



PRACTICE GUIDANCE: ENGAGING YOUNG ADULTS AND THEIR FAMILIES IN TREATMENT

I. RATIONALE:

Nearly one quarter (23%) of BSAS admissions across all levels of care are young adults between 18 and 25 years of age – young people moving out of adolescence and into adulthood but not completely in either stage. They face a wide array of risks, including some greater than those faced by older adults. Young adults report higher rates of opioid use at admission than any other age group: two-thirds (66%) report heroin use, and nearly one-third (30%) report non-prescription opioid use.¹ More than half (56%) of young adults report needle use in the past year. The CDC recently reported that the rate of past-year heroin use increased more than 100% among those 18 to 24 years old, between 2002 and 2013.² Twenty to 24 year olds have the highest HIV incidence rates³ and a rapidly increasing incidence of viral hepatitis.⁴ Unintentional injury, including overdose⁵, suicide and homicide are the leading causes of death.⁶ Young adults are found to experience higher rates of problem gambling than older adults.⁷ Nearly two in ten (18.7%) young adults smoke cigarettes.⁸

This is also an age when mental health disorders begin to emerge, compounding effects of substance use. SAMHSA reports that at least one-fifth of youth admitted to treatment are diagnosed with a co-occurring mental health disorder⁹ BSAS admission data reflect SAMHSA's findings: more than a quarter (27%) of BSAS young adult admissions report mental health counseling; the same proportion report using medication for mental health problems; and 14% report mental health related hospitalization. However, other studies suggest that these reports provide only part of the picture. For example, a 2008 multi-site study¹⁰ across all levels of care found that on the basis of the Global Assessment of Individual Need (GAIN), 67% of young adults met criteria for a co-occurring mental health disorders.ⁱ

Within this population, data also suggest that LGBT and gender non-conforming young adults, facing homophobia, stigma and rejection, experience behavioral health disorders, including

¹ 2013 Admissions data drawn from ESM/EIM submissions.

² Centers for Disease Prevention and Control, Vital Signs: Demographic and Substance Use Trends Among Heroin Users — United States, 2002–2013, available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm64e0707a1.htm>

³ Center for Disease Control and Prevention, HIV/AIDS, Statistics Overview, <http://www.cdc.gov/hiv/statistics/basics/>. Accessed July 2015

⁴ MA/DPH Bureau of Infectious Disease Office of HIV/AIDS, Shifting Epidemics: HIV and Hepatitis C Infection among Injection Drug Users in Massachusetts (2010). Available as pdf at: <http://www.mass.gov/eohhs/docs/dph/aids/shifting-epidemics-report.pdf>. Accessed July 2015

⁵ Since 2000 opioid overdose deaths in Massachusetts, across all ages, have increased three fold. Data available at:

Massachusetts Injury Surveillance: Drug Overdoses and Poisonings at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/dmoa/injury-surveillance/reports/drug-overdoses-and-poisonings.html>; and City and County Level Overdose Data available at:

<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/city-and-county-level-overdose-data.html>. Accessed July 2015

⁶ CDC: <http://www.cdc.gov/injury/wisqars/leadingcauses.html>

⁷ Breyer, J.L., et al. Young adult gambling behaviors and their relationship with the persistence of ADHD. *J Gamb Stud.* 2009 June; 25(2): 227-238. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2775442/>

⁸ CDC, Current Cigarette Smoking Among Adults in the United States, available at:

http://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm

⁹ Adolescents with Co-occurring Disorders, SAMHSA, available at: <http://www.oas.samhsa.gov/2k5/youthMH/youthMH.pdf>, accessed July 2015.

¹⁰ Dennis, M. L., White, M., & Ives, M. L. (Eds.). (2009). Individual characteristics and needs associated with substance misuse of adolescents and young adults in addiction treatment. New York: Springer.

substance related disorders, at greater rates than their heterosexual peers.¹¹ These facts make a compelling argument for ensuring treatment responds effectively and comprehensively to young adults. BSAS is committed to a system of care for young adults that recognize that their life stage affects their risks, resources and paths to recovery. Given their presence throughout the system of care, providers at every level should be prepared to respond to the needs and the strengths of these young people and their families.

