

State of California



YOUTH TREATMENT GUIDELINES

Revised
August 2002

**Youth Treatment Guidelines
Table of Contents**

Executive Summaryiv

Introductionv

Section I. Definitions1

Section II. Guiding Principles for Youth Treatment3

Section III. Target Population4

Section IV. Outcomes4

Section V. Service Components4

- A. Outreach
- B. Screening
- C. Initial and Continuing Assessment
- D. Diagnosis
- E. Placement
- F. Treatment Planning
- G. Counseling
- H. Youth Development Approaches to Treatment
- I. Family Interventions and Support Systems
- J. Educational and Vocational Activities
- K. Structured Recovery Related Activities
- L. Alcohol and Drug Testing
- M. Discharge Planning
- N. Continuing Care

Section VI. Service Coordination and Collaboration12

- A. Case Management and Complementary Services
- B. Critical Linkages

Table of Contents (continued)

Section VII. Culture and Language13

Section VIII. Health and Safety Issues14

- A. Care and Supervision
- B. Medication Management
- C. Emergency Services
- D. Detoxification Services
- E. Buildings/Grounds

Section IX. Legal and Ethical Issues16

- A. Voluntary Treatment
- B. Consent, Confidentiality, and Criminal Reporting
- C. Notice of Program Rules, Client Rights, and Grievance Procedures

Section X. Administration17

- A. Program Rules and Procedures
- B. Program Staffing
- C. Program Data Collection and Reporting

California Department Of
Health Care Services
SUD Resource Center
MS 2623
P.O. Box 997413
Sacramento, CA
95899-7413

(800) 879-2772 (California Only)
(916) 327-3728
FAX: (916) 323-1270
TTY: (916) 445-1942
Internet: <http://www.dhcs.ca.gov>
Email: ResourceCenter@dhcs.ca.gov

EXECUTIVE SUMMARY

Numerous studies periodically document the substantial prevalence of alcohol and other drug (AOD) use among youth. Alcohol remains the most widely used substance among youth, and marijuana is the most frequently used illicit drug among older students. Inhalants are most popular among younger students and its use is at an all time high. Recent trends indicate that the onset of AOD use is occurring at younger ages, and there are alarming increases in the use of “club drugs” such as methamphetamine, MDMA (ecstasy), gamma-hydroxybutyrate (GHB), Rohypnol and Ketamine.

Far from being an isolated problem, early and persistent AOD use is part of a syndrome of problem behaviors that affect not only the youth themselves, but their families and communities as well. Academic difficulties, criminal activity, health-related consequences, poor peer and family relationships, mental health issues, early sexual activity and teen pregnancy often accompany AOD use. Adolescence is an important time of physical growth and psychosocial maturation, and AOD use interferes with these normal developmental phenomena. AOD use can cause delays or long-term deficits in normal physical, intellectual, social, and emotional development. When AOD use begins at an early age, it can result in permanent developmental and neurological damage.

Most systems serving youth report that AOD use is a major problem among the youth they serve; however, those in need of treatment are not consistently identified or referred for services. Generally, only those youth which cause serious problems in relation to their AOD use tend to be identified and receive services, usually in the most restrictive settings (group homes, juvenile hall, or correctional institutions). This lack of intervention and treatment results in a huge cost to society, which escalates over time as these youth reach adulthood and enter the criminal justice system or require more serious and costly services.

For the most positive outcomes among youth experiencing AOD-related problems, they must have access to age-appropriate intervention and treatment, practical support such as life skills training and employment, and meaningful opportunities for involvement and leadership. Youth need programs that address their developmental issues, provide comprehensive and integrated services, involve families, and allow youth to remain in the most appropriate, but least restrictive setting, so they can be served within the context of their families, classroom and community. Historically, the AOD treatment service system has not served youth well because it was designed and intended for adults.

California has a pressing need for a coordinated system of treatment services designed specifically for youth with AOD problems. The model system will provide multiple and diverse services and treatment approaches to holistically address a youth’s AOD-related problems, surround youth with opportunities to succeed, and prevent more severe problems in adulthood. These guidelines are an important part of a long-term effort targeting the youth population with comprehensive and integrated services.

