Mountain Manor Treatment Center—Baltimore:

Manual for a Short-Term Residential Treatment Program for Adolescent Substance Use Disorders

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INTRODUCTION

Mountain Manor Treatment Center—Baltimore (MMTC) was founded in 1989 and is part of Maryland Treatment Centers, a larger and older system of behavioral healthcare programs for adults and adolescents in Maryland. MMTC is an urban community substance abuse treatment provider with a mission to serve inner-city Baltimore, public sector, agency-involved (juvenile justice and social services), and impoverished youth who characteristically have been underserved by inadequate and scarce treatment resources. MMTC strives to provide consistent, high-quality, chemical dependence treatment with a program that offers an individualized continuum of care for adolescent patients and their families.

To meet this ambitious goal, MMTC offers a continuum of services, including short-term residential, day treatment (partial hospital), intensive outpatient, and outpatient levels of care. In order to address the many domains that may be affected by substance use disorders, MMTC also provides special education day school, mental health services, medical care, and family therapy. Although many levels of care are available at MMTC, this manual concentrates on the **short-term residential treatment** program (Fishman et al., 2003).

MMTC's target population is characterized by youth with a high severity of substance abuse and youth who are often found to be refractory to previous treatment interventions. In addition, this population has high rates of emotional/behavioral symptoms, co-morbid psychiatric disorders, social and economic deprivation, and significant functional impairment across several psychosocial domains. In order to care for these challenging patients, MMTC has developed a short-term residential treatment program designed for adolescents who require a high-intensity level of care for substance use disorders. The program has core treatment elements to address issues common to most adolescents with substance use disorders, and it provides additional services that allow for the implementation of individual recovery plans targeted to unique patient needs and the combination of impairments that may hinder their recovery.

This manual describes MMTC's patient population, core treatment program, integrated spectrum of special services, and infrastructure. The manual was prepared under the auspices of the CSAT Adolescent Treatment Models (ATM) initiative, a multisite, national effort to identify promising models of adolescent substance abuse treatment. The Baltimore ATM project also included a treatment outcomes study, results of which will be published elsewhere. Data presented in this manual were derived from the ATM study data set and reflect a representative sample (n = 153) of MMTC patients admitted during the period from June 1999 to June 2000.

CHAPTER 1 OVERVIEW OF THE MMTC SHORT-TERM RESIDENTIAL PROGRAM

MMTC Residential Patient Population

Demographics

Approximately half of all MMTC patients reside in Baltimore City. Because of the scarcity of adolescent treatment services in the area, MMTC's geographic catchment area extends to the broader region surrounding Baltimore and to nearby metropolitan Washington, DC. Patients are also drawn from various counties throughout Maryland, as well as the adjoining States of Delaware and Virginia.

Referrals come from the juvenile justice system, other government agencies, outpatient treatment providers, schools, parents, and a variety of other sources. More than half (54%) of the participants in the ATM study were referred to treatment by the courts, and two-thirds (66%) had been incarcerated during the 90 days immediately prior to admission.

MMTC's average daily census is 65 patients. That census is of mixed gender and is approximately two-thirds male and one-third female. The age range is from 11 to 20, with an average age of 16. There is a separate young adult track for patients aged 18 to 20. The racial composition of the program is roughly one-third African American and two-thirds Caucasian.

MMTC Patient Demographics

- *Census: The program averages 65 adolescents, from Baltimore and surrounding communities*
- *Ages range from 11 to 20*
- *Average age is 16*
- *2/3 are Caucasian*
  1/3 are African American
- *2/3 are male*
- *54% are court referred*
- *71% are not in school*
- *53% live with parent(s)*

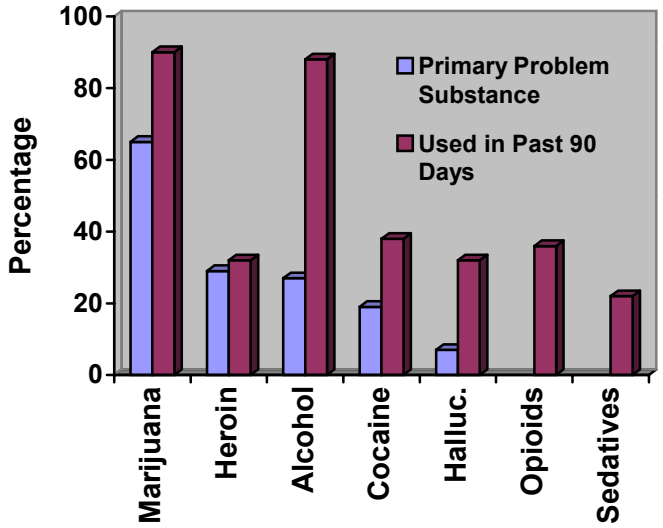
The primary funding source is Medicaid, followed by commercial insurance, State agencies (such as juvenile justice) for adolescents in their care and custody, and a small State program that provides supplemental funding for uninsured or underinsured "gray area" adolescents.

Most patients have impaired psychosocial functioning across several domains. Many have a history of high-risk sexual behavior and memory problems. Most patients have some level of legal involvement. The majority of patients have family and educational problems. Only 53% are currently living with a parent, and only 29% are in school.

Drug Use Characteristics

Figure 1 illustrates the drug use pattern of MMTC's patients for the 90-day period prior to admission. Marijuana is the most prevalent drug of abuse. A sizable percentage of patients report the use of a variety of illicit drugs other than marijuana. Specifically, many high-severity adolescents report needing treatment primarily for heroin (29%) and cocaine (16%).

Figure 1. Substance Use on Admission to MMTC



Most are high-frequency users, and many use daily. Approximately 96% have used substances on 15 or more days in the 90 days preceding admission (a categorical threshold criterion used as an index of severity). The great majority of patients (91%) meet criteria for the full syndrome of substance dependence.

As is typical of adolescents, most are poly-drug users. Many meet criteria for poly-drug dependence, even if they do not meet criteria for dependence on any single drug. Even those who do not meet criteria for dependence have experienced very severe degrees of impairment associated with their drug use.

Marijuana is the most prevalent drug of abuse. Sixty-five percent need treatment for marijuana dependence, 29% for heroin dependence, and 16% for cocaine dependence.

Most of the patients (71%) have had one or more prior treatment episodes. Nearly half (46%) have participated previously in residential treatment.

Many of the patients present with co-occurring mental and behavioral disorders. Over half (56%) have had prior psychiatric treatment, and 80% report being significantly disturbed by mental or psychological problems during the past year.

MMTC's primary focus is to provide a continuum of individualized, high-quality services to high-severity, inner-city youth with substance use disorders. The program's goal is to address substance abuse and the wide range of associated problems in order to decrease the degree of impairment, support adolescent development, and restore productive functioning.

Core Treatment Components

MMTC Centralized Linkage Model

Core Treatment Components
- *Traditional medical model*
- *Milieu therapy*
- *Adolescent adaptation of 12-Step model*

Special Services Components
- *Primary medical care: assessment, treatment, and education*
- *Psychiatric evaluation and treatment*
- *Educational/cognitive assessment and remediation*
- *Legal/conduct rehabilitation*
- *Family support services*
- *Young adults program*
- *Continuity of care discharge program*

The core components of the residential treatment program are part of every patient's experience at MMTC. MMTC provides a high-intensity 24-hour treatment program, combining elements of the traditional medical model, milieu therapy approach, and an adolescent-specific adaptation of the 12-Step model.

Medical Model

The MMTC philosophy asserts that addiction is best considered as a chronic relapsing condition. Dependence can be reliably diagnosed and is defined in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) (DSM-IV) (American Psychiatric Association, 1994) as a pathologic condition that is manifested by a compulsive desire for the drug (or drugs), despite serious adverse consequences. It has been demonstrated that this chronic condition is amenable to medical treatment (McLellan, 2002). Because MMTC considers addiction to be a treatable chronic medical condition, one of the core treatment components is based on a traditional medical model. MMTC's medical component is directed by professional clinicians who employ individualized evaluation, monitoring, and diagnosis-based treatment interventions. Overall direction of the treatment team is provided by a psychiatrist with adolescent expertise and additional certification in addiction medicine. Initial substance use, medical, and psychosocial assessments are performed by an interdisciplinary team consisting of a nurse, physician, substance abuse counselor, and education specialist.

In addition to the diagnosis and treatment of substance use disorders, some patients require medical monitoring and/or intervention for conditions associated with drug use, as well as pre-existing medical conditions unrelated to their drug use. Some adolescents require fairly intensive medical management of their withdrawal symptoms. These individuals are managed by the medical staff with the aid of objective observation tools and frequent monitoring of signs and symptoms of withdrawal. Pharmacological treatments (e.g., substitute agonist tapers) are used during acute opiate or alcohol withdrawal. Special emphasis is placed on supportive care and comfort. Expectations of treatment participation and compliance are greatly reduced during detoxification in recognition of the clinical status and level of severity of debilitating symptoms.

Patients are screened and treated for medical complications common to drug-abusing populations, such as hepatitis, tuberculosis, HIV, and other sexually transmitted diseases

(STDs). Patients are also monitored, and their treatment is coordinated with their primary care physicians for pre-existing conditions, such as diabetes and sickle-cell anemia.

Additionally, many patients have co-occurring psychiatric disorders. These are identified and treated onsite. This service is described in more detail in the Special Services Components section.

Milieu Therapy Approach

Adolescents can be greatly influenced by their peers, both negatively and positively. The therapeutic milieu, with its powerful peer group influences, is one of the program's most important discovery tools. The MMTC program incorporates some features of the therapeutic community (TC) model, which employs programmatic techniques that emphasize the group milieu as the locus of recovery. Specific goals from the TC repertoire are incorporated into MMTC's core therapy and are based on using the community group as the agent of change. These goals include the following:

- Normalizing of peer and other interpersonal relations
- Practicing developmentally appropriate social roles
- Social skills acquisition
- Learning peer support and confrontation skills
- Learning non-aggressive, pro-social assertiveness and conflict resolution skills.

The overarching goal of the therapeutic milieu is the induction into a healthier peer group and a positive group identity that emphasizes recovery and overcoming adversity.

12-Step Model

Originally, the MMTC program drew extensively from the methods of 12-Step facilitation. This remains a central theme, with close ties to the 12-Step fellowship, a strong emphasis on induction into Narcotics Anonymous/Alcoholics Anonymous (NA/AA) participation, and onsite and off-premises NA/AA meetings. Approximately half of the clinical staff is composed of individuals in recovery.

The 12-Step facilitation has been adapted to the developmental and cognitive levels of MMTC's adolescent patients. The program has established a connection to a network of community NA/AA meetings and potential sponsors that specialize in engaging young people. Additionally, the traditional 12-Step approach has been adapted through a developmentally appropriate translation of the core concepts contained in the first 4 steps, including

1. Acknowledgement of a substance problem and unmanageability

2. Acknowledgement of the need for help

3. Recognition and acceptance of useful sources of help—such as treatment, family, school, mentorship, and a network of sober supports and friends

4. Development of a searching and fearless (courageous) moral inventory.

In summary, all MMTC patients receive the core components that are based on a combination of the medical model, therapeutic milieu, and an adolescent-focused adaptation of the 12-Step model to help meet their therapeutic goals. Not only does each patient receive a comprehensive individualized assessment and treatment plan with individualized goals based on his or her unique matrix of needs, but they also gain skill and strength by meeting certain common programmatic goals as members of the community that shares a set of common needs and goals.

Special Services Components

It is MMTC's philosophy that one style or form of substance abuse treatment does not fit all. Although the core components are necessary, they are not sufficient to address the unique matrix of needs seen in MMTC's adolescent population. MMTC's residential program addresses this issue by using a strategy of *centralized linkage*, linking the core components with several key adjunctive treatment components to address impairment in different psychosocial domains. This model is based on the concept that adolescent addiction is embedded in the developmentally dictated, major functional domains of adolescent daily life. Functional deficits in these major domains act as critical sustaining factors for addiction, contributing to a cycle of progressive severity and impairment. MMTC's approach targets these psychosocial domains as crucial areas for functional rehabilitation, with rehabilitative (or habilitative) therapeutic interventions aimed specifically at each. These psychosocial domains are as follows:

- Medical/health status
- Emotional/psychiatric status
- Educational/cognitive status
- Legal/behavioral status
- Family/recovery environment status.

The special services to address these domains in the centralized linkage model are built into the MMTC program and are central to the purposes of the program as a whole. Below is a description of the special services offered at MMTC.

Primary Medical Care: Assessment, Treatment, and Education

Primary medical care is both a core component and a special services component, depending on the needs of the patient. The program's target population includes a high proportion of patients with a variety of health problems and health risk behaviors. Because of the chaotic lifestyle associated with substance use disorders, and because many come from chaotic families, most patients have not had adequate primary health care screening and treatment. Those with chronic or episodic medical conditions have usually engaged in health care

services in a haphazard fashion. One of the program's special components is medical evaluation, treatment, and referral.