Effective treatment for young adults is an emerging field, as is understanding of young adults in general, but essential factors have been identified: ensuring treatment is developmentally responsive, engaging families, and applying a harm reduction framework.

Developmentally Responsive Treatment: Understanding developmental status of young adults is indispensable in responding effectively. A key to this understanding is recognition that ‘young adulthood’ is not a developmental stage entirely distinct from adolescence. Eighteen years of age as the marker of ‘adulthood’ is an artificial construct establishing a point of independence from parental control, and carrying certain rights and responsibilities, such as voting and acquiring debt. Developmentally, there is no distinction between a person who is 17 years 11 months, and someone who is 18, and there may be little developmental difference between an individual who is 16 and one who is 20. Thus research, best practices and recommendations often span ‘youth and young adults’, i.e. adolescence and young adulthood. Much of what we know applies to both groups.

The second key is understanding brain and cognitive development of late adolescence and young adulthood. Unevenness in brain growth and changes (some areas move ahead while others lag behind) results in limited capacity for abstraction and executive functioning, i.e., capacity to perceive risk, foresee consequences and delay action. The areas of the brain that support planning, anticipation, decision-making and accurate reading of social situations and emotional states are particularly delayed in relation to other areas such as motor and sensory development. Increased production of dopamine, a key neurotransmitter of the reward/satisfaction circuits, stimulates sensation seeking and risk taking. Dopamine in a sense ‘primes’ the brain to assess potential rewards and overlook potential risks. This increases susceptibility to substance dependence, since many substances also stimulate the reward/satisfaction circuits. In treatment, a substance dependent young adult may perceive few rewards in the prospect of abstinence.¹² The notion of ‘hitting bottom’ is unlikely to be persuasive. Nor would we want young people to experience the world of loss and sorrow that ‘hitting bottom’ often means. Rather, motivational approaches should identify and emphasize rewards that are meaningful to the young adult, for example, getting and holding a job, getting back in the good graces of a girl or boyfriend, being able to visit family, playing sports and engaging in other rewarding pursuits.

In addition, the normal adolescent process of ‘culling’ of synaptic connections¹³ -- the links by which one brain cell connects to another -- leads to weakening of previously learned behaviors, identity and values. This results in an unstable ability to transfer learning from one situation to another. During this period learning requires more reinforcement: repetition using varied forms of teaching and media.

Developmental lags do not mean that young adults are incapable of thinking things through and acting responsibly. It means they need structure and guidance to elicit their capacities for

¹¹ See A Provider’s Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender Individuals, SAMHSA, available at: <http://store.samhsa.gov/product/A-Provider-s-Introduction-to-Substance-Abuse-Treatment-for-Lesbian-Gay-Bisexual-and-Transgender-Individuals/SMA12-4104>; and BSAS Practice Guidance: Serving LGBT Youth and Young Adults and Their Families. Both accessed July 2015.

¹² NIDA: Drugs, brain and behavior: the science of addiction, available at: <http://www.drugabuse.gov/publications/science-addiction>

¹³ The result of this process in adults is greater mental focus, lower overall activation, faster reaction and better performance.

sound reasoning and understanding. Structure is often elusive in an economy where a young person's opportunities for rewarding, meaningful employment are limited, restricting access to resources that might support long-term commitments and stable lifestyles. Despite this, many in this age group make choices that demonstrate their capacities for responsibility and boldness – perhaps a 'flip side' of risk taking. More than two-fifths of Peace Corp volunteers are between 18 and 25, nearly half of those in the US military are between 18 and 30. In these and other organizations, young people undertake and carry out considerable responsibilities, demonstrating resourcefulness, resilience and dedication – evidence of desires for meaningful lives.

All of these developmental areas can be profoundly affected by personal characteristics and history. Loss, illness, injury and abuse can undermine capacities, while strong family connections, school success or economic opportunities can support them. Particular attention must be paid to experiences of trauma – including childhood abuse, community violence and combat exposure -- since these can inhibit ability to learn and remember, accurately read social situations, and assess risk. A trauma-informed approach is critical.¹⁴

The challenges and successes of this developmental stage suggest that a key component of treatment is establishment of clear, supportive structures – both in program design and in individual treatment relationships. Treatment providers will need to support young adults in making decisions, taking time to help them think through decisions, and expecting them to need repeated instructions and suggestions. Providers will need to respond to young adults with tolerance in the context of clear expectations and consequences. Abstinence may be gained through small steps, and response to relapse should focus on continued engagement in treatment.

