# Adolescent Substance Abuse Recovery Support Services Proposal

## Report and Recommendations to the Alcohol and Drug Abuse Administration by the Designated Advisory Group

**Advisory Group Participants (note that the participants do not have a direct programmatic or financial interest in the development of these proposed services :**

Marcia Andersen (MHA), Pamela Brown (Anne Arundel County Health Department), Ann Geddes (The Maryland Coalition of Families for Children's Mental Health), Barbara Groves (Maryland Treatment Centers, Inc.), David Jones (Baltimore Mental Health Systems), Jackie Powell (Department of Human Resources), William Rufenacht (Anne Arundel County Health Department), Celia Serkin (Montgomery County Federation of Families for Children's Mental Health), Joan Smith (MHA), Stan Weinstein (Woodburne Center)

**Chair:** Peter R. Cohen (ADAA)

**Group Coordination and Resource Support:** Rena Mohamed and Kathleen Herring (Mental Hygiene Administration/University of Maryland Innovations Institute); Doreen Cavanaugh (Georgetown University Health Policy Institute)

**Process for Creating Recommendations:** The council was provided with the following information in preparation of two telephone conferences:

1. "Designing a Recovery-Oriented Care Model for Adolescents and Transition Age Youth with Substance Use or Co-occurring Mental Health Disorders", 2009, SAMHSA (http://gucchdtacenter.georgetown.edu/resources/Recovery_Report_Adolescents%20-%20FINAL.pdf)

2. Specific articles on principles of adolescent recovery

3. Information on the State of Georgia Club House Model for Adolescent Substance Abuse (http://www.imaginehope.com/Adolescent-Recovery-Clubhouse/clubhouse-community-for-recovering-youth.html)

The first teleconference involved discussing the above materials and determining the need for a webinar to hear from experts about designing a recovery-oriented care model.

The webinar was held on June 1, 2012. The first hour included an overview by Randy Muck, formerly an adolescent substance abuse and recovery expert from SAMHSA, now

Senior Clinical Consultant with Advocates for Youth and Family Behavioral Health Treatment followed by presenters from the Pima Prevention Partnership, Tuscon, Arizona, who were pioneers in the development of adolescent substance abuse clinical and support services, which include the juvenile justice population and provide a recovery model of support with weekly meetings, social activities, self-management and recovery training. The second hour involved a discussion of the council regarding recommendations for the ADAA.

The ADAA medical director collated the responses, distributed a draft to the participants for comment and then submitted these recommendations to the ADAA.

**The ADAA Charge for the Advisory Council:** To make recommendations to the ADAA regarding the application of Maryland State Alcohol Tax Funds for the establishment of adolescent substance abuse support services

**Vision:** To support and maintain adolescents and families in recovery in the community from substance abuse or co-occurring substance abuse and mental health challenges

**Values and Principles:**

1. A process of healthy "discovery" in the absence of substance use may a more meaningful term than "recovery" for many substance abusing and dependent adolescents because of their lack of accumulated life experience, skills and interests.
2. Discovery and recovery in this group of adolescents tends to be non-linear, where forward progress and growth can be erratic and can alternate with relapses.
3. For some adolescents, harm reduction is a necessary early intervention, in which engagement and retention in treatment take priority, predating the stages of recovery and/or discovery.
4. Peer support is a necessary element in fostering treatment engagement and progressing through the stages of recovery and discovery
5. Services should be culturally and linguistically competent and relevant to the needs of its consumers.
6. Support services must, therefore, reflect systems, developmental and family-focused approaches to the field of treatment, by adopting the following qualities of
    a. focusing on "recovery and discovery" of the adolescent and family
    b. being age appropriate
    c. being developmentally appropriate
    d. being strength-based
    e. promoting resiliency
    f. maximizing family engagement and collaboration
    g. respecting a broader definition of family
    h. promoting peer support

i. fostering social connectedness in the context of living in a community
j. relying upon consumer and provider collaboration
k. linking with other community agencies and supports
l. promoting culturally competence

**Population Eligibility:** Adolescents (12 – 17) with primary substance abuse disorders or co-occurring mental health disorders that hinder substance abuse recovery

**Structural Models:** The advisory group considered three different programmatic structures for delivering support services. Please note: The wellness and recovery center and clubhouse model are similar enough that they will be deemed identical.

