

**DBHS Practice Protocol**

**COMPREHENSIVE ASSESSMENT AND TREATMENT FOR SUBSTANCE USE  
DISORDERS IN CHILDREN AND ADOLESCENTS**

**(Formerly known as Practice Improvement Protocol #10)**



**Developed by the  
Arizona Department of Health Services  
Division of Behavioral Health Services  
(ADHS/DBHS)  
Effective- August 30, 2009**

**NOTE:**  
**This Clinical Practice Protocol has required implementation elements. Providers are required to implement the identified Service Expectations, as clearly identified in this document.**

**Title**

**Comprehensive Assessment and Treatment for Substance Use Disorders in Children and Adolescents**

**Goal/What Do We Want to Achieve Through the Use of this Protocol?**

To strengthen the capacity of Arizona’s behavioral health system to utilize evidence-based, culturally relevant, and developmentally appropriate practices in the assessment and treatment of substance use disorders in children and adolescents.

**Target Audience**

This protocol is specifically targeted for Tribal and Regional Behavioral Health Authorities (T/RBHAs) and their subcontracted network and provider agency staff who complete assessments, participate in the service planning process, provide therapy, case management and other clinical services, or supervise staff that provide these services to children and adolescents with substance use disorders and their families.

**Target Population(s)**

This practice protocol has been developed for all children and adolescents referred to the behavioral health system at risk for or with substance use disorders and their families.

**Attachments**

[Attachment A: Adolescent Substance Abuse Screening Instruments](#)

[Attachment B: Adolescent Substance Abuse Comprehensive Assessment Instruments](#)

[Attachment C: Evidence Based Practices for Adolescent Substance Abuse Treatment](#)

[Attachment D: Recommended Specialty Topics for Trainings](#)

**Definitions**

[Alcohol and Drug Abuse Program](#)

[Alcohol and/or Drug Services, Intensive Outpatient Program \(IOP\)](#)

[Evidence Based Practices \(EBP\)](#)

## **Background**

Substance use disorders usually start during adolescence; early age of onset and more rapid progression through the stages of substance use are risk factors for substance use disorders.<sup>1</sup> It is critical that treatment programs be designed specifically for adolescents as there are numerous differences between adolescent and adult substance use disorders. Adolescent substance use disorders have far-reaching neurological, developmental, social and economic ramifications. The numerous adverse consequences associated with adolescent substance use disorders include fatal and nonfatal injuries from alcohol- and drug-related motor vehicle accidents, suicides, homicides, violence, delinquency, psychiatric disorders, and risky sexual practices.<sup>2</sup>

Longitudinal studies have also established associations between adolescent substance use disorders and (1) impulsivity, alienation, and psychological distress,<sup>3</sup> (2) delinquency and criminal behavior,<sup>4</sup> (3) irresponsible sexual activity that increases susceptibility to HIV infection,<sup>5</sup> (4) psychiatric or neurological impairments associated with drug use, especially inhalants, and other medical complications.<sup>6</sup>

The trend toward early onset of substance use disorders has increasingly resulted in adolescents who enter treatment with greater developmental deficits and possibly greater neurological deficits than have been previously observed<sup>7</sup>.

***Academic Problems:*** Impairment in academic functioning is a hallmark of substance use disorders in adolescence.<sup>8</sup> A deterioration in school performance, including attentional difficulties in the classroom and declining grades, warrants investigation into the potential causes, which should include a screening for substance use disorders.

***Developmental Problems:*** Substance use can prevent an adolescent from completing the developmental tasks of adolescence and young adulthood and influence later behaviors such as dating, marrying, bearing and raising children, establishing a career, and building rewarding personal relationships.<sup>9 10</sup> Because substance use alters the way individuals approach and experience interactions, the adolescent's psychological and social development is compromised, as is the formation of a strong self-identity. Instead of developing a sense of empowerment from healthy personal development, the substance-using adolescent is likely to acquire a superficial and false self-image as he becomes more deeply entrenched in the drug experience.<sup>11</sup> Use of alcohol or drugs may also hinder adolescents' emotional and intellectual growth. Some adolescents may use substances to compensate for a lack of rewarding personal relationships. Treating an adolescent with substance use disorders as early as possible maximizes the opportunity to stem these initially short-term, but potentially long-term, ill effects.