In addition, helping young men and women to build a structure for meaningful lives can illuminate the possibilities of rewards in education, employment and nurturing relationships.

Engaging Families: A growing and consistent body of research documents improved treatment outcomes arising from family participation in treatment.^{15, ii} This is true even when the family is, or is perceived to be, alienated from the young adult (or vice versa). Family participation provides opportunities to more fully understand the young adult's life experience, resources and risks, address substance use in the family, and develop potential recovery supports. Understanding intergenerational patterns, whether of substance use or other challenges, may open possibilities of change and healing for all. Exploring the family's narrative can dilute resentment and blame, and help treatment staff frame family engagement in terms of recovery for the whole family.

Work with families involves education, outreach and engagement. Treatment providers should be prepared to help family members understand what is involved and needed in treatment and recovery, what is available, and how their participation can improve outcomes and support recovery. They may also need to recognize and respond to families' burnout and resistance to renewed hopes.

Family members may inquire about resources and possibilities when the young adult is not in treatment or when the young adult declines to consent to family involvement. In those cases, providers should be prepared to provide information about and referrals for supports and resources, while explaining confidentiality protections. Participation in family therapy can motivate the young adult's engagement in treatment, and family therapy and family support services should

¹⁴ See Resources section for information on trauma-informed practice.

¹⁵ Center for Substance Abuse Treatment. Substance Abuse Treatment and Family Therapy. Treatment Improvement Protocol (TIP) Series, No. 39. DHHS Publication No. (SMA) 05-4006. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004. Available at: <http://store.samhsa.gov/product/TIP-39-Substance-Abuse-Treatment-and-Family-Therapy/SMA12-4219>. Accessed July 2015

be made available, directly or through Qualified Service Organization Agreements (QSOAs), regardless of concurrent participation of the young adult in treatment.¹⁶

Knowledge of the variations among families – cultural differences, family roles, expectations, values, understanding of substance use, sexual orientation, gender identity and gender expression – is critical to engagement and should inform individualized approaches.

Young adults may define their own ‘families’, and may already have their own families, and be committed to partners and children. Nearly one-quarter of young adults admitted to treatment have children. Assessments and treatment planning will need to explore the status of these relationships and incorporate needed supports and services, such as parent-child visits, child care, parenting education, and early intervention, among others.

Harm Reduction: Given the risks young adults face, treatment approaches should integrate strategies that reduce negative consequences associated with substance use and other potentially injurious behavior. In terms of substance use, these strategies represent a continuum from safer use, to managed use, to abstinence. Harm and risk reduction open a range of options that individuals can define as attainable goals in terms of substance use and other risks, while allowing the young person to invest in treatment and recovery. Particular attention should be paid to addressing opioid use, sex and sexuality, and overall wellness.

Opioid Use and Dependence: Given the rates of opioid use and opioid overdose, a comprehensive approach is necessary, regardless of the level of care. Medication assisted treatment – through a variety of methods -- is well established as effective in treating opioid use disorders. The norm throughout the system of care should be well-defined QSOAs among providers to make medication assisted treatment available and to ensure smooth transitions, swift responses to referrals and well-coordinated care. Opioid overdose prevention, recognition and response should be integrated at all levels of treatment for the young adult, their families and significant relationships.

Sex and Sexuality: It is particularly important to address sexuality and risky sexual behavior. Nearly half of STD’s reported in 2013 were among those 15 to 24 years old; 20 to 24 year olds have the highest rates of gonorrhea and chlamydia infections.¹⁷ Sex is a prime example of behavior where perceived rewards vastly overshadow perceived risks. Staff must be confident and competent to address sexual behavior, sexuality, sexual orientation, gender identity and gender expression. Staff should be skilled in intervening ‘in the moment’ to promote safety – e.g., safe sex, safety from assaults, testing for STD’s, HPV vaccinations – and to intervene to ensure safety for gender non-conforming young adults.