INTRODUCTION

In 1998, the California Legislature enacted the Adolescent Alcohol and Drug Treatment and Recovery Program Act (Assembly Bill 1784, Baca, Chapter 866, Statutes of 1998), better known as the Baca bill. Approximately \$5 million annually was designated to support comprehensive alcohol and other drug (AOD) treatment for adolescents. Twenty counties were funded with Adolescent Treatment Program (ATP) funds based on an index of need indicators (adolescent deaths, hospitalizations, arrests, automobile collisions, and school incidents, related to adolescent AOD use.)

The Baca bill authorized the Department of Alcohol and Drug Programs to develop standards and procedures to implement the ATP. The Department established a standards development workgroup. This workgroup was comprised of representatives from various disciplines and county systems, with a wide range of expertise in areas such as youth AOD abuse and treatment; adolescent development; youth mental health issues; child welfare, family reunification, and foster care; juvenile justice and probation; education; and, research and evaluation. The first meeting of the standards workgroup was held in March 2000.

Until recently, there were few AOD treatment programs designed specifically for youth and no standards of practice for youth or safeguards to ensure their safety and protection. As counties and providers began to develop new youth programs, this lack of standardization and youth treatment resources presented implementation problems. Current AOD standards and regulations offered little assistance, as they have no specifics related to youth and their unique needs. Therefore, the immediate goal of the workgroup was to identify and document the treatment models and intervention research had found to be effective with youth. These best practices were included in this document to ensure that youth intervention and treatment services are safe, appropriate, and cost effective. They were developed and intended to be used in conjunction with, not to conflict with or duplicate, other applicable laws, regulations or standards that govern programs serving youth.

These guidelines focus on ways to specialize treatment for youth and provide guidance to counties and providers as they develop and operate their youth treatment services. It is hoped that the guidelines will also serve as: 1) an educational resource for policymakers and professionals working in other youth services systems; 2) a guide for juvenile and family court judges for choosing and placing youth in effective programs; and, 3) a benchmark for counties and programs to establish their own written protocols for youth AOD treatment services based on local need.

SECTION I. Definitions

“ADA” means the federal Americans with Disabilities Act.

“Adolescence” means the period of life between puberty and maturity, which is generally accepted as the ages 12 through 17, inclusive.

“Assessment” is an ongoing process by which the treatment team collaborates with the youth, family, and others to gather and interpret information necessary to determine their level of problem severity, match their clinical needs to the appropriate level of treatment, and evaluate progress in treatment.

“AOD” means alcohol and other drugs.

“ASAM” means the American Society of Addiction Medicine.

“Case management” means an ongoing process by which the program establishes linkages with other service systems and its providers, acts as liaison between the youth and those other systems, and coordinates referrals to ensure access to necessary services to assist youth and their families to address their special needs.

“Clinically managed residential treatment” means the level of care equivalent to Adolescent Level III in the ASAM PPC-2R. This level of care is provided in either a facility licensed by the Department of Social Services or in a Department-licensed adult alcoholism or drug abuse recovery or treatment facility with an approved waiver to serve adolescents.

“Co-existing disorders” means the co-existence of both a DSM IV-defined substance related disorder and an Axis II, III, IV, or V mental health disorder.

“Co-morbidity” means the co-existence of both a DSM IV-defined substance related disorder and an Axis I major mental health disorder (also known as dual diagnosis).

“Continuum of care” means a full range of AOD services available to address the diverse needs of youth. A full continuum of care generally includes prevention, intervention, and treatment, with a variety of settings and services included within each category.

“Department” means the Department of Alcohol and Drug Programs.

“Detoxification” means acute abstinence syndrome requiring medical monitoring and management.

“Diagnosis” means a process of examination to determine the nature of a problem or set of problems, and the decision or opinion based on that examination.

“**DSM IV**” means the *Diagnostic and Statistical Manual of Mental Disorders IV*.

“**Early Intervention**” (or secondary prevention) means the level of care equivalent to Adolescent Level .05 in the ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition-Revised (PPC-2R). This level of care is delivered in a variety of settings and usually consists of brief contact or a series of contacts designed to explore and address problems or risk factors that appear to be related to substance abuse. It is most appropriate for youth with low AOD problem severity (experimental and regular use) and those who do not meet the diagnosis for a substance related disorder.

“**Family**” means the nuclear family (parents, grandparents, siblings, stepparents, adoptive parents, foster parents, or legal guardians), extended family (aunts, uncles, cousins), significant others, mentors, or persons viewed as family members when a youth has no identifiable family.