***Family and Peer effects:*** Substance abuse disorders tend to aggregate in the families. This may be in part due to some common genetic influences within families; however, there is substantial evidence of environmental mediation. Parental drug use, as well as drug use by older siblings, is a significant risk factor for the development of adolescent

substance use. However, the mechanism of transmission is complex, with individual personality dimensions mediating the effect of sibling and parent influences.<sup>12</sup> Association with delinquent peers has been one of the hallmarks of the development of adolescent substance use disorders. However, while the common notion has been that peers create “peer pressure” to consume substances, most studies support the notion that there exists a complex process by which individuals select peer groups, then in turn influence these, as well as influenced by them.<sup>13</sup>

***Genetic and Environmental Influences:*** Twin and adoption studies have demonstrated that considerable shared environmental influences exist for initiation of substance use, and that genetic influences become more apparent when environments allow for their expression.<sup>14</sup> Genetic influences on the development of substance use disorders may act through a direct effect on psycho-physiological reactions to substances or their metabolism, or indirectly through genetic effects on personality traits such as behavioral disinhibition, which leads to substance experimentation.<sup>15</sup> Thus, genetic factors influence individual risks, but do not account for population wide shifts in patterns of substance use.

***Juvenile Delinquency and Crime:*** There is a strong and consistent association between conduct disorder and substance use among adolescents.<sup>16</sup> An increasing number of adolescents entering residential treatment for substance use disorders have been criminally active and mandated to treatment by the criminal justice system.<sup>17</sup> Drug testing data collected on male juvenile arrestees through the National Institute of Justice (NIJ) confirms a strong and continuing relationship between the extent of drug use and juvenile crime.<sup>18</sup>

***Mortality:*** Alcohol-related motor vehicle accidents exact a heavy toll on society in terms of economic costs and lost productivity. Nearly half (45.1 percent) of all traffic fatalities are alcohol-related, and it is estimated that 18 percent of all drivers between the ages of 16 to 20 years, totaling 2.5 million adolescents and young adults, drive under the influence of alcohol.<sup>19</sup>

***Sexually Risky Practices:*** Adolescents who use alcohol and illicit drugs are more likely than others to engage in sexual intercourse and other sexually risky behaviors. A positive correlation has been demonstrated between alcohol use and frequency of sexual activity. Substance use among adolescents is also associated with early sexual activity, an important factor in the prevalence of sexually transmitted diseases (STDs) including human immunodeficiency virus (HIV) infection. Substance use can also decrease an individual's discrimination in the selection of sexual partners and can increase the number of partners and the likelihood of risky sexual practices thereby heightening the risk of STDs.<sup>20</sup>

Another substance use consequence related to sexual behavior is unwanted pregnancy. Out of an estimated 200,000 young women under the age of 18 who gave birth to a live infant each year, an estimated 12.4 percent used alcohol, 21.9 percent smoked cigarettes

and 5.7 percent used marijuana or cocaine while they were pregnant; these behaviors increase the risks of fetal alcohol syndrome, miscarriage, and restricted fetal growth.<sup>21</sup>

**Trauma:** Multiple pathways have been proposed to explain the temporal link between trauma and substance abuse in adolescents.<sup>22</sup> A review of these theories demonstrates that the road connecting these disorders runs both ways: trauma increases the risk of developing substance abuse, and substance abuse increases the likelihood that adolescents will experience trauma.

Although it is unclear exactly how many adolescents who abuse drugs or alcohol also have experienced trauma, numerous studies have documented a correlation between trauma exposure and substance abuse in adolescents. In the National Survey of Adolescents, individuals who had experienced physical or sexual abuse/assault were three times more likely to report past or current substance abuse than those without a history of trauma.<sup>23</sup> In surveys of adolescents receiving treatment for substance abuse, more than 70% of patients had a history of trauma exposure.<sup>24 25</sup> This correlation is particularly strong for adolescents with posttraumatic stress disorder (PTSD). Studies indicate that up to 59% of adolescents with PTSD subsequently develop substance abuse problems.<sup>18 21 26 27 28</sup> Recent research in this area also suggests that traumatic stress or PTSD may make it more difficult for adolescents to stop using, as exposure to reminders of the traumatic event have been shown to increase drug cravings in people with co-occurring trauma and substance abuse.<sup>29 30</sup>

## **Procedures**

Because of the unique challenges faced by adolescents with substance use disorders, including the potentially damaging and long-term consequences of substance use, it is critical that treatment programs be tailored to effectively screen, diagnose, and treat this population. The following eight elements must be incorporated into all adolescent substance abuse treatment programs:

- Comprehensive Screening and Assessment
- Integrated Treatment
- Family Involvement in Treatment
- Developmentally Appropriate Treatment
- Gender and Culturally Competent Treatment
- Engagement and Retention in Treatment
- Treatment Outcomes
- Continuing Care

### **1. Comprehensive Screening and Assessment**

**Screening** is a relatively brief process designed to identify adolescents who are at increased risk of having substance use disorders that warrant immediate attention, intervention, or more comprehensive evaluation. Screening is a triage process, and should

---

be employed with all children and adolescents entering the system; please refer to [Attachment A: Adolescent Substance Abuse Screening Instruments](#). Screening instruments should not be used to provide a psychiatric diagnosis; rather, they are utilized to help identify possible substance use issues and the need for further assessment and evaluation. If the screening raises concerns about substance use, the clinician should conduct a more formal evaluation to determine whether the adolescent meets criteria for substance use disorders.