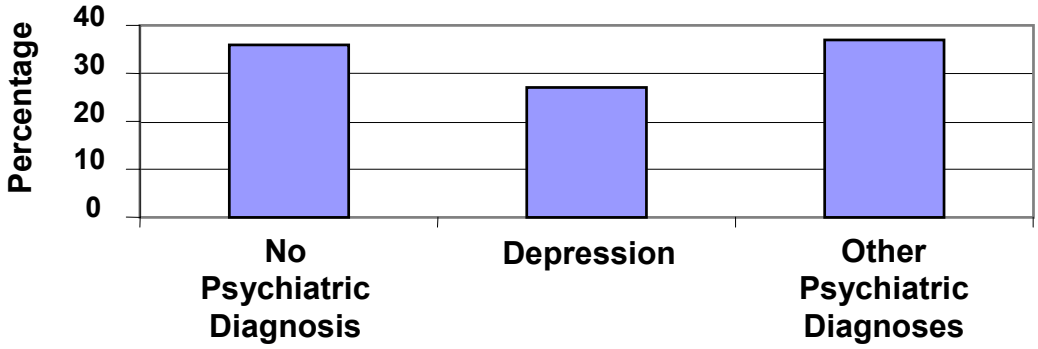
Comprehensive medical care and skilled nursing care are provided for all residents in the program by a team of physicians, physician assistants, and licensed nurses. Every patient receives a complete physical examination, as well as an evaluation of their health history and health risk behavior. All patients receive screening for STDs, substance use, and immunization status; girls also receive gynecologic screening. MMTC provides assessment, monitoring, and treatment for most common health conditions and attempts to identify and coordinate with any previous community providers.

One of the goals of this component is to promote health awareness among the patients and to reinforce their role in their own primary health care. They receive instruction on a wide variety of health and risk-behavior topics. Considerable effort is made with each patient's family to identify and make arrangements for a regular source of primary health care as part of discharge planning. Every patient receives a referral appointment to the identified primary care provider soon after discharge.

Psychiatric Evaluation and Treatment

It is well documented that adolescents with substance use disorders are at considerable risk of having co-morbid psychiatric disorders (Kandel et al., 1999). The program's target population includes a high percentage of patients with severe emotional disturbances and/or psychiatric disorders (Figure 2). Some have been diagnosed and treated prior to admission; many more are diagnosed and treated while in the program. Approximately 33% of patients receive pharmacotherapy for psychiatric disorders (the most common being depressive disorders, attention deficit/hyperactivity disorder, and bipolar disorder).

Figure 2. MMTC Adolescents With Substance Use Disorders and Co-Occurring Psychiatric Disorders



In many cases, it is difficult to differentiate the symptoms of various autonomous disorders from substance-related symptoms, and with most there is broad overlap. Counselors are cross-trained in the recognition of symptoms and syndromes, and they are instructed in making referrals to in-house psychiatrists as needed.

Psychiatric evaluations, treatment, and treatment team meetings are provided by psychiatrists who specialize in adolescent addiction psychiatry. The program is designed to manage a considerable level of psychiatric acuity. The psychiatric treatment also includes various psychotherapeutic strategies implemented and supervised by psychiatrists and/or psychologists. Staffing includes 24-hour nursing, which permits the administration of medications, as well as skilled around-the-clock observation and monitoring of symptoms and treatment response. Other critical treatment elements are the staff training, supervision, and culture, creating a therapeutic milieu that can tolerate and manage severe psychiatric symptoms (e.g., disorganized and agitated behaviors, self-injurious behaviors, suicidal threats). Specialized training and procedures are used for behavior management as needed, including de-escalation techniques, specialized risk assessments, special observation precautions, "prn" (intermittently, as needed) medications, and, rarely, therapeutic holds. Psychologists with expertise in adolescent addiction also perform psychological assessments for cognitive and emotional functioning.

The psychiatric program component includes a significant emphasis on post-discharge linkages to further mental health care, including expedited referrals to outpatient treatment. Given the relative high psychiatric acuity of many of the patients, some patients need to be transferred to residential specialty psychiatric treatment, and the treatment team has developed close working relations with a variety of other community providers.

Educational/Cognitive Assessment and Remediation

Data from the Baltimore ATM study indicate that most patients (71%) are not currently attending school. MMTC believes that it is important to reinforce the role of school as one of the developmentally appropriate central activities of an adolescent's daily life. All patients undergo an educational assessment and attend school onsite during their stay at MMTC.

The population of MMTC includes many patients with severe cognitive and educational disturbances. Many have dropped out of school or have been expelled from school because of their drug use and/or related behavioral difficulties. Many others, though not formally disenrolled, have simply stopped attending or attend sporadically. Even when they do attend school, they are often intoxicated or recovering from a drug use episode to the point that participation and performance are severely impaired. Many suffer from persisting substance-related cognitive impairment, usually reversible, but sometimes long lasting.

One purpose of this component is to reinforce the role of school as a developmentally appropriate central activity in an adolescent's daily life and to model school participation and achievement as a critical part of recovery. Each MMTC patient undergoes a full educational evaluation, including a battery of testing, a review of school records, and a review of an individualized educational plan (IEP) if the patient has been previously identified as a special education student. Often, cognitive limitations and/or learning disabilities have gone unrecognized in the student's past. Cognitive and academic achievement evaluations help clarify patient functioning. Careful consideration is given to individual capacities so that the in-treatment educational experience can enhance self-esteem and provide positive reinforcement for the role of the student.

The MMTC program includes a full school with 3 hours of programming daily, which is considerably more than that provided by most short-term residential placements under typical "home and hospital" teaching requirements. The content of the school curriculum is carefully linked to the overall treatment program, including the following: recovery-oriented materials, such as biology and health sciences of drug use; reading skills, using NA and other recovery materials; and writing skills, using life-story essays and Step-work. The school is certified by the Maryland State Department of Education and directed by a specialist in adolescent treatment and special education. Because of the certification and staffing, the school is formally able to transfer credits.

Another major focus of the curriculum is pre-vocational and life-skills training, which includes interview training, money management, and role-playing. School may be an untenable situation for some students. Some have been permanently expelled, some cannot tolerate a normal classroom setting, and some are too old to return to high school. Therefore, MMTC provides a general equivalency diploma (GED) preparation track and vocational referrals for these patients. No patient is exempt from continuing his or her education or embarking on a vocational training path.

Effort is made to coordinate with each student's home school, so that a patient can earn credits for educational work while in treatment, and to facilitate the eventual reintegration of the recovering student into the home school environment. Efforts are also made to support, coach, and prepare materials to navigate the admission, review, and dismissal (ARD) process to obtain special education services where needed.

Legal/Conduct Rehabilitation

The program's target population includes a high proportion of patients with histories of delinquent behaviors and juvenile justice system involvement, and many patients meet criteria for disruptive behavior disorders. More than half of the patient population have been court-ordered into treatment. Many have been in detention and/or have active legal involvement, including probation or pending charges. The majority of MMTC's patients have been involved extensively in illegal behaviors beyond drug use (including theft, assault, and trafficking), whether or not they have been involved in the juvenile justice system.

One of the special program components is a thorough legal evaluation and remediation of legal and conduct problems. For those patients with current legal involvement, their legal status becomes a crucial treatment tool. For example, the probation officer becomes an important member of the team, using potential legal sanctions as both an incentive and a consequence to shape treatment engagement and response. Detailed reporting to judges is the norm, and staff members occasionally

Most patients are involved in illegal behaviors, and more than half have been court-ordered into treatment. Because the program works with probation officers, potential legal sanctions often serve as an incentive for treatment engagement and behavior change at MMTC.

accompany patients to court. Active coordination with the courts is often helpful with aftercare plans. Sometimes probationary mandated outpatient care for the ambivalent adolescent is enough leverage to prolong abstinence and treatment compliance.

Staff members are trained in conduct remediation. This engenders a therapeutic milieu that not only can tolerate and manage some degree of behavioral disturbance (as opposed to many treatment centers that discharge patients for insubordination or disruption), but also control and reshape it. The patterns of severe behavioral disturbance that are reflected in the patients' histories are frequently expressed as disruptive behavior in treatment. Some patients may display behaviors such as oppositionality, aggression, making threats, fighting, possession of contraband, substance possession and usage, excessive horseplay, tantrums, inappropriate sexual activity, and theft. Because these behaviors are inextricably connected to patients' drug use and to their capacity for treatment response, these behaviors, when they occur, are critical target symptoms for the treatment program. On the one hand, the maintenance of a safe, orderly treatment environment models the expectation of mutually cooperative and pro-social behavior. On the other hand, tolerance of some degree of disruption and developmentally appropriate adolescent frenetic energy sets a more real world atmosphere and acknowledges that longstanding patterns of behavior do not change overnight.

A systematic behavioral contingency plan and therapeutic milieu reinforce positive behaviors, decrease negative behaviors, and incorporate prosocial behavior as important community values.

A systematic behavioral contingency plan is used (with rewards, consequences, and frequent feedback) to reinforce positive pro-social behavior and extinguish negative behavior. To obtain "levels," the patient must complete 12-Step recovery assignments and engage in appropriate pro-social behavior. The various levels of achievement are linked to privileges. Patients must, themselves, practice self-assessments of their own behavior, as well as seek out and obtain formal feedback and approval from numerous staff members and peers in order to earn their levels. Individualized behavior contracts are sometimes used for patients with particular difficulties. Patients also participate in a variety of conduct-focused specialty groups, such as a dealer's group, values clarification, anger management, and/or peer conflict mediation.

In addition to managing behavior, the therapeutic milieu transmits the notion that appropriate behavior, respect, and mutual support are community values. It is a recurrent theme in discussions at regularly scheduled and impromptu community meetings at which the community as a whole must take responsibility for individual behavior and everyone shares responsibility for his or her brothers and sisters. This aspect of the program borrows heavily from the TC approach, with its philosophy of "right living." Important goals include an introduction to the following: acquisition of group living and conflict resolution skills, rehabilitation/habilitation of activities of daily living, and an articulation or clarification of values. The therapeutic milieu itself serves as an agent of change, gradually allowing adolescents with unregulated behavior and emotions to begin the process of internal self-regulation, by using the milieu's intensive external structure as a tool. This structured milieu also models aspects of external structure and features of a recovery environment that the adolescents will use in their home, school, and other systems following discharge.

Family Support Services

It is MMTC's goal to bring families together to reinforce the importance of parental attitudes, monitoring, and supervision in controlling adolescent drug use and problem behaviors. Each patient has a family evaluation, and all families are expected to participate in family therapy.

The program's target population includes a high proportion of patients with disrupted or impaired families. Many have home environments that are not conducive to recovery, because parents are absent, not supportive, or not effective at setting limits, or have their own substance abuse problems. Many come from neighborhoods that are drug infested. One goal of this component is to bring families together and reinforce the importance of parental attitudes, monitoring, and supervision in controlling adolescent drug use and problem behaviors. While identifying family impairment and training parents (and surrogate parents), it is also crucial to recognize and emphasize the assets that each family member brings, in order to win the family over to active treatment participation.

Each patient receives a thorough family evaluation. Supervised visiting occurs each weekend, preceded by a mandatory multi-family group session with both didactic and interactive components. Additionally, each family is expected to participate in individual family therapy sessions, both with and without the patient. These sessions are conducted by the patient's primary counselor/case manager throughout the week. The counselors also rotate through the weekend schedule, to have greater access to families who work or live far away. Families may be difficult to engage because of chaotic conditions, lack of readiness to change, or practical barriers to participation, such as work scheduling or lack of transportation. To overcome these barriers, MMTC offers transportation for families, and counselors often use the telephone for family therapy and contact.

Re-integration into the community is another goal of the family component, with planning for discharge beginning as soon after admission as possible. The family home treatment contract is an important tool for reinforcement of the need for structure, continuation of the model of behavioral contingency begun in treatment, and reinforcement of commitment to ongoing outpatient treatment. Unfortunately, there are some patients who do not have viable home situations. For these patients, the focus shifts to finding alternative recovery environments. An effort is made to identify alternative resources within the extended family. It is also considered part of the scope of family therapy to help extended families with planning in such difficult processes as custody and public benefits.

Therapeutic mediation among adversarial family members is sometimes necessary. Occasionally, evaluation and referral of impaired family members are necessary, and more often than one would like, patients require placement in other residential treatment settings, such as group homes, foster care, extended treatment, or sheltered care programs. Family therapists may assist with financial arrangements, preparation of referral materials, and coordination among families, agencies, payers, and therapists.

Young Adults Program

MMTC maintains a separate treatment program track for young adults aged 18 to 20, with 17-year-olds sometimes included on the basis of maturity. This track consists of 10 to 15 young adults who are separated from the younger patients for most of the day and receive programming that is more suitable to their developmental level. There is special emphasis on issues related to the transition to adulthood and independent living. It also reinforces their group identity and gives them a kind of special status as being different from the "little kids." Placement in this program helps them to accept that they are emerging adults and that they are expected to take real responsibility for their behavior and choices.