“**Group home**” means a facility licensed by the Department of Social Services, which provides 24-hour nonmedical care and supervision to children in a structured environment.

“**Intensive outpatient treatment**” (or day treatment) means the level of care equivalent to Adolescent Level II in the ASAM PPC-2R. This level of care is usually provided in a school or community-based program that extends the school day to include a wide array of services. It is appropriate for youth with severe problems related to their AOD use that have the potential to distract from recovery efforts.

“**Medically-managed residential treatment**” means the level of care equivalent to Adolescent Level IV in the ASAM PPC-2R, and is appropriately provided only in a hospital setting.

“**Outpatient treatment**” means the level of care equivalent to Adolescent Level I in the ASAM PPC-2R. This level of care may be provided in any age-appropriate setting and is appropriate for youth with low to medium problem severity.

“**Screening**” means the use of a brief and simple questionnaire to identify youth that may need AOD treatment by uncovering indicators of AOD problems.

“**Substance abuse**” means alcohol and other drug abuse.

“**Youth**” means the period of life between childhood and maturity.

“**Youth development philosophy**” means a concept that promotes developmental asset building, social supports and services, and job skill and workforce opportunities to help reduce problem behaviors and produce positive long-term outcomes for youth.

“Youth in at-risk environments” are minors whose environment increases their chance of using alcohol and other drugs, dropping out of school, teen pregnancy, and involvement in criminal activity.

SECTION II. Guiding Principles for Youth Treatment

These guidelines incorporate scientific research and clinical practice from both the AOD treatment field and children’s service systems. They reflect the overarching principles of AOD treatment that characterize the most effective approaches and interventions, and the philosophy of care for children that recognizes their developmental and multiple needs, involves families, and assures child safety.

AOD abuse and dependence among youth is a complex problem. It is generally the result of multiple factors, including: 1) a biological predisposition toward substance use or other problem behaviors; 2) psychological factors such as depression or distress; and, 3) social factors such as family, community, and peer relationships. Biopsychosocial factors should be considered in order to maximize the benefit youth will obtain from treatment. The biopsychosocial model integrated into these guidelines will help draw attention to the complexity of factors that lead to substance related disorders and aid in understanding and treating these disorders.

Substance-related disorders among youth occur in varying degrees of severity. A youth’s AOD use can range from experimental use with minimal consequences to abuse and dependence with continued severe consequences. The level and type of treatment provided should be consistent with the youth’s degree of AOD problem severity. The adolescent criteria in ASAM’s *Patient Placement Criteria for the Treatment of Substance Abuse Related Disorders* is available to determine appropriate placement.

A full continuum of care should be available to address the varying levels of services needed by youth, and allow for movement back and forth across levels as treatment progresses or regresses. In addition to formal treatment, the continuum of care for youth and their families should include pre-treatment options (mentoring, brief interventions, harm reduction, etc.), relapse prevention (either before, during, or after formal treatment), and aftercare services.

SECTION III. Target Population

- A. The target population for youth treatment is individuals ages 12 through 17 (inclusive).
- B. To serve youth ages 18 through 21 and individuals younger than age 12, the program should:
 - 1. Document clinical appropriateness individually for each client; and,
 - 2. Have a written protocol that addresses developmentally appropriate services for that age group.
- C. Admission priority should be based on program design, client assessment, and clinical judgement.

SECTION IV. Outcomes

- A. Counties should assess the desired system level outcomes, such as:
 - 1. increases in youth-specific programs/treatment capacity;
 - 2. increased access to youth specific services;
 - 3. increased quality of services; and,
 - 4. achieving and maintaining a continuum of care for youth.
- B. Programs should assess the desired client level outcomes for youth in treatment, such as:
 - 1. reduction and/or elimination of AOD use;
 - 2. improved level of functioning in major life domains; and,
 - 3. placement and safe treatment in the most appropriate, least restrictive settings.

SECTION V. Service Components

- A. Outreach
 - 1. Counties should provide or arrange for outreach services that identify AOD-abusing youth and encourage them to take advantage of treatment services.

2. Outreach efforts should target youth in at-risk environments.
3. High priority should be placed on linking with public systems already serving youth with AOD problems, such as schools, child welfare, public health, mental health, and juvenile justice.
4. Outreach activities should also include educating professionals and policy makers in these systems so that they become referral sources for potential clients.

