision requirements. The form must detail:
   a. Date and the begin and end time of supervision;
   b. The follow-up from previous supervision;
   c. The topics covered in the current supervision;
   d. The actions to be taken based on feedback; and
   e. Signatures are required by the clinical supervisor and the clinician.

18. Clinical supervision focuses on the client and family concerns that may impact the implementation of the client’s Service Plan and Treatment Plan, or as identified by the clinician as appropriate. See individual sections of this manual for detailed supervision requirements.

19. The clinical supervisor performs the critically important role of educating, encouraging, guiding, supporting, and monitoring clinicians as assigned and appropriate to need.

20. The clinical supervisor provides the direct clinical oversight to monitor, tracks, and trains clinical staff in PROVIDER NAME philosophy, values, policies and procedures, as well as upholds fidelity compliance with name EBP models and other evidence-based practices utilized by clinical staff. See individual sections of this manual for detail supervision requirements. See individual sections of this manual that detail training and monitoring compliance requirements.

21. The clinical supervisor provides oversight and maintenance of PROVIDER NAME evidence-based practices’ fidelity requirements by utilizing fidelity tools, as appropriate and available to specific practices.

22. The clinical supervisor provides or arranges for specific clinical training and additional supervision as an outcome of client crises, critical incidents, or PROVIDER NAME-wide staff and client safety concerns, and issues that may affect client, staff or PROVIDER NAME well-being and security. See individual sections of this manual that detail evidence-based practice fidelity requirements.

23. The clinical supervisor is responsible for a clinician’s initial and on-going clinical training to develop and maintain quality services that support the client’s and his or her family’s successful outcomes. See individual sections of this manual that detail training and monitoring requirements.

24. The Job Title of administrative staff in charge of files and the clinical supervisor provides maintenance of confidentiality of all PROVIDER NAME staff, client and family interactions and Protected Health Information, per HIPAA and CFR Part 2 regulations. See individual sections of this manual that detail training and monitoring requirements.

25. The clinical supervisor reviews all clinical assessments, interpretive summaries, Service Plan, and Treatment Plan documents prior to the clinician finalizing with the client. See individual sections of this manual that detail training and monitoring requirements.

• The agency is to include this or to amend based on decisions made in item 7.

26. The clinical supervisor ensures quarterly reviews of various elements of client files are conducted. See individual sections of this manual that detail training and monitoring requirements.

27. The clinical supervisor develops and implements oversight of tracking client outcomes. See individual sections of this manual that detail training and monitoring requirements.
28. The clinical supervisor oversees all critical incidents, crises, and emergencies occurring with clients and their families. The clinical supervisor must act to maintain the safety and wellbeing of him or her, the clients and families, other staff, and the public as a primary responsibility. See individual sections of this manual that detail training and monitoring requirements.
   - The agency must determine if this function is solely that of the clinical supervisor or is shared with other job titles.

29. For IOP services, non-independently licensed clinicians are required to provide to their respective practice boards documentation of supervision conducted by a practitioner whose practice board and scope of practice allows supervision of a non-independently licensed clinician. See individual sections of this manual that detail supervision requirements.
   - See Item 7 above, and insert the appropriate clinician that makes the decision of who can or cannot provide clinical supervision and revise this standard as appropriate.

30. The clinical supervisor provides supervision for clinicians rendering outpatient behavioral health services that are non-credentialed or are non-independently licensed when the Behavioral Health Services Division has approved supervisory certification for the PROVIDER NAME to employ or contract with such practitioners.
   - If the agency holds a BHSD supervisory certification, it must include the responsibilities and actions necessary to maintain the certification into its policies and procedures manual.

31. The clinical supervisor is held to the same level or responsibility, and implementation of clinical supervision when PROVIDER NAME has other sites which provide behavioral health services.
   - If the agency operates separate sites or in separate facilities located at one physical site, the agency must determine how supervision is provided at each site or facility.
   - The agency must provide detailed procedures as to how the central lead clinical supervisor obtains reviews, and responses to clinical reviews when located at different sites or separate facilities.

IV. SUPERVISION OF BEHAVIORAL HEALTH SERVICES

C. Core Competencies

Policy Number: 1
Approval Date:
Revision Date:

Purpose: To deliver effective thriving-focused and integrated services by qualified clinical staff to assist a client and his or her family reach his or her treatment goals. PROVIDER NAME recognizes treatment of a substance disorder requires practitioners to be specifically training in its evidence-based practice-name models utilized. Research has demonstrated by only utilizing mental health treatment modalities with a client
experiencing substance use are ineffective; while practitioners specifically trained in substance disorders assist clients achieve greater levels of substance use reduction.

Policies:
1. PROVIDER NAME policies and procedures support appropriate core competency training of clinicians rendering services to clients and their families.
2. The supervisory assessment of clinical staff measure clinical skills pertaining to core competencies listed at time of hire or contract, and as needed for currently employed or contracted clinicians.
3. Within 10 working days of hire or contract, a clinician completes initial assigned training to include implementing its evidence-based practice name models and any other evidence-based practices utilized by PROVIDER NAME.
4. An individualized clinician development plan determines specific education and training needs for each clinician. The plan is maintained in the clinician’s personnel or contractor file. An individual clinician’s need for supplementary training in support of program needs is determined by the clinical supervisor on a case-by-case basis.
5. When funding is available, PROVIDER NAME provides specialized training to clinicians.
6. Clinicians are provided training or opportunity for training in core competencies (listed below), as appropriate to need and assigned work duties. Staff training may include non-clinical staff whose job functions include client and family contact.
7. Clinician training is guided by required competencies in support of PROVIDER NAME EBPs-name the models and other evidence-based practices utilized by agency.

Staff Responsible for Implementation
Clinical Supervisor
- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. Clinicians must hold a current State of New Mexico license and meet practitioner qualifications to render Medical Assistance Division (MAD) services; see 8.321.2 NMAC. Clinician core-competencies include clinical knowledge of the required elements of services, experience in providing specific services, and the supervisory requirements include but are not limited to the following:
   a. Thriving and resiliency philosophical orientation and skills;
   b. Cultural competency;
   c. Stage-wise interventions;
   d. Knowledge of developmental stages;
   e. Motivational interventions;
   f. Trauma-sensitive care;
   g. Development and maintenance of the comprehensive Service Plans and Treatment Plans;
   h. Adolescent development (if the agency will render adolescent services)
   i. Background in geriatric behavioral health services (If the agency will service a sizable geriatric population.)
   j. Initial training and on-going training of evidence-based practices utilized by the
agency;
k. Refresher trainings as appropriate to assigned duties;
l. 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;
m. Identification of clinical and psychosocial needs of client population, especially regarding co-occurring disorders (COD) and interactions of the various disorders;
n. Psychopharmacology and its effects on substance, mental and emotional health issues, and on clients with co-occurring disorders (COD);
o. Drugs of abuse, related symptoms, and possible interventions related to adolescent development, and stages of treatment for the age group(s) served;
p. Severe emotional disturbances, serious mental illness, and other mental health diagnoses with related symptoms and effects exacerbating substance use, and/or substance effects; and
q. Working with behaviorally disruptive, unruly, violent, and suicidal clients or their family members.
2. Clinicians receive training within 10 calendar days of hiring or contracting on PROVIDER NAME evidence-based practices - name models used. For services the clinician must have completed the EBP training prior to him or her rendering services.
3. A comprehensive supervisory assessment utilizing direct observation of the clinician and review of client files is conducted within the 30 working days of the start the clinician’s first date of service, and quarterly thereafter. Individual sections of this manual provide directions to the clinical supervisor what competencies to assess.
4. Records of trainings attended, certificates of completion, or other evidence of completed trainings are kept in the clinician’s personnel or contractor file; this also includes in-house training. Documentation of training must include: the agenda of the training, proof of attendance at the training, any continuing educational units (CEU), name and professional licensure of trainer.
5. Additional in-depth training for specific client populations, such as co-occurring disorders (COD), is conducted with clinicians as appropriate to needs assessed by the clinical supervisor: at the time of hire, after 30 working days of rendering services, and during quarterly review of client files.
6. Supervision of clinician competencies related to core competencies is specifically documented. The clinical supervisor provides and documents supervision of clinician competencies utilizing PROVIDER NAME standard observation and feedback forms.
SECTION V - PHILOSOPHY OF APPROACH AND PRINCIPLES OF PRACTICE

Table of Contents

1. Engagement, Alliance and Rapport
2. Guiding Principles of Thriving
3. Cultural Competency
4. Gender Self-Identification Support Competency
5. Developmentally Appropriate Care
6. Motivational Approaches
7. Trauma-informed System of Care
H. Co-Occurring Disorders
V. PHILOSOPHY OF APPROACH & PRINCIPLES OF PRACTICE
A. Engagement, Alliance and Rapport

Policy Number: 1
Approval Date:
Revision Date:

Purpose: Engagement is a fundamental element of the treatment process. Effective engagement increases client and family 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 of building trust, alliance and rapport with the client and his or her family, and are continuously applied in every interaction with the client and his or her family to assure retention in all aspects of treatment and other integrated services.

- (If the agency provides adolescent service, include this)

It is imperative that adolescent services (under 18 years of age) and adult services (18 and older) be provided separately to ensure clients receive developmentally appropriate services. PROVIDER NAME follows its evidence-based practice -name model requirements of age, gender, trauma separation and client safety. In some instances, PROVIDER NAME may provide separate services by gender or for those clients with trauma-related concerns in order to provide a safe and supportive environment for them and others. The client’s treatment file provides documentation as to why the client attends a subset group of the general client population.

Policies:
1. 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 a client and his or her family.
2. PROVIDER NAME trains and supervises staff regarding matching treatment and support interventions to the client’s or family’s capacity to work on identified issues and how to develop and maintain the client’s and family’s alliance and rapport.
3. PROVIDER NAME supports clinicians’ engagement with the belief of the prevalence of co-occurring disorders (COD) and plans appropriate engagement strategies related to multiple disorders.
4. 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. PROVIDER NAME trains clinicians how to incorporate the client's culture into treatment and support services towards enhancing the development of the therapeutic alliance (culture may indicate other factors than societal norms, and include gender, group identity, etc.).
6. PROVIDER NAME requires that clinicians receive specific supervision and coaching regarding establishing and maintaining therapeutic engagement at frequent intervals or when a previously unserved client population seeks services.
Staff Responsible for Implementation

Clinical Supervisor
- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:

1. The clinical supervisor and Human Resources manager develop questions for clinical staff interviews to assist in determining the level of knowledge, awareness, and understanding the applicant has concerning building alliance and establishing rapport with a client and his or her family.

2. The clinical supervisor is responsible to observe within the first 30 working days of a new hire or contractor to determine:
   a. The clinical staff’s competency to establish an alliance using developmentally and functionally appropriate motivational strategies by actively and specifically applying these skills;
   b. The clinical staff’s competency to, as accurately as possible, match interventions to the client’s and his or her family’s capacity to work on identified issues.
   c. The clinical staff’s competency to develop a collaborative alliance that fosters the sense of having a caring relationship between clinical staff and the client and his or her family.
   d. The clinical staff’s competency to apply knowledge and skills related to cultural competency to foster rapport and alliance.
   e. The clinical supervisor also assesses if the clinician applies PROVIDER NAME (a) through (d) above procedures in a suitable and appropriate manner to a client. The clinical supervisor meets to discuss. Thereafter, the clinical supervisor observes least quarterly. The clinical supervisor provides as necessary additional training and monitoring to a clinician. The clinical supervisor utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the clinician’s personnel or contractor file.

- The agency determines the turnaround.
- The agency must establish exact months in each quarter the clinical supervisor will observe the clinicians. The agency may set aside specific days of each month to schedule clinician observation to then rotate staff so every clinician receives his or her observation supervision within a quarter.

3. The clinical supervisor is responsible for providing professional supervision, coaching sessions, and ongoing training related to engagement practices to clinical staff during name the scheduled times, i.e. at every bi-weekly meeting. The clinical supervisor implements a schedule to assist the clinical staff gain competency in the areas listed above (a-d). The clinical supervisor utilizes PROVIDER NAME standardized observation and feedback form and files it in the clinical staff’s personnel or contractor file.

- Remember supervision includes each client’s treatment plan being discussed or reviewed individually, whether in a group setting or one-on-one. MAD suggests the agency refers to its EBP model’s requirements.

4. The clinical supervisor quarterly conducts a review of randomly selected client files to determine whether the clinician’s entries document his or her compliance with (a)
through (d) above procedures. The clinical supervisor meets to discuss. The clinical supervisor develops a corrective action plan specifically for clinical staff to address any short-comings in the clinician’s competencies.

- The agency determines the turnaround.
- The agency must establish exact months in each quarter the clinical supervisor will observe the clinicians. The agency may set aside specific days of each month to schedule clinician observation to then rotate staff so every clinician receives his or her observation supervision within a quarter.

5. The clinical supervisor and Quality Officer (use Job Titles) review during the third month of the second quarter of it’s the operating year 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 client or family being served.

6. The clinical supervisor presents within two weeks of his or her review recommendations for changes to Job Title.

7. Job Title presents within two months to the Board of Directors his or her recommendations.

8. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval.

9. When the decision is made to retain the current practices, the clinical supervisor works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as a refresher.

V. PHILOSOPHY OF APPROACH & PRINCIPLES OF PRACTICE

B. Guiding Principles of Supporting Youth to Thrive

Policy Number: 1
Approval Date:
Revision Date:

**Purpose:** There are two aspects of supporting youth to thrive that are distinct, but are interrelated and support one another:

1. Thriving-oriented support is what PROVIDER NAME staff offer in support of the client’s and family’s own efforts to thrive; and

2. The process of supporting youth refers to how a client and his or her family are impacted by a mental and/or substance disorder and how the client and his or her family actively manage the client’s disorder and reclaim life in his or her community.

**Policies:**

1. PROVIDER NAME’s approach reflects a philosophy of support that is strengths and resiliency based specific to counseling the client and his or her family towards health
and wellness related to substance use, mental health issues or co-occurring disorders. PROVIDER NAME utilizes culturally competent, and trauma-informed services that specifically support youth towards thriving and are developmentally appropriate for the persons being served. This should be reflected in their:
   a. Evidence based practices (EBP), including those for treating co-occurring disorders, including EBP reviews;
   b. Educational materials;
   c. Staff training;
   d. Supervision
2. PROVIDER NAME maintains a commitment to a service-orientation based on its thriving and resiliency philosophy, values, and beliefs.
3. PROVIDER NAME provides timely and effective supervision and support for all EBP.
4. The agency establishes a regular timeline for clinical supervision related to supporting youth.

