State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF ADDICTION SERVICES
PO BOX 362
TRENTON, N.J. 08625-0362

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

RAQUEL MAZON JEFFERS
Director

February 2, 2011

Dear Addictions Community:

On behalf of the Adolescent Task Force, the New Jersey Division of Addiction Services (DAS) is pleased to release the Task Force's final report. We wish to express our gratitude to the members of the Task Force who dedicated their time and valuable expertise to this process.

The New Jersey Department of Human Services (DHS), Division of Addiction Services (DAS) participates on the National Association of State Alcohol and Drug Abuse Directors (NASADAD) Child Welfare Conference Committee. In July 2008, the Committee recommended that states develop an Adolescent Substance Abuse Task Force to improve and identify evidence-based treatment models for the delivery of adolescent treatment and recovery support services. The Task Force was established by and operated under the authority of the DHS DAS in January 2009, meeting bimonthly with an end date of January 2010.

The enclosed report represents the effort of the broad range of stakeholders who participated in the Task Force, including Adolescent Substance Abuse Treatment Providers, Recovery Support Providers, Consumers, Interested Community Members, Representatives from the Department of Children and Families (DCF), the Juvenile Justice Commission (JJC), the Department of Education (DOE), DHS and the Counties.

The recommendations proposed by the Task Force and its subcommittees will guide the development of a more competent system of treatment for adolescents with substance abuse disorders and their families in New Jersey. DAS will bring this report to various stakeholder forums for discussion, and we look forward to hearing the input from the community on the report's recommendations. The Task Force members identified strengths and challenges in this system and recommended improvements in the areas of: 1) service delivery, 2) systems; and, 3) workforce to enhance adolescent substance abuse treatment. DAS acknowledges the Task Force members for their commendable work and commitment.

Sincerely,

Raquel Mazon Jeffers
Director

Enclosure

New Jersey Division of Addiction Services
Adolescent Substance Abuse Task Force
Final Report – January 11, 2011

The New Jersey Department of Human Services (DHS) Division of Addiction Services (DAS) participates on the National Association of State Alcohol and Drug Abuse Directors (NASADAD) Child Welfare Conference Committee. Its purpose is to foster and support the development of effective alcohol and other drug abuse prevention and treatment programs throughout every state. In July 2008, the Committee recommended that states develop an Adolescent Substance Abuse Task Force to identify best practices, retention, engagement and recovery support services. DAS had already examined data and identified problems of retention and engagement with the adolescent population in treatment. The recommendation of an Adolescent Substance Abuse Task Force fit DAS priorities at the time to improve and identify evidence-based treatment models for the delivery of adolescent treatment and recovery support services. *(Please note that this document will refer to the Adolescent Substance Abuse Task Force as Task Force).*

The goal of the Task Force is to identify strengths, opportunities and challenges in adolescent substance abuse treatment and to recommend changes and improvements to service delivery, systems and workforce. Recommendations identify actionable goals and steps that can be utilized to transform and enhance the adolescent treatment system.

In 2008, DAS solicited applications from individuals with clinical, administrative and systems expertise who have experience and knowledge working with adolescents within a substance abuse treatment agency licensed by DAS as well as individuals with demonstrated knowledge and expertise in the provision of prevention, early intervention, and recovery support services for adolescents. By invitation, DAS included systems partners such as the Division of Child Behavioral Health Services (DCBHS), the Division of Youth and Family Services (DYFS), Department of Education (DOE) and the Juvenile Justice Commission (JJC). DAS also actively solicited an adolescent and a family consumer to sit on the task force.

The Task Force was established in January 2009, meeting bimonthly with an end date of January 2010, in which to prepare their final report to be presented to DAS Director, Raquel Mazon Jeffers.

The Task Force developed a definition of substance abuse treatment specific to adolescents as the first step toward developing a system of care that addresses the specific needs of the adolescent. The definition is as follows: "*Adolescent substance abuse treatment is a dynamic collaborative process in which competent staff helps to empower adolescents and their support system in identifying and overcoming challenges that are related to their substance use. This is achieved through an integrated strength-based, outcome driven approach delivered across a continuum of*

services designed to promote and sustain client-centered wellness and recovery from substance abuse."