B. Screening

Youth are far less likely than adults to be referred to treatment by a parent, family member, or self. Therefore, it is important that professionals who work with youth be able to identify youth AOD problems and refer these youth for further assessment and/or treatment. A high priority should be placed on identifying children with AOD problems within other public service systems, such as schools, child protective services, county mental health, perinatal AOD programs, probation, and, Medi-Cal and Healthy Families programs.

1. Youth who have been identified to be at risk for AOD problems should be screened, using a tool designed for adolescents, to uncover indicators of AOD and related problems. Youth with possible AOD problems as identified through the screening should be referred for a more comprehensive assessment for substance related disorders, as described in “C” of this Section.
2. The screening tool should be brief and simple and should be easily administered with minimal training.
3. The screening tool should have applicability across diverse populations and be developmentally appropriate.

C. Initial and Continuing Assessment

Assessment is not a single event upon the youth’s admission to the program, but an ongoing process to gain insight into a youth’s unique abilities, strengths, and needs. Assessment should be comprehensive, multi-faceted, and culturally, as well as developmentally, appropriate. Assessment should be used in the treatment planning of each individual admitted to treatment, and incorporate contextual factors contributed by family/caregiver circumstances.

1. Except for early intervention programs, the program should complete a comprehensive assessment on all youth with indications of possible AOD-

related problems (as a result of a brief screening), including those being admitted to treatment.

2. After screening indicates a probable need for treatment, the assessment should provide the information necessary to determine and document the level of severity of the youth's AOD-related problems and specifically address the level of care he/she should receive, as described in "E" of this section.
3. The assessment tool should be designed specifically for the developing adolescent, have established reliability and validity, and capture data related to the major life domains of an adolescent. This assessment tool should include, but not be limited to, issues of substance abuse, mental health, physical health, legal, development, school/education/employment, and family/peer relationships. The assessment tool should also be strength-based in order to accurately assess the youth's unique abilities and needs. As recommended, a staff person qualified to administer the instrument should perform assessments.
4. The assessment should include a health screening (including a medical health history, disease screening, dental, and mental health). (Programs assessing a youth should seek advice from public health professionals whenever appropriate.) If the health screening identifies an issue that warrants further evaluation, the program should provide or arrange for a physical examination and/or referral to the public health department or other appropriate care site, and take reasonable steps to assist the minor in accessing and receiving necessary care. Programs should develop and keep current lists of adolescent health provider referrals and provide appropriate assistance in accessing necessary health care services based on health assessment findings.
5. The assessment should include an evaluation of the youth's developmental and cognitive levels; and social, emotional, communication and self-help/independent living skills.
6. As soon as possible, the program should assess and identify safety issues, such as risk of suicide; current, or history of, physical and/or sexual abuse; or perpetration of physical or sexual abuse on others. The assessment should include an evaluation of risk to self and others. If the assessment indicates high risk of danger to the youth or others, an appropriate referral should be made immediately and the family/guardian should be notified. The assessment should be conducted with appropriate consent as provided by law.

7. The initial assessment should be completed as soon as possible, with the initial assessment occurring no later than 30 days after admission. Programs should attempt to gather as much information as soon as possible, and keep updating as more information is obtained (it may take some time to build trust and rapport with the youth before he/she will reveal more detailed and honest information).

D. Diagnosis

1. As part of the comprehensive assessment described in “C” of this Section, youth should be assessed to determine whether they meet the diagnostic criteria of a substance related disorder in *DSM IV*.
2. Except as provided in 3 and 4 below, all youth accepted for treatment in outpatient, intensive outpatient, and residential treatment should meet diagnostic criteria for a substance related disorder in the *DSM IV*.
3. A youth whose AOD use symptoms are severe, but who does not meet the diagnostic criteria, may be appropriate for admission to outpatient treatment for further evaluation.
4. If the presenting AOD history is not adequate to substantiate a diagnosis, the program may use material submitted by collateral parties (family members, legal guardians, etc.) that indicates a high degree of probability of such a diagnosis.