The young adult program is operated in one of MMTC's main buildings in an area that is physically distinct from that of the younger adolescents. The young adult unit serves as the living quarters for the male young adults, as well as program space for both males and females. The young adults are allowed more intergender contact than the younger patients. They are also generally afforded a greater degree of freedom, with periods of less intensive structure, with an overall emphasis on learning self-regulation skills. Whenever possible, the young adults are encouraged to have a special community leadership role, including peer mentorship for the younger patients. For many of the young adults, the educational programming is less prominent, focusing on pre-GED and/or vocational instruction and referral.

Continuity of Care Discharge Program

Residential treatment is often the first step in the recovery process. In order to support ongoing recovery, MMTC makes discharge plans that are unique to each patient, ensuring that treatment gains are not lost and that the patient has the continued support necessary to achieve his or her goals. It is the expectation that most patients will continue their care either in MMTC's partial hospitalization program or intensive outpatient program, or in another community substance abuse treatment program, depending primarily on geographical proximity. The goal of this special component is to make the transition to another level of care a smooth one.

The majority of discharged patients remain in the MMTC system in the partial hospitalization program, intensive outpatient program, and/or HealthQuest (an integrated mental health outpatient clinic). For those patients who are not planning to continue treatment at MMTC, referrals to other outpatient substance abuse programs and specialty outpatient treatments (such as family counseling, mental health counseling, or psychiatric care) are made. On the basis of the centralized linkage model, emphasis is placed on decentralizing patient information and care at discharge. Linkages to community services in each of the adjunctive treatment domains, with referrals, communication of treatment goals, and sharing of treatment records, are important in successful community re-integration. In particular, this can include the following: referrals to outpatient psychiatric providers and/or primary care medical providers, coordination of return to or re-enrollment in community schools, coordination of involvement by probation officers and the courts in mandated

treatment plans, and explicit expectations for family participation in ongoing treatment, supervision, and monitoring.

Discharge planning also facilitates the youth's support and identification with the community. An effort is always made to connect adolescents to the culture of NA/AA through youth-specific NA/AA meetings and home groups. It is hoped that they will continue to attend meetings and make use of this community support after discharge.

Summary

MMTC is a short-term residential addictions treatment program for adolescents. MMTC's mission is to provide a high-quality, individualized continuum of care to high-severity, inner-city youth with substance abuse disorders. MMTC's goal is to address substance abuse and the wide range of associated problems to decrease the degree of impairment, support adolescent development, and restore productive functioning.

Each patient receives the core treatment components, which are based on a combination of a traditional medical model of assessment and treatment, a milieu therapy approach, and an adolescent-specific adaptation of the 12-Step model. In addition, the program provides individualized treatment that targets multiple domains of impairment through a centralized linkage model with an array of special services. These special services include the following: psychiatric evaluation and treatment, psychological evaluation, educational/cognitive remediation, legal/conduct rehabilitation, family support services, primary care medical assessment, treatment, education, a young adults program, and a continuity of care discharge program.

These core and special components enable the program to address the needs of a wide spectrum of youth, especially those with high severity of drug involvement, a variety of co-morbid psychosocial and psychiatric impairments, and histories of treatment failure. The program operates within a broad and integrated continuum of services, providing ongoing treatment at various levels of care, enabling patients to sustain therapeutic gains begun in the residential program.

CHAPTER 2 IMPLEMENTATION OF THE MMTC SHORT-TERM RESIDENTIAL PROGRAM

The previous section described the goals, philosophy, and treatment components of the MMTC residential adolescent substance abuse treatment program. This section delineates the process of implementing MMTC's approach.

Admissions Coordination

Admission Criteria

MMTC receives referrals from many sources, such as community treatment facilities (e.g., psychiatric hospitals and clinics, other substance abuse treatment centers), State and Federal agencies (e.g., Maryland Department of Juvenile Justice), and family/self. First, it is important to determine the appropriateness of MMTC residential treatment. This process begins with the referral source.

Admission Criteria

- *Catchment area is Maryland; Delaware; southern Pennsylvania; Washington, DC; and northern Virginia*
- *Ages 12 to 20*
- *Meet ASAM Patient Placement Criteria for medium-intensity (Level III.5) or high-intensity (Level III.7) residential treatment—DSM-IV criteria for substance-related disorders and at least two of the six ASAM dimensional criteria*

The catchment area for MMTC is primarily all of Maryland; Delaware; southern Pennsylvania; Washington, DC; and northern Virginia. The referring source is routed to the admissions specialist to determine the appropriateness of treatment at MMTC. All patients must be between the ages of 12 and 17 for adolescents and 18 and 20 for young adults. Patients must have a primary diagnosis of alcohol or drug dependence, but they may also have a secondary mental health diagnosis. They must be sufficiently stable so that they are not a danger to themselves or someone else. Patients with a history of violence, sex offenses, or setting fires are individually evaluated for appropriateness.

Additionally, patients must meet specifications set forth by the American Society of Addiction Medicine (ASAM) for the adolescent Patient Placement Criteria for Level III medically monitored intensive inpatient treatment (Mee-Lee et al., 2001). The MMTC residential treatment program is appropriate for ASAM Level III.5 (clinically managed medium-intensity residential treatment) and Level III.7 (medically monitored high-intensity residential treatment). (The ASAM Level system is not to be confused with MMTC's level system of behavior management, described above.)

To qualify for ASAM Level III.5 and III.7 placement, the adolescent must meet the DSM-IV criteria for substance-related disorders (American Psychiatric Association, 1994) *and* meet at least two of the six dimensional criteria from the ASAM assessment dimensions.

Even considering these specific criteria, it is sometimes difficult to determine appropriate treatment placement for some adolescents. The admissions team consults with the administrator and/or the medical director for the appropriateness of admission for questionable candidates. The administrator and other selected staff members may conduct an information-gathering interview prior to the formal admission process. Once the appropriateness of treatment setting has been established, the admissions team gathers basic demographic, clinical, and funding coverage information. A utilization review nurse will meet with prospective patients if funding issues arise or if there are questions related to the appropriateness of admissions. A utilization review form is used to gather data to formulate diagnostic impressions and placement on the ASAM criteria.

ASAM Dimensional Criteria

1. *Acute intoxication and/or withdrawal potential*
2. *Biomedical conditions and complications*
3. *Emotional, behavioral, or cognitive conditions and complications*
4. *Readiness to change*
5. *Relapse, continued use, or continued problem potential*
6. *Recovery/living environment*

Once it is established that residential treatment is appropriate, authorization from primary or secondary funding sources must be obtained prior to admission. Funding sources include Federal Medical Assistance, State of Maryland Health Choice Managed Care Organizations, contracted insurance carriers, State of Maryland Alcohol and Drug Abuse Administration, Maryland Department of Juvenile Justice, Maryland Department of Social Services, State of Delaware Child Mental Health, Youth Rehabilitative Services, District of Columbia Superior Court, and private pay. (Patients who are eligible for Medical Assistance reimbursement must follow the assistance program's admission protocol of going off-grounds to be evaluated by an approved physician and social worker who are not on the MMTC staff. Both the physician and social worker evaluations must support inpatient admission if Medical Assistance funding is to be received.) Third party reimbursement coverage is verified through patient accounting, but the clinical approval for admission is done separately through utilization review.

Those patients who meet the admissions criteria and have satisfied the regulations set forth by their funding agency enter into MMTC's admissions process. The admissions process was established to respond efficiently and effectively to referrals for appropriate patients to MMTC's intermediate care facility within the regulations established by the State of Maryland.

MMTC Admission

- *Intake, utilization review, and treatment placement*
- *Detoxification if needed*
- *Comprehensive assessment*
- *Treatment planning*

Day of Admission Procedures

Once admission has been approved through utilization review, the patient and the family/agency representatives accompanying the patient are brought to the admissions office. Transportation for admission is available from trained drivers, who use

unmarked company vehicles. At least one of the staff members must be the same sex as the patient who is being transported.

Since most of MMTC's patients are minors, parents or guardians are encouraged to accompany patients. When patients are in the care and custody of a social service agency (such as juvenile justice), an agency representative may give the consent for treatment. Additionally, minors may consent themselves to substance abuse treatment in Maryland. Court orders and like documentation should be available if these agencies do not send a representative during the admissions process.

The following forms are completed on admission by the appropriate consenting party:

- Admitting form
- Statement of consent for treatment
- Statement of confidentiality about other drug abuse patients
- Consent for release of confidential information
- Disclaimer of liability
- Patient grievance procedure
- Consent for emergency treatment
- Expressive art therapy consent form
- Release of liability
- Photo consent form
- Media interview consent
- Consent for haircut
- Consent to participate in off-grounds activities
- Consent to participate in offsite programs
- Visitors approval form
- Consent for psychological and educational testing

- Consent of release of information to/for parents/guardians, referral sources, schools, financial reimbursement purposes, etc.

After signing forms, patients and any guardians go through an orientation consisting of a review of the patient handbook and an explanation of the program and rules; selected patients are offered the ORYX survey (patient outcome measures at admission and discharge as part of compliance with the Joint Commission on Accreditation of Healthcare Organizations regulations). Next, two trained staff members of the same sex as the patient perform a required search of the patient and his or her belongings. Any non-allowable items are returned to the parents/guardians or placed in a secure area in the residents building until discharge. Contraband items (e.g., cigarettes, matches, small amounts of illicit drugs) are disposed according to protocol. Illegal items (e.g., weapons, significant amount of drugs) will result in the police being contacted.

The patient is seen within 24 hours by a physician's assistant for a more thorough evaluation, including a complete medical history and physical examination.

The nursing staff performs the initial evaluation of the patient once in treatment. The nurse performs a nursing assessment; identifies any immediate or urgent medical, withdrawal, or psychiatric concerns; and continues the orientation process, focusing on illness education (regarding addiction, HIV, STDs, etc.). The nurse also performs a tuberculin skin test and offers a hepatitis B vaccination. Any other medical concerns are addressed at this time. Baseline laboratory specimens are collected within 24 hours. The patient is seen within 24 hours by a physician's assistant for a more thorough evaluation, including a complete medical history and physical examination. Withdrawal risk is assessed in a standard way, based on the patient's substance use history. Specialty assessments are made for withdrawal and withdrawal risk, including symptom checklists, vital signs, and standardized instruments, such as the Subjective Opiate Withdrawal Scale (SOWS), the Objective Opiate Withdrawal Scale (OOWS), or the Clinical Institute Withdrawal Assessment for Alcohol (CIWA).

If the patient is at risk for physiological withdrawal symptoms, a *detoxification protocol* is begun. The goals of detoxification treatment are safety, prevention of medical and psychiatric morbidity, patient comfort, and avoidance of side effects of treatments. Incomplete amelioration of withdrawal symptoms is <u>not</u> used as an aversive treatment technique. Patients who are experiencing withdrawal symptoms receive specialized medical monitoring several times per day. They may also receive various combinations of the following treatments:

- Decreased stimulation. Patients are provided access to special detoxification rooms, where they can partially "retreat" with less stimulation during the period when they are most symptomatic. These rooms are also close to the nurse's station, providing greater access to monitoring. In general, patients who are undergoing detoxification have fewer demands placed on them, as they are considered "sick" and are not generally expected to fully participate in treatment activities.

- Pharmacological treatments for opiate withdrawal. Medications are used routinely for opiate withdrawal. MMTC's standard approach is to use various combinations of clonidine, ibuprofen, bismuth salicylate (Pepto-Bismol), diphenhydramine (Benadryl), and dicyclomine (Bentyl) for the relief of symptoms. Occasionally, substitute agonist therapy is used in the form of a methadone taper (e.g., in the case of pregnancy or methadone withdrawal).

- Pharmacological treatment of alcohol withdrawal. Although it is infrequent, alcohol withdrawal of sufficient severity to require substitute agonist replacement is routinely treated with a benzodiazapine taper, typically with diazepam (Valium) or chlordiazepoxide (Librium). Sometimes oxazepam is used when there is suspicion of severe liver disease or if there is a need for closer titration.

- Pharmacological treatment of nicotine withdrawal. Nicotine withdrawal is routinely treated for all heavy smokers with a tapering regimen of topical nicotine patches.

- Miscellaneous pharmacological treatments. For the significant insomnia caused by withdrawal from a variety of substances (e.g., marijuana, alcohol) a taper of mild hypnotics (namely diphenhydramine or trazodone) is frequently used. Very infrequently, other miscellaneous pharmacological treatments are used (e.g., bromocriptine for cocaine withdrawal, methylphenidate for methamphetamine withdrawal). The short-term psychiatric sequelae of withdrawal or prolonged intoxication are also sometimes treated pharmacologically (e.g., cocaine-induced psychosis, hallucinogen-induced perceptual distortion, inhalant-induced delirium).

Comprehensive Assessment and Treatment Plan

Newly admitted patients receive a comprehensive assessment from MMTC's multi-disciplinary team. Patients are assigned to a primary counselor by the end of the admission day by the clinical program director. Within 72 hours of admission, the primary counselor completes the biopsychosocial assessment and the Problem Oriented Screening Instrument for Teenagers (POSIT) and then begins to develop an initial individualized treatment plan. Each patient is also evaluated for educational strengths and weaknesses with the Wide Range Achievement Test (WRAT-3). The patient is then presented to the entire treatment team for assessment and modification of the treatment plan.