Using this definition as its benchmark, the Task Force looked at the New Jersey adolescent treatment system as it exists to assess for strengths and to recommend improvements. Three Subcommittees were established and charged to make actionable recommendations for improvement and movement towards an adolescent treatment competent system and on how to finance the system changes or restructure financing. The Subcommittees are as follows: (I) Evidence-Based Treatment and Outcomes; (II Workforce Development and Competent Treatment Network; and (III) Integrating Adolescent Systems.

TASK FORCE RECOMMENDATIONS:

The primary goal of the Task Force was to make recommendations, that when implemented, would develop a system of care that could provide effective, developmentally sensitive client-centered substance abuse treatment and services in accordance with the definition developed by the Task Force.

The Task Force identified the following needs along the subcommittee areas. First, in areas of treatment, the Task Force identified the need for the use of evidence-based practices in order to improve standards of care and higher retention and completion rates. Second, the current workforce struggles with staff retention and recruitment. In order to support a transformation of the adolescent treatment system, the ongoing development of an adolescent competent workforce has been identified as another area for improvement. Finally, there are gaps within the current adolescent treatment system as well as systems that serve the substance abusing adolescent. These limitations create barriers to treatment and impact continuity of care. To meet these needs additional resources and services are needed as well as enhanced communication and collaboration among all adolescent serving systems.

The overall theme that came from the Task Force is to develop a community-based approach. The Task Force recognizes the need for residential treatment and the need to add other services for a full continuum of care designed specifically for adolescents. The Task Force recommended development of a recovery-oriented system of care for adolescents and their families or support networks. Co-occurring services, family involvement and recovery support services should be included on the full continuum, through the use of guidelines, funding, and regulation.

SUBCOMMITTEE RECOMMENDATIONS:

I. Evidence-Based Treatment and Outcomes Subcommittee

DAS reached out to the Center for Substance Abuse Treatment (CSAT) regarding recommendations for a compendium of evidence-based practices for adolescent substance abuse treatment programs and shared this information with the Task Force.

This information was reviewed by Subcommittee members and, along with their own experience and expertise, used to develop the following recommendations.

1) **Resources for adolescent treatment should focus on a system of care that is community-based and concentrates on the least restrictive level of care that would help adolescents sustain recovery through community supports to prevent the disease from becoming more acute.** This would include: in-home services, increased family services, substance abuse case management, a fuller continuum of outpatient services, short-term residential stays for adolescents, and recovery supports and programs targeted specifically for marijuana dependent adolescents. These recommendations will be discussed in more detail in the Integrated Adolescent Systems Subcommittee section.

2) **Cross training of DAS and DCBHS providers on the system and services that are available for adolescents.** There continues to be a gap in services for youth with co-occurring disorders and integration between mental health and substance abuse services. Co-occurring youth must have competent assessments and care in both mental health and substance abuse systems. It was recommended that DAS service providers become better able to utilize and coordinate with the services of the Child Behavioral Health System of Care. In turn they thought that the child behavioral health care system would benefit from understanding what traditional substance abuse providers offer as a resource for those clients who are currently served in the DCBH system.

3) **Treatment programs designed specifically for adolescents dependent on marijuana.** CSAT has developed a series of evidence-based treatments called Cannabis Youth Treatment (CYT) and one example of recommended practice from this series is Adolescent Community Reinforcement Approach (ACRA). According to the National Survey on Drug Use and Health (NSDUH), marijuana continues to be the most commonly used drug among adolescents, and the New Jersey Substance Abuse Monitoring System (NJSAMS) data confirms the same in New Jersey.

4) **Adolescent treatment should include a component for in-home treatment provided by appropriately credentialed and trained clinicians.** In-home services would include an array of interventions that could include a family component using evidence-based practices. These services can be initiated either upon discharge from a residential facility to assist the adolescent transition back into the community or for adolescents assessed for outpatient treatment where obstacles or resistance prevent families from engaging in treatment outside of the home. At the end of treatment, there can be opportunities to continue in-home services, transition to another treatment service, and link with community or recovery supports depending on clinical assessment of the adolescent and family's needs and or resources.

5) **Adolescent treatment should include recovery case management services.** For those clients with multiple systems involvement and difficulty engaging in treatment, recovery case management services provide access to recovery support services,

coordination among agencies that provide services and treatment to adolescents and community integration.