E. Placement

Individuals and agencies making placement decisions for youth needing treatment should do the following:

1. Make every effort to keep the youth in the least restrictive environment, unless moving them into a more restrictive program is the only way to protect themselves or others from harm, or if all potential less restrictive environments have proven ineffective. ASAM’s PPC provides a guideline for determining treatment setting and service matching.
2. Take into consideration the age, developmental stage, gender, culture, and behavioral, emotional, sexual or criminal problems of the youth and existing clientele, to ensure that the youth and other clients would not be adversely impacted by their interaction.
3. Except for early intervention programs, a program should serve male youth only, or female youth only, unless:

- a. the program addresses gender-specific issues in determining individual treatment needs and therapeutic approaches; and,
- b. the program provides regular opportunities for separate gender group activities and counseling sessions.

F. Treatment Planning

1. Except for early intervention programs, programs should develop a written individual treatment plan for each youth, based on information collected in the comprehensive assessment.
2. The treatment plan should be developed in conjunction with the youth and involve the youth in recognizing and appreciating his/her unique strengths and assets as well as clarifying needs.
3. The treatment plan should address multiple problems experienced by the youth (including but not limited to mental health, education, family, medical illness, legal issues), and the complementary services needed to deal with these problems.
4. Services and therapeutic approaches identified in the treatment plan should reflect the youth's gender, and chronological, emotional, and psychological age.
5. A physical health questionnaire designed for client and/or parent/guardian self-administration should be used and discussed with the youth by an appropriately trained staff member in the context of treatment plan development. Treatment plans should contain specific goals for achieving physical health based on the identified needs and treatment plan priorities.
6. The treatment plan should include goals with realistic objectives and timeframes for completing. These should be mutually agreed upon by the program, the youth, and, whenever possible, his or her family/caregiver.
7. The initial treatment plan should be completed at least within 30 days of admission. Progress in treatment should be regularly monitored and treatment plans modified as needs arise or change during treatment, at various stages of the youth's development and recovery, or at least every six months.

G. Counseling

1. Except in early intervention programs, each youth should be assigned a primary counselor when admitted to treatment. The primary counselor is responsible for building the youth's emotional trust and safety, recognizing

the youth's individual strengths and assets, and assisting him/her to achieve success appropriate for his/her developmental stage.

2. The program should provide individual counseling sessions as clinically appropriate and specified in the treatment plan, but at least:
 - a. upon admission to treatment to help orient the youth to treatment;
 - b. to develop and revise treatment plans;
 - c. as needed for youth who are uncomfortable with the group process or unready to discuss specific issues in a group setting;
 - d. for crisis intervention; and,
 - e. for discharge planning.
3. Programs should provide group counseling sessions as clinically appropriate and as identified in the treatment plan.
4. The program should provide didactic groups as clinically appropriate and as identified in the treatment plan.

H. Youth Development Approaches to Treatment

1. Programs should integrate a youth development philosophy as the foundation of treatment for youth. Youth development approaches include the following:
 - a. assessment and treatment planning processes that are strength-based rather than deficit-based;
 - b. uncovering what is unique about the youth and building on his/her individual abilities and strengths;
 - c. frequent expressions of support and consistent, clear and appropriate messages about what is expected of the youth; and,
 - d. encouragement and assistance in developing multiple supportive relationships with responsible, caring adults.
2. Programs should provide or arrange for opportunities for youth to:
 - a. advise and made decisions related to program policies and procedures that impact them;
 - b. plan, organize, and lead program activities and projects;
 - c. develop social skills and decision-making abilities;
 - d. learn values and marketable skills for adulthood; and,
 - e. contribute to their community and serve others.

I. Family Interventions and Support Systems

Research has found that effective treatment for youth almost always involves the family, and the effectiveness of family therapy has been documented extensively, especially among those youth who are normally the most difficult to treat. Therefore, whenever possible, parents/caregivers should participate in all phases of their child's treatment. However, it makes no ethical or legal sense to insist on the involvement of estranged parents in decision-making regarding their child's treatment. Instead, the program should create new opportunities for youth to develop supportive relationships with appropriate adults who will remain involved in their lives, both during treatment and recovery, and beyond.

1. Programs should make efforts to:
 - a. identify family dynamics, engage and include the family in the youth's treatment as early as possible (as part of the intake and assessment process), if clinically appropriate and specified in the treatment plan; and,
 - b. provide individual family counseling, multi-family groups, and parental education sessions as clinically appropriate and specified in the treatment plan.
2. The program should assist the youth in developing a support system to help reinforce behavioral gains made during treatment, and provide ongoing support to prevent relapse.