Staff Responsible for Implementation
Clinical Supervisor; Quality Manager

Procedures:
1. PROVIDER NAME adopts the use of EBPs appropriate to the target population, level of staff readiness, and organizational readiness to support the EBP to fidelity.
2. PROVIDER NAME distributes written or electronic information appropriate to supporting youth to thrive.
3. The clinical supervisor and Quality Officer audit during the second quarter of the operating year whether PROVIDER NAME evidence/research based practices and programs are being implemented to fidelity and are appropriate for the population being served. The clinical supervisor presents within two weeks of the audit his or her recommendations to executive staff.
4. The clinical supervisor and Human Resources manager develop questions for clinical staff interviews to assist in determining the level of awareness and understanding the applicant has concerning thriving and resiliency beliefs and practices, as well as the complexities of substance, mental and emotional, and co-occurring disorders
5. The clinical supervisor is responsible to observe within the first 30 working days of a new hire or contract to determine the clinical staff’s competency to render services addressing the complexities of substance, mental and emotional, and co-occurring disorders (COD), and if he or she applies such services in a suitable and appropriate manner to a client.
6. PROVIDER NAME standardized observation recording and feedback form and files it in the clinician’s personnel or contractor file.
7. PROVIDER NAME supervises service staff, especially regarding supportive services are integrated within a continuum and work to help clients and families manage the day to day challenges of life instead of focusing on illness and pathology.
V. PHILOSOPHY OF APPROACH & PRINCIPLES OF PRACTICE
C. Cultural Competency

Policy Number: 1
Approval Date:
Revision Date:

Purpose: 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 client and his or her family, providers, and professionals that enables that system, agency, or those professionals and community providers to work effectively in cross-cultural situations.

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, medical condition, gender identity, sexual orientation, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), developmental disability, genetic information, or other such conditions.

Policies:
1. PROVIDER NAME encourages and aids clinical staff to increase their knowledge and understanding of cultural differences and acknowledge and surmount personal cultural assumptions and biases.
2. PROVIDER NAME encourages and support clinical staff changes in thought and behavior to address culturally based biases.
3. PROVIDER NAME maintains awareness of the unique values, preferences, and strengths of clients and their families and communities.
4. PROVIDER NAME adapts 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. PROVIDER NAME trains clinical staff in cultural competency for the populations served upon hire and thereafter annually.

Staff Responsible for Implementation
Clinical Supervisor

* Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The clinical supervisor and Human Resources manager develop questions for clinical staff interviews to assist in determining the level of awareness and understanding the applicant has concerning cultural inclusion and practices.
2. The clinical supervisor is responsible to observe within the first 30 working days of a new hire or contract to determine the clinical staff’s competency to render services addressing the complexities of cultural differences and the clinician’s personal cultural assumptions and biases, and if he or she applies such services in a suitable and
appropriate manner to client. The clinical supervisor meets to discuss. Thereafter, the clinical supervisor observes at least quarterly. The clinical supervisor provides as necessary additional training and monitoring. The clinical supervisor utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the clinician’s personnel or contractor file.

- **The agency determines the turnaround.**
- **The agency must establish exact months in each quarter the clinical supervisor will observe the clinicians. The agency may set aside specific days of each month to schedule clinician observation to then rotate staff so every clinician receives his or her observation supervision within a quarter.**

3. The clinical supervisor quarterly conducts a review of randomly selected client files to determine whether the clinician’s entries document his or her compliance in addressing the complexities of a client’s cultural differences and if the clinician’s personal cultural assumptions and biases are present in his or her file entries. The clinical supervisor develops a corrective action plan for clinician to address any short-comings in his or her competency.

- **The agency must establish exact months in each quarter the clinical supervisor will observe the clinicians. The agency may set aside specific days of each month to schedule clinician observation to then rotate staff so every clinician receives his or her observation supervision within a quarter.**

4. The clinical supervisor and Quality Officer (use Job Titles) during the second quarter of the operating year audit determines whether PROVIDER NAME evidence-based practices continue to be 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 client and family being served.

5. The clinical supervisor presents within two weeks of the audit his or her recommendations for changes to Job Title.

6. The Job Title presents within two months to the Board of Directors his or her recommendations.

7. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval.

8. The clinical supervisor and Job Title of trainer schedule training for changes to the current EBP or for the new EBP.

9. When the decision is made to retain the current practices, the clinical supervisor works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as a refresher.
V. PHILOSOPHY OF APPROACH & PRINCIPLES OF PRACTICE
D. Gender Self-Identification Support Competency

Policy Number: 1
Approval Date:
Revision Date:

Purpose: PROVIDER NAME recognizes that self-identification of gender plays a significant role in how the sex of the client is expressed in the social context. For PROVIDER NAME staff, the use of the term ‘gender’ is a descriptive word used to illustrate a client’s self-identification of the client’s differences in the social expression of biology, not as a way to describe what is a correct for expressing a client’s self-identity.

Include if the agency will render adolescent services: Additionally, adolescent females have become the fastest growing segment of the juvenile justice system across the United States over the past twenty years. Adolescent females in behavioral health settings may experience complicated mental health, substance use, and primary health care needs and may not fare well in systems designed for their male counterparts. Gender competency is often discussed in application to the female population only. PROVIDER NAME recognizes the unique needs of females and males in the treatment population, and strives to provide treatment appropriate to either and in segregated groups as possible and appropriate.

Policies:
1. 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 conducts routine business in ways that produces effective and empowering outcomes for all clients, whether they identify as male, female, or any other term describing their gender or sexual identity. Some of these are determined as:
2. Encourages and aids staff to increase their knowledge and understanding of gender competency issues, concepts and practical implementation related to engagement practices.
   a. Trains and supervises clinicians or changes related to appropriate behaviors to address gender identity biases.
   b. Maintains systems and individual clinicians’ awareness of the unique values, preferences, and strengths of clients, their families, and communities.
   c. Adapts gender competency considerations into treatment practices, as appropriate and possible, and includes natural and informal supports.
   d. Supervisory process actively monitors clinician and agency gender competency practices and initiates feedback or corrective action related to a perceived breach of stated policy or client complaint.
3. PROVIDER NAME maintains a strict non-discrimination stance related to sex, gender identity, and sexual orientation.
4. PROVIDER NAME maintains commitment to gender competence throughout the organization as evidenced in the active application of this subsection’s policies and procedures and ongoing quality audits. Practices include:
a. Supports and coaches related to clinician’s 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 clinician competencies related to gender competency and develops corrective action plans as appropriate and needed.
d. Maintains consistent best practice application related to gender competency.
e. Quality assurance processes assess supervisory practices related to how an individual clinician is monitored for gender competency and reports findings and recommendations to the executive board.

Staff Responsible for Implementation
Clinical Supervisor
- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The clinical supervisor and Human Resources manager develop questions for clinical staff interviews to assist in determining the level of awareness and understanding the applicant has concerning gender identification.
2. The clinical supervisor is responsible to observe within the first 30 working days of a new hire or contract to determine the clinical staff’s competency to render services addressing the complexities of gender self-identification and the clinician’s personal gender assumptions and biases, and if he or she applies such services in a suitable and appropriate to client. The clinical supervisor meets to discuss. Thereafter, the clinical supervisor observes at least quarterly. The clinical supervisor provides as necessary additional training and monitoring. The clinical supervisor utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the clinician’s personnel or contractor file.
- The agency determines the turnaround.
- The agency must establish exact months in each quarter the clinical supervisor observes the clinicians. The agency may set aside specific days of each month to schedule clinician observation to then rotate staff so every clinician receives his or her observation supervision within a quarter.
3. The clinical supervisor quarterly conducts a review of randomly selected client files to determine whether the clinician’s entries document his or her compliance in addressing the complexities of a client’s gender self-identification and the clinician’s personal gender assumptions and biases are present in his or her file entries. The clinical supervisor develops a corrective action plan for clinical staff to address any shortcomings in his or her competency.
4. The clinical supervisor researches on a semi-annual basis-name the months to identify service population needs and trends related to gender competency services to guide the effective implementation of services for both males and females 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.

5. The clinical supervisor in first month of the operating year submits a report to the Job Title of his or her recommendations to maintain current practices or amend these practices based on the results of his or her research.

6. Job Title presents within two months to the Board of Directors his or her recommendations.

7. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval.

8. The clinical supervisor and Job Title of trainer schedule training for changes to the current EBP or for the new EBP.

9. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as a refresher.

V. PHILOSOPHY OF APPROACH & PRINCIPLES OF PRACTICE

E. Developmentally Appropriate Care

Policy Number: 1
Approval Date:
Revision Date:

Purpose: To support a client reach his or her treatment goals, treatment interventions must be individualized and consistent with and determined by the client’s and family members’ developmental stages of treatment and stage of change.

Policies

1. PROVIDER NAME ensures clinical staff receives training in developmentally appropriate interventions.

2. PROVIDER NAME ensures developmentally and functionally appropriate interventions are applied by clinicians to substance use and mental health issues and other co-morbid conditions that the client may be experiencing.

3. PROVIDER NAME ensures developmentally and functionally appropriate interventions are documented in the client’s Service Plan and Treatment Plan.

4. PROVIDER NAME ensures clinical staff training in Stage-wise interventions to ensure staff familiarity and support of Stage-wise interventions.

5. PROVIDER NAME ensures that Stage-wise interventions are applied independently to substance use and mental health issues and other co-morbid conditions that the client may be experiencing.

6. PROVIDER NAME ensures that Stage-wise interventions are documented in the client’s Service Plan and Treatment Plan.
Staff Responsible for Implementation

Clinical Supervisor

- *Remember to list the Job Title, not the function he or she is fulfilling.*

Procedures:

1. The clinical supervisor and Human Resources manager develop questions for clinical staff interviews to assist in determining how competent the applicant is in recognizing and applying appropriate stage of treatment interaction to a client’s current developmental and functional stage.

2. The clinical supervisor is responsible to observe within the first 30 working days of a new hire or contract to determine the clinical staff’s competency to render services addressing different client developmental stages, and address related different conditions, circumstances, and diagnoses, including functional capacity, and if he or she applies Stage-wise services in a suitable and appropriate manner to the client. The clinical supervisor meets to discuss. Thereafter, the clinical supervisor observes at least quarterly. The clinical supervisor provides as necessary additional training and monitoring. The clinical supervisor utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the clinician’s personnel or contractor file.
   - *The agency determines the turnaround.*
   - *The agency must establish exact months in each quarter the clinical supervisor will observe the clinicians. The agency may set aside specific days of each month to schedule clinician observation to then rotate staff so every clinician receives his or her observation supervision within a quarter.*

3. The clinical supervisor quarterly conducts a review of randomly selected client files to determine whether the clinician’s entries document his or her compliance in addressing Stage-wise services. The clinical supervisor develops a corrective action plan for clinical staff to address any short-comings in his or her competency.

4. The clinical supervisor and Quality Officer (use Job Titles) review during the second month of the second quarter of the operating year whether PROVIDER NAME Stage-wise practices continue to be 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 client and family being served.

5. The clinical supervisor presents within two weeks of the review his or her recommendations for changes to Job Title.

6. The Job Title presents within two months to the Board of Directors his or her recommendations.

7. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval.

8. The clinical supervisor and Job Title of trainer schedule training for changes to the current EBP or for the new EBP.
When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as a refresher.

V. PHILOSOPHY OF APPROACH & PRINCIPLES OF PRACTICE
F. Motivational Approaches
Policy Number: 1

**Purpose:** The purpose of using motivational Interviewing (MI) is to engage a client to support him or her make discoveries and offer assistance as the client learn ways he or she can self-manage, and to understand in his or her own terms the impact of substance use and mental health disorders on his or her life and family’s life. The purpose of Contingency Management is to provide positive reinforcement for a client’s new behaviors that counter the loss of focus on life supporting beliefs, attitudes, and actions with verbal or written recognition and/or tangible rewards to reinforce positive behaviors as abstinence or reductions in use (frequency or quantity.)

**Policies:**
1. PROVIDER NAME ensures staff receives training in to ensure staff familiarity and support in use of MI.
2. PROVIDER NAME ensures MI is applied independently to substance use and mental health issues and other co-morbid conditions that the client may be experiencing.
3. PROVIDER NAME ensures MI interventions are documented in the client’s Service Plan and Treatment Plan.
4. PROVIDER NAME ensures staff is trained and understands contingency management principles and practices.

**Staff Responsible for Implementation**
Clinical Supervisor
- Remember to list the Job Title, not the function he or she is fulfilling.

**Procedures:**
1. The clinical supervisor and Human Resources manager develop questions for clinical staff interviews to assist in determining the level of awareness and understanding MI practices of the applicant.
2. The clinical supervisor is responsible to observe within the first 30 working days of a new hire or contract to determine the clinical staff’s competency to render motivational interviews, and if he or she effectively utilizes contingency management principles and practice, and if he or she applies such services in a suitable and appropriate manner to the client. The clinical supervisor meets to discuss. Thereafter, the clinical supervisor...
observes at least quarterly. The clinical supervisor provides as necessary additional training and monitoring. The clinical supervisor utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the clinician's personnel or contractor file.

- The agency determines the turnaround.
- The agency must establish exact months in each quarter the clinical supervisor will observe the clinicians. The agency may set aside specific days of each month to schedule clinician observation to then rotate staff so every clinician receives his or her observation supervision within a quarter.

3. The clinical supervisor quarterly (list the specific dates) conducts a review of randomly selected client files to determine whether the clinician's entries document his or her compliance by incorporating motivational interviewing into service delivery and the effective utilization of contingency management principles and practice. The clinical supervisor develops a corrective action plan for clinical staff to address any shortcomings in his or her competency.

4. The clinical supervisor researches on a semi-annual basis (based on operational year-name months) to identify service population needs and trends related to MI competency services to guide the effective implementation of services for, and implements business and treatment practices as appropriate.

5. The clinical supervisor in the first month of the first quarter of the new operating year submits a report to Job Title his or her recommendations to maintain current practices or amend these practices based on the results of his or her research.

6. The Job Title presents within two of months his or her recommendation to the Board of Directors.

7. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval.

8. The clinical supervisor and Job Title of trainer schedule training for changes to the current EBP or for the new EBP.

9. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as a refresher.