Assessments

Initial Assessments

- *Biopsychosocial assessment*
- *POSIT*
- *Educational assessment—WRAT-3*

Biopsychosocial Assessment

MMTC's biopsychosocial assessment is completed by the patient's primary counselor and focuses on the following major life domains:

- Demographics, contact information
- History of the presenting problem, reason for current admission
- Precipitating stressors to admission
- Referral source information
- Drug use history, including the following: primary drug(s) of choice, quantity, frequency, route of administration, last use of drugs and alcohol, length of current abstinence, withdrawal symptoms, and drug use–related problems
- DSM-IV substance abuse and dependence symptom checklist and corroborating data
- Gambling history
- Prior treatment history
- Family history, including current living situation, family substance use, family psychiatric history, and recovery environment
- School, including current status, last attendance, past performance, behavior problems, and special education history
- Vocational history
- Social/peers, including gang involvement and drug use among peers
- Sexuality, including sexual experience, contraception use, partner history, sexual orientation, pregnancy, and children
- Psychiatric history, including prior diagnoses, prior treatment, current and/or past medications, and abuse history (physical, emotional, and/or sexual)
- Legal history, including arrests, detention, and current legal status
- Medical history
- Patient self-assessment, including triggers, reinforcers, belief in higher power, religiosity, assets and strengths, weaknesses and vulnerabilities, and social supports
- Mental status assessment
- Initial formulation and plan

- Initial problem and goals list

- ASAM Patient Placement Criteria checklist grid with corroborating data.

Problem Oriented Screening Instrument for Teenagers (POSIT)

The POSIT was developed by the National Institute on Drug Abuse for screening and referral of adolescents. This is a rationally based, empirically supported assessment tool designed to identify deficits, risks, and strengths in several domains. This screening instrument identifies areas that require further evaluation, assists with patient placement decisions, and provides information pertinent to care plans and treatment strategies. It addresses the following 10 functional adolescent problem areas:

- Substance use
- Physical health
- Mental health
- Family relations
- Peer relations
- Educational status
- Vocational status
- Social skills
- Leisure and recreation
- Aggressive behavior/delinquency.

Cognitive/Educational Assessment

All newly admitted patients are seen shortly after admission (usually the next day) for educational achievement screening for assignment to the appropriate classroom setting, as well as to establish educational treatment goals through the WRAT-3. This instrument provides grade equivalent scores for reading, spelling, and mathematics.

Once the initial assessments and treatment plan are completed and the results are reviewed with the patient, each newly admitted patient is then presented to the entire treatment team for evaluation and modification of the treatment plan.

Treatment Team

The treatment team meeting is an essential aspect of quality care at MMTC. MMTC's treatment team provides a forum for case formulation and treatment planning, ongoing review of patient treatment progress, case management, clinical supervision, and teaching, as well as discussion of other general clinical issues. The treatment team meets at least twice per week as a whole and at least twice weekly in sub-teams consisting of half of the counselors (covering half of the patients).

Treatment Team Members

- Primary counselors (nine)—Primary counselors present newly admitted cases to the treatment team and also provide ongoing updates on the clinical management of previously admitted patients.

- Program director—The clinical program director uses the treatment team as an opportunity to observe the ability of primary counselors to conceptualize and properly manage the overall treatment and disposition of patients under their assignment. The program director provides clinical oversight, helps the team develop realistic treatment goals and plans, and uses the designated treatment team time to monitor patient progress and clinical case management.

- Administrator—In addition to providing primary clinical oversight and serving as a resource for program counselors, the administrator shares the role of the main facilitator of the treatment team with the clinical program director. Given the time constraints in a busy, complex, and dynamic treatment setting, these facilitators manage the allotted treatment team time (2 hours per meeting) to allow for efficient clinical case management.

- School principal—The school principal presents updates on school behavior and academic progress, develops educational goals for patients, and communicates with each patient's home school regarding transfer credits, special education needs, and reintegration.

- Director of nursing—The director of nursing provides updates on medical status, laboratory test findings, medication compliance and side effects, and patient behavior in the residential unit.

- Utilization review nurse—The utilization review nurse provides updates on each patient's payer certification status and coordinates the completion and submission of required treatment plans.

- Discharge coordinator—The discharge coordinator gathers patient information to contribute to the discharge plan and provides alternatives for comprehensive aftercare/continuing care strategies.

- Mental health coordinator—The mental health coordinator provides and receives information regarding co-occurring psychiatric disorders, psychotropic medications, behavior management, and referral sources. The mental health coordinator also acts as a physician extender for psychiatric treatment.

- Psychiatrist—The psychiatrist assists clinicians in conceptualizing patient impairment and treatment, as well as assists in increasing the recognition of co-occurring psychiatric disorders. During treatment team meetings, the psychiatrist has an opportunity to share

information from psychiatric evaluations and also gathers information on the effects of prescribed medication.

- Counselor technician supervisor—The counselor technician supervisor provides clinical observations of patients' behavior and receives information regarding day-to-day behavior management.

Key Elements of Treatment Team Meetings

The following elements are included in treatment team meetings:

- Newly admitted patients are presented by their assigned counselors to the full treatment team in a timely manner (within 7 days of admission).

- Treatment plans are formulated for all newly admitted patients, and they are updated and reviewed for previously admitted patients.

- Relevant patient and staff concerns are reviewed and discussed with representatives from all clinical disciplines.

- Treatment progress and level application are reviewed for each patient who is petitioning for a higher level.

- Treatment progress as related to behavior management issues is reviewed [e.g., all patients who are at level 3, on "elopement" status (confined to the residents building because of at-risk behavior), or on "block" status (ordered to stay at least 10 feet from another patients because of inappropriate behavior)].

- Discharge and aftercare plans are formulated and reviewed.

- Physical health concerns of patients are reviewed and discussed.

- Psychiatric issues (e.g., medication, psychiatric evaluations) are reviewed and discussed with a program psychiatrist.

- Items of general interest are announced.

On an as-needed basis, some patients who are having difficulties in the program may appear personally before the full treatment team for a frank, but supportive, review of their treatment progress. The treatment team members give an emphatic message of special concern and also seek the input of the patient in developing or revising behavior management plans, treatment plans, and/or aftercare plans.

Once the patient has been admitted, assessed, and detoxified (if necessary), and initial treatment plans have been developed, the patient joins the rest of the treatment community. Below is a discussion of how the remainder of residential treatment is implemented.

MMTC Residential Treatment Components

A mixture of therapeutic methods, techniques, and modalities are utilized in the residential program. All patients participate in the core treatment components: therapeutic milieu, group therapy, individual therapy, community group meetings, and education. Some patients also participate in different special service components: primary medical care, psychiatric treatment, family therapy, and specialty groups (e.g., motivation enhancement, anger management). Making sure that each patient receives the appropriate services is a multi-disciplinary team responsibility. Below is a description of these services.

Core Treatment Components

<u>Therapeutic Milieu</u>

The therapeutic milieu is used to specifically assist the newly recovering adolescent normalize peer and other interpersonal interactions and relationships, practice developmentally appropriate social roles, acquire appropriate social skills, learn how to access and accept peer support, and learn peaceful assertiveness and conflict resolution skills.

Core Treatment Components

- *Therapeutic milieu with level system*
- *Group therapy*
- *Individual therapy*
- *Community group meetings*
- *Education*

Trained counselor technicians are the "frontline" staff members who take the lead in implementing day-to-day behavior management for the patient community. Staff members are always present, and no adolescents are unsupervised as they go through their day of school, assessments and/or treatment, meals, and leisure activities. Counselor technicians are responsible for communicating, enforcing and reinforcing behavioral standards, ensuring group and individual safety, and providing individual (e.g., time-out, referrals to medical team, problem solving) and interpersonal intervention (e.g., de-escalation, therapeutic holds, conflict resolution) when necessary. Patients are taught about personal boundaries. One of the strict rules of the therapeutic milieu is "no contact" between patients. They are expected to develop appropriate boundaries and respect other people's boundaries. All staff members model appropriate behavior and respect for patients, staff, and visitors alike.

It is difficult to describe the elements that contribute to a successful therapeutic milieu since it is a dynamic process. One of the factors that has been most successful at MMTC is the "level system." The level system is used to facilitate modification in substance-using behavior as well as developmentally appropriate social behavior. This is done by enhancing the patient's knowledge of addiction and recovery, reinforcing appropriate social behavior, and decreasing or extinguishing inappropriate behavior.

MMTC's level system incorporates the first three Steps of an adolescent-adjusted, traditional 12-Step model and a behavior management plan with rewards in the form of privileges that can be earned or rescinded as reinforcers for meeting behavioral expectations (Table 1). The levels are as follows:

- Level A—This is the entry level for all newly admitted patients.

- Level I—The patient becomes part of the recovery planning process by taking personal responsibility for his or her substance use and recovery. With the help of his or her counselor, the patient identifies strengths, weaknesses, substance use risk factors, and future goals to develop a treatment and aftercare plan.

- Level II—At level II, the patient is expected to accept the need for change and is willing to invest his or her energy in learning the skills necessary to achieve abstinence and prevent relapse.

- Level III—At level III, the patient is well-motivated to successfully complete residential treatment. The patient demonstrates behavioral competence and developmentally appropriate emotional regulation by successfully living in the patient community, consistently following directions, and abiding by the rules. The patient is willing to and beginning to accept the help of others. The patient is learning, accepting, and beginning to internalize recovery principles. The focus begins to shift toward taking personal responsibility for pursuing aftercare/continuing care goals.

Table 1. MMTC Level System

Level	Time Frame	Step	Special Privileges
A	First 7 days following admission		
1	Generally achieved 14 days following admission	Step 1—Acknowledgement of a substance problem and unmanageability	Three telephone calls per week
2	Generally achieved within 3 weeks of admission	Step 2—Acknowledgement of the need for help	Four telephone calls per week; off-grounds fellowship meetings
3	Generally achieved 30 days following admission	Step 3—Recognition and acceptance of useful sources of help Step 4—Make a searching and fearless personal inventory	One telephone call per day; off-grounds recreational outings; off-grounds fellowship meetings

To implement the level system, on admission, MMTC provides all new patients with the patient handbook, which includes a two-page description of the level system. This explains the purpose, guidelines, and privileges associated with the level system. All new patients are placed on level A for 1 week. All newly admitted patients must obtain special permission to make phone calls until they earn a level.

Each patient has an individual level team that consists of his or her primary counselor, the day shift counselor technician coordinator, the evening shift counselor technician coordinator, a school representative, a nursing representative, the activities counselor, and one other staff member of the patient's choosing.

After 1 week, patients may petition for level I after they have become acclimated to the facilities' program and have been evaluated for behavioral appropriateness. At each level change request, petitioners must gather signatures from all staff members on their level team in support of their request and also justify why they deserve the level they are seeking. The primary counselor presents the completed petition to the treatment team. The primary counselor may solicit the opinions of the team members to validate the patient's adherence to acceptable behavior and progress in substance abuse steps before granting or taking away a level. Behavior during the previous 7 days is considered. Logs and incident occurrence sheets are used to document behavior problems and become part of the review process.

The higher the level, the greater the expectation for behavioral compliance. However, compliance is not the only consideration. Demonstrated effort, significance of changes made, openness to feedback, and willingness to make amends are important indicators of patient progress.

MMTC has developed "phase packets" to assist patients' progress through the level system. These packets include a variety of assignments focused on the first 4 of the 12 Steps. These phase packets generally correspond to the tiered level system. Although patients may independently progress from one phase packet to the next, regardless of whether they have achieved the next level, failure to successfully complete these packets can result in a patient not receiving a level advancement. Descriptions of the phase packets are as follows:

- Phase I—This packet provides activities that help patients in evaluating their own substance use and the problems it has caused in their lives. This packet provides a non-confrontational way to motivate the patient to engage in recovery by first privately articulating the impairments associated with his or her drug use and hopefully recognize that his or her life is out of control and that help is needed. When the patient has completed the packet and is ready, he or she shares this information with the small recovery group for feedback and support.

- Phase II—This packet provides activities that help the patient examine irrational, self-destructive substance use behaviors; identify defense mechanisms that get in the way of recovery; develop reliance on a "higher power" for help; and increase awareness and involvement in NA/AA groups. Developmentally, it is difficult for adolescents to turn over their lives to anyone or anything, since they are very invested in taking charge of their own lives. Therefore, the notion of higher power has been adapted to be more effective with MMTC's adolescent population. The meaning of higher power is very individual and can take on a variety of meanings, but it is basically trusting in and asking for help from something positive beyond one's self, usually a parent, a sponsor, a counselor or other professional helper, nature, a spiritual energy or life force, or God.

- Phase III—This packet has activities to prepare the adolescent for discharge, arming the patient with an ability to detect and handle the warning signs of relapse. The activities also provide practice in planning an abstinent lifestyle and handling the daily emotions and decision processes that are necessary to maintain abstinence while pursuing aftercare goals.

- Phase IV—This packet has activities to prepare the adolescent for an abstinent lifestyle beyond discharge. This packet requires the patient to make an objective personal inventory to identify strengths and weaknesses and make plans to become the person he or she wants to be. There are also exercises to practice becoming a helping member of the recovering community by assisting newer and/or struggling MMTC patients.