The adolescent substance abuse *assessment* process is a more comprehensive and individualized examination of the psychosocial needs and problems identified during the initial screening; this includes assessing for mental health and substance abuse disorders, other associated issues, and recommendations for treatment intervention. Of note, this assessment process differs from the ADHS/DBHS Core Assessment, as the adolescent substance abuse assessment is specialized for adolescents who have screened positive. Components of an adolescent substance abuse assessment should include, but are not limited to clinical interviewing and review of previous records. Consideration should be given to psychological testing if clinically indicated. The assessment should be completed by staff that is trained and qualified in administering and interpreting the standardized assessment. Valid and reliable instruments are necessary for creating an effective assessment process; equally important is the knowledge on how best to use these instruments. Please refer to [Attachment B: Adolescent Substance Abuse Comprehensive Assessment Instruments](#).

The completed comprehensive assessment for the adolescent should include substance use disorder assessment and diagnosis, toxicology evaluation through the collection of bodily fluids or specimens, mental health assessment and diagnosis, testing for STDs if clinically indicated (including HIV, Hepatitis B and C), TB screening if clinically indicated, and assessment of the need for medical detoxification if clinically indicated. A comprehensive list of assessment components as recommended in the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMSHA/CSAT) Treatment Improvement Protocol 31 includes: <sup>31</sup>

- History of use of substances, including over-the-counter and prescription drugs, tobacco, and inhalants; age of first use; frequency, length, and pattern of use; mode of ingestion; treatment history; and signs and symptoms of substance use disorders, including loss of control, preoccupation, and social and legal consequences
- Strengths and resources to build on, including self-esteem, family, other community supports, coping skills, and motivation for treatment
- Medical health history and physical examination, noting, for example, previous illnesses, ulcers or other gastrointestinal symptoms, chronic fatigue, recurring fever or weight loss, nutritional status, recurrent nosebleeds, infectious diseases, medical trauma, and pregnancies
- Sexual history, including sexual orientation, sexual activity, sexual abuse, and STD/HIV risk behavior status
- Developmental history

- Mental health history, with a focus on depression, suicidal ideation or attempts, attention-deficit disorders, anxiety disorders, and behavioral disorders, as well as details about prior evaluation and treatment for mental health problems
- Family history, including the parents, guardians', and extended family's history of substance use, mental and physical health problems and treatment, chronic illnesses, incarceration or illegal activity, child management concerns, and the family's ethnic and socioeconomic background and degree of acculturation
- School history, including academic and behavioral performance, and attendance problems
- Vocational history, including paid and volunteer work
- Peer relationships, interpersonal skills, gang involvement, and neighborhood environment
- Juvenile justice involvement and delinquency, including types and incidence of behavior and attitudes toward that behavior
- Social service agency program involvement, child welfare agency involvement (number and duration of foster home placements), and residential treatment
- Leisure-time activities, including recreational activities, hobbies, and interests

#### **Service Expectations:**

- **Substance use disorder screening must be employed with all adolescents entering the behavioral health system using standardized screening instruments**
- **Adolescent substance use disorder treatment providers/programs must conduct comprehensive assessments that include the following:**
  - **Comprehensive substance use assessment and diagnosis using standardized assessment instruments and interview with the adolescent and caregiver**
  - **Screening and assessment of medical issues**
  - **STD screening (including HIV, Hepatitis B and C) if clinically indicated**
  - **TB screening if clinically indicated**
  - **Assessment of the need for detoxification if clinically indicated**
  - **Toxicology evaluation, through the collection of bodily fluids or specimens**

## **2. Integrated Treatment Approach**

Individualized service plans (ISPs) should be comprehensive, addressing each of the adolescent's needs including their substance use disorder. The substance use disorder should not be the only focus of treatment; treatment should also address medical, psychiatric, psychological, social, vocational, and legal problems. In addition, adolescents with substance use disorders should be treated in the least restrictive setting that is safe and effective. <sup>1</sup>