J. Educational and Vocational Activities

1. Programs should fully integrate the youth's educational program into the youth's clinical program by:
 - a. providing youth access to educational instruction while in treatment, in accordance with state law;
 - b. working with the educational system to address the youth's school related problems; and,
 - c. developing a plan to assist the youth to successfully transition back into the community educational system, if appropriate.
2. Programs should provide or arrange for educational sessions and culturally appropriate materials that address issues such as HIV/AIDS and other health matters (Sexually Transmitted Diseases (STDs), tuberculosis, hepatitis, nutrition), as well as, sexuality/family planning, violence prevention, independent living skills, and smoking cessation.

3. As appropriate, programs should provide or arrange for academic and work-readiness skills, career planning, and job training for youth. The program should also develop and maintain collaborations with local vocational programs and the workforce investment board and its youth council.

K. Structured Recovery-Related Activities

Intensive outpatient and residential programs should provide or arrange for both therapeutic and diversionary recreation. Therapeutic activities include art therapy, journal writing, and self-help groups. Diversionary recreation activities include sports, games, and supervised outings.

L. Alcohol and Drug Testing

1. Except for early intervention programs, programs should provide or arrange for alcohol and drug testing for all youth.
2. The frequency of alcohol and drug testing should be determined individually for each youth based on clinical appropriateness, and should allow for rapid response to the possibility of relapse.
3. Alcohol and drug test results are meant to assist in diagnosis, confirm clinical impressions, help modify the youth's treatment plan, and determine the extent of the youth's reduction in AOD use. Clinical decisions should not be based solely on these results.

M. Discharge Planning

1. Except for early intervention programs, programs should, in cooperation with youth, develop a written discharge and/or aftercare plan that contains elements to sustain gains made in treatment.
2. The adolescent patient discharge criteria contained in ASAM's *Patient Placement Criteria for the Treatment of Substance Abuse Related Disorders* is available to help determine length of stay and discharge readiness.
3. Programs should complete a written summary for each youth discharged from treatment that contains client profile information consistent with standard data sets. The summary should document progress towards goals and measurable outcomes during treatment, and characterize the youth's long-term success or need for further assessment and/or referral.

N. Continuing Care

Programs should provide or arrange for continuing care services to youth after the completion of formal treatment, and whenever professional intervention is needed, to prevent relapse and support the youth's transition into recovery. Continuing care services may include, but are not limited to, coordination of goals, identification of signs of relapse and a plan to respond to such signs, family involvement, linkages to other services as necessary, aftercare sessions, transition and emancipation options, and, self-help and peer support groups.

SECTION VI. Service Coordination and Collaboration

A. Case Management and Complementary Services

Except for early intervention programs, programs should provide or arrange for case management services for every youth in treatment. If the case manager function is provided directly by the treatment program, the case manager should:

1. Have training and skills in the following areas:
 - a. AOD treatment, an understanding of addiction, and the intergenerational nature of AOD abuse;
 - b. familiarity with community resources and other youth service systems (education, child welfare, juvenile justice, mental health, etc.);
 - c. physical and sexual abuse;
 - d. family dynamics; and,
 - e. legal issues (informed consent for minors, disclosure of confidential information, child abuse/neglect reporting requirements, and duty-to-warn issues).
2. Arrange for, ensure access to, and coordinate complementary services identified in the youth's treatment plan. If allowed by specific funding requirements (i.e., State General Fund or federal Substance Abuse Prevention and Treatment Block Grant), youth treatment funds may be used for necessary complementary services if alternate funding is not available.
3. Communicate regularly with the primary counselor to coordinate and monitor the services and activities for the youth and his/her family, as identified in the youth's treatment plan.
4. Be the youth's advocate and liaison with other systems, help the youth and family negotiate the various service systems, and coordinate referrals.

5. Network and communicate with other community agencies providing services to youth in the program (including schools, child welfare, juvenile justice, employment development, mentoring, mental health, primary medical care, etc.), and as much as possible, coordinate case management with these various other agencies/systems, which may include group case management meetings.