Counselors or other treatment team members may independently demote a patient to a lower level for failure to meet behavioral expectations. They do not need to wait for a team discussion.

It is ultimately each primary counselor's privilege, for their assigned patients, to decide how long a patient will be demoted and what that patient needs to do to "earn" his or her level back. The opportunity to return to a level by a patient usually involves making amends to an offended party, demonstrating appropriate behavior for a particular period of time, and writing justification for restoring the previous level. However, major infractions (e.g., fighting, being sexually inappropriate, running away, using contraband) result in an automatic demotion to level A for 1 week.

Additionally, patients may become less motivated to behave well if they have achieved level 3, and no additional rewards are available. Therefore, each patient who has previously advanced to level 3 is reviewed for appropriateness to maintain that level every week. Patients may have their level demoted if they do not sustain level 3 behavior standards. It is important that level 3 patients maintain behavioral expectations, given their role model status for the rest of the community.

Although the milieu is a therapeutic tool in and of itself, it also provides a structured, safe environment to employ MMTC's other services, which may not be as effective or even possible in a chaotic, poorly controlled situation.

Group Therapy

All patients participate in daily group therapy sessions. Groups consist of six to nine patients and are led by the patients' primary counselor. Groups meet for 90 minutes daily, Monday through Friday. The primary goal of group therapy at MMTC is to facilitate understanding and change by utilizing a cognitive-behavioral approach. Group discussions and exercises provide a forum for patients to explore factors related to their substance abuse and dependence, sharing each other's individual stories as illustrations and helping each other with support and confrontation.

The pragmatics of organizing a group can be a challenge for the counselor. At MMTC, group membership changes frequently as new patients are admitted and others are discharged. Additionally, patients vary in age, stage of recovery, and readiness to change. This arrangement has the disadvantages of threats to group cohesion, differences in maturity levels, and varying recovery needs, but it also has some advantages. New members are readily accepted into a functioning group and are initiated into the group process quickly. Both older and younger adolescents can benefit from a mentoring relationship. Adolescents who are further along toward recovery are often helpful in challenging the pre-contemplative patient in ways that are not as readily accepted when coming from an adult.

Group therapy at MMTC is adapted to meet the needs of recovering adolescents. Group dynamics and processes are used to elucidate the relations between drug use, impairment, and consequences. Didactic and directive elements are also used. Most substance and recovery education, phase packet work, introduction and explanation of the level system, and 12-Step fellowship are done during group time. More active and fun, experiential activities are frequently used to match adolescent learning styles and promote treatment engagement. The counselors also have the flexibility of using individual therapy sessions to address some issues that surface in group therapy or issues that pertain to an individual but that have not been addressed by the larger group.

Counselors also participate in treatment team meetings. Because of MMTC's average daily census of 65 adolescents and young adults, the treatment team meets twice per week, with half of the counselors presenting their patients at one of the two meetings. All counselors meet after these treatment team meetings to briefly review patients' level of progress and particular patients exhibiting difficult behaviors such as aggression or attempted elopement. Additionally, each counselor is supervised individually to review his or her entire caseload weekly. These meetings provide a forum for patient review and the development of or changes to individual treatment plans. This not only encourages the counselor to conceptualize each patient's treatment, but also gives the counselor an opportunity to benefit from the experiences and successful individual and group strategies of other counselors.

Individual Therapy

The patient's primary addictions counselor performs individual therapy both in regularly scheduled sessions and in brief impromptu sessions. These sessions are often used to fill gaps in the patient's substance use and recovery education, explain the program, address behavior issues and expectations, review case management issues, re-establish and/or review goals of treatment, interface with juvenile justice or other community agency personnel, and examine long-term goals and discharge planning. The content of individual therapy may primarily concern substance use directly, or it may focus on family issues or psychological/psychiatric problems. Counselors frequently use individualized motivational enhancement techniques during these sessions to facilitate readiness to change. Patients vary in their stages of change relative to their substance use. A patient may be in a different stage from the majority of his or her group, and the counselor may elect to use these individual sessions to address this.

One of the psychiatrists or the mental health coordinator may also perform individual psychotherapy. A psychiatrist sees the patient if he or she is admitted to MMTC on psychotropic medications or if the nurse or counselor thinks that a psychiatric evaluation is needed. Evaluation and regular psychotherapy sessions are provided as necessary. (The Psychiatric Treatment section below provides details.)

Community Group Meetings

All of the MMTC patients are part of the residential community. They all participate in weekly community meetings. This gives them the opportunity to discuss grievances and solve problems that arise as a part of living and recovering together. They are also publicly recognized and awarded for achievements such as increased participation in the program, improvements in interpersonal interactions, keeping their rooms clean, and progress in recovery. The patients also have an opportunity to recognize and applaud staff members who have been particularly helpful during the week. Staff members use this time to applaud one another and give public support for their hard work. The community meeting is generally considered to be a respite from the hard work of recovery and a time to stop and celebrate successes small and large.

Education

Each patient is assessed for academic achievement on admission, and a personalized education plan (PEP) is developed by the principal of MMTC's onsite, school program. Since patients come from many different school jurisdictions, the principal must often make individual contracts with the student's home school. The patients attend class daily onsite for approximately 16 hours per week. The school is certified by the Maryland State Department of Education and is able to award credits to students toward graduation and even grant diplomas for those patients who complete their full requirements while in treatment.

Each school jurisdiction has its own curriculum. MMTC uses State of Maryland curriculum guidelines to develop instructional goals and objectives. The MMTC curriculum is generalized in order to meet the requirements of local area school districts. The school will implement programs required by the home school if requested. School content is not necessarily geared toward drug abuse and addiction in the daily curriculum because of the need to focus on State-mandated content. However, educational materials on substance abuse are incorporated into the school program/curriculum when possible.

If a student is suspected of having special learning needs, the patient is referred to a MMTC psychologist. A cognitive assessment is completed, and a recommendation for special education services is made if appropriate. If the assessment determines a reading skill deficit, the student receives more individualized attention in audio-visual formats. Some special materials are available, and a teacher assistant is in the class to assist in areas of special need.

Many of the students at MMTC have not been attending school for an extended period, and/or their schools have expelled them. They are often dropped from the rolls of their local

school. The principal at MMTC will work with the local schools to re-enroll the students, so that education can continue while at MMTC and upon discharge. If possible, the principal also attends IEP meetings with the student's home school prior to discharge to advocate for the student's reintegration with his or her regular school in the community.

Special Services Components

Primary Medical Assessment, Treatment, and Health Education

Special Services Components

- *Primary medical assessment, treatment, and health education*
- *Psychiatric treatment*
- *Family therapy*
- *Specialty groups*

Primary medical care is both a core component and a special service component, depending on the needs of the patient. Many patients are admitted with a variety of health problems and a history of health risk behaviors. Comprehensive medical and skilled nursing care is provided for all residents in the program. A team of physicians, physician assistants, and licensed nurses provide 24-hour assessment, monitoring, and treatment for most common health conditions and facilitate access to emergency and specialty care as needed.

Because of the chaotic lifestyle associated with substance use disorders, and because many individuals come from chaotic families, most patients have not had adequate primary health care screening and treatment. Therefore, every patient receives a complete medical history review and physical examination, along with a health needs target checklist. Those with chronic or episodic medical conditions are identified, and the medical staff attempts to identify and coordinate with any previously involved community providers. The program's core component in this domain is medical evaluation. The special component in this domain is the individual treatment and referral for those with special needs.

All patients receive screening for STDs (including syphilis, HIV, chlamydia, gonorrhea, and hepatitis B and C) and an immunization update. The girls receive reproductive health services, including gynecologic screening, complete with a Pap smear and pelvic and breast exams for those who have not received one recently.

One major goal of this service is to promote health awareness among the patients, reinforce their role in their own primary health care, and decrease health risk behaviors. All patients participate in a series of "health recovery" groups aimed at health and risk-behavior topics, including the following:

- STDs/HIV
- Sexual abstinence and safety
- Injury prevention
- Nutrition
- Specialty topics as needed (i.e., pregnant or parenting teenagers, when appropriate).

Each family is encouraged and assisted to identify and make arrangements for a regular source of primary health care as part of discharge planning. Every patient receives a referral appointment to the identified primary care provider soon after discharge.

Psychiatric Treatment

Adolescents with substance use disorders are at considerable risk of having co-occurring psychiatric disorders. Many patients present with a history of psychiatric problems that pre-date substance abuse, some patients have psychiatric distress and/or disorders associated with extensive substance use, and others do not exhibit problems until later during treatment. The goals of the psychiatric treatment component are to screen, assess, and treat psychiatric problems whenever they present during a patient's stay at MMTC.

The psychiatric treatment team consists of psychiatrists, psychologists, and a mental health coordinator. Additionally, nurses and counselors are cross-trained in the recognition of symptoms and syndromes, and they make referrals to in-house psychiatrists as needed. Psychiatric referrals are made to the mental health coordinator (a doctoral-level counselor or psychologist), who gathers information from the patient, his or her family, and other outside informants. The mental health coordinator serves as a liaison between the counselors, psychiatrists, patient families, outside agencies, and insurance providers to facilitate individual treatment that incorporates ongoing psychiatric care. The patient's guardian is informed of the evaluation and treatment plan, and consent for treatment is obtained.

Treatment often consists of individual psychotherapy every 1 to 2 weeks with the psychiatrist, psychopharmacological agents (if needed), and monitoring with feedback through the mental health coordinator from the nurses and counselors.

Other important psychiatric treatment elements are the staff training, supervision, and culture, creating a therapeutic milieu that can tolerate and manage severe psychiatric symptoms. Specialized training and procedures are utilized for behavior management as needed, such as de-escalation techniques and techniques to handle disorganized and agitated behaviors. Although rarely used, protocols for therapeutic holds are also a part of staff training. Additionally, specialized risk assessment and management techniques are implemented to manage patients with self-injurious behaviors and suicidal threats. When patient safety is in question, 24-hour monitoring by the nursing staff or special observation precautions (such as constant observation or shadowing the patient) are used.

The psychiatrist also functions as the team leader to the addiction counselors in the treatment planning and disposition of all patients admitted to MMTC. The counselors present new and/or particularly difficult patients during treatment team meetings. The treatment plan is developed or revised under the supervision of the psychiatrist. The psychiatrist is also involved in some formal training of the mental health coordinator and the addiction counselors by providing in-service sessions throughout the year. The primary goal of these in-service sessions is to increase knowledge, skills, and expertise in identifying and managing co-occurring mental health issues.

Occasionally, psychiatric assessments are required for the purpose of discharge planning. For example, a probation officer or insurance company may request an assessment at the time of admission to ensure that the patient is being treated and/or discharged to an appropriate setting. The psychiatric program component emphasizes post-discharge linkages to additional mental health care, including expedited referrals to outpatient treatment. Given the relative high psychiatric acuity of many of the patients, some need transfer to ongoing residential specialty psychiatric treatment. The treatment team has developed close working relations with a variety of community providers to facilitate the continuity of psychiatric care.

Family Therapy

Family involvement is an integral part of the treatment process at MMTC. Adolescents are not independent individuals, and their treatment and recovery are affected by their families. Many patients come from disrupted or impaired families. Many have home environments that are not conducive to recovery, such as absent or ineffectual parents, unsupportive parents, and/or parents with substance abuse problems of their own. The goal of family therapy at MMTC is to develop and implement a therapeutic family plan to develop an environment that will support the patient's recovery and transition back to the community.

Each family receives a family evaluation by the patient's addiction counselor to identify family strengths and weaknesses. They are primarily evaluated for the following:

- Substance use disorders among family members. Individuals with substance abuse issues are identified and referred for appropriate treatment.

- Knowledge of substance dependence and recovery. Some parents have very little information regarding substance abuse, treatment, and recovery. Counselors may choose individual sessions or groups of family members to present didactic information.

- Effective parenting skills. Some parents do not have good parenting skills in general, and many are ill prepared to cope with adolescents with substance use disorders or co-occurring psychiatric conditions. The patients at MMTC present with a variety of severe problems that challenge even the best of parents. The family therapy goals in this area are to strengthen parental attitudes toward recovery and abstinence, empower them to develop and use techniques to modify their adolescent's problem behaviors, and help the parents develop effective monitoring and supervision relative to their child's substance use.

- Discharge environment risk. Each family is evaluated to determine its ability to provide a safe environment that is conducive to the patient's recovery. If the counselor believes that the family can provide an adequate environment with supportive intervention, then discharge is planned for home, with the recommendation and referral for continued therapeutic family intervention. Unfortunately, some patients do not have viable home situations, despite attempts at intervention. For these patients, the focus of family therapy then shifts to finding alternative recovery environments, such as extended family, group

homes, foster care, or other sheltered care programs. In keeping with the MMTC philosophy of continuity of care, a great deal of effort is spent contacting, coordinating, and identifying funding for alternative placements when necessary.