V. PHILOSOPHY OF APPROACH & PRINCIPLES OF PRACTICE

G. Trauma-informed System of Care

Policy Number: 1
Approval Date:
Revision Date:

Purpose: PROVIDER NAME defines trauma-informed care as a specific type of care 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 clients who receive behavioral health services.

**Policies:**

1. PROVIDER NAME clinical staff assesses at intake the client’s current and past trauma.
2. PROVIDER NAME clinical staff addresses current or past trauma in an individualized Service Plan and Treatment Plan as appropriate.
3. PROVIDER NAME clinical staff develops with the client trauma related safety plan that includes specific client triggers that lead to maladaptive behaviors, early warning signs, and strategies to manage and minimize stress.
4. PROVIDER NAME clinical staff promotes **Trustworthiness** by making tasks involved with service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to PROVIDER NAME.
5. PROVIDER NAME clinical staff maintains engagement through careful application of alliance and rapport strategies.
6. PROVIDER NAME clinical staff maintains consistency in practice, and maintains boundaries that are appropriate to PROVIDER NAME.
7. PROVIDER NAME clinical staff **Collaborate** to maximize coordination and sharing of power between clinical staff and the client and family. This translates to an approach that is respectful of strengths and vulnerabilities with the overall intent to help clients become empowered to act as the directors of their own lives.
8. PROVIDER NAME provides **Safety** when:
   a. Clinical staff attends to the physical and emotional safety of the client and their family, and staff.
   b. Clinical staff strives to match level of clinician’s experience and skill with the client’s and family’s needs.
   c. The clinical supervisor provides training and support for field work situations that may expose clinical staff to unsafe conditions and situations.
   d. The clinical supervisor certifies that clinical staff competency and effective use of trauma-sensitive care practices to avoid triggering and/or escalating trauma-related episodes.
   e. The clinical supervisor provides for clinical staff backup (additional qualified and trained staff, etc.) during crisis situations.
   f. The clinical supervisor ensures the clinical staff safety which must include adequate supervision and respite planning to prevent and/or mitigate the accumulative stress of working with traumatized clients. Training about ethics, confidentiality and reporting issues is conducted regularly, see annual training calendar.
   g. The administrative staff and the clinical supervisor develop, adopt, train staff, implement, and conduct quality management regarding trauma-sensitive policies, procedures, and continually evaluates the physical and therapeutic environment regarding safety for staff and clients who have experienced trauma.
9. PROVIDER NAME clinical staff support client **Choice** to maximize the client’s and his or her family’s experiences of choice and control.
10. PROVIDER NAME clinical staff interacting in any regard with a client and his or her family is trained in trauma sensitive care.
11. PROVIDER NAME clinical staff ensures referral sources and consultation for trauma related issues are available as appropriate to need.

12. PROVIDER NAME clinical staff **Empowers**, encourages, and supports the client and his or her family by prioritizing the client’s and his or her family’s empowerment and skill building. Clinical staff recognizes and supports effective treatment and support as empowering the client and his or her family to maximum possible self-efficacy, parental or self-regulation of behaviors, attitudes and expressions, and parental (for adolescents) or self-management of the whole life, as far as functional ability permits.

**Staff Responsible for Implementation**

Clinical Supervisor

- *Remember to list the Job Title, not the function he or she is fulfilling.*

**Procedures:**

1. The clinical supervisor and Human Resource manager develop questions for clinical staff interviews to assist in determining the level of awareness and understanding trauma-informed principles and practices.

2. The clinical supervisor is responsible to observe within the first 30 working days of a new hire or contract to determine the clinical staff’s competency to render services addressing trauma-informed principles and practices, his or her effectiveness to meet the unique needs of each client, and if he or she applies trauma-informed principles and practices in a suitable and appropriate manner to the client. The clinical supervisor meets to discuss. Thereafter, the clinical supervisor observes at least quarterly. The clinical supervisor provides as necessary additional training and monitoring. The clinical supervisor utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the clinician’s personnel or contractor file.
   - *The agency determines the turnaround.*
   - *The agency must establish exact months in each quarter the clinical supervisor will observe the clinicians. The agency may set aside specific days of each month to schedule clinician observation to then rotate staff so every clinician receives his or her observation supervision within a quarter.*

3. The clinical supervisor quarterly conducts a review of randomly selected client files to determine whether the clinician’s entries document his or her compliance by incorporation of trauma-informed services. The clinical supervisor develops a corrective action plan for clinical staff to address any short-comings in his or her competency.

4. The clinical supervisor during the fourth quarter of the operating year whether PROVIDER NAME trauma informed care evidence-based practices continue to be appropriate, comprehensive, and support integrated services. During this time, the clinical supervisor conducts a review of new trauma-informed care EBPs that have demonstrated effectiveness in reducing the negative impact of the functional issues being addressed while increasing the positive functioning of the client or family being served.
5. The clinical supervisor in the first month of the first quarter of the agency’s operating year submits a report to the Job Title recommendations to maintain current practices or amend these practices based on the results of his or her research.

6. The Job Title presents within two months his or her recommendations to the Board of Directors.

7. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval.

8. The clinical supervisor and Job Title of trainer schedule training for changes to the current EBP or for the new EBP.

9. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as a refresher.

V. PHILOSOPHY APPROACH AND PRINCIPLES OF PRACTICE

H. Co-Occurring Disorders

Policy Number: 1
Approval Date: 
Revision Date: 

Purpose: PROVIDER NAME has a commitment to treating clients with co-occurring disorders (COD). Agency-wide efforts will be made to welcome and support clients with COD. Behavioral health treatment must identify and recognize all a client’s disorders in order to provide comprehensive, integrated and individualized services to assist the client move toward his or her goals.

General Policies:
1. PROVIDER defines ‘co-occurring disorders’ (COD) when a client has a substance-related and a mental or emotional disorder.
2. PROVIDER defines ‘co-morbid’ disorder when a client has an interrelated medical, cognitive, and/or developmental disorder and condition.
3. PROVIDER NAME utilizes appropriate “best practices” and evidence-based practices (EBP) interventions for a client with COD.
4. PROVIDER does not discharge a client from services due to a determination of COD. Referrals with appropriate follow-up to assure care may be made due to PROVIDER NAME clinical capabilities and caseload capacity issues, but never due to presence of one or more co-occurring disorders.
5. PROVIDER NAME provides a welcoming, empathic, integrated, continuous, comprehensive service center to clients and their families.

Practice Standards:
1. Each client diagnosed with a COD has a Service Plan and Treatment Plan which identifies COD as a primary issue. Specific goals, objectives and interventions are
identified for each primary COD. A client’s Service Plan develops a comprehensive set of staged, integrated program services and treatment interventions for each disorder that is adjusted as needed to take into account issues related to the other disorder.

2. Service Plan development is made with the client, his or her family, his or her multi-disciplinary team (MDT) members, and other external individuals involved in the overall treatment program as possible with the purpose to integrate interventions for the COD throughout the course of services.

3. If the client with COD is receiving services, the clinical supervisor leads MDT and Internal Service Team (IST) meetings with the client’s clinician in attendance to stay informed of conditions, progress, and other aspects of services that may impact the client’s treatment services.

4. Each client receives specific education regarding participation in treatment for his or her COD. The MDT members identify both the target of the interventions (e.g., specific symptoms, social problems, substance use behaviors, etc.) and the interventions to address both the substance use and mental health issues, and how the interventions will bring about positive change. One example of such integration is helping a client learn and practice strategies to cope with his or her psychiatric symptoms that appear to contribute to his or her substance use. Another example is providing psycho-education to a client to help him or her understand how his or her continued substance use worsens his or her psychiatric illness. The MDT members may suggest Comprehensive Community Support Services or Behavior Management Skills. Services not available at PROVIDER NAME may be referred as appropriate and available in the community mindful of possible limitations of funding sources.

5. Continuous treatment relationship providers (such as the client who receives Behavior Management consultant waiver services) are strongly encouraged to participate in the development of the client’s Service Plan (and be members of the MDT) with providers of episodic interventions for either disorder (inpatient, detox, residential). Service Plans for clients with COD address multiple domains of functioning, as informed by the assessment findings, and specifically address functional impairment related to mental health, substance use, co-occurring and other co-morbid disorders. All issues identified through: the assessment and interpretive summary; client interactions with others; or self-identification by the client are specifically addressed in the Service Plan. When PROVIDER NAME does not offer services a client requires, the MDT members seek outside the agency for practitioners to render these services.

6. PROVIDER NAME Internal Service Team (IST) is comprised of assigned internal agency staff and is led by the clinical supervisor. When the client is receiving additional behavioral health services outside the agency, IST members maintain documented communication linkages with the client’s behavioral health practitioners and other critical service linkages as identified in the client’s assessment, interpretive summary, and Service Plan (e.g. HIV health care; criminal justice, courts, PO’s, etc.). The IST serves clients and families with service needs identified in multiple domains, such as COD substance and mental health disorders, and specifically assure services are coordinated and consistent across domains within PROVIDER NAME service array. The clinical supervisor is responsible to ensure his or her clinical supervision supports the clinician address the client’s COD complex needs identified in his or her assessment, interpretive
summary, Service Plan, and Treatment Plan. The clinical supervisor schedules the clinician’s regular supervision time to meet individually outside any other group supervision.

- Include the process of supervision:
  - Is there a pre-set day it is done?
  - Is supervision arranged by preset appointments or does the clinical supervisor or clinician schedule separate supervision times?

7. PROVIDER NAME determines appropriate clinical or other care based on a level of care services criteria, assessment, interpretive summary, Service Plan, and Treatment Plan. Services cannot be refused based on substance use, mental, behavioral, or emotional disorders, or COD. If PROVIDER NAME does not have the clinical capabilities or service capacity to treat a client, the clinician must work with the client to identify other practitioners in the community to provide these services, and the clinician is to conduct follow-up to assure the client is receiving appropriate care.

8. The clinician and clinical supervisor must make every attempt to engage these practitioners in MDT meetings.

**Staff Responsible:**

Clinical Supervisor

- Remember to list the Job Title, not the function he or she is fulfilling.

**Procedures:**

**A. Welcoming**

1. The clinical supervisor during the second quarter of the operating year reviews program descriptions, orientation materials, and educational materials to determine if the documents present a welcoming and accepting atmosphere for clients with COD.

2. The clinical supervisor presents to Job Title within two weeks of the review his or her recommendations to revise documents or to retain the current versions.

3. Job Title presents within two months his or her recommendations to the Board of Directors.

4. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval.

**B. Treating and Coordination**

1. The clinical supervisor and Human Resources (HR) manager develop questions for clinical staff interviews to assist in determining the level of awareness and understanding COD principles and practices.

2. The clinical supervisor is responsible to observe within the first 30 working days of a new hire or contract to determine the clinical staff’s level of COD principles and practices, his or her effectiveness to meet the unique needs of each client, and if he or she applies PROVIDER NAME COD principles and practices in a suitable and appropriate manner to client. Thereafter, the clinical supervisor observes at least quarterly* and provides timely feedback-applying agency determines the turnaround. The clinical supervisor provides as necessary additional training and monitoring. The clinical supervisor utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the clinician’s personnel or contractor file.
*The agency must establish exact months in each quarter the clinical supervisor will observe the clinicians. The agency may set aside specific days of each month to schedule clinician observation to then rotate staff so every clinician receives his or her observation supervision within a quarter.

3. The clinical supervisor quarterly conducts a review of randomly selected client progress notes to determine whether the clinical staff have incorporated PROVIDER NAME COD principles, practices, and philosophy. The clinical supervisor develops a corrective action plan for clinical staff to address any short-comings in his or her competency.

4. The clinical supervisor researches in the second quarter of the operating year to identify service population needs and trends related to COD interventions and practices to guide the effective implementation of services, and implements business and treatment practices as appropriate.

5. The clinical supervisor presents to Job Title within two weeks after the close of research his or her recommendations to maintain current practices or amend these practices.

6. The Job Title presents within two months to the Board of Directors his or her recommendations.

7. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board's approval.

8. The clinical supervisor and Job Title of trainer schedule training for changes to the current EBP or for the new EBP.

9. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) schedule annual clinical staff training as a refresher.
SECTION VI - INITIATION OF SERVICES

Table of Contents

A. Client Early Engagement

B. Eligibility Requirements for MAD Behavioral Health Services - General

C. Assessment and Interpretive Summary

D. Client Orientation

E. Multi-disciplinary Team

F. Agency Internal Service Team

G. Treatment Plan

H. Treatment Plan Essential Elements
VI. INITIATION OF SERVICES
A. Client Outreach and Recruitment into Services

Policy: 1  
Approval Date: 
Revision Date: 

Purpose: PROVIDER NAME conducts outreach, accesses and retains referrals, and implements policies and practices to reduce client drop outs and no shows while maintaining the client’s continued participation in treatment. It is critical to the success of PROVIDER NAME efforts to provide quality services to its clients and families, and to support, honor, and validate administrative and clinical staff as they rendered services.

Policies:
1. Foster respectful and coordinated relationships with possible referral agencies, such as court systems, school counselors, youth activity programs (parks and recreation, after school programs).
2. Minimize the time between intake and start of services.
3. Prior to the start of service, the client is assigned a clinician who familiarizes him or herself with the client’s past and current treatment history. By having a prepared clinician, the client (1) does not have to wait while the clinician reads his or her file, and (2) the clinician is able to actively engage the client in services.
4. Provide flexible schedules to the client to ensure his or her availability to attend sessions.
5. Support provisions to increase frequency of contacts in early stages of treatment, as appropriate.
6. Institute a system of reminders beyond telephone message, such as text messaging and email reminders the day prior and the day of services to increase client and family attendance at sessions.
7. Actively reach out to clients with repeated no shows (see Hazard and Emergency Plan for details of this).
8. Provide ongoing structured supervision and training to clinical staff to support their growth professionally and provide clinical support when a client presents with challenging and complex needs and concerns.
9. Provide a tool for administrative and clinical staff to offer suggestions and then participate in activities to improve services. Agency offers in other sections of the manual avenues to participate, such as internal quality team member.

Staff Responsible for Implementation
Clinical Supervisor
   • Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The clinical supervisor and Human Service Manager within the first quarter of the operating year review the internal administrative and clinical staff satisfaction survey
tool. The intent is to determine whether the tool continues to capture the data necessary to evaluate the effectiveness of these policies and procedures.