6) **Require and support family-based treatment.** Adolescent treatment should utilize a family-centered treatment approach that focuses on the unique needs and resources of the individual families. Family-centered treatment acknowledges the influence and importance of family, provides for family involvement addressing family issues and creates a mechanism for recovery.

7) **Implement Peer Services.** Peer services are valuable for adolescent clients but present many problems for implementation. The Task Force recommended that strong guidelines be developed for these services,, that the qualification of the Peer Mentor and scope of services is very clearly defined, the service is allowed only in a setting where formal or informal supervision is available (Mentor and Mentee are never alone together) and that strong management of the service is incorporated.

8) **Transition Intensive Outpatient and Partial Care structures to implement a Fee-for-Service (FFS) system for outpatient care which includes a full array of services and allows the provider to individualize the treatment.** The FFS network should allow the provider to be reimbursed for nine to fifteen hours of services each week which should include the following: Individual therapy, Group Therapy, Didactic, Family Therapy, Multi family Group, and Transportation. In-Home Services, Case Management and Peer Services would be implemented as described and this FFS Network was considered one option to make it available. Treatment should be tailored to meet the specific needs identified and addressed in all phases of assessment, treatment planning, service delivery, linkages, and recovery supports.

9) **DAS introduced the Learning Collaborative Model to the Task Force.** The goal of the Learning Collaborative is to build capacity among participant agencies. The Learning Collaborative provides an opportunity to strengthen affiliations among providers and systems, expand effective models of practice and identify service gaps. The Task Force concurred that the collaborative would provide additional resources in establishing a best practice integrated adolescent treatment system of care.

II. Workforce Development and Competent Treatment Subcommittee

This subcommittee recommends building a better qualified workforce specializing in adolescent treatment through the provision of competent clinical supervision and ongoing continuing education designed to meet the needs of treatment providers and the clients served.

1) **Develop an "add on" credential for adolescent treatment specialists.** The subcommittee recommends that agencies providing adolescent substance abuse treatment train their staff with a curriculum specific to adolescent core competencies using an Evidence-Based Practice provided by DAS. To sustain a qualified workforce in providing adolescent treatment for substance youth disorders, staff will receive clinical

supervision and ongoing continuing education designed to meet the needs of treatment providers and the clients they serve. Staff trainings will be documented in individual staff files.

III. Integrating Adolescent Systems Subcommittee

This subcommittee recognizes that in order for the substance abusing adolescent to succeed in treatment and maintain recovery, then collaboration, coordination and communication with other youth service systems must occur. Collaboration within and across systems eliminates redundancy and overlap of services and promotes comprehensive, integrated services for substance abusing adolescents. The overarching goal for adolescent treatment and integrated systems is empowering each adolescent to achieve abstinence and function within their community and family system as well as gain the tools needed to succeed as an adult. Additional recommendations include:

1) Distribute and train on the Department of Human Services (DHS) and Department of Children and Families (DCF) acronym list. All systems that work with substance abusing adolescents should understand the "language" of each system. This will help guide each system in responding to situations that arise when multiple systems are serving the same youth/family. Individuals in each system should know about their own system as well as other systems.

2) Implement a universal Strengths/Needs Assessment tool for youth discharged from treatment to ensure seamless transition back into the community. For example, a Substance Assistance Coordinator, or if one is not available, a school guidance counselor, can work directly with the systems serving the adolescent to develop a plan that identifies what the youth needs after discharge (i.e., wraparound services, recovery case management, linking with other systems, etc.).

3) An adolescent best practice integration of systems model should be built within the framework of the adolescent FFS model that was recommended by the Best Practices Subcommittee. Four areas should be considered when developing a FFS description tailoring treatment to adolescents: What are the treatment needs for the individual adolescent; How do we shape the current system within the FFS model to meet the needs of the adolescent regardless of which door the adolescent enters; How do we stabilize an adolescent back into the family/community setting; and What enhanced services will be included in the FFS model?

CONCLUSION:

The recommendations proposed by the Task Force and its subcommittees are essential to the process of developing a more competent system for substance abuse treatment of adolescents in New Jersey. DAS acknowledges the Task Force members for their commendable work and commitment. The Task Force members identified strengths and challenges in this system and recommended changes and improvements to service delivery, systems and workforce to enhance adolescent substance abuse treatment.