Wellness: Comprehensive health and wellness programming goes a long way to supporting harm reduction. Through referrals (supported by QSOA’s) for physical health care, testing and vaccinations can be addressed as part of overall health assessments. Smoking cessation reduces risks of relapse and long-term health problems. Structured physical activities provide a sense of overall well-being while promoting health, this providing rewards that can be experienced physically.¹⁸

¹⁶ See: Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide. Available at: <http://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/principles-adolescent-substance-use-disorder-treatment>. Accessed July 2015

¹⁷ CDC Fact Sheet: Reported STDs in the United States: 2013 National Data for Chlamydia, Gonorrhea and Syphilis, available at: <http://www.cdc.gov/std/stats/default.htm>. Accessed July 2015

¹⁸ CDC National Center for Disease Prevention and Health Promotion, Physical Activity and Health, Adolescents and Young Adults, available at: <http://www.cdc.gov/nccdphp/sgr/adoles.htm>

II. GUIDANCE:

A. Organization:

Policy:

- Policy explicitly states agency's commitment to engaging young adults and their families, by providing:
 - Treatment that is responsive to developmental status;
 - Family education, therapy and supports either directly or through referral;
 - Participation of young adults and family members in program design and assessment.
- Policy describes agency's commitment to using a harm reduction approach to service provision, specifically that:
 - Continued participation in treatment is not contingent on uninterrupted abstinence;
 - Response to relapse focuses on keeping young adults and their families engaged in treatment.

Operations:

- Outreach efforts are directed toward youth and young adult venues including schools and colleges, community centers, neighborhoods, streets and homeless shelters.
- Agencies build collaborative relationships and referral systems within the BSAS System of Care to ensure smooth transitions.
- Agencies build collaborative relationships with
 - Local primary care and mental health providers, including DMH;
 - Early intervention and parenting service providers; and
 - Advocacy and cultural organizations.
- Collaborative relationships are established through Qualified Service Organization Agreements (QSOA) which specify:
 - Procedure for making and following up on referrals;
 - Identification of key contacts at each agency; and
 - Process for periodic evaluations of the collaboration.
- Agencies not providing medication assisted treatment establish QSOA's with providers of medication assisted treatment; QSOA's specify mechanism for care coordination.
- Agencies investigate innovative approaches including:
 - Flexible structures and schedules for services;
 - Use of technology and social media for outreach, for maintaining engagement and for ongoing recovery support;
 - Harm reduction and wellness programming, including smoking cessation; and
 - Methods of using existing payment mechanisms in creative ways, i.e. for off-site groups, phone 'therapy'.

- Agencies review communication systems such as voicemail and websites to reduce/eliminate complex communication (e.g. multi-step voicemail menus or website links)
- Websites, posters and brochures emphasize agency's commitment to youth and young adults by displaying images of diverse young people.
- Agencies actively engage families and other supportive relationships in treatment, directly or through QSOA's that is not contingent upon the young adult's concurrent participation in treatment.
- Agencies establish mechanisms for providing family therapies either directly or through QSOA referrals.
- Agencies monitor trends in youth and young adult alcohol and drug use and periodically evaluate services in light of changes.

Supervision, Training & Staff Development:

- Training and staff development efforts ensure staff are knowledgeable and skilled in applying knowledge about
 - Adolescent and young adult development, particularly effects of cognitive and neurological changes;
 - Gender differences in development and in effective treatment approaches;
 - Sexuality, sexual orientation, gender identity and gender expression¹⁹ as specific areas of youth and young adult exploration and development;
 - Motivational and harm reduction principles and strategies;
 - Trauma and trauma-informed services;
 - Cultural variations, including youth and young adult culture, cultural and family perceptions of roles and abilities of youth and young adults, and cultural influences on substance use and recovery;
 - Family systems and family therapy resources;
 - Youth and young adult gambling and problem gambling; and
 - Resources and requirements of Departments of Children and Families, Youth Services, Corrections, Mental Health and Massachusetts Rehabilitation Commission.
- Staff can apply knowledge in understanding and exploring:
 - Physical effects of alcohol and drugs on youth and young adults, e.g. effects on brain development and behavior.
 - Developmentally different processes of recovery, and relapse, for youth and young adults, e.g. young adult perceptions of risk or capacity to anticipate consequences, losses resulting from use are different from those of later adulthood.

¹⁹ See BSAS Practice Guidance: Serving LGBTQ Youth and Young Adults and Their Families, available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>.