2. The clinical supervisor presents to Job Title within two weeks of the review his or her recommendations to maintain current practices or amend these practices based on the results of his or her research.

3. The Job Title presents within one month his or her recommendations to the Board of Directors.

4. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval. A copy of the Board of Director’s report and determinations is provided to administrative and clinical staff.

5. When the decision is made to retain the current tool, the Job Title within two weeks provides administrative and clinical staff a summary of the Board of Director’s report and determination.

VI. INITIATION OF SERVICES

B. Eligibility Requirements for MAD Behavioral Health Services

Policy Number: 1
Approval Date: 
Revision Date: 

Purpose:

1. PROVIDER NAME must comply with funding source requirements of eligibility in order to be reimbursed for rendering services. The presenting individual must meet the medical necessity for a service. This may mean for a client he or she must meet specific criteria in addition to meeting a Medical Assistance Programs (MAP) category of eligibility or other eligibility thresholds of a funding source. There should be little if any duplication of information requested of the individual during the intake process.

2. The intake process is to ensure a smooth, client-friendly process that establishes the foundation for a life free of problematic substance use.

3. The intake process is to gather client information that will determine service availability and the client’s medical necessity for services.

4. The intake process also ensures that all new clients complete initial assessments and orientation to the agency including client responsibilities, rules, regulations and rights, PROVIDER NAME meets federal, state and local rules and regulations related to intake and admissions, and that PROVIDER NAME ensures annual review and action to its policies and procedures manual.

• REMEMBER – The agency must be approved to allow non-independently licensed behavioral health practitioners render assessment services. If not, either the agency schedules assessments only with independently licensed practitioner or it refers individuals outside the agency to complete an assessment.
Policies:
1. For a Medical Assistance Division (MAD) behavioral health service to be rendered, the client must have a behavioral health evaluation or assessment (assessment) completed within the past 12 month period recommending behavioral health and supportive medically necessary services.
2. PROVIDER NAME must comply with MAD’s and other funding sources’ limitations as to the level and licensure of practitioners who are allowed to render a behavioral health assessment.
3. PROVIDER NAME intakes consists of three distinct set of actions:
   a. Gathering of client information for insurance billing;
   b. Completing agency forms; and
   c. Gathering of information (assessments, informants, other diagnostic tests) by the authorized clinician to guide him or her and the client determine next steps towards services.
4. The intake process gathers basic client information including demographics, contact information, social security number, emergency contact information, educational status, reason for seeking service, and other information needed. The information is 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; possible client experienced trauma; psychological characteristics; physical conditions; spiritual beliefs; method of payment for services; and outcome expectations. All information gathered is kept confidential in accordance with State and Federal confidentiality requirements (see Section I of this manual). If the client approves, family members or friends may be present during all or any part of the intake process.
5. Specifically for IOP services:
   a. The client must have a current (within the past 12 months) MAD recognized behavioral health assessment with a diagnosis of substance disorder and the practitioner must recommend IOP as a medically necessary service.
   b. The client must have an American Society of Addiction Medicine (ASAM) assessment that determines if the client meets the Level II Intensive Outpatient Services criteria before IOP services may be rendered. Other outpatient behavioral health services may be rendered until these requirements are met (individual, group, family).

Staff Responsible for Implementation
Clinical Director Job Title
Administrative Staff Manager Job Title
   • Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The Job Title of the administrative staff utilizes a scheduling system (name it) to assign a Job Title to begin the client intake processes 3(a-b) and whenever possible assign an authorized clinician to complete the intake process 3(c) after the completion of a and b.
   • This is up to the agency – it may have a clinician render all 3 sets of intake actions, or it may be divided up differently.
2. If a clinician is unavailable, an appointment to complete the clinical portion of the intake is scheduled as soon as possible. If this occurs, the Job Title locates a clinician to briefly assess the mental stability of the individual and if necessary, refer to emergency response services.
   • 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. A client identified as experiencing a crisis that may cause threat to life or limb, is in withdrawal, or may endanger others, shall be addressed by the clinical supervisor or other senior program authority to ensure that he or she receives the appropriate level of care, whether hospitalization, immediate intake, involving law enforcement, homeless shelters, food or clothing referrals, etc, to secure the individual or family continued well-being as far as possible.
   • The agency in Section III Hazard and Emergency Management has determined the chain of authorized personnel to respond to crises. Insert that information here.

3. The Job Title prepares an adequate number blank intake files each week.
4. The Job Title schedules an intake room that is private and welcoming to an individual.
5. Job Title is warm and welcoming to each individual.
6. The Job Title is familiar with forms so he or she does not ask information on one form that the client answered on previous form.
   • The agency may consider having one page with all the information of the required multiple documents and the Job Title fills in this information onto the other documents after the intake.

7. The clinician gathers information to determine:
   a. If the individual has a current assessment, and if so the clinician requests the individual to complete a release of information for the clinician to receive the assessment; or
   B. If there is not a current assessment or the previous assessment may not accurately reflect the current condition of the client, the clinician starts the assessment during the intake or schedules an appointment for the assessment. The assessment process must be thorough enough for the clinician to render a valid diagnosis, interpretive summary with treatment recommendations while not unduly delaying in its completion.
   • The agency inserts its predetermined schedule for the completion of the assessment, such as up to 3 visits with the individual to gather information, four days to complete the interpretive summary and render a diagnosis.

8. When an individual presents him or herself for behavioral health services and has a current MAP category of eligibility, yet does not have current assessment, then he or she may receive outpatient psychotherapy (individual, family, and group) from a clinician until such time as his or her assessment, interpretive summary is completed and a diagnosis rendered.
9. After the assessment is completed, the clinician and client determine service availability and treatment options. It is the clinician’s responsibility to determine if the client meets the level of care criteria for specialized behavioral health services, such as IOP.

10. Specific to IOP, if the clinician recommends IOP and his or her scope of practice and licensure allows, he or she determines if the client further meets the ASAM criteria for Level II Intensive Outpatient Services and the client agrees, then IOP services may be scheduled. If not, another clinician meeting licensure or scope of practice completes the ASAM criteria assessment. Again, no IOP services may be rendered until the client has a diagnosis of substance use and meets ASAM criteria for Level II Intensive Outpatient Services.
   - Failure to comply with this will result in the recoup of any paid IOP service claims.

11. The clinical supervisor quarterly conducts a review of randomly selected client files to determine whether the clinician’s or administrative staff’s entries document his or her compliance with client intake policies and procedures. The clinical supervisor develops a corrective action plan for clinical staff to address any shortcomings in his or her competency.
   - The agency must establish exact months in each quarter the clinical supervisor will observe the clinicians. The agency may set aside specific days of each month to schedule clinician observation to then rotate staff so every clinician receives his or her observation supervision within a quarter.

VI. INITIATION OF SERVICES

C. Assessment and the Interpretive Summary

Policy Number: 1
Approval Date:
Revision Date:

Purpose: The evaluation or assessment (assessment) gathers information and engages the client (and family, as appropriate) to establish the presence or absence of a substance dependency, mental or emotional disorders, co-occurring disorders (COD), and related functional impairments across multiple domains. The interpretive summary determines the client’s readiness for change, identifies strengths and problem areas that may affect treatment processes towards individual and/or family and engages the client (and family) in an appropriate service relationship.

Policies:
1. PROVIDER NAME consistently uses appropriate assessment tools and processes.
2. PROVIDER NAME conduct both clinical and support services assessments as appropriate to perceived or potential need of the client.
3. PROVIDER NAME provides protocols and procedures detailing the use and application of appropriate assessment tools that must be informed by the complex considerations related to assessing a client experiencing substance dependency, mental or emotional disorders, or COD.
4. PROVIDER NAME utilizes a formal assessment instrument that demonstrates integrated assessment of both mental and substance disorders. The assessment is current, (at least within the last 12 months) signed and dated by an independently licensed clinician if the client has a Medical Assistance Programs (MAP) category of eligibility.

5. The assessment process identifies all other concurrent issues that may adversely affect support efforts. The assessment includes all of the following domains of information with the suggested added domain specific to cultural considerations of religion and spirituality:
   a. DSM Diagnoses
   b. Behavioral health service history, including past substance use patterns, and mental health symptom patterns
   c. Biomedical conditions and complications
   d. Client's deficits, functional impairment, cognitive impairment, limitations, barriers to service, and strengths, goals, and desired behaviors and capabilities
   e. Issues related to trauma including trauma history, crisis history, and crisis resolution
   f. Hospitalizations, incarceration, legal system involvement, housing and employment status
   g. Current medications and prior medication history
   h. Current physical health status and prior health history
   i. Identification of all other concurrent issues that may adversely affect the client’s efforts to thrive
   j. Readiness to change and developmental stage
   k. Causality

6. Assessments must have an interpretive summary documenting specific priorities, interactions and self-reinforcing processes as well as a current DSM or ICD diagnosis.

7. The clinical staff rendering services is familiar with the interpretive summary priorities that inform the client’s Treatment Plan and Service Plan especially regarding functional impairment resulting from COD. A client diagnosed with COD, must have a Service Plan and a multi-disciplinary team.

8. The interpretive summary is considered the ‘informative’ document for all persons who interact with the client and his or her family during the course of services, and is updated or modified dependent upon new understanding, remission of symptoms, stabilization, and increased sobriety.

9. The interpretive summary and the assessment it distills from must be considered a living document of the client and his or her family’s current need for services.

10. The interpretive summary and the assessment it distills from specifically informs the development of an individualized and thriving oriented Service Plan and Treatment Plan for the client and his or her family.

11. The interpretive summary and the assessment it distills from informs appropriate intensity and duration of service and service review, and is revisited at regular intervals, or as the symptom picture changes due to mental health remission, substance use reduction, changes in medication and effects, resolution of crises, etc.

12. The interpretive summary is used to formulate a collaboratively developed Service Plan and a Treatment 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 interpretive summary and assessment indicates that other issues may need to be addressed. This means if the client elects not to receive additional services, he or she has the right to continue with the service(s) he or she determines are appropriate at that time. It is thru the clinical engagement process a client may be willing to investigate and seek other medically necessary services.

11. Initial Risk Assessment and Safety Planning:
   a. If the client or family is in obvious crisis, appropriate care shall be taken to refer to, obtain, or provide service as needed.
   b. If needed, emergency services are utilized, and the clinical supervisor oversees all emergency situations.
      • The agency in Section VI Hazard and Emergency Management has determined the chain of authorized personnel to respond to crises. Insert that information here.

Staff Responsible for Implementation
Clinical Supervisor
   • Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. PROVIDER NAME protocols and procedures detail the use and application of appropriate assessment tools, and specifically detailing how the complex considerations related to assessing a client experiencing substance dependency, mental or emotional disorders, COD* (*see other sections of this manual.)
   • The agency must provide specific information here or as an appendix of the assessment tools it utilizes and how a clinician determines when additional or specialized tools are to be utilized.
2. The clinician within XXX number of calendar days from the start of the client's assessment completes the interpretive summary and renders a diagnosis, recommending service priorities in the client's Service Plan to clearly and specifically address the interactions and self-reinforcing processes related to the co-occurring disorders diagnosis.
3. The clinician updates the client's assessment at least every 12 months and includes an interpretive summary, new Service Plan, and new Treatment Plan.
4. The clinical supervisor quarterly (list the specific dates) conducts a review of randomly selected client assessments and interpretive summaries to assess if the clinical staff is implementing PROVIDER NAME policies and procedures, principles and philosophies. The clinical supervisor develops a corrective action plan for clinical staff to address any short-comings in his or her competency.
5. The clinical supervisor during the third quarter of the operating year conducts a review of its assessment tools and protocols, research assessment tools that may better match a specific client population or its general population.
6. The clinical supervisor presents within two weeks of the review his or her recommendations to Job Title.
7. The Job Title presents within two months to the Board of Directors his or her recommendations.
8. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board's approval.

9. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as a refresher.

VI. INITIATION OF SERVICES

D. Client Orientation

Policy Number: 1

Approval Date:
Revision Date:

Purpose: The PROVIDER NAME requires all new clients and their families as appropriate attend an orientation which includes client responsibilities, rules, regulations and rights, assurances PROVIDER NAME meets federal, state and local rules and regulations related rendering behavioral health services.

- The agency may elect to hold a separate orientation session or do this as part of the intake process. Insert here how it proposes to accomplish its client's orientation.

Policy: PROVIDER NAME provides a new client and family as appropriate with information on his or her rights and responsibilities as detailed in Section II of this Manual.

Staff Responsible for Implementation

Clinical Supervisor

- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:

1. The Job Title provides the individual at the start of the intake process with a written Client Responsibilities Agreement form or the Parental Responsibilities Agreement form to review and sign. If the client refuses to sign, Job Title refers the client and family to other agencies.

2. The Job Title provides step by step instructions to client that elects to grieve PROVIDER NAME requirement to sign the Agreement how to file an internal grievance and appeal rights and procedures (see Section II of this manual).

3. The Job Title provides the individual at the start of the intake process with PROVIDER NAME site specific written Hazard and Emergency Response Plan.

4. The Job Title provides the individual at the start of the intake process with PROVIDER NAME written internal grievance and appeal process.

5. The Job Title quarterly (list the months) conducts an audit of randomly selected client intake forms to assess if staff is implementing PROVIDER NAME policies and
procedures, principles and philosophies. The Job Title develops a corrective action plan for clinical staff to address any short-comings in his or her competency.

6. The clinical supervisor conducts a review during the second month of the fourth quarter of the operating year of the Client and Paternal Agreement forms to determine if there is a need to revise the form(s).

7. The clinical supervisor presents within two weeks of the audit, his or her recommendations to Job Title.

8. The Job Title presents within two months to the Board of Directors his or her recommendations.

9. The Job Title develops and implements with administrative staff revised policies and procedures, forms and materials with the updated material within 30 working or calendar days of the Board’s approval.

10. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as a refresher.

VI. INITIATION OF SERVICES
E. Multi-disciplinary Team

Policy Number: 1
Approval Date:
Revision Date:

Purpose: Integrated multi-disciplinary teams (MDT) are a cornerstone of competent behavioral health service implementation. The MDT 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 multi-disciplinary approach. Goals of treatment are more effectively met when other domains of functioning in which a client is typically impaired are also addressed. PROVIDER NAME coordinates elements of treatment and rehabilitation to ensure that MDT members are working toward the same goals in a collaborative manner.