Specialty Groups

As the need arises, special group therapy sessions are implemented when several patients have similar experiences that may not be of common interest to the rest of the patient population. These special group therapy sessions are in addition to the core daily group sessions and are usually organized around a particular theme. New groups are added when new needs are identified, and other groups are suspended during periods that they are not needed. Below are examples and brief descriptions of many of the groups available at MMTC.

- Anger management group. Any staff member can refer a patient who is having difficulty with anger, fighting, frequent arguments, and emotional outbursts. The focus of this group is to help the patient recognize and accept his or her anger, as well as develop coping strategies, such as decreasing impulsivity, making conscious behavioral choices, and learning self-calming techniques.

- Refocus group. This group is composed of patients who are having difficulty following rules, respecting staff and peers, and maintaining attention in school, or are defiantly resistant to participating in any aspect of the recovery program. This is a daily group that focuses on motivational enhancement in a group format.

- Coping skills group. Many of MMTC's patients lag behind in emotional maturity and have limited repertoires of coping skills. The goal of this group is to introduce commonly occurring stressful scenarios that adolescents may face and then provide coping options and techniques. Developmentally, it is often difficult for adolescents to connect current behavior with likely consequences, and this is particularly evident in this population. Therefore, this group makes a special effort to increase the patient's ability to make sound decisions by recognizing issues, implementing coping skills, and selecting options that are based on some knowledge of the likely consequences.

- NA/AA groups. All patients attend traditional NA/AA group meetings at MMTC every evening. Young adults also attend at least one meeting in the community every week. Younger adolescents attend at least one meeting in the community during their stay at MMTC to acquaint them with the activity and encourage their continued use of this resource after discharge.

- Art therapy group. The adolescents refer themselves to this weekly group. Arts projects are introduced by a trained art therapist. The patients benefit from the non-verbal mode of expression and look forward to this very popular group. For some, this gives them an opportunity to remember how to enjoy activities that do not revolve around taking drugs.

- Activity therapy group. Prosocial leisure activities are planned weekly. Many patients have given up leisure activities and have forgotten how enjoyable life can be without getting high.

- Phoenix rising group. This is a group for those patients who are having difficulty with grief and loss. Many of MMTC's patients have lost a parent, sibling, boyfriend or girlfriend, or others because of substance abuse, illness, or accident. Many have difficulty coping with parents who have abandoned them.

- Drug dealer group. This group is specifically for those adolescents who have been dealing drugs. The goal is to help them recognize the relationships between trafficking behavior, substance abuse and dependence, and violence and recovery.

- Gender-specific groups. Male and female adolescents often face very different challenges on their road to recovery. At times, special groups are formed to provide an opportunity for each gender group to discuss and deal with their issues. So far, most of the adolescents expressing the need for this group and benefiting from it have been female, but male patients are encouraged to take advantage of this opportunity as well.

- Sexual abuse group. Many of MMTC's adolescents have been victims of sexual abuse. This group is open to all patients who have experienced sexual abuse as a child, in their current relationships, or as a result of their drug abuse behavior. Although it is open to all, this group generally consists of adolescent girls who vary widely in their stage of recovery from sexual abuse.

- HIV/STD groups. This is a monthly educational group designed to provide information on prevention and treatment of STDs. Adolescents with substance abuse and dependence disorders engage in all types of risky behaviors and are at particular risk for sexually transmitted infection. This group is facilitated by State Health Department personnel.

- Peer mediation group. This is a group of patients selected for their leadership abilities and their success at adapting and excelling in the program. These patients serve as role models for other patients and are instrumental in facilitating interpersonal problem resolution among fellow patients.

- 12-Step study groups. These groups are conducted every weekend for those patients who need or want help in completing their phase packets to achieve their Steps in their recovery process. This is a voluntary activity, and patients are self-selected for participation.

- Visit processing groups. Patients are allowed visitors (parents and other family, but not friends) on Saturday. Sometimes these visits evoke strong emotions that are difficult to cope with. This group occurs right after visiting hours and allows the patients an opportunity to share their experiences and feelings. This group has been found to be very therapeutic and decreases the number of aggressive episodes following emotionally charged family visits.

- Spirituality groups. These groups are conducted every Sunday, and participation is voluntary. It is a non-denominational exploration and expression of spirituality and its relation to recovery.

Discharge Planning

Discharge planning is a critical part of treatment at MMTC. Patients have accomplished abstinence by confinement and have participated in substance dependence/abuse education and recovery skill acquisition, but thoughtful discharge planning will be necessary to assist the recovering patient in reintegrating into the community successfully. Discharge planning is an ongoing process that essentially begins on admission to the residential treatment program and continues beyond discharge. Discharge planning is a collaborative effort involving counselors, the treatment team, the individual patient, his or her family, and other agencies (i.e., juvenile justice and social service agencies). The discharge process is very important in actualizing the MMTC philosophy that continuity of care is necessary to maintain the therapeutic gains made in residential treatment and support the next step in lifelong recovery.

An aftercare coordinator manages the overall discharge planning. The aftercare coordinator works closely with counselors, individual clients, parents/guardians, and external agencies in developing integrated aftercare plans. This position requires a background in substance abuse treatment, case management, and knowledge of community treatment providers and related social service agencies to effectively reach MMTC's goals.

Final referral and placement following residential treatment at MMTC depend on several factors, including individual needs (e.g., continued substance use disorder and/or mental health treatment, educational/vocational needs), family needs and abilities, the legal system, and financial considerations. Many patients have the option of continuing their care through the outpatient programs at MMTC (partial hospitalization, intensive outpatient, and outpatient). They can continue to receive group, individual, and family therapy, as well as psychiatric followup and treatment.

Some patients, because of their distance from MMTC or previous therapeutic relationships in the community, do not continue treatment at MMTC. The aftercare coordinator, in conjunction with the counselor, patient, and patient's family, establishes contact with a provider in the patient's community. The patient's treatment progress at MMTC is shared with the community provider to ensure continuation of treatment for the substance use disorder and any psychiatric treatment and medication that have been prescribed. The purpose of communicating directly with other agencies/settings is to facilitate the continuum of care, bridging the gaps between treatment episodes so that patients are not hampered by personal or system barriers that interfere with continued care. If an adolescent will continue treatment elsewhere, the aftercare coordinator will work with the patient and patient's family to arrange initial appointments. If the patient will need followup psychiatric or primary medical care, the aftercare specialist will attempt to arrange these types of followup services. The aftercare specialist will also arrange to transfer any needed records to the followup care

site. The assumption is that by providing these case management services, MMTC will increase the likelihood that the patient will continue in treatment and get the needed care.

Special attention is given to the discharge living environment. As described in the Family Therapy section under Special Services Components, the home environment is evaluated for appropriateness. The patient is discharged to home if the family can provide an environment that can support the patient's ongoing recovery. If the family needs support to provide this, the family may continue therapy on an outpatient basis at MMTC. If the aftercare coordinator and counselor think that the home environment will be detrimental to the patient's recovery, alternative placement is sought.

Once the final discharge plan has been developed, a final discharge meeting with the patient and his or her family is held. The discharge planning process and final discharge meeting itself present unique opportunities—"teachable moments"—that can have a strong impact on the change process. By actively engaging the adolescent to the extent possible in his or her aftercare decisions and final outcome, the program can empower the adolescent to articulate personal choices and to recognize the connection between his or her progress and engagement in treatment and his or her eventual placement, support, and recovery.

Summary

MMTC's goal is to address substance use disorders and the wide range of associated problems to decrease the degree of impairment, support adolescent development, and restore productive functioning. Implementation of the MMTC short-term residential program is a complex, but manageable, process. Patients are primarily from Maryland; Delaware; southern Pennsylvania; Washington, DC; and northern Virginia. Patients are 12 to 20 years of age and meet the ASAM Patient Placement Criteria for medium-intensity (Level III.5) or high-intensity (Level III.7) residential placement (primary diagnosis of alcohol or drug dependence or abuse and meet at least two of the six ASAM dimensional criteria). Many also have a secondary mental health diagnosis. Initial admission to MMTC involves intake and utilization review to determine appropriate treatment placement, detoxification if needed, a comprehensive assessment, and treatment planning. The treatment program has core components that all patients receive (therapeutic milieu with level system, group therapy, individual therapy, community group meetings, and education). Most patients also receive an individualized combination of special services components (primary medical assessment, treatment, and health education; psychiatric treatment; family therapy; and a variety of specialty groups). All treatment is geared toward reintegration into the community. Discharge planning is an ongoing process that essentially begins on admission and continues beyond discharge. Discharge planning is a collaborative effort involving counselors, the treatment team, the individual patient, the patient's family, and other agencies. Careful discharge planning is considered essential in actualizing the MMTC philosophy that continuity of care is necessary to maintain the therapeutic gains made in residential treatment and to support the next step in lifelong recovery.

CHAPTER 3 INFRASTRUCTURE OF THE MMTC SHORT-TERM RESIDENTIAL PROGRAM

MMTC has developed a complex system to provide consistent, high-quality, chemical dependence treatment through a program that offers an individualized continuum of care for each patient and his or her family. An enormous effort by each member of the multi-disciplinary staff is essential to fulfilling MMTC's mission. Below is a description of MMTC's clinical team, education team, administrative team, and support services staff (including responsibilities, qualifications, training, and ongoing supervision), followed by a brief discussion of the financial aspects of the program, as well as MMTC's community partners.

MMTC Multi-Disciplinary Team

Clinical Team
Psychiatrists
Psychologists
Physician/Adolescent Medicine Specialists
Primary Counselors
Mental Health Coordinator
Counselor Technicians
Physician Assistants
Nurses
Utilization Review Nurses
Admission Specialists
Aftercare Coordinator
Family Therapist
Art Therapist
Recreational Therapist

Education Team
Teachers
Teacher's Administrative Assistant

Administrative Team
Medical Director
Administrator
Associate Administrator
Clinical Program Director

Support Services Staff—medical records, human resources, clerical, dietary matters, housekeeping, maintenance/facilities, transportation, and security

Clinical Team

Psychiatrists

MMTC enjoys the services of psychiatrists with interest, experience, and training in the area of adolescent addiction medicine. They supply psychiatric services directly to the patients, provide supervision and guidance in the development of treatment plans, and are a rich source of information and education in promoting professional development to the entire clinical staff. MMTC psychiatrists also design and participate in systematic research in the area of adolescent substance abuse disorder treatment. Clinically, they perform assessments, make diagnoses for patients with co-occurring disorders, and provide ongoing therapy. They also provide followup treatment for those patients who come to MMTC on psychotropic medications. The medical director and associate medical director have board certification in Added Qualifications in Addiction Psychiatry and ASAM certification in Addiction Medicine.

Psychologists

MMTC also provides psychological services through doctoral-level psychologists with specialty experience assessing adolescents with substance abuse disorders and co-occurring psychiatric disorders. The psychologist is responsible for providing assessments of

cognitive, behavioral, and emotional functioning with recommendations for treatment, educational/vocational training, referrals, and aftercare residential placement. The psychologist also provides consultations for the counselors and is an educational resource for staff development.

Physician/Adolescent Medicine Specialist

MMTC uses the services of a pediatrician who specializes in adolescent medicine and is well-experienced in the treatment of adolescents with substance abuse disorders. The pediatrician is responsible for supervising and reviewing all admission histories and physicals performed by physician assistants. The pediatrician is available for consultation on physical medicine issues presented by any of MMTC's patients and directs the medical care for those adolescents presenting with medical problems. The pediatrician is board certified in adolescent medicine with experience and expertise in adolescent addiction medicine.

Primary Counselors

MMTC employs nine full-time counselors, who are each responsible for six to eight patients. They have primary responsibility for implementing the individual treatment and case management for their caseloads of six to eight patients. They also are responsible for participation in the development of individual treatment plans, as well as the interpretation and implementation of these plans. A multi-disciplinary team, consisting of all counselors, the program director, mental health care coordinator, administrator, utilization review nurse, director of nursing, and a psychiatrist, develops treatment plans. The team meets for 2 hours twice per week to discuss all patients. The counselors are responsible for collecting admission information from referring agencies, parents, admitting and staff nurses, and the patient through a thorough biopsychosocial assessment. The counselor begins an initial treatment plan and presents the patient to the treatment team for further development of the patient's treatment plan to address his or her substance use disorder and associated impairments. Counselors are also responsible for reporting their patients' treatment progress to the treatment team so treatment plans can be modified as patient needs change.

The counselor is responsible for implementing the treatment plan through daily group therapy sessions, weekly (or more) individual sessions, and family sessions as needed. Counselors vary in how they conduct their group therapy sessions; they vary in their strengths and favorite techniques. However, all counselors are well-trained in a variety of therapeutic techniques, and all meet or exceed the following core competencies:

- Demonstrates comprehensive knowledge of addiction and dual diagnosis treatment
- Demonstrates comprehensive knowledge of appropriate and effective clinical techniques with individuals, groups, and families
- Demonstrates knowledge of appropriate referral sources
- Demonstrates knowledge of adolescent developmental needs and issues.

All patients are expected to receive substance use disorder education and recovery skill training, but groups may also concentrate on motivation to change, issues interfering with recovery (such as behavior, emotional, or interpersonal problems), and the development of future goals, such as decreased legal involvement and education/vocational training options.