- Staff are knowledgeable about and skilled in engaging young adults, their families and significant others, including knowledge about managing mobile devices and uses of social networking.
- Staff are knowledgeable about phases and processes of coming out for LGBT and gender non-conforming youth.
- Staff are trained in understanding opioid use and dependence and opioid overdose prevention, recognition and response.²⁰
- Supervisors explore staff beliefs and attitudes about young adults, sexual behavior, sexual orientation, and family participation in treatment.
- Supervision and staff training support application of family systems theory to work with young adults and their families, for example, in understanding how patterns of relationships and behaviors develop and how they can change.

B. Service Delivery and Treatment:

Assessment:

- Assessments include review of
 - Developmental status;
 - Sexual orientation, gender identity and gender expression;
 - Education and school experiences;
 - Employment history and experiences;
 - Current living situation, including length of time at current location and recent moves;
 - Trauma history, including child maltreatment, unintentional injuries, combat experiences;
 - Mental health status, including suicidality;
 - Gambling history;²¹
 - Family and other important relationships, including young adults status as parents and their relationships with their children;
 - Primary care relationships and current providers;
 - Current medications, conditions for which prescribed, status of prescription, contact information of prescriber;
 - Health and sexual health including risk of STD, HIV, HepC;
 - Overdose risk and history;²²
 - Individual's own goals.
- Assessments identify peers and adults who can provide committed support to the individual's recovery.

²⁰ See BSAS Practice Guidance: Integrating Opioid Overdose Prevention Strategies into Treatment, available at: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>.

²¹ Screening tools for gambling disorders, available at: <http://www.ncrg.org/resources/brief-biosocial-gambling-screen> and http://www.divisiononaddiction.org/bbgs_new/

²² BSAS Practice Guidance: Integrating Opioid Overdose Prevention Strategies into Treatment. Op cit.

Planning: Treatment Plans:

- Identify and establish coordination with individuals' significant relationships, schools, employers, primary care providers, and others who may promote recovery;
- Include participation by family; if individual decides that his or her family should not be contacted, plan specifies a date when this decision will be reviewed;
- Include services and resources that match the individual's developmental status and capacities, such as education, employment, additional assessments as needed;
- Include plan for obtaining physical health cares, including testing as needed, with individual's consent, for STD's, HIV and HepC;
- Are built on harm reduction approaches, identifying potential rewards in behavior change.

Service Provision

- Agencies employ practices shown effective with this developmental group,²³ e.g.:
 - Motivation Enhancement
 - Motivational Interviewing
 - Contingency Management
 - Adolescent Community Reinforcement Approach
 - Community Reinforcement and Family Training and other evidence-based family therapies (see Resources section).
- Staff use a variety of approaches to establish and maintain engagement including mobile devices, and are able to discuss ways to use mobile devices and social networking to support sobriety and recovery, as well as ways these resource might undermine recovery.
- Agencies incorporate physical activities and expressive opportunities (such as music and poetry) as treatment components, ensuring strong, engaged staff monitoring.
- Relapse prevention efforts focus on short-term planning, focusing on potential rewards in maintaining recovery as well as on risks, especially in social settings and interactions with peers.
- Psycho-educational programs are used in ways that reinforce learning, e.g. by addressing specific topics more than once, in different formats.
- Health education programs address sexuality and sexual health, focusing on harm reduction strategies.

Family Involvement: When the individual does not consent to family involvement, staff and individual establish plan to revisit this decision. Staff explain to family restrictions of 42 CFR Part 2, and provide family supports and services, directly or through referral. In all other cases, the following services are provided:

- Parents and significant others are engaged in treatment, either directly or through referral to organizations linked to treatment provider through QSAO; both QSOA and individual referrals include provision for care coordination.

²³ NIDA Principles of Adolescent Drug Abuse Treatment – Research Based Guide

<http://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide/principles-adolescent-substance-use-disorder-treatment>. Accessed July 2015.