B. Critical Linkages

1. The program should develop strong linkages with existing health, mental health, social, educational, mentoring, and employment development programs that provide services to youth. This includes the AOD services system as well, since AOD prevention programs and perinatal treatment programs provide opportunities for identification and referral of youth with AOD problems.
2. The program should collaborate with other agencies providing services to the youth as indicated by the client's needs and in order to ensure a coordinated approach. These may include, but should not be limited to, Department of Health Services, Department of Social Services (foster care and child welfare), Employment Development Department (work development and training), Department of Education, Department of Mental Health, juvenile justice (courts and probation) and other community based organizations providing services to youth.
3. When applicable, and in accordance with state and federal laws regarding disclosure of confidential information, the program should include representatives from these other agencies during case conferences and treatment planning.

SECTION VII. Culture and Language

- A. Programs that serve youth whose primary language is not English, including sign language, should have or make available, as needed, skilled bilingual staff and/or interpreters.
- B. Staff should be trained in specific cultural issues, traditions, and beliefs in order to provide the most appropriate treatment for youth within the community.
- C. All print and audio-visual materials used for educational purposes should be culturally, linguistically, and literacy appropriate for the youth and families being served.

D. Staff should foster an environment of acceptance of different sexual orientations and should be prepared to address issues of sexuality and sexual identity, including those of gay, lesbian, and bisexual youth.

E. The program must comply with all ADA requirements.

SECTION VIII. Health and Safety Issues

A. Care and Supervision

1. The program should provide a reasonable level of age-appropriate structure, care, and supervision to ensure the safety and security of youth and staff at all times while on the program site. Appropriate care and supervision includes the maintenance of rules for the protection of youth; supervision of youth schedules and activities; monitoring of food intake/special diets (when meals or snacks are served); and storing, distribution, and assistance with taking medications (see “B” of this Section).
2. Youth have the right to be accorded dignity in their personal relationships with staff and other persons, and to be free from corporal or unusual punishment, exploitation, prejudice, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, sexual harassment, mental abuse, or other actions of a punitive nature.
4. Program consequences/discipline for a youth’s inappropriate behavior in the program must be non-violent, age/developmentally appropriate, non-aversive, and clearly stated in the program’s rules and procedures.
5. Programs should have written procedures for signing youth in and out of program sites. Program staff should ensure the availability of secure, safe and reliable transportation for youth to and from the program site and to supportive services. The program should never leave a youth alone to wait for his/her ride.
6. Programs, in consultation with their county agencies, should establish a protocol for the submission of program incident reports, including the reporting of such incidents as injuries that require medical evaluation or treatment; suspected physical, sexual or psychological abuse; transmissible diseases (non-STDs); and, deaths.
7. All programs should conduct a criminal record review of all staff who will have any contact with youth while they are at the program. If the review discloses that the individual has been convicted of or is the subject of any criminal investigation relating to any felony or misdemeanor perpetrated

against a child, the program shall prohibit that individual from employment that results in any contact with youth while they are at the program. The program should keep the results of the criminal record review in a confidential portion of the personnel file.

8. All programs should develop training to increase staff awareness and skills in the detection of youth injury, disease, child abuse, and neglect to ensure youth welfare. Programs should also have written policies and procedures concerning appropriate staff response to and preparation for such issues.

B. Medication Management

Programs should manage youth's prescription medication in accordance with all applicable laws (i.e., those governing school sites and residential AOD treatment programs). Programs that are not otherwise regulated in this area should develop and implement a written protocol for the self-administration and management of youth's prescription medications that ensures the following:

1. medications are reviewed and documented in the youth's chart upon admission to the program and records are periodically updated;
2. staff members directly involved in individual client care are made aware in writing of a youth's medication regimen; and,
3. provisions are made for appropriate and secure storage and self-management of a youth's medications to minimize risk of tampering, loss, or contamination.

C. Emergency Services

1. At least one staff member on all shifts should be trained and certified in first aid and cardiopulmonary resuscitation to ensure adequate emergency services are available when youth are present.
2. All programs should develop written protocols and procedures in case of a medical or psychological emergency. Programs should establish referral relationships with emergency facilities. All staff involved in direct client care should be trained in the emergency care procedures.

D. Detoxification Services

Youth in need of detoxification services should be placed in the most appropriate site for the provision of services.