1. Wellness and Recovery Centers: services are provided within programs that offer clinically-based recovery and support. Clinical services may also be provided by the center. Admission to the club house and eligibility for receiving support services is contingent on continuing in clinical substance abuse or co-occurring treatment or aftercare
2. Clinic-based model: clinics help the adolescent and family apply for supportive services and ensure that the appropriate linkages and follow through is achieved.. The adolescent would receive vouchers for specific support services
3. Club House Model: services are administered within the budget of a program that does not provide direct clinical services, but provides support for the adolescent and family in collaboration with existing treatment programs. Admission to the club house and eligibility for receiving support services is contingent on continuing in clinical substance abuse or co-occurring treatment or aftercare

The advisory group favored a clubhouse/wellness/recovery center approach that 1) has a more naturalistic, non-office programmatic structure, 2) is community-based, and 3) fosters age-appropriate prosocial affiliations and activities. More consideration should be given to programs that 1) are able to develop working local partnerships, that include youth, families, child-serving agencies, providers, and community representatives; and 2) can leverage community resources.

**Services offered by this model:**

1. Range of services potentially provided:
   a. recovery support groups facilitated by staff focused on coping with day-to-day challenges for the adolescent and family, including asset development
   b. “opportunistic” problem solving, guidance and enhancement of effective communication skills
   c. prosocial activities provided onsite or by field trips

d. independent living skill development to prepare the older adolescent for leaving home or other non-familial settings
e. case management and coordination of clinical care, school, work and other supportive resources
f. crisis prevention, management, intervention, triage, and post-crisis follow-up, with promotion of protective factors and reduction of risk factors
g. vouchers that promote recovery with help in completion of applications; obtaining identification cards; acquiring critical materials for work, school, recreational and avocational activities
h. educational tutoring
i. mentoring
j. job readiness and coaching
k. transportation options to assure attendance and adherence
l. onsite, age and developmentally appropriate self-help groups: NA, AA, Smart Recovery, etc.
m. provision of snacks and other nutritional support, after school or work, through the evening and on weekends
n. promotion of healthy living including: diet, exercise, stress reduction skills, and practicing consistent sleep patterns
o. peer to peer support, including leadership development
p. family engagement activities
q. opportunities to give back to the community (volunteering)
r. alumni involvement to provide outreach and support the viability of the program the development and provision of a community-based directory of public support, advocacy, legal, housing, recreational, vocational, and educational agencies for adolescents and their families

2. Response to a request for proposal (RFP) or invitation for bid (IFB) will require the applicant's describing how cultural issues, gender issues, and trauma-based care will be addressed by program
3. The ADAA and the funded support services programs should strongly consider the inclusion of externally funded evidence-based prevention efforts that intervene with at-risk families and children who are affiliated with the adolescent's recovery support program

**Locations:** With 24 jurisdictions, the first established centers of supportive services should be located regionally, in selected urban, suburban and rural settings, and strategically placed to be accessible to an optimal number of participants in the surrounding communities. Program applicants will propose a location that best fulfills these necessities.

**Staffing:** At the onset, staff will include bachelors to master's level staff, supervised by a licensed clinical social worker. The program should provide a proposal for the inclusion of the following additional staff:

1. Youth peer-to-peer workers
2. Caregiver peer-to-peer workers
3. Opportunities for university student internships, including a focus on outreach to students who are also consumers

**Evidence-Based Practices Provided**

1. A universally applied cognitive behavioral approach to supporting recovery, eg. Seven Challenges or another CBT manualized approach. The Department of Juvenile Services has invested time and money in the Seven Challenges. Therefore serious consideration should be given to fostering that modality to maintain a consistency in clinically supportive language and interventions between the detention program and the recovery support center.
2. Technological supports: continued contact by way of texting, emailing, phone calls, special website for providing recovery resources and information, communication with staff and for confidential peer forums
3. EBP's should be based upon a foundation of empathy, motivational enhancement, community reinforcement and family enhancement, while focusing on the qualities that foster clinical improvement: youth and family resilience, self-efficacy, self-advocacy, communication and coping skills, stress management, maintaining social supportive relationships and resource connection, and acquiring a sense of mastery of developmentally appropriate tasks and challenges.
4. The program should include a proposal about it intends to measure progress concerning improvement in the areas specifically stated in item 3.

**Outcomes to be Measured**

SMART, the ADAA's electronic health care recording system, should be utilized to measure the overall effectiveness of these support systems. These outcomes, based upon National Outcome Measures, promoted by SAMHSA, are positively fostered by the effective practice of evidence-based practices. The following outcomes can be measured by SMART:

1. Abstinence: Past use, dependence and abuse symptoms
2. Rehospitalization, or readmittance to residential treatment
3. Criminality
4. Retention in school
5. Retention in treatment

6. Success in transferring from one level of care to another
7. Self-help attendance

**Needed Technical Assistance:**

The ADAA has already received the assurance of continued support in finding assistance for the development of clubhouse and recovery center models from the following resources:

1. University of Maryland Innovations Institute
2. Georgetown University Health Policy Institute
3. State of Georgia Division of Addictive Diseases
4. Advocates for Youth and Family Behavioral Health Treatment