Policies:
1. The client-centered MDT Service Plan is the joint responsibility of the clinical supervisor, the clinician, the multi-disciplinary team, and the client.
2. “Individualized” services means that steps, strategies, services, interventions, and intensity of involvement is focused on specific measurable and objective client goals and are unique for each client and his or her family.
3. 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 specifically addresses the interactions and self-reinforcing processes related to COD diagnoses with an integrated approach to services provided.
4. Each goal is arrived at through specific and clear collaboration with the client and have outcomes stated in measurable terms.
5. The clinical supervisor schedules and conducts MDT meetings regularly or as needed, but not less than once a month for each client.
6. Structured lines of communication are present with MDT members: the client (and family), and other service providers.
7. The MDT members monitor stages of change for each disorder, and responds to each disorder with the appropriate stage-wise intervention.
8. The MDT members monitor the care provided to persons with COD specifically to guide services that are provided within the various elements of treatment), Behavior Management Skills (BMS), Comprehensive Community Support Services (CCSS), inpatient treatment, as appropriate or for a client without COD, to engage other providers to coordinate services so the client is not scheduled for services during the time he or she has other obligations, i.e., probation check-ins, school.
9. The expertise and the skills of staff, clinicians, prescribers, supervisory staff, and other members of the MDT represent both substance use and mental health disorders, and specifically address COD as needed.
10. MDT members regardless of position, provides information about the client and his or her family, which needs to be received as both valuable and pertinent to the client’s process. Specific practices that enhance information sharing include:
   a. Formal case presentation format
   b. Regularly scheduled MDT meetings during times the client and as appropriate his or her family are available to attend.
   c. Structured lines of communication with all MDT members with one another and with the client and family.
   d. The clinical supervisor monitors team interaction and maintaining a thriving, strength-based service approach.
   
   • In most cases it is the clinical supervisor, the agency must determine who manages the MDT meetings and amend all sections where this is noted.
   e. Keeping clear records of cases reviewed and decisions adopted by the MDT. The clinician records suggestions, alternatives, and discusses for each client on individual forms which the clinician places in the client’s file within two working days of the MDT meeting.
   f. Clinicians with expertise and skills in both substance use and mental health disorders are assigned to a client with COD.

Staff Responsible for Implementation
Clinical Supervisor

• Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The client’s MDT membership is based upon the client’s (at least) annual assessment and interpretive summary. MDT membership may change through the course of the client’s treatment due to his or her involvement with other service providers or changes in staffing.
2. The client and as appropriate his or her family are the cornerstone members of the MDT. As such, every opportunity is considered when arranging MDT meetings to ensure the client’s and family’s attendance.

3. The clinical supervisor serves as the MDT lead and guides the effort to improve the outcomes of the client and his or her family as appropriate to age and functioning.

4. The clinician serves as a MDT member and assists and guides the process of the client.

5. The client’s and his or her clinician’s efforts are informed by the MDT members considering what course of action must be followed, what goals to focus on in specific order, etc.

6. MDT members meet at least once a month to discuss with the client his or her needs, goals of service, and how these are being met. At the clinician’s or client’s request, additional MDT meeting may occur. MDT meetings are scheduled far in advance to assist MDT members’ continued participation.

7. The MDT members monitor stages of change for each disorder, and respond to each disorder with the appropriate stage-wise intervention. All interactions of the MDT members are guided by thriving principles and a strengths-based approach.

8. MDT members act to ensure services are integrated as far as possible. This means PROVIDER NAME employs or contracts for appropriate resources to ensure all co-occurring disorder-functional impairments, or co-morbid disorders, are addressed in an integrated and comprehensive manner. If PROVIDER NAME does not employ or contract individuals with the skill set or education to meet the client’s complex needs, the clinician refers the client to outside practitioners with the specific skills set or education.

9. Supervisory staff maintains positive working relationships within the MDT environment so that contributions from all members are utilized to develop the integrated approach to treatment.

10. Decisions of MDT membership are determined by the clinical supervisor, the client, and family as appropriate.
   a. The expertise and skills of MDT members represent substance use and mental health disorders, as well as COD as appropriate.
   b. If a referral is made for other specialized behavioral health services, as far as possible, PROVIDER NAME seeks input regarding the client being served within that program with careful observance of all Protected Health Information (PHI) related laws, rules and regulations.

11. The MDT members ensure comprehensive and integrated care is provided to the client, within PROVIDER NAME capacity and competency, is appropriate and specifically addressing the issues identified in the client’s Service Plan. Documentation of MDT meetings and roster of attendees, cases reviewed and decisions adopted by the MDT are recorded in logs and placed in PROVIDER NAME client’s file within two working days of each MDT meeting.

12. The clinical supervisor quarterly conducts a review of randomly selected client files to determine whether the clinician’s entries documents MDT member inclusion and is compliance with MDT policies and procedures, principles and philosophies. The clinical supervisor develops a corrective action plan for clinical staff to address any shortcomings in his or her competency.
VI. INITIATION OF SERVICES
F. Agency Internal Service Team

Policy Number: 1
Approval Date:
Revision Date:

Purpose: The Service Plan provides the clinician and client with guidance to develop an specific Treatment Plan. To assist the clinician PROVIDER NAME establishes a client-specific Internal Service Team (IST) which provides recommendations to the client's clinician on strategies and approaches, provides insights into the client's participation in services, and supports the clinician when his or her client presents with challenging and complex needs and concerns. The IST meetings follow 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, drawing upon the expertise and experience of the clinician's peers and supervisors.

Policies:
1. The IST members review the client’s Treatment Plan at least every 90 calendar days.
2. The clinical supervisor schedules and conducts IST meetings regularly and as needed, but not less than once a week.
3. The IST members monitor stages of change and responds to the clinician’s stage-wise interventions.
4. The expertise and skills of internal staff, clinicians, prescribers, supervisory staff, and other members of the IST represent both substance use and mental health disorders, and specifically address COD as appropriate.
5. Documentation of IST meetings and rosters, cases reviewed and decisions adopted by the IST are recorded in logs and placed in the client’s file within two working days of each IST meeting.
6. IST members, regardless of position, provide information and insight about the client and his or her family, which is received as both valuable and pertinent to the client’s process. Specific practices which enhance information sharing include:
   g. Formal case presentation format is utilized;
   h. Regular and consistent IST meetings are scheduled and held;
   i. Defined lines of communication with all IST members and with the client and family are maintained;
   j. Clinical review and auditing of IST interactions and PROVIDER NAME thriving strength-based service approach are conducted;
   k. Completion and retention of ISP meetings and adopted decisions by the IST are placed in the client’s file;
   l. Appropriate and timely updating a client’s Treatment Plan.

Staff Responsible for Implementation
Clinical Supervisor
Procedures:
1. The clinical supervisor serves as the IST lead and guides the team’s effort to assist and support the clinician.
2. The clinician informs and requests feedback from the IST members concerning the course of treatment in order to meet the client's goals.
3. IST members meet at least once a week to discuss the client’s treatment services and review the clinician’s strategies and approaches to assist in meeting the client’s needs and goals. The clinician may request additional IST meetings as he or she deems necessary.
4. The IST members assist the clinician monitor the client’s stages of change and develop strategies and recommendations with the appropriate stage-wise interventions. All IST members’ interactions are guided by thriving principles and a strengths-based approach.
5. The clinical supervisory staff maintains positive working relationships within the IST environment, so that contributions from all IST members are utilized to develop integrated practices.
6. Decisions as to participation in the IST are determined by the clinical supervisor and the clinician. The expertise and skills of IST members represents substance use and mental health disorders, as well as COD as appropriate.
7. The IST provides the clinician the oversight to ensure that comprehensive and integrated care is provided to the client specifically addressing the issues identified by the client’s Treatment Plan. Documentation of IST meetings and roster of attendees, and decisions adopted by the IST are recorded in logs and placed in the client’s file within 2 working days of each IST meeting.
8. The clinical supervisor quarterly conducts a review of randomly selected client files to determine whether the clinician’s entries documents IST member inclusion and is compliance with IST policies and procedures, principles and philosophies. The clinical supervisor develops a corrective action plan for clinical staff to address any short-comings in his or her competency.

VI. INITIATION OF SERVICES
G. Service/Treatment Plan
Policy Number: 1
Approval Date:
Revision Date:

Purpose: For PROVIDER NAME to assist a client to reach his or her treatment goals there must be a standardized treatment plan form which individualizes the client’s plan of interventions and the assigned responsibilities between the client, his or her family, and the clinician. The Treatment Plan (Treatment Plan) provides a client with a road map of his
Policies and Procedures Manual – Initiation of Services

Supporting Youth to Thrive Manual

or her services that compliments other services he or she may receive from the agency or outside the agency. The Treatment Plan is to be viewed as a document that evolves with time, the client’s growth, the client’s changing needs, and newly available approaches or services.

Policies:
1. The client's Treatment Plan is to be developed prior to the initiation of services. The client may receive outpatient services of individual, family and group while his or her Treatment Plan is under development.
2. The Treatment Plan must be reviewed at least every 90 calendar days of service.
3. The clinician and the client (and family as appropriate) review portions of the Treatment Plan when there is a change in presentation of the client or he or she is experiencing a crisis, safety is in question, relapse is possible or has occurred.

Staff Responsible for Implementation
Clinical Supervisor
- Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The initial development of a client’s treatment goals is completed in collaboration with the clinician, the client and his or her family as appropriate.
2. The client’s initial Treatment Plan must be completed prior to the first date of services. This initial Treatment Plan may stand as it is or may be updated thereafter. The first Treatment Plan review is conducted at a minimum within 90 calendar days from the start of services, and every 90 calendar days thereafter for the duration of active services.
3. The following procedures are used and reviewed by supervisory staff:
   a. The Treatment Plan is formulated using a collaborative style of engagement. Treatment planning focuses on the areas of the client’s Service Plan that are related to his or her substance disorder and as appropriate, his or her co-occurring disorder.
   b. The client-centered plan is guided by what the client wishes and his or her family, as appropriate, to accomplish and the methods that are acceptable to the client.
   c. The Treatment Plan is formulated to describe the steps, strategies, interventions, duration and intensity of involvement focused on measurable and objective client goals aligned with the client’s diagnosis, Interpretive Summary, and Service Plan.
   d. The clinical supervisor oversees the Treatment Plan, its reviews and updates with the clinician.
   e. The clinician providing services incorporate strengths as well as challenges into the Treatment Plan and work together to develop a plan that best serve the client.
   f. Progress on goals is monitored and documented in treatment notes by the clinician within one calendar day of each session and placed in the client’s file.
   g. The treatment notes accurately document services provided for all areas identified in the client’s Treatment Plan.
   h. PROVIDER NAME Treatment Plan is formatted to allow the recording of substance and mental health issues and how these are to be addressed, as well as functional
and other bio-psychosocial issues, stage-wise placement, and also client and family specific goals as appropriate.

9. The clinical supervisor quarterly (list the specific dates) conducts a review of randomly selected client treatment notes to assess if the clinical staff are implementing these policies and procedures, principles and philosophies. The clinical supervisor develops a corrective action plan for clinical staff to address any short-comings in his or her competency.

VI. INITIATION OF SERVICES
H. Service/Treatment Plan Essential Elements
Policy Number: 2
Approval Date:
Revision Date:

Purpose: PROVIDER NAME Treatment Plan requirements provide the foundation from which the clinician, client and his or her family move toward attaining positive outcomes. It is imperative for each client to have positive outcomes there are consistent, standardized elements detailed in the overall Treatment Plan. Each element of the Treatment Plan dovetails into the other elements, building a solid foundation. Specific elements of a client’s Treatment Plan may require updating or revision at different times than other elements.

Policies:
1. The Treatment Plan addresses the needs of the client across domains and must include the following elements.
2. Safety Planning – A Safety Plan is developed, maintained and updated to reflect a client’s changing circumstances or when signal events warrant. The clinician is responsible for reviewing with the client his or her Safety Plan at least once a month to revise or maintain the Plan.
3. Runaway, Missing Person and Elopement Risk Management Assessment – A Risk Management Assessment is conducted and updated to reflect a client’s changing circumstances or when signal events warrant. If the client has a risk of runaway elopement, his or her Safety Plan details how the risk will be managed by the client and as appropriate his or her family.
4. Crisis Planning - A Crisis Plan is developed, maintained, and updated to reflect a client’s changing circumstances or when signal events warrant, and related to specific client and family needs. Crisis planning addresses appropriate interventions that may have been previously successful, are preferred courses of treatment, the self-monitoring of triggers and stressful conditions, and natural supports and resources. The clinician is responsible for reviewing with the client his or her Crisis Plan at least once a month to revise or maintain the plan.
5. Suicidality Prevention Plan – A Suicidality Prevention Plan is developed, maintained, and updated to reflect a client’s changing circumstances or when signal events warrant.
A Suicidality Prevention Plan contains individualized protocols for the possibility of suicidality which are inclusive of assessment of risk, referral to appropriate care if needed, and information and pathways to communicate risk to the client’s family and other supports for the client. The clinician is responsible for reviewing with the client his or her Safety Plan at least once a month to revise or maintain the plan.

6. **Relapse Prevention Planning** – A Relapse Prevention Plan is developed, maintained, and updated to reflect a client’s changing circumstances or when signal events warrant. A Relapse Prevention Plan identifies the client’s experiences from past and present substance use that may lead to his or her possible or actual relapse, and contains strategies to prevent a relapse or reduce the impact of a relapse on the client and his or her family.
   a. A Relapse Prevention Plan identifies as many triggers the client and clinician recognize and from these develop strategies to assist the client manage his or her triggers.
   b. The (name the model) has specific relapse prevention planning as part of the curriculum. *It may provide the primary model and documentation of such planning to prevent duplication of clinical services. PROVIDER NAME utilizes its EBP Model for this planning. NOTE – if the agency’s EBP does not have this component, do not include this paragraph.*

7. **Continuing Care and Discharge and Aftercare Plan** – A Continuing Care, Discharge and Aftercare Plan is developed, maintained, and updated to reflect a client’s changing circumstances or signal events warrant. A Continuing Care, Discharge and Aftercare Plan are initiated at the start of services and contain three subparts. The clinician and the client review and update the plan at least every 90 calendar days to reflect the client’s current attainment of his or her goals. As the client moves towards completion of services, the discharge subpart of the plan is reviewed at least every other week of services and is more specific and detailed to support the client immediately before and then after services end.