Counselors also provide many case management services. They are responsible for the following:

- Keeping third party reimbursement agencies informed of progress and treatment needs to obtain reauthorization for continued services

- Responding and communicating with patients' families and interested parties, such as juvenile justice and social service agencies

- Developing and facilitating discharge planning in conjunction with the aftercare coordinator regarding substance use disorder treatment, living environment, and education.

The counselor is in a unique position to identify the needs of patients and refer them to special services on an individual basis, such as psychiatric evaluation and treatment, psychological evaluation, or specialty groups for therapy.

All counselors must have a minimum of 1 year of college (a bachelor's degree is preferred), with 2 to 4 years of counseling experience with adolescents with substance use disorders. They must be licensed in Maryland as a Certified Addictions Counselor.

Mental Health Coordinator

MMTC employs one full-time mental health coordinator (MHC). The MHC acts as a liaison between the medical, psychiatric, and clinical facets of the treatment program in order to facilitate the coordination of patient care while the adolescent is an inpatient and makes plans and referrals for the continuation of care after discharge. The MHC performs a triage function for psychiatric and psychological assessment referrals. The MHC gathers historical and current information from patients, families, staff members, and referring agencies and coordinates psychiatric care for inpatients. The MHC provides appropriate feedback regarding case management and mental health issues and also relays information between nursing, medical, and clinical staff members, as well as patients and their families. The MHC is available for crisis intervention when necessary. The MHC is also a mental health educational resource for staff members, patients, and families.

The MHC has a minimum of a master's degree, but a doctoral degree is preferred. The MHC has at least 2 to 4 years of experience with adolescents with substance abuse disorders and co-occurring psychiatric disorders. The MHC must, at a minimum, be a Certified Professional Counselor–Alcohol and Drug (CPC-AD) or be working toward certification; ideally, the MHC should be a Licensed Professional Counselor (LPC), a Licensed Clinical

Alcohol and Drug Counselor (LCADC), or a Licensed Clinical Social Worker–Certified (LCSW-C).

Counselor Technicians

MMTC employs approximately 40 full-time counselor technicians (CTs) for 24-hour coverage, 7 days per week. There are typically 11 technicians during the day, 11 during evening hours, and 7 during the night. Each CT is responsible for a particular group of adolescents each shift. Their main responsibility is to maintain the therapeutic milieu, incorporating some features of the therapeutic community model, which uses programmatic techniques, emphasizing the group milieu as the locus of recovery. CTs help patients reach their goals of the following: normalizing peer and other interpersonal relations, practicing developmentally appropriate social roles, acquiring social skills, learning peer support and confrontation skills, and learning peaceful assertiveness and conflict resolution. One of the most important goals of the therapeutic milieu is induction into a healthier peer group that is struggling with the initial formation of a positive group identity that emphasizes recovery and overcoming adversity.

In an effort to realize the goals, CTs model appropriate social behaviors and are well trained in crisis prevention and intervention. This includes skills in isolating distraught patients, one-on-one problem solving, group problem solving, crisis de-escalation, and therapeutic holds when absolutely necessary for patient safety. CTs are responsible for enforcing behavioral compliance with social norms and facility rules, providing supervision as groups move from one location to another (e.g., resident hall, classroom, cafeteria, game room), as well as one-on-one monitoring of patients at risk for suicide and/or elopement.

CTs must have a minimum of a high school education or GED or are currently working toward this requirement. They must also have either 2 years of experience working with this population or personal experience with a substance use disorder with at least 2 years of successful recovery. Those CTs in recovery are excellent role models and provide a sense of hope to patients struggling with addiction.

Physician Assistants

MMTC employs one full-time and one part-time physician assistant. Their primary function is to provide medical treatment to all of MMTC's patients under the supervision of the medical director. The medical treatment primarily addresses the signs and symptoms of illnesses secondary to chemical dependency, as well as those problems directly associated with detoxification. They are also responsible for the ongoing care of any pre-existing conditions that the patients may present with, such as seizure disorders, diabetes, or sickle-cell anemia.

The physician assistants perform histories and physicals on all newly admitted patients, develop the initial medical treatment plan, refer to outside specialists as needed, and assess patients on an emergency basis as needed. The physician assistants are part of a multi-disciplinary team and serve other needs as well. They provide patient/parent teaching, serve

as consultants to nursing and counseling staffs, assist in the planning and implementation of new treatment services, participate in staff development, and participate in research efforts.

The physician assistants must be licensed by the State of Maryland Board of Physician's Quality Assurance and certified by the National Commission on Certification of Physician Assistants.

Nurses

MMTC employs nine full-time nurses, including the director and assistant director of nursing. The staff is composed of registered nurses (RNs) and licensed practical nurses (LPNs). MMTC has two nurses present every day and one nurse present every night, all working 12-hour shifts. The director of nursing is present during the day on Monday through Friday. Staff nurses are responsible for the following:

- Medical admission interviews
- Nursing care plans
- Communication of patient needs to the physician assistants and physicians
- Referrals for psychiatric care
- Laboratory specimen collection
- Tuberculosis assessment
- Communication of dietary needs to the dietician
- Administration of medications and monitoring their effects
- Evaluation of medical emergencies and the initiation of emergency services
- Daily, 24-hour monitoring of patients requiring detoxification.

The director and assistant director of nursing are capable of performing staff nursing duties and provide supervision, leadership, and continuing education to their staff members. In addition, they contribute in the development and implementation of policies, procedures, and goals that enable the nursing staff to fully support organizational objectives. The director of nursing is also responsible for coordinating yearly CPR recertification and first aid training for MMTC employees.

The director of nursing must be a RN with at least a bachelor's degree and 5 to 8 years of experience working with patients with substance use disorders. The assistant director of nursing should be a RN, with at least an associate's degree and 5 years of experience with this population. The staff nurses must be either RNs or LPNs with at least 2 years of technical training and, preferably, experience working with this population. All nurses must have either an active RN or LPN Maryland license in good standing.

Utilization Review Nurses

MMTC employs two full-time utilization review nurses. They are responsible for patient assessment and the development of treatment plans. They must assess the adolescents' substance use problem, identify the severity of their substance use disorder, and match the treatment plan with need according to ASAM Patient Placement Criteria (see chapter 2).

They must communicate the recommended treatment plan to third party reimbursement agencies as required by those agencies and maintain documentation of pre-authorization. This can be a complicated task, since all agencies differ in their requirements and the benefits they are willing to assign for particular levels of patient need. Therefore, one of the duties is to educate the reimbursement agencies on adolescent substance use disorders and appropriate, effective treatment. They are also responsible for informing the administrator and direct care providers (MMTC counselors) of the restrictions or particular treatment components dictated by the third party agency. For example, a utilization review nurse is responsible for informing the counselor that the agency is willing to pre-authorize treatment if, and only if, the child is going to receive psychiatric evaluation and therapy. The counselor would then be responsible for implementing this part of the treatment plan. Once the initial pre-certification is obtained, each patient's counselor is responsible for obtaining and documenting re-authorization.

The utilization review nurse must have a minimum of an associate's degree (a bachelor's degree or higher is preferred). Knowledge of adolescents with substance use disorders, as well as experience with communicating and obtaining authorizations from third party agencies, is preferred.

Admission Specialists

MMTC employs two full-time admission specialists for the short-term residential program. They are responsible for conducting the initial evaluation of each prospective patient and making recommendations regarding admission. They need an extensive knowledge of addiction and the addiction process, as well as the ASAM Patient Placement Criteria, to match the appropriate treatment with each individual's current needs. They are also responsible for communicating this information to agencies that are seeking treatment for their populations (i.e., juvenile justice agencies). They are responsible for interpreting and developing regulatory and contractual standards and arrangements with referring agencies regarding admissions to MMTC.

The admission specialists are responsible for accepting referral calls from patients, patient families, and responsible public agencies (i.e., probation officers, social workers). They must collect information from a variety of sources regarding substance use history, social impairment, judicial involvement, family history, and clinical criteria for admission. They assist in making decisions regarding the priority of each admission and the evaluation of emergency situations. They must provide information to patients, the patients' families, the public, and responsible public agencies on adolescent substance use disorders, dual diagnosis, and the continuum of care available for effective treatment.

The admission specialists must have a minimum of a bachelor's degree (a master's degree is preferred). They should have experience working with adolescents in a residential community and, preferably, have experience communicating with the public regarding adolescent substance abuse and treatment.

Aftercare Coordinator

MMTC employs one full-time aftercare coordinator. The coordinator is responsible for creating an optimum continuing care plan for patients who are being discharged from the residential program. Discharge may be due to completion of the program, therapeutic discharge for failure to comply with the program, self-discharge against medical advice, or administrative discharge due to the inability to obtain adequate funding. The MMTC residential program is not a long-term solution for the chronic remitting/relapsing nature of substance use disorders. Therefore, the aftercare coordinator ensures that patients are referred for the treatment that is appropriate to each adolescent's individual needs.

The aftercare coordinator must have a minimum of a high school diploma, and a bachelor's degree or higher is preferred. The coordinator must have a comprehensive knowledge of addiction and dual diagnosis treatment and be able to develop good working relationships with others involved with MMTC's patients, such as other recovery programs, alternate environmental placements (halfway houses), juvenile justice and social service agencies, and insurance companies. The coordinator develops comprehensive discharge plans with information from multiple sources, such as case managers, counselors, parents, probation officers, social workers, physicians, and the patients.

Family Therapist

The counselors provide family therapy services for their patients. In addition, MMTC enjoys the services of a family therapist who assists and supports the counselors in working with referred families. The focus of family therapy can be parenting skills, family dynamics, and substance use disorder education, strengthening the living environment to support the adolescent's recovery, sibling interpersonal dynamics, and family communication skills. The family therapist also provides consultation to other MMTC care providers and contributes to staff development in the area of understanding the role of family, adolescent addictions, and recovery.

The family therapist must have a minimum of a master's degree, licensure or certification to provide therapeutic services in the State of Maryland, and experience working with families whose member(s) have a history of substance use disorders.

Art Therapist

MMTC employs one part-time art therapist. The task of the art therapist is to assist patients, through various graphic and plastic media, in giving form and expression to thoughts, feelings, and emotions that might otherwise be too threatening to verbalize. The art therapist is a member of the treatment team and works with individual patients and with groups of patients in special art therapy groups once per week. The art therapist consults with the rest of the treatment team to identify patients that might benefit from art therapy and also provides feedback to other care providers if patient issues come to light that warrant special attention. The art therapist must have at least a bachelor's degree and also should have experience providing art therapy to adolescents with substance use disorders.

Recreational Therapist

MMTC employs one full-time and one part-time certified recreational therapist. The recreational therapist develops and implements daily group recreational activities and works with some patients to develop individual recreational plans. The recreational therapist must have a minimum of a bachelor's degree (or a master's degree for certification) and experience with adolescent recreation.

Supervision of the Clinical Staff

Supervision of the clinical staff and staff development are critical to providing the highest quality care to the patients at MMTC. Supervision and ongoing training are primarily provided by the clinical program director, the mental health coordinator, and the administrator. Additionally, the counselor technician supervisor provides additional supervision of counselor technicians.

Counselors participate in weekly individual and weekly group supervision. On a weekly basis, the clinical program director and the mental health coordinator meet individually with each counselor for the purposes of ongoing case review, treatment planning, and aftercare planning. Through the use of a clinical supervision form, each adolescent's treatment plan and progress are evaluated, as well as the counselor's skills and knowledge of appropriate therapeutic techniques. Each adolescent's discharge plan is also reviewed through the use of an aftercare tracking form. This is used to manage information about the status of aftercare planning, allowing the supervisors to monitor the counselor's execution of critical tasks in preparation for the client's discharge. Some of the key tasks monitored include substance abuse treatment referral disposition, mental health referral disposition, completion of discharge summary, and status of preparation of treatment records (such as copies of psychiatric evaluations, psychological testing reports, and school progress reports) for transfer to other agencies.

The clinical program director and mental health coordinator meet with all counselors in a group format on a weekly basis. This type of supervisory meeting allows the supervisors to communicate with the counseling team as a whole and gives the counselors an opportunity to interact and provide input on clinical case management and share strengths and weaknesses. On a more informal basis, supervision is also provided daily in a status meeting that reviews case management needs and strategies for each patient. Twice-weekly treatment team meetings also afford an opportunity for all clinical staff members to review specific patients and their treatment in a more didactic, in-depth manner.

Training of the Clinical Staff

Clinical staff training at MMTC is equally important to patient care. MMTC provides a variety of training activities for employees; some activities are mandatory, and some are optional but highly encouraged for professional growth and development. Mandatory training is required by regulatory bodies, such as the Maryland Alcohol and Drug Abuse

Administration (ADAA), the Maryland Department of Juvenile Justice, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Regulatory bodies require that clinical staff members are trained in CPR and first aid. MMTC requires crisis prevention and intervention training. Educational topics are planned on a yearly basis, but additional ones are added when there is a particular interest or need. Some of the frequent topics in the past include the following:

- ASAM Patient Placement Criteria
- Adolescent development
- Psychotropic medications for adolescents
- Motivational enhancement therapy (MET) training
- Cognitive-behavioral therapy
- Ethics and professionalism
- HIV/AIDS prevention
- Adolescent sexuality
- Learning disabilities
- Crisis intervention
- Group therapy skills enhancement
- Biology of drug abuse
- Current research in drug abuse
- Family therapy.