1. When indicated, appropriately trained personnel under the direction of a physician or other health care professional should monitor medical detoxification with specific expertise in management of alcohol and drug detoxification and withdrawal.
2. Written protocols should be developed and staff trained to ensure that all programs have the capacity to adequately manage and/or make referral arrangements for youth that appear at the program site under the influence.

E. Buildings/Grounds

1. All residential facilities must be licensed in accordance with applicable state licensing statutes and regulations and remain in compliance with such requirements.
2. All facilities should be clean, sanitary, and in good repair at all times for the safety and well being of youth, staff, and visitors.

SECTION IX. Legal and Ethical Issues

A. Voluntary Treatment

AOD treatment is a voluntary process; however, the AOD treatment system often serves youth who “volunteer” for treatment as a choice to avoid more severe consequences (school expulsion, juvenile detention or a felony conviction, placement in group home, or a parental consequence). Such “coerced” treatment can be successful, if youth are assessed and matched with the appropriate level of treatment, and the program makes attempts to motivate the youth to change.

1. If a youth appears to be mismatched to court-ordered treatment, the treatment program has a right to refuse treatment based on clinical assessment, but should make a recommendation and referral for more appropriate placement.
2. The program should overcome resistance and encourage participation by utilizing strategies with demonstrated effectiveness (using role models, involving the family, motivation through positive and appealing activities).

B. Consent, Confidentiality, and Criminal Reporting

Programs must comply with state and federal laws and regulations regarding informed consent for children, disclosure of confidential information such as patient-identifying information (including communication with parents, guardians, courts), child abuse and neglect reporting requirements, and duty-to-warn issues (threats of violence, HIV infection risk, criminal activity).

C. Notice of Program Rules, Client Rights, and Grievance Procedures

Upon admission, all youth should be personally advised of, and given a copy of, the program rules, client rights, and the complaint and/or grievance procedures. These should be culturally, linguistically, and literacy appropriate for the youth and families being served. The program should post these items in a noticeable place in the facility.

SECTION X. Administration

A. Program Rules and Procedures

The program should have written program policies and procedures, client rules and rights, and complaint and/or grievance procedures. All staff should receive training on the program rules, policies, and procedures.

B. Program Staffing

1. Each youth treatment program should have at least the following core staff:

- a. a program or clinical supervisor, who should have management experience (i.e., staff supervision, fiscal operations, or business administration), and education and experience in AOD addiction counseling;
- b. an AOD counselor, who should be certified by an AOD addiction counselor credentialing organization; and,
- c. a family therapist, who should be licensed as either a marriage and family therapist, clinical social worker, psychologist, or a registered intern under the supervision of a licensed therapist. The family therapist may be a contracted employee.

2. The core staff should have training and/or skills in the following areas:

- a. AOD treatment, an understanding of addiction, the intergenerational nature of AOD abuse, and the dynamics of adolescent recovery;

- b. effective and developmentally-appropriate interventions and approaches for treating AOD-abusing youth;
 - c. assessment of AOD use disorders, mental health disorders (psychotic, affective, anxiety, and personality), and cognitive impairments;
 - d. psychoactive medications prescribed to youth, their benefits, and their potential side effects and interactions with other medications or substances;
 - e. child development and normal adolescent growth and development;
 - f. therapeutic recreational therapy;
 - g. family dynamics;
 - h. detection of youth injury, disease, abuse, and neglect;
 - i. HIV/AIDS and other health issues (STDs, hepatitis, smoking, etc.);
 - j. cultural competence, including ADA requirements;
 - k. community resources and other youth treatment systems (schools, child welfare, mental health, juvenile justice system, etc.);
 - l. methods and meanings of drug and alcohol testing, as well as the benefits and limitations;
 - m. legal issues (informed consent for minors, disclosure of confidential information, child abuse/neglect reporting requirements and duty-to-warn issues);
 - n. program rules and procedures; and,
 - o. client rights and grievance procedures
3. Programs should retain written evidence of the required staff licensure, skills, and training.
 4. Programs should provide for or arrange for continuing education for all clinical staff to enhance their specialty and keep up with trends, new technology, etc.

C. Program Data Collection and Reporting

1. Counties and providers are responsible for collecting and submitting data to the Department, such as the California Alcohol and Drug Data System (CADDs) admission and discharge forms.
2. Counties and providers may be required to provide additional data for monitoring or evaluation purposes, as requested by the Department.