- Staff provide information and explanations to family members about the BSAS System of Care, levels of care, referral process and community resources.
- Parent and significant other involvement in treatment is not contingent upon young adult entering or remaining in treatment and family services are provided, directly or through referral, even if young adult refuses or leaves treatment.
- Parents and significant others are informed of resources such as Learn to Cope, Section 35, and resources available on the BSAS website (see Resources listed below).
- Agencies employ therapies shown effective for families²⁴, such as:
 - Brief Strategic Therapy
 - Family Behavior Therapy
 - Functional Family Therapy
 - Multidimensional Family Therapy

III. MEASURES:

Programs can assess their effectiveness by examining data and information specific to their goals in applying standards. For example:

- Increase in established QSOA's with other care providers and regular reviews of effectiveness of reviews and referrals.
- Tracking:
 - Length of time in treatment;
 - Re-admissions, which are treated as indications of continued engagement;
 - Engagement of families.
- Periodic surveys of individuals served and their families.

IV. FORMS:

[Global Appraisal of Individual Needs](http://www.chestnut.org/li/gain/): An evidence-based assessment used in conjunction with a number of research studies and evidence based adolescent treatment approaches. For information: <http://www.chestnut.org/li/gain/>.

V: RESOURCES

All links accessed July 2015

Massachusetts:

MA-DPH-BSAS: Office of Youth and Young Adult Services:

<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/addictions/drugs-and-alcohol/youth-services.html>

OYYAS Resource Listing: <http://www.mass.gov/eohhs/docs/dph/substance-abuse/oyyas-directory-digital.pdf>

²⁴ ibid

Massachusetts Substance Abuse Information and Education Helpline: <http://helpline-online.com>, 800-327-5050.

BSAS Principles of Care and Practice Guidance:

<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/program-licensing/principles-of-care-and-practice-guidance.html>

Treatment Services for Youth and their Families

Serving LGBTQ Youth and Young Adults and Their Families

Responding to Relapse

Engaging Veterans in Treatment

Access for Persons with Disabilities

Integrating Opioid Overdose Prevention into Treatment

MA Opioid Overdose Prevention web page:

<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/prevention/opioid-overdose-prevention.html>

Opioid Overdose Prevention and Reversal Information Sheet:

In English: <http://www.mass.gov/eohhs/docs/dph/substance-abuse/naloxone-info.pdf>

In Portuguese: <http://www.mass.gov/eohhs/docs/dph/substance-abuse/naloxone-info-pt.pdf>

In Spanish: <http://www.mass.gov/eohhs/docs/dph/substance-abuse/naloxone-info-sp.pdf>

MA Opioid Overdose prevention core competencies:

<http://www.mass.gov/eohhs/docs/dph/substance-abuse/core-competencies-for-naloxone-pilot-participants.pdf>

Massachusetts Health Promotion Clearinghouse: provides free downloads and brochures on alcohol, drugs and other topics; available at: www.mass.gov/maclearinghouse or call 1-800-952-6637 (TTY: Use MassRelay at 711 or 1-800-720-3480).

Massachusetts Council on Compulsive Gambling: <http://www.masscompulsivegambling.org>, 800-426-1234.

Section 35: Massachusetts General Laws Chapter 123, Section 35 permits the courts to involuntarily commit someone whose alcohol or drug use puts themselves or others at risk. Such a commitment can lead to an inpatient substance abuse treatment for a period of up to 90 days.

To read the statute visit:

<https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter123/Section35>

For more information visit:

<http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/addictions/drugs-and-alcohol/section-35-faq.html>

Learn to Cope: Learn to Cope is an organization that hosts support groups for parents and family members dealing with a loved one with a substance use problem, particularly opiates and other drugs. Meetings are held weekly in several communities in Massachusetts. Training on overdose prevention, recognition and response, and naloxone kits are available through the meetings. For a list of meeting locations, and other information, go to:

<http://www.learn2cope.org>

Massachusetts Department of Mental Health:

Transitional Age Youth Initiatives: www.mass.gov/dmh/tay

Young Adult Resources: <http://www.mass.gov/eohhs/docs/dmh/publications/young-adult-resource-guide.pdf>

Massachusetts Rehabilitation Commission: <http://www.mass.gov/eohhs/gov/departments/mrc/>
UMass Medical School – Learning and Working During Transition to Adulthood:
<http://www.umassmed.edu/transitionsrtc>

Homelessness:

Massachusetts 211, search for shelters and resources at:
<http://www.mass211help.org/search.aspx>

Youth on Fire: <http://www.aac.org/about/our-work/youth-on-fire.html>

Bridge Over Troubled Waters: <http://www.bridgeotw.org>

Gay, Lesbian, Bisexual and Transgender Adolescent Social Services: Provides drop-in, sexual health screening and prevention, housing stabilization & case management, and a range of other services for GLBTQ youth and young adults. <http://www.jri.org/glass>.