The clinical staff members are required to attend 80% of the training sessions and are strongly encouraged to attend as many sessions as their schedules will allow. All MMTC staff members are invited and encouraged to attend.

Education Team

Teachers

MMTC employs five full-time teachers. Teachers are responsible for the assessment of all patients' current academic functioning, as well as designing and implementing individualized education plans. They are responsible for planning long-term goals and short-term objectives for each patient's educational program. They provide functional curriculum in reading, writing, math, and citizenship. They provide remedial educational services to the patients who lag behind expected achievement levels because of a lack of experience related to substance use, cognitive limitations, or particular learning disabilities. They also develop, plan, and provide daily life skills necessary for independent living, such as budgeting, understanding transportation schedules, understanding how to access governmental agencies and services, and earning a GED.

The teachers must have at least a bachelor's degree, 2 to 4 years of teaching experience, and teacher certification from the Maryland State Department of Education.

Teacher's Administrative Assistant

MMTC employs one full-time teacher's administrative assistant (TAA). The TAA is responsible for performing academic achievement assessments for all new patients to assist the teachers in developing an appropriate IEP. The TAA is also responsible for maintaining all patients' school records while at MMTC. This includes obtaining their previous school records, maintaining their records while they attend school at MMTC, and submitting appropriate documentation of credits earned at MMTC to their school after discharge.

The TAA must have a minimum of a high school diploma or GED and some experience working with adolescents with substance use problems.

Administrative Team

Medical Director

The primary responsibility of the medical director is the direction, operation, and administration of procedures used in the clinical treatment offered to patients. However, the medical director, administrator, and associate administrator compose the management team that implements and oversees all facets of MMTC's operations. The medical director assumes primary responsibility for clinical management, including oversight of medical, psychiatric, nursing, and pharmacy services, as well as the establishment of standards for substance use disorder treatment in MMTC's acute, short-term residential facility. The medical director is responsible for the development and implementation of State and national standards in order to achieve the highest quality of addiction services. The medical director establishes the line of authority and supervision that culminates with key personnel members who ensure that the organizational structure is consistent with policies and procedures. The medical director serves as a liaison between the board of directors and key administrative personnel in order to set policy, make budgetary forecasts, and guide the program to operate within those parameters, subject to revenues and cost factors.

Administrator

The administrator is responsible for establishing MMTC as a comprehensive, multi-service facility for the treatment of adolescents with substance use disorders and securing the continued and successful operation of the facility. The administrator, along with the medical director, is responsible for administrative, clinical, medical, and managerial functions, including policies and procedures that develop and implement standards for the highest quality delivery of services.

While the administrator's prime responsibility is to have authority for the overall quality of direct and indirect services to patients and their families, with particular attention to clinical program services and staff human resources, he or she is also responsible for maintaining the flow of information back and forth from the board of directors through the organization. The administrator supervises the inpatient program director, director of education, outpatient adolescent director, medical records director, human resources director, and director of

nursing. The administrator chairs treatment team meetings and participates in supervisory, staff development, department head, and research meetings to facilitate communication throughout the facility.

The administrator also has fiscal responsibilities, specifically monitoring expenses and revenues and making decisions accordingly. The administrator is responsible for compiling a monthly report for the board of directors, which includes new hires/resignations/discharges, overtime, outpatient and inpatient statistics, program initiatives, performance improvement plans, regulatory affairs, outpatient and inpatient referral sources, and the inpatient payer mix. The administrator keeps records on a fiscal year basis to keep the board abreast of inpatient and outpatient admissions, inpatient patient days, outpatient contacts, inpatient average length of stay, and inpatient average daily census.

The administrator also has human resource responsibilities. The administrator must ensure the presence of an appropriate complement of qualified, competent staff members who are in compliance with ever-changing JCAHO accreditation standards and State licensures and certification. Since minimizing staff turnover at all levels of employment is beneficial to patient care and MMTC, the administrator must be attentive to the staff's needs in terms of job advancements, salary increases, and creating job satisfaction. To ensure the highest quality of care and patient safety, the administrator must provide timely interventions concerning any incident investigations and possible disciplinary actions.

The administrator must have a bachelor's degree or higher in human services, psychology, or social work and have more than 8 years of experience in residential addictions treatment. He or she must be licensed in Maryland as a LCADC or LCSW.

Associate Administrator

The overall responsibility of the associate administrator is to support the administrator. While the administrator is responsible for the clinical or direct patient care issues, the associate administrator is responsible for "non-clinical" or indirect patient care issues. The associate administrator manages all of the support services and is the safety officer for the facility. The associate administrator's prime responsibility revolves around environmental issues affecting patient and staff comfort and safety, such as maintenance, dietary matters, housekeeping, transportation, groundskeeping, and security. The associate administrator supervises the maintenance supervisor, dietary supervisor, transportation supervisor, and security personnel.

The associate administrator must have a minimum of a high school diploma and should have at least 2 years of college, with 2 years of related experience.

Clinical Program Director

The clinical program director is responsible for the daily development, implementation, and supervision of all non-medical clinical services provided by the primary counselors and counselor technicians. This position oversees treatment planning, new admission processing,

discharge coordination, and community liaison with external agencies, such as the Maryland Department of Juvenile Justice. The clinical program director conducts the full staff treatment plan review of all patients, as well as schedules all classes, lectures, and clinical meetings. The clinical program director also develops new specialty groups as the need arises. The clinical program director establishes and maintains the therapeutic milieu through which the principles of recovery are transmitted and put into practice. The clinical program director also supervises the documentation process for all patients.

The clinical program director must have a bachelor's degree; however, a master's degree is preferred, with a minimum of 2 years related experience.

Support Services

MMTC also employs a number of other individuals who do not provide direct patient care but are critical to the success of its operations. These include the following:

- Medical records—3.5 employees, including a director and transcriptionists
- Human resource director—1 full-time human resource director who maintains employee records and benefits
- Clerical staff—3.5 employees who provide clerical and administrative support
- Dietary staff—6 employees who provide three nutritionally sound meals and snacks per day
- Housekeeping staff—6 employees who provide cleaning services
- Maintenance/facilities—4 employees who provide onsite maintenance and facilities upkeep
- Transportation staff—6 drivers who provide transportation for inpatients and outpatients, including transport for admission, court appearances, outside physician appointments when needed, and special recreational outings
- Security—1.8 security guards who provide services during the night for the entire facility.

Finances

The overall financial operation of the program is based on the billing of a variety of third party payers (the largest being the Maryland Medical Assistance/Medicaid Program) for reimbursement based on a bundled per diem rate. This facility receives no additional supplements in Federal, State, municipal, or foundation grants or donations. The program is operated by a privately held "C corporation" and operates at an approximately break-even

level. The program is classified under Maryland State regulations as an intermediate care facility for chemical dependency services (ICF-CD).

The MMTC payer mix is as follows:

- Medicaid (non-managed care), 40 to 50%
- Medicaid (managed care), 10 to 20%
- Commercial insurance, 5 to 10%
- Governmental contract purchase of care agreements, 30 to 40%
- Self pay, 1%
- Uncompensated care, ~5%.

Per diem rates are negotiated with individual payers. Per diem rates tend to be bundled, inclusive of professional (including physician) fees. The exception is that some contracts allow for the additional unbundled reimbursement of laboratory and/or pharmacy fees at cost. Unmanaged Medicaid is administered through the usual Federal program and State block grant procedures under a strictly cost reimbursement system. The State of Maryland imposes a maximum, which provides a rate cap on allowable costs within which ICF-CD programs operate.

Since July 1997, Maryland has undertaken a Medicaid managed care initiative, and a portion of the program's patients are funded that way. Maryland Medicaid managed care has a mental health carve-out, which is distinguished from substance abuse services. Substance abuse services are included as a component of somatic care. Under this system, Medicaid patients are assigned to Medicaid managed care organizations (MCOs), which are responsible for providing somatic medical care, including substance abuse. MMTC contracts with these Medicaid MCOs like any other commercial provider, with a negotiated per diem rate and a utilization management gatekeeping function.

Managed care, including Medicaid managed care, constitutes approximately 15 to 30% of patients. These patients require pre-certification for admission and ongoing certification for continued stay under "medical necessity" criteria as determined by managed care reviewers. Most commercial MCOs have their own idiosyncratic criteria. Maryland has mandated the use of the ASAM criteria for the Medicaid MCOs. Some managed care agencies approve several weeks of treatment once a need has been initially demonstrated; others want day-to-day updates on patient progress and re-justification of services. This, of course, requires considerable resources, and much time is expended by the clinical team, the administrative team, and the business office over these and related utilization reviews and management functions.

A significant portion of patients (approximately 40 to 50%) continue to be funded under non-managed Medicaid. Services for these patients are reimbursed at a per diem rate set to match the facilities costs, up to a prescribed cap. This rate is usually adjusted annually according to a Medicaid cost report audit. These patients are certified for admission under an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) system, requiring certification through an independent examination by a physician and an independent psychosocial

assessment by a social worker. This level of care certification is required under Maryland regulations for non-managed Medicaid reimbursement for an ICF. Treatment can be provided by any referring treatment providers (e.g., clinics, outpatient program or practices, community agencies, State agencies). MMTC also has a referral relationship with a number of local independent community providers that have a particular interest in MMTC's target population, can be available at relatively short notice to perform screening evaluations for referrals, and can provide level of care certification as appropriate. Under current Maryland Medicaid regulations, an initial level of care certification through the EPSDT evaluation/referral system provides certification for up to 30 days of residential care. Up to two subsequent 15-day extensions are allowable on the basis of need and treatment plan, and they require certification with justification of need by independent evaluation through the EPSDT system. This reimbursement system thereby routinely allows lengths of stay of 30 days and, with further incremental extensions through justification, lengths of stay up to 60 days for patients 17 years of age or younger and 45 days for patients who are 18 to 20 years old.

MMTC also makes use of additional contracts to provide care to its community of adolescents. The Maryland Alcohol and Drug Abuse Administration provides funding on a contractual basis for "gray area" patients, that is, those who are uninsured or underinsured. ADAA has its own internal utilization management system, based on ASAM criteria. ADAA will often provide sliding scale supplemental funding to uninsured or "self-pay" patients (especially important for the so-called "working poor" families who are not eligible for Medicaid coverage). ADAA will also sometimes provide funding to extend length of stay for treatment of patients who have coverage under commercial insurance that may have utilization review criteria that are significantly more restrictive than the ASAM criteria. MMTC also has a variety of smaller volume contracts from State agencies from surrounding areas (including Delaware, Virginia, and the District of Columbia) to provide adolescent services that patients in these areas cannot obtain locally.

Community Relations and Community Partnerships

Since its inception, MMTC has forged links with stakeholders in the immediate surrounding neighborhood, as well as the larger community as a whole. Some of the community partnerships are described below.

Community Advisory Board

This board provides input to MMTC regarding program operation and its impact on the local neighborhood. The community advisory board meets quarterly to review ongoing program operations and new programs in development.

Academic and Research Partners

- Johns Hopkins University School of Medicine. MMTC has a history of a long collaborative relationship with Johns Hopkins. The MMTC medical director, program psychiatrists, and pediatricians have faculty appointments at Johns Hopkins Hospital.

Additionally, MMTC has served as a training site for Johns Hopkins medical students, psychiatry residents, and fellows.

- University of Maryland. For many years, MMTC has served as a training site for social work students from the University of Maryland. Some members of the professional clinical staff at MMTC are on the faculty at the University of Maryland.

- Potomac Healthcare Foundation (PHF). MMTC has established a collaborative relationship with PHF (and with academic partners at Johns Hopkins) to conduct evaluation research. PHF has taken the lead as the primary evaluator on CSAT-funded projects at MMTC, including the current Adolescent Treatment Models initiative (evaluating the residential program), the Targeted Capacity Expansion (TCE) program (evaluating the outpatient program), and the Adolescent Residential Treatment program (evaluating the transition from inpatient to outpatient treatment at MMTC).

- Baltimore City Health Department, Baltimore Substance Abuse Systems (BSAS). MMTC has a history of working closely with local governmental agencies, including the health department and BSAS, the local agency that administers all publicly funded substance abuse treatment services in the city. Some joint initiatives include the placement of MMTC substance abuse counselors in local school settings for early identification and early intervention services and the current TCE initiative, which is developing a linked system of care providing substance abuse, mental health, and primary medical care services to adolescents in the community.

Summary

It takes a diverse group of dedicated individuals to address the issues involved in treating adolescents with substance use disorders. MMTC is fortunate to have staff members who are from such a varied range of disciplines and who are dedicated to providing quality chemical dependence treatment with a program that offers an individualized continuum of care for each patient and his or her family. MMTC's clinical, educational, and administrative teams, along with support services, innovative financial specialists, and community partners, are continually evolving to meet the challenge of providing treatment for adolescents with substance use disorders.

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