**Staff Responsible for Implementation**

**Clinical Supervisor**

- *Remember to list the Job Title, not the function he or she is fulfilling.*

**Treatment Plan Essential Elements:**

- *Note: some communities have limited access to first responders and law enforcement personnel. Insert the appropriate agencies as appropriate; example: the community does not have a local police department and rely on the State Police or Sheriff Departments. Another community may be located on tribal land. It may access law enforcement from tribal police or the Bureau of Indian Affairs. Some communities do not have a 911 response system. Insert the correct information in the procedures detailing the name and phone number to contact.*
1. **Safety Planning:**
   a. If the client or family is experiencing safety concerns at the time of intake the Job Title of intake person engages the clinical supervisor to immediately meet with the client and family as appropriate, to determine the most appropriate level of emergency or urgent care intervention to taken. The current crisis is assessed for bio-medical crises, nutrition, hydration, risk of harm to self or others, adequate shelter, and other significant crisis conditions. An Interim Safety Plan is developed immediately with the clinical supervisor and the client.
   b. If intervention services can be obtained through PROVIDER NAME, the clinical supervisor takes immediate steps to arrange for these intervention services.
   c. If PROVIDER NAME does not offer such intervention services, the clinical supervisor engages clinical staff to assist in securing referrals for the client and family.
   d. The clinician, client and family as appropriate review the Safety Plan at least monthly to reflect a client’s changing circumstances or when signal events warrant, and related to specific client and family needs.
   e. When the client is engaged in services and the client expresses that he or she is in danger, the clinician assists the client follow his or her Safety Plan. The clinician maintains continuous contact with the client until such time the client regains control of her safety or emergency responders arrive. The clinician must contact his or her clinical supervisor to determine if emergency responders are contacted; it is the clinical supervisor who makes contact. The clinician may determine emergency responders are required before he or she is able to contact the clinical supervisor. The clinician contacts the appropriate emergency responder agency providing client contact information, location, and a description of the danger the client may be experiencing. As soon as possible, the clinician informs his or her clinical supervisor. The clinical supervisor contacts the CEO as appropriate.
   f. If there the clinician suspects or witnesses child or adult abuse, neglect or exploitation, he or she is to immediately contact the clinical supervisor to determine the appropriate agency(ies) to contact for reporting as it may depend on the physical location of the client or family member. The Job Title within 24 hours of a critical incident submit a report to the client’s MCO if a member, or to MAD if under the Fee-for-Service benefit plan following each’s prescribed protocol.
   g. Once the client has been located and deemed safe, the clinician and client meet to review the current Safety Plan to update the plan or continue with the plan as is written.
   h. A client identified as experiencing a safety concern that may cause threat to life or limb, are in withdrawal, or may endanger themselves or others are referred to the clinical supervisor to ensure that the client receives a referral to the appropriate level of care, whether hospitalization, immediate intake, involvement of law enforcement or first responders, homeless shelters, food or clothing referrals, etc, to secure the client’s and family’s continued well-being as far as possible.
2. **Runaway, Missing Person and Elopement Risk Management:**

   a. If the Risk Management Assessment indicates the client requires a level of care and supervision beyond the scope PROVIDER NAME (e.g., considered a high risk for noncompliant behavior and/or elopement), the clinical supervisor and the CEO determine if the current services should be deferred at the moment, and if so, provides the client and his or her family with alternative services so the client receives the most appropriate level of care. This may include assisting the client into an out of home placement or inpatient facility. The clinician, client and family as appropriate review the Risk Management Plan at least monthly and more frequency if the client’s behaviors indicate a higher probability of elopement.

   b. If the client is under 18 years of age and is not an emancipated adult and plans or has runaway or eloped, or is a missing person, the clinical supervisor must gather information from the client’s family and friends, IST members and if the client has a MDT, these members about the client’s whereabouts and if anyone has individual knowledge if the client plans to run away or elope, and if the client has explicitly stated plans about running away or eloping when he or she was last seen or had communications.

   c. If a client under 18 years of age (and is not an emancipated adult) does elope, the CEO, Clinical Supervisor, family members, and as appropriate entities of law enforcement, juvenile justice system, Children, Youth and Families Department (CYFD), and/or all other parties with jurisdiction are notified by the clinical supervisor as soon as the suspected elopement is verified. Witnesses who last saw the client are asked to make note of gender, age, clothing worn, emotional state, and other details that may be of help in locating the client.

   d. If a client 18 years of age and older (or is an emancipated adult) fails to attend therapy sessions for a one week period (3 sessions):
      
      i. The clinician reviews the client’s Crisis, Safety and Relapse Plans to assess possible safety concerns (such as a physically abusive partner or high risk medical condition).

      ii. If the clinician fails to locate any person who has seen or had contact with the client during this time period, the clinical supervisor reviews the client’s therapy chart, discusses with the client’s IST members the level of risk the client may be experiencing based on past history, and if the client has a Multi-disciplinary Team (MDT) coordinate with these members, to determine if the clinical supervisor should contact local law enforcement to report the client as a missing person. The clinical supervisor will within 2 working days complete treatment notes detailing the situation, concerns, and actions taken.

   e. PROVIDER NAME staff cooperates to its full ability with law enforcement, but all decisions, notifications, and communications with these authorities is made by the clinical supervisor with the CEO’s approval. The Job Title within 24 hours of a critical incident submit a report to the client’s MCO if a member, or to MAD if under the Fee-for-Service benefit plan following each’s prescribed protocol.
3. Crisis Planning
   a. A Crisis Plan is developed, maintained, and updated to reflect a client’s changing circumstances or when signal events warrant and related to specific client and family needs. The clinician, client, and family as appropriate review Crisis Plan at least monthly.
   b. When a client is identified as experiencing a crisis that may cause threat to life or limb, is in withdrawal, or may endanger him or herself, or others, whoever first encounters the client must immediately locate the client’s clinician (or on-call clinician). The clinician determines if his or her clinical supervisor’s or the on-call supervisor’s assistance is required to ensure the client receives a 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 client’s and family’s continued well-being as far as possible.
   c. The Crisis Plan must contain sufficient information and provide adequate guidelines so the client and his or her family have concrete information regarding resources, specifics of the client’s care and needs, and the client’s preferred course of treatment or intervention. An Interim Crisis Plan focuses on the immediate needs and welfare in order to stabilize the client and family to the extent services may begin, continue or are placed on hold.
   d. The Interim Crisis Plan and the Crisis Plan are intended to avoid the use of emergency services, avoid loss of client 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. It is imperative PROVIDER NAME undertake the necessary actions to provide the client and his or her family immediate assistance itself or through other agencies.
   e. The Job Title within 24 hours of a critical incident submit a report to the client’s MCO if a member, or to MAD if under the Fee-for-Service benefit plan following each’s prescribed protocol.

4. Suicidality (including threats of self harm to self and others)
   a. If a clinician has reason to believe that a client is at immediate risk for suicide, he or she must immediately notify the clinical supervisor, ensuring the client is not left unattended. The clinician, the clinical supervisor, the client and his or her family (as appropriate) begin reviewing the client’s Crisis Plan or if one has not been established, develop Interim Safety Plan and Crisis Plan. The clinician monitors the client and the family daily to support them follow through on the recommendations made by the clinical supervisor and as appropriate, the client’s IST and MDT.
      i. The clinician, client, and family as appropriate review the Crisis Plan at least monthly to reflect the client’s current attainment of his or her goals.
   f. If a client reports in an individual session or group session he or she is feeling suicidal, or if a friend, parent, teacher reports that the client has made suicidal comments, a suicide assessment is conducted immediately as possible to assess to client’s level of threat. The suicide assessment is conducted by the clinician and
reviewed by the clinical supervisor to support the development of the client’s Interim Safety Plan and Crisis Plan.

g. In the event of a medical emergency, the clinical supervisor immediately requests an ambulance and the client is transported to the appropriate hospital facility. Only the clinical supervisor or his or her designee may call for emergency responder services, unless there is an immediate threat of live or limb to the client or others.

h. In all of the above situations, the client’s family (if client is under 18 years of age) or when the emancipated or adult client has agreed to a release of information) is made aware of the situation as soon as possible. If the clinician feels that the family's response may be negligent or damaging to the client, a CYFD or Adult Protect Services report is made by the clinical supervisor.

i. If the client is 18 years or older, refuses help, and is immediate danger of self-harm or is threatening individuals, the local law enforcement agency is contacted by the clinical supervisor to prevent 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, are construed as intent to self-harm or harm others. This is the most conservative course of action and carries the least potential for the situation to escalate.

j. The clinical supervisor is contacted after a referral to the local law enforcement agency when the emergency situation is actively occurring and poses an immediate threat to the client or others.

k. In any situation where a client reports feeling suicidal, whether it is a low or high risk situation during an individual or group session, the clinician immediately attempts to determines if the client has any potentially lethal objects or substances on his or herself. If so, the clinician is to immediately implement PROVIDER NAME Hazard and Emergency Response Plan (Section 1 of this Manual).

l. At the first opportunity, the clinician, client, and family develop Interim Safety and Crisis Plans that focuses on stabilizing the client and family.

m. The clinical supervisor contacts the client’s IST and MDT members and provides updates of the client’s current status in case the client’s other services may be impacted.

n. The clinician monitors the client and the family daily to support them follow thru on the recommendations made by the clinical supervisor and as appropriate, the IST and MDT until the clinician determines the client has stabilized.

o. The Job Title within 24 hours of a critical incident submit a report to the client’s MCO if a member, or to MAD if under the Fee-for-Service benefit plan following each’s prescribed protocol.

5. **Protocol for Afterhours Suicidal Situations**

   i. PROVIDER NAME has a 24-hour on crisis call number. This number is posted throughout the facility and is posted on all agency client forms.

   ii. If a client indicates a threat of suicide or harm to others, the clinical supervisor on-call notifies the family immediately (if client is under 18 years of age, or the emancipated or adult client has agreed to a release of information).
iii. In the event that the family may not be available or helpful, the clinical supervisor gathers critical information from the client regarding the situation. This information determines if the local law enforcement agency is called for immediate assistance.
iv. The clinician and his or her clinical supervisor are to follow steps a-j above.
v. The Job Title within 24 hours of a critical incident submit a report to the client’s MCO if a member, or to MAD if under the Fee-for-Service benefit plan following each’s prescribed protocol.

6. **Relapse Prevention Planning:** Relapse planning and prevention must include the following:
   a. 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.
   b. The Relapse Plan must address all substance related issues, and take into account the interrelated mental health issues indicated by COD diagnoses.
   c. Identify signs and symptoms of relapse.
   d. Identify causes and contributing factors to relapse, including internal and external triggers.
   e. Provide the client and his or her family positive social activities and skills available.
   f. The clinician, client, and family as appropriate review the Relapse Prevention Plan at least monthly to reflect the client’s current attainment of his or her goals.
   g. Develop specific strategies to address each identified contributing factor of relapse:
      i. Potential safety concerns
      ii. Medication management directive related to substance use
      iii. Targeted behaviors
      iv. Identification of signs and symptoms of relapse
      v. Drop-out considerations
      vi. Environmental precautions
      vii. Coping strategies, e.g. relaxation, mindfulness, exercise, etc
      viii. Natural support planning
      ix. Advanced determination of what signifies the resolution of the relapse
      x. Advance directives for loss of self-control related to substance use.

7. **Continuing Care, Discharge, and Aftercare Plan**
   a. The Continuing Care, Discharge, and Aftercare Plan is maintained and updated to reflect a client’s changing circumstances or when signal events warrant. A Continuing Care, Discharge and Aftercare Plan is initiated at the start of services. The clinician, client and his or her family as appropriate collaborate to develop a plan that identifies services and supports needed or desired, and specifies steps for obtaining these services
   b. The clinician, client, and family as appropriate review the Continuing Care, Discharge, and Aftercare Plan at least monthly to reflect the client’s current attainment of his or her goals.
c. As the client moves towards completion of services (starting at a minimum of his or her last 6 weeks of services), the Discharge and Aftercare portions of the plan are reviewed at least every other week of services and are more specific and detailed to support the client immediately before and then after services terminate.

d. The clinician, client, and family explore suitable resources and develop a plan of who contacts other community service providers.

- If the evidence-based program (such as the Matrix Model) does not specifically include transition from active treatment into aftercare, the agency must develop aftercare planning.

e. The Job Title of who does the aftercare services follows up with the client and family on the Aftercare portion of the plan to ensure their continuing engagement and commitment to the in client’s process.

f. If PROVIDER NAME is not the selected agency to continue the client’s behavioral health services after discharge, the clinician and client develop as part of the Discharge portion of the plan to select a provider agency and practitioner.

g. The clinician and client determine what treatment documents are to be released to the new practitioner to ensure relevant evaluation findings and assessment of unmet needs are shared.

h. The clinical supervisor in the third month of the third quarter of the operating year conducts a review of randomly selected client Treatment Plan and subparts (1-5 listed above) to assess whether the clinical staff is implementing the PROVIDER NAME policies and procedures, principles and philosophies. The clinical supervisor develops a corrective action plan for clinical staff to address any short-comings in his or her competency.

i. The clinical supervisor during the third month of the third quarter of the operating year, interviews clinical staff to determine whether the standardized treatment plan templates require updating or revisions.

j. The clinical supervisor presents within two weeks of the review, his or her recommendation to Job Title.

- The agency must determine the chain of approval for changes to its treatment plan templates.

k. Job Title presents within two months to the Board of Directors his or her recommendations.

l. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval.

m. When the decision is made to retain the current formats, the Job Title of trainer works with the

n. Job Title (whoever makes the training calendar) to schedule annual clinical staff training as refresher.
SECTION VII - TREATMENT IMPLEMENTATION PRACTICE STANDARDS

TABLE OF CONTENTS

A. Fundamentals of Substance Use Treatment
B. Evidence-based Practices Adaptations for Particular Populations Served
C. Encouraging and Monitoring Abstinence
D. Pharmacotherapy and Medication Management
E. Multifamily Group Engagement Practices
VII. Treatment Implementation Practice Standards

A. Fundamentals of Substance Use Treatment

Policy Number: 1
Approval Date:
Revision Date:

**Purpose:** Substance use disorders are complex, chronic health conditions that require an array of treatment options. The fundamental principles of supporting youth to thrive are described as long-term and mostly cooperative efforts similar to the long-term support needed for a chronic illness. For some, such support is required as a life-long engagement. Substance disorder treatment is intended to serve clients who may be actively using substances. While traditional outpatient services (individual, family and group) provide many clients with the appropriate level of care, a number of clients require intensive levels of care, such as intensive outpatient services (IOP). PROVIDER NAME offers a program to clients requiring a higher level of care than clients accessing outpatient services.