The Massachusetts Commission on Lesbian, Gay, Bisexual & Transgender Youth: A Massachusetts Department of Public Health website providing resources for GLBT Youth. Statewide resources for GLSBT Youth and Young Adults. <http://www.mass.gov/cgly/youth.htm>

Peer Resources:

Massachusetts Peer Recovery Support Centers:
<http://hria.force.com/HelpLineSearch?id=a0PA0000006Hp2XMAS>

Young People in Recovery: Peer organization supporting organization of young adults into recovery 'clubs' <http://youngpeopleinrecovery.org>

Trauma Informed Care:

Substance Abuse and Mental Health Services Administration. *Trauma-Informed Care in Behavioral Health Services*. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 14-4816. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. Available at: <http://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816>

Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. Available at: <http://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884>

Evidence Based Family Therapies:

Brief Strategic Family Therapy: <http://www.bsft.org>

Family Behavior Therapy:
[http://www.nrcpfc.org/ebp/downloads/CommonlyUsedEPBs/Family%20Behavior%20Therapy%20\(FBT\)_8.22.13.pdf](http://www.nrcpfc.org/ebp/downloads/CommonlyUsedEPBs/Family%20Behavior%20Therapy%20(FBT)_8.22.13.pdf) Functional Family Therapy
<http://www.functionalfamilytherapy.com>

Multidimensional Family Therapy: <http://www.mdft.org>

Adolescent Community Reinforcement Approach (A-CRA):
<http://ebtx.chestnut.org/Treatments-and-Research/Treatments/A-CRA>

Community Reinforcement and Family Training:
<http://www.robertjmeyersphd.com/craft.html>

Gambling:

Gambling Problems: An Introduction for Behavioral Health Service Providers, available at:
<http://store.samhsa.gov/product/Gambling-Problems-An-Introduction-for-Behavioral-Health-Services-Providers/SMA14-4851>

Problem Gambling Toolkit, available at: <http://store.samhsa.gov/product/Problem-Gambling-Toolkit/PGKIT-07>

Other:

Supported Education Evidence-Based Practices (EBP) KIT: Provides information and resources for implementing supported education to enable consumers to pursue goals that have been interrupted due to symptoms of behavioral health conditions. Includes information on getting started, delivering services, and evaluation, available at:
<http://store.samhsa.gov/product/Supported-Education-Evidence-Based-Practices-EBP-Kit/SMA11-4654CD-ROM>.

Smart Phone Apps:

Gustafson, et al *Smart Phone App to Support Recovery from Alcoholism*
<http://archpsyc.jamanetwork.com/article.aspx?articleid=1847578>.

SoberGrid: A smartphone app for Android and IOS to assist sober people in connecting with each other. Visit: <http://www.sobergridapp.com>.

BSAS welcomes comments and suggestions. Contact: BSAS.Feedback@state.ma.us.

ⁱ Y.Chen et al. Prevalence and comorbidity of major internalizing and externalizing problems among adolescents and adults presenting to substance treatment. *Journal of Substance Abuse Treatment* 34 (2008) 14-24.

ⁱⁱ For a review and summary of research on family involvement see: Steinglass, P. Family systems and motivational interviewing: A systemic-motivational model for treatment of alcohol and other drug problems. *Alcoholism Treatment Quarterly*. 2008, 26:1-2, 9-29; and Springer, David W.; McNeece, C. Aaron; Arnold, Elizabeth Mayfield; Family Based Treatment. *In: Substance abuse treatment for criminal offenders: An evidence-based guide for practitioners*. Springer, David W.; McNeece, C. Aaron; Arnold, Elizabeth Mayfield; Washington, DC, US: American Psychological Association, pp.69-85, 252, xiii. [Chapter]. Also: Hornberger, S. and S. L. Smith. Family involvement in adolescent substance abuse treatment and recovery: What do we know? What lies ahead? *Children and Youth Services Review* 33 (2011) 570–576
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