**Standards:**

1. THE PROVIDER has and continues to: adopt evidence-based practices or programs (EBPs), train staff, supervise staff, and adhere to the elements and principles of the evidence-based programs or practices.
2. Clients are always met where they “are at”, and are not expected to be in an active state of abstinence or substance use reduction, in order to receive services.
3. All clients are assessed for co-occurring mental health disorders, as well as possible physical health related issues that may impact the success of the client.
4. Clients and families are included in all treatment planning and are in collaborative agreement with treatment goals and objectives agreed upon by all parties. This means that treatment goals are client and family driven, and are not simply determined by the clinician and others.
5. The Continuing Care, Discharge, and Aftercare Plan contains mandatory treatment elements required (if only as interim portions to be reviewed and updated in the first three sessions) on the first day of services, such that any client that does not complete treatment for any reason has some link to potential resources in the community should he or she choose to access them.
6. Pharmacological treatment is welcomed and NEVER discouraged by any PROVIDER NAME staff. Clients receiving substance use disorder treatment are never to be stigmatized, punished, discharged, discouraged, etc. for complying with prescribed medication use related to substance, mental health or physical health disorders.

VII. Treatment Implementation Practice Standards

B. EBP Adaptations for Particular Populations Served

Policy Number: 1
Approval Date:
Revision Date:
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 practice or program curriculum that takes place on a case-by-case basis, or as needed by differing needs within the treatment setting.

The term ‘systemic adaptations’ describes the systems-level adaptations required to address specific needs of discrete populations, which may include exclusive populations of clients. These populations may include subsets of co-occurring substance and mentally/emotionally disordered persons based on race, ethnicity, spiritual values, sex, gender identity, developmental ability, sexual orientation, religion, age, adolescent in transition to adulthood, geographic location (e.g., rural vs. urban), military personnel, veterans, or other populations identified by PROVIDER NAME in need of discreet services.

When PROVIDER NAME does adapt its EBP, clinicians are to 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).

Policies:
1. As far as possible, systemic adaptations to the name EBPs 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 clinical staff implement the adapted model in a uniform manner.
   - The EBP is not limited to the EBP. If the agency will be utilizing other EBPs they must be listed above or attach as an appendix to the Manual. Include here the appendix number or letter
2. The clinical director and the CEO maintain a structure that is flexible to make adaptations to name EBP to include consultation with representative community members of the population to be served to gain insight into adaptation needs and requirements.
3. The CEO supports appropriate adaptations within PROVIDER NAME treatment system model.
4. The clinical supervisor guidance to clinical staff assures systemic adaptations are understood and implemented while monitoring and maintaining fidelity to the name EBP.
5. The clinical supervisor and Quality Lead assure ongoing reviews and audits to determine if the adaptations results in improved client outcomes.

Staff Responsible for Implementation
Clinical Supervisor and CEO
   - Remember to list the Job Title, not the function he or she is fulfilling.
Procedures:

1. The clinical supervisor during the third month of the second quarter of the operating year discusses with the Internal Service Team (IST) members if there is a need to adapt name EBPs to meet the needs of a specific population PROVIDER NAME currently serves or may serve.

2. If the clinical supervisor agrees with the need for an adaptation of an EBP, he or she undertakes within two weeks research for alternative methods that complement and do not negatively impact the fidelity of the name EBP.

3. The clinical supervisor presents within three weeks of the start of research his or her recommendations to Job Title.

4. The Job Title presents within two months to the Board of Directors his or her recommendations.
   - May or may not be a Board decision to make.

5. The clinical supervisor develops and implements with administrative staff revised policies and procedures, forms and materials with the updated material within 30 working or calendar days of the Board’s approval.

6. The clinical supervisor arranges with Job Title of who oversees training dates of training for all clinical staff.

7. The clinical supervisor and Human Resources Manager develop questions for clinical staff interviews to assist in determining the level of awareness and understanding evidence-based principles, programs and practices.

8. The clinical supervisor is responsible to observe within the 30 working days of a new hire or contract to determine the clinical staff’s level of PROVIDER NAME adapted EBP(s) principles and practices, effectiveness to meet the unique needs of each client, and if the clinician applies PROVIDER NAME EBP(s) principles and practices in a suitable and appropriate manner to clients. Thereafter, the clinical supervisor observes at least quarterly and provides timely feedback.* The clinical supervisor provides as necessary additional training and monitoring. The clinical supervisor utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the clinical staff’s personnel or contractor file.
   - Agency determines the specific time period – 5 days after the observation, 1 day whatever works.

9. Once the adapted EBP is implemented, the clinical supervisor for two months conducts weekly targeted audits of client files who have received adapted EBP services to determine whether the clinical staff has incorporated PROVIDER NAME EBP process. The clinical supervisor develops a corrective action plan for clinical staff to address any short-comings in his or her competency.

10. The clinical supervisor and the Quality Team lead develop an evaluation tool to determine what impact on client outcomes the EBP adaptation has made. The tool must be completed prior to the start of the clinical staff’s implementation of the EBP adaptation.

11. The clinical supervisor begins utilizing the EBP evaluation tool one month after clinical staff is trained.

12. The Job Title after 6 months of the EBP implementation prepares a report based on the findings of the evaluation tool and presents his or her recommendations to Job Title.
13. Job Title will present within two months to the Board of Directors his or her recommendations.
   - *Agency must determine who the final authority is for making this type of decision.*
14. The clinical supervisor develops and implements with administrative staff revised policies and procedures, forms and materials with the updated material within 30 working or calendar days of the Board’s approval.
15. The clinical supervisor arranges with Job Title of who oversees training dates of training for all clinical staff.
16. The clinical supervisor implements the process starting at Item 1 above to make any adjustments to the approved EBP adaptations.
17. When the decision is made to retain the current practices, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as a refresher.

VII. TREATMENT IMPLEMENTATION PRACTICE STANDARDS

C. Encouraging and Monitoring Abstinence

Policy Number: 1
Approval Date:
Revision Date:

Purpose: A client’s progress towards his or her goals, beginnings of abstinence, and his or her maintenance of abstinence are co-owned by the client and PROVIDER NAME. The client has the responsibility to ‘work’ and ‘stick’ to his or her goals. PROVIDER NAME has the responsibility to maintain clinical staff competency to support the client. The clinical staff consistently utilizes its name EBP model in order for the clinical supervisor to assess its success in offering services that support a client’s abstinence goals.

Policies:
1. Moving 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. Relapse and reduced use are part of the thriving process, and the cyclical nature of addiction, and relapse are recognized and thoughtfully addressed by clinicians and multi-disciplinary teams (MDT) and Internal Services Teams (IST). The MDT and IST address all treatment and rehabilitative issues with the intent to support the client reduce his or her symptoms and improve his or her functioning.
3. Treatment interventions are informed by thriving oriented principles including harm reduction as a significant step on the road to thriving.
4. PROVIDER NAME determines if substance use screenings will be conducted based fidelity requirements of its EBP model and by PROVIDER NAME value system that screening are viewed as an opportunity to support a client, not punish the client.
5. PROVIDER NAME elects to conduct substance use screening utilizing internal clinical staff or outside contracted staff.
6. PROVIDER NAME determines which screenings it will utilize, such as:
   a. Urine drug screens
   b. Breathalyzer tests
   c. Laboratory testing
   d. Mouth swabs, etc., as appropriate
7. PROVIDER NAME utilizes the client’s screening results as an immediate opportunity for treatment intervention, not as a mechanism for discharging the client.
8. PROVIDER NAME adheres to name EBP model’s substance use screening fidelity standards.
9. PROVIDER NAME and Quality Team lead ensure that its abstinence protocols are regularly researched for most current effective outcomes and appropriateness for in-house or referral to an outside facility for substance use screenings.

Staff Responsible for Implementation
Clinical Supervisor
   •  Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. PROVIDER NAME adheres to its fidelity model’s requirements for substance use screening and follows standard protocols for the collection and testing of bodily fluids.
2. A client diagnosed with substance or co-occurring disorders will not be discharged or referred out by PROVIDER NAME solely based on the client experiencing substance use relapses.
3. PROVIDER NAME strives to have appropriate service capability to match the needs of the client. If PROVIDER NAME does not have the clinical capacity or capability to meet the client’s needs, the clinical supervisor assists the client locate and reaches out to a provider or practitioner with the capacity and capability to meet the client’s unique needs.
   a. If client’s needs meet a step-down of services (inpatient or residential stay) into, the client may elect to enter services at PROVIDER NAME,
   b. If a client was terminated from PROVIDER NAME services (to enter into a higher, lower level of care, or opted out of any service), and later seeks PROVIDER NAME services again, his or her prior termination of services are not factored into consideration of his or her current request for services. It is possible five months ago the client was not in the Stage-wise level to commit to services; however is now.
4. The monitoring of a client’s abstinence may be mandated the New Mexico Juvenile Justice System, state courts, or other agencies. There may be different rules and protocols specified by such agencies that the client must adhere to as determined by contractual agreements. Ordered screenings or tests by these agencies do not supplant PROVIDER NAME substance use screenings. The clinical supervisor provides outreach to these agencies to facilitate their understanding PROVIDER NAME substance use screening are not to be utilized to determine client compliance to ordered abstinence. The therapeutic relationship the client and clinician could be severely damaged by
doing this. The clinician and the client approach a failed substance use screen is an opportunity for applying thriving principles.

5. The clinical supervisor and Human Resources manager develop questions for clinical staff interviews to assist in determining the applicant's level knowledge of abstinence support and monitoring.

6. The clinical supervisor is responsible within the first 30 working days of a new hire or contract to determine the clinical staff's competency to render services utilizing these abstinence policies, procedures, principles and practices, his or her effectiveness to meet the unique needs of each client, and if he or she applies such services in a suitable and appropriate manner to client. The Job Title meets to discuss. Thereafter, the clinical supervisor observes at least quarterly. The clinical supervisor provides as necessary additional training and monitoring. The clinical supervisor utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the clinical staff's personnel or contractor file.

   - The agency determines the turnaround.

7. The clinical supervisor quarterly conducts a review of randomly selected client files to determine whether the clinician's entries document his or her compliance in implementing abstinence policies and procedures, principles and philosophies. The clinical supervisor develops a corrective action plan for clinical staff to address any shortcomings in his or her competency.

   - The agency determines the turnaround.

8. The clinical supervisor within the third month of the first quarter of the operating year reviews its abstinence procedures to determine whether they continue to meet the needs of the clients or if there are other methods better suited to the population it serves. The clinical supervisor within two weeks after the review forwards his or her recommendations to Job Title.

9. The clinical supervisor presents within two weeks of the completion of the review his or her recommendations to Job Title.

10. Job Title presents within two months to the Board of Directors his or her recommendations.

11. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board's approval.

12. When the decision is made to retain the current formats, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as refresher.
VII. TREATMENT IMPLEMENTATION PRACTICE STANDARDS

D. Pharmacotherapy and Medication Management

Policy Number: 1
Approval Date:
Revision Date:

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 the use of a thriving-based approach including shared decision making, informed consent, and an active role on multi-disciplinary teams (MDT).

Policies
1. As a member of the MDT, the client’s prescribing practitioner:
   a. Considers prescribing psychiatric medications despite active substance use as appropriate, with particular care regarding substance related conditions, cravings, and effects of medications on substance use issues. If the client takes prescribed physical health medications (such as diabetes), the prescribing practitioner is a member of the mdt to monitor the physical medication for possible drug interactions;
   b. May prescribe medications to support substance use reduction and to manage urges and cravings;
   c. Provides education and educational materials to the clinician, the client, and family about medications advantages and side-effects;
2. PROVIDER NAME advocates for a client who is under 21 years of age to utilize a prescriber who has experience and knowledge of adolescent and young adult development.
3. PROVIDER NAME advocates for all clients with co-occurring disorder (COD) to utilize a prescriber who has COD training and/or prior experience treating individuals with COD.
4. PROVIDER NAME advocates for all clients with COD to utilize a prescriber who as experience with ethno-pharmacology which takes into account the study of the effect of ethnicity on responses to prescribed medication, especially drug absorption, metabolism, distribution, and excretion.

Staff Responsible for Implementation
Clinical Supervisor
   • Remember to list the Job Title, not the function he or she is fulfilling.

Procedures:
1. The clinical supervisor offers the client’s prescriber the opportunity to be a MDT member. If the prescriber is not available for face-to-face attendance, the clinical supervisor arranges:
   a. Conference line for the prescriber to call into;
b. If the prescriber is unable to attend mdt meetings, the clinical supervisor works with the prescriber to provide a summary of any effects and/or side-effects the medications may be presenting to the client;
c. If the prescriber refuses to participate in mdt meetings (in any format), the ceo reaches out to the prescriber to determine what barriers he or she states are impeding his or her participation;
d. The CEO works with the clinical supervisor and the prescriber to remedy the barriers.

2. The clinical supervisor ensures MDT and Internal Service Team (IST) members do not advocate against a client’s utilization of appropriately prescribed medication.

3. The clinician requests from the prescriber medication information that may impact the client’s success in his or her services. An example may be a physical health medication that causes dizziness, so the clinician schedules appointments outside of this time or the prescriber changes the time the client takes this medication so the client can fully participate in his or her services.

4. The clinical supervisor gathers experience and training information from local prescribing practitioners to assist a client select a practitioner that has knowledge and understanding of his or her unique considerations (i.e. race, age, physical health issues).

5. The clinical supervisor is responsible to observe within the first 30 working days of a new hire or contract to determine the clinical staff’s competency and willingness integrate a client’s pharmacotherapy into his or her treatment services and be inclusive of the client in his or her medication management, and if he or she applies such services in a suitable and appropriate manner to client. The Job Title meets to discuss. Thereafter, the clinical supervisor observes at least quarterly. The clinical supervisor provides as necessary additional training and monitoring. The clinical supervisor utilizes PROVIDER NAME standardized observation recording and feedback form and files it in the clinician’s personnel or contractor file.
   • The agency determines the turnaround.

6. The clinical supervisor quarterly conducts a review of randomly selected client files to determine whether the clinician’s entries document his or her compliance of the integration of the client’s pharmacotherapy and shared responsibilities for the management of his or her medications, and if the clinician’s personal assumptions and biases concerning the use of pharmacotherapy as an effective are present in his or her file entries. The clinical supervisor develops a corrective action plan for clinician to address any short-comings in his or her competency.
   • The agency determines the turnaround.
VII. TREATMENT IMPLEMENTATION PRACTICE STANDARDS

E. Multi-family Group Engagement Practices

Policy Number: 1
Approval Date: 
Revision Date: 

Purpose: The therapeutic involvement of families throughout the thriving process is associated with improved treatment outcomes. The planning of family-based services involves defining the client's family in broad and flexible terms, setting essential goals, and determining the desired outcomes.

Policies:
1. PROVIDER NAME throughout its policies and procedures manual reflect its support of the provision of family interventions.
2. PROVIDER NAME staff provides a welcoming environment to families of clients being served and families are actively engaged by staff.
3. PROVIDER NAME, requires (as deemed appropriate by the age or the legal standing of the client) the family to be included during Intake and Service Planning.
4. PROVIDER NAME does not have a formal client childcare function to provide childcare; however, arrangements may be made as necessary and as possible to facilitate the client's consistent attendance.
5. PROVIDER NAME maintains a current list of positive social and recreational resources appropriate for families to participate with the client.
6. PROVIDER NAME employs family engagement strategies, including alliance building, skills development and problem-solving.
7. PROVIDER NAME clinician determines and emphasizes the client’s family strengths and supports and works towards enhancing these, and aids family members to recognize the barriers to the client’s change and assist the family work through these barriers with the client.
8. PROVIDER NAME clinicians attempt to the best of their clinical expertise determine family member 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.
9. PROVIDER NAME clinicians engage the client's family into committing to significant change, and to become significant partners in furthering the therapeutic progression of the client and his or her family members.
10. PROVIDER NAME staff interactions with a client and his or her family members are warm and welcoming to foster hope and focus towards thriving for both the client and his or her family.
11. PROVIDER NAME clinicians provide family-related skills education and coaching, so family members and the client recognize their common goals of thriving.
12. PROVIDER NAME clinicians provide coaching for basic communication skills, and model the application of structured problem solving techniques, setting boundaries, removing triggers, and managing behaviors.
13. PROVIDER NAME clinicians provide family-oriented psycho-education related to the client’s disorder(s), as appropriate to need and presence of family members in the treatment setting.

14. PROVIDER NAME clinicians provide solution-oriented input for distress related to the client’s disorder(s). 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 client’s disorder(s).

15. PROVIDER NAME clinicians encourage the client’s family participation in recreational activities with the client. This can be framed as a cooperative and therapeutic whole-family activity.

16. PROVIDER NAME clinicians provide referrals to the client and his or her family for individual family therapy outside the scope of services, as appropriate.

17. Job Title of who posts referral list to crisis lines and other urgent services in case of crisis, relapse, or difficult behavior, and includes this information on all client forms.

**Staff Responsible for Implementation**
Clinical Supervisor

- *Remember to list the Job Title, not the function he or she is fulfilling.*

**Procedures:**
1. Clinicians consistently employ family engagement strategies, including alliance building, skills development and problem-solving. If a clinician determines the family is struggling with these concepts into practice, he or she individually meets with the clinical supervisor for assistance. The clinical supervisor may attend sessions to observe the dynamics and offer support to the clinician.

2. Clinicians determine and emphasize the family strengths and supports to enhance them, and aid family members recognize the barriers to change the client faces, and help the family to develop strategies to assist the client appropriately manage barriers. If a clinician determines the family is struggling with these concepts into practice, he or she individually meets with the clinical supervisor for assistance. The clinical supervisor may attend the next session to observe the dynamics and offer support to the clinician.

3. Clinicians utilize their professional skills to assist the family members determine its family roles, family and cultural values, and norms of behavior within the family unit, and create the therapeutic alliance that includes the clinician, the client and his or her family members, as appropriate within the treatment setting. If a clinician determines the family is struggling with these concepts into practice, he or she individually meets with the clinical supervisor for assistance. The clinical supervisor may attend the next session to observe the dynamics and offer support to the clinician.

4. Clinicians engage the clients’ families to commit to significant change, and to become significant partners in furthering the therapeutic progression of the clients. If a clinician determines the family is struggling with these concepts into practice, he or she individually meets with the clinical supervisor for assistance. The clinical supervisor may attend the next session to observe the dynamics and offer support to the clinician.
5. Clinicians utilize their professional skills to interact with the client and his or her family to instill the family hope and focus towards thriving in both the client and his or her family. If a clinician determines the family is struggling with these concepts into practice, he or she individually meets with the clinical supervisor for assistance. The clinical supervisor may attend the next session to observe the dynamics and offer support to the clinician.

6. Clinicians provide each client’s family related skills, education, and coaching unique to the client to support family members and the client recognize their common goals of thriving. If a clinician determines the family is struggling with these concepts into practice, he or she individually meets with the clinical supervisor for assistance. The clinical supervisor may attend the next session to observe the dynamics and offer support to the clinician.

7. Clinicians provide coaching to the clients’ families for basic communication skills, and models how conflict through application of structured problem solving techniques, setting boundaries, removing triggers, and managing behaviors moves the client forward in his or her personal goals. If a clinician determines the family is struggling with these concepts into practice, he or she individually meets with the clinical supervisor for assistance. The clinical supervisor may attend the next session to observe the dynamics and offer support to the clinician.

8. Clinicians provide family-oriented psycho-education related to clients’ disorders with their family members during sessions. If a clinician determines the family is struggling with these concepts into practice, he or she individually meets with the clinical supervisor for assistance. The clinical supervisor may attend the next session to observe the dynamics and offer support to the clinician.

9. Clinicians provide solution-oriented input for distress related to the client’s disorders. This distress may be of two types; practical distress related to finances, time, obtaining services, and supervision of a youthful client; and internal distress related to emotional and psychological responses and reactions to the client's disorder(s). If a clinician determines the family is struggling with these concepts into practice, he or she individually meets with the clinical supervisor for assistance. The clinical supervisor may attend the next session to observe the dynamics and offer support to the clinician.

10. Clinicians support the clients' families' participation in joint recreational activities. This can be framed as a cooperative and therapeutic whole-family activity. If a clinician determines the family is struggling with putting these concepts into practice, he or she individually meets with the clinical supervisor for assistance. The clinical supervisor may attend the next session to observe the dynamics and offer support to the clinician.

11. Clinicians provide family referrals for individual family therapy, as appropriate.

12. Clinicians provide clients and their families, as part of the various Treatment Plan elements, the process to receive emergency or crisis support during PROVIDER NAME working hours and for after hours.

13. Job Title posts a current referral list of crisis lines and other urgent services in case of crisis, relapse, or difficult behavior after the client has been discharged from services. This information is also provided as part of the client's Aftercare portion of his or her Treatment Plan.
14. The clinical supervisor is responsible to observe within the 30 working days of a new hire or contract to determine the clinical staff’s competency to assess family dynamics, his or her knowledge of and implementation of appropriate techniques to support families, and if he or she applies PROVIDER applies such services in a suitable and appropriate manner to a client. The clinical supervisor meets to discuss. Thereafter, the clinical supervisor observes at least quarterly and provides timely feedback. The clinical supervisor provides as necessary additional training and monitoring. The clinical supervisor utilizes the PROVIDER NAME standardized observation recording and feedback form and files it in the clinical staff’s personnel or contractor file.

- The agency determines the turnaround.
- The agency must establish exact months in each quarter the clinical supervisor will observe the clinicians. The agency may set aside specific days of each month to schedule clinician observation to then rotate staff so every clinician receives his or her observation supervision within a quarter.

15. The clinical supervisor quarterly conducts a review of randomly selected client files to determine whether the clinician’s entries document knowledge of and implementation of appropriate techniques to support families, and if he or she applies such services in a suitable and appropriate manner to a client. The clinical supervisor meets to discuss. The clinical supervisor develops a corrective action plan for clinical staff to address any short-comings in his or her competency.

- The agency determines the turnaround.
- The agency must establish exact months in each quarter the clinical supervisor will observe the clinicians. The agency may set aside specific days of each month to schedule clinician observation to then rotate staff so every clinician receives his or her observation supervision within a quarter.

16. The clinical supervisor in the third month of the fourth quarter of the operating year reviews this policy and procedures to determine if revisions are necessary.

17. The clinical supervisor presents within two weeks of his or her review recommendations to Job Title.

18. The Job Title presents within two months to the Board of Directors his or her recommendations. The Board may or may not make this decision.

19. The Job Title with administrative staff disseminates the revised policies and procedures, forms, and materials within 30 working or calendar days of the Board’s approval.

20. When the decision is made to retain the current formats, the Job Title of trainer works with the Job Title (whoever makes the training calendar) to schedule annual clinical staff training as refresher.
SECTION VIII – AGENCY QUALITY MANAGEMENT

TABLE OF CONTENTS

A. Considerations and Measurements of Quality

- The agency must determine the structure of its personnel that participate in or leads a quality team.
  - Some agencies may be small and quality functions are assigned to a few key staff members.
  - Larger agencies may require separate staff whose functions are exclusively on monitoring services, evaluating quality and outcomes of services, recommending changes to services, and finally monitoring and evaluating approved changes.
  - The agency must tailor its policies and procedures to describe how it accomplishes quality.

- Examples – The agency has a clinical director and several clinical supervisors.
  - The agency may have the clinical director conduct all the clinical staff’s reviews and evaluations of competency.
  - Or the agency may utilize its clinical supervisor to oversee a number of clinicians.
  - The CEO may be the clinical director.
  - An agency must undertake a thoughtful and reasonable approach to delegating quality task.

- Remember to utilize the job title of an individual who has a number of different functions instead of having a separate name for each function.
VIII. AGENCY QUALITY OVERSIGHT

A. Considerations and Measurements of Quality

Policy Number: 1
Approval Date:
Revision Date:

Purpose: PROVIDER NAME requires staff to engage in systematic monitoring, assessment, and evaluation of various aspects of its services: physical facility, office, and building; changes in the healthcare system of its clients; attention to funding source directives, funding opportunities; alliance and rapport, cultural, gender, trauma-informed care, motivational approaches, stage-wise care competencies, and co-occurring disorder competencies; shifting needs for services based on accurate community needs assessments, outcomes, and best practices. Each section of this manual is embedded with specific procedures that are necessary to develop, maintain, and enhance client and family quality services.

Key Considerations:
The following are key considerations in PROVIDER NAME quality management (QM) processes and procedures:

1. Outcomes and evaluation: In order to clearly determine practice efficacy and develop strategies that enhance services, it is imperative that PROVIDER NAME measures benchmarks and outcomes resulting from its services. Key client and family processes and outcome measures relevant to services and implemented best practices are tracked to inform its goals and objectives towards quality improvement of services. Key outcomes include:
   a. Reduced use/abstinence
   b. Decreased mental health symptomatology
   c. Employment/school
   d. Decreased criminal justice involvement
   e. Housing
   f. Social support and connectedness
   g. Access to services
   h. Increase engagement in primary care and hospitalization.

2. Organization Fluidity/Adaptability: In the context of QM, PROVIDER NAME fluidity refers to the ability of it to utilize quality assurance (QA) principles and practices to steer its course towards the continuous quality improvement (CQI) of services while maintaining the most fluid and adaptable stance related to:
   a. Change in the overall fiscal environment
   b. Community needs
   c. Behavioral healthcare system
   d. Overall healthcare system.

Such changes may include technological changes and advances, systemic changes within it, funding opportunities, emerging practices, and rapid response to key staff turnover.
3. **Best practices or Evidence-Based Practices (EBP):** 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 client's desired outcomes can be delivered with fewer problems and unforeseen complications. Best practices and EBP 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 or EBP is only applicable to particular condition or circumstance and may have to be modified or adapted for similar circumstances. In addition, a "best" practice or EBP can evolve to become better as improvements are discovered.

**Measuring Quality:**

1. Reviewing, evaluating, changing or adapting PROVIDER NAME Policy and Procedure Manual schedules are maintained to ensure that policies and procedures are current with all other applicable change and modifications to the organization business stance, funding changes, service implementation changes, staff changes, etc.
2. Reviewing and evaluating clinical supervision processes to ensure that all required supervisory practices are adequately accomplished and implemented.
3. Scheduling reviews of records and recordkeeping processes to assess that satisfactory records and documentation are maintained and protected adequately both electronically and physically.
4. Evaluating to confirm or deny clinical staff is monitored and that clinical competencies are maintained.
5. Assessing organization issues do occur at scheduled times to assure organization success.
6. Meeting documents of Multi-disciplinary Team (MDT) and Internal Service Team (IST) to determine quality of supervision, continual oversight and feedback to clinicians.
7. Conducting assessments of the interpersonal relationships among staff to determine level of quality.
8. Monitoring of agency documents to measure alignment with all applicable law, rules, regulations, etc.
9. Reviewing 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.
10. Reviewing and oversight of fiscal compliance to ensure funding sources reporting responsibilities.
11. Monitoring of engagement rate and evaluating best practices or EBP to increase or sustain high engagement to initial service rates.
12. Monitoring, evaluating and reporting of client retention in service, service duration, drop-outs and no-shows, and discharge data to determine client engagement and retention success.
14. Monitoring, assessing, and evaluating training efforts to assure alignment with all applicable quality controls, and to the mission and values of the organization.

15. Assessing, evaluating, reporting, and developing CQI work plans to address needed changes or sustain current quality management processes and protocols for fit to agency/program need and effectiveness.

16. Assessing, evaluating, reporting, and developing CQI work plans to address needed changes or sustain quality management related to controls and standards.
APPENDIX A

Federal Employment Protections Overview

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
- Joint labor-management committees and other training programs.

The Age Discrimination in Employment Act 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, protects employees over the age of 40 from discrimination in benefits.

The Americans with Disabilities Act 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.

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.

The **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.

The **Civil Rights Act of 1866 (Section 1981)** (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.

The **Genetic Information Nondiscrimination Act** of 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
- Joint labor-management committee
The New Mexico Crisis and Access Line

Online access:
nmcrisis.com

Call:
855-662-7474
or
855-227-5485 (TTY)

Together we can make New Mexico the best place to be a kid.

Share New Mexico

An online community space to find public and private sector information about issues impacting the quality of life of New Mexicans.
www.sharenm.org/communityplatform/newmexico

United Way

For community resources
DIAL 211