A matching of treatment settings, interventions, and services to the strengths and needs of each adolescent and their family is imperative, given that a single treatment approach will not adequately address the complex needs of all adolescents. At a minimum, the ISP should identify the following:

- *Strengths* of the adolescent and their family, including available natural supports
- *Problems* of the adolescent and their family, including substance use, psychosocial issues, medical problems, and psychiatric disorders
- *Goals* to address the target problems, including those that help the adolescent recognize and acknowledge responsibility for the problems associated with their substance use and take into account their preference for addressing these problems
- *Objectives* that are realistic and measurable steps for achieving each goal
- *Time frames* for the achievement of the stated goals/objectives
- *Appropriate interventions* including treatment strategies and services that are needed to achieve the goals/objectives. The specified treatment strategies and services should include the identification of the individuals who will be providing treatment, an expected timetable for achieving the objectives, the date the ISP will be reviewed, and where treatment is to take place<sup>32 33</sup>
- Assessment methods for *measuring* the extent to which goals/objectives and interventions are fulfilled
- *Collaborating* with educational, legal, and external support systems and their role in the ISP

Implementing Evidence Based Practices for adolescents with substance use disorders is recommended in order to maximize positive treatment outcomes; please refer to [Attachment C: Evidence Based Practices for Adolescent Substance Abuse Treatment](#). In order to use EBP effectively, staff must be trained and qualified, as indicated by adequate training and implementing practices to fidelity. Programs must be able to demonstrate which EBP is implemented, how training is conducted, and how fidelity is monitored.

Psychopharmacologic interventions for the underlying substance use disorder can also be considered for adolescents. Evidence is mounting for medications targeting alcohol-related cravings such as naltrexone, acamprosate, and ondansetron in adolescent case reports<sup>1</sup> and for a buprenorphine in the treatment of adolescent opiate dependence in a randomized control trial.<sup>34</sup> Due to the need for more research in this area, the informed consent process should include detailed rationale when treating adolescents with these medications.

Psychiatric disorders that are co-occurring with substance use disorders should be treated; specific psychotherapeutic interventions, depending on the co-occurring psychiatric condition, should be employed.<sup>1</sup>

Treatment outcomes should be continually assessed; the ISP should be modified to ensure that it meets the adolescent's changing needs and to ensure that progress is being made

toward the treatment goals. If progress is not being made, a re-evaluation of the ISP should occur to determine what changes are necessary to promote progress.

**Service Expectations:**

- **The ISP must comprehensively address the adolescent's substance use, medical, psychiatric, psychosocial, vocational/educational, and legal issues**
- **The ISP must be updated to reflect the changing needs of the adolescent and to ensure progress is being made**
- **Programs must be able to demonstrate which EBP is implemented, how training is conducted, and how fidelity is monitored**

### **3. Family Involvement in Treatment**

Engaging both the adolescent and caregiver, as well as maintaining close links with the adolescent's family, community, school, and other involved systems, ensures greater success in treatment.

As family members and caregivers play an important role in treatment initiation, engagement and in treatment outcomes, all efforts should be made to engage families. As previously reviewed, substance use disorders tend to aggregate in families. Therefore, it is important to not only engage family members and caregivers in the adolescent's treatment, but to also consider referring them for substance use disorder treatment if needed. Adolescents benefit from the integration of their family in their substance use disorder treatment in several ways. These benefits include positive treatment outcomes, increased likelihood of the adolescent's ongoing recovery, increased help for the family's recovery, and the reduction of the impact of substance use disorders on different generations in the family. The benefits for the treatment professionals include reduced resistance from adolescents, increased flexibility in treatment planning, an increased skill set, and improved treatment outcomes.

Some of the specific benefits of family involvement in adolescent substance abuse treatment are:<sup>35</sup>

- *Family interventions can help modify the maladaptive family relationship patterns that can contribute to, or result from, adolescent drug abuse.* Research has shown that family interventions can bring about improvements in overall family functioning and parenting practices by helping parents: create clearer rules and standards for behavior; develop predictable rewards and consequences; and improve their effectiveness in monitoring school performance and peer relationships.

- *Family members are key to helping with co-occurring disorders.* The treatment of adolescents who use alcohol and drugs is often complicated by the presence of a co-occurring psychiatric disorder. The ability of family members to observe psychiatric conditions and to support the adolescent in seeking help when psychiatric conditions worsen may be a critical component of the adolescent recovery process.
- *Family members are needed as change agents in the adolescent's environment.* Interventions that can help parents understand these complex systems, the potential allies that exist within them, and how to change the systems most effectively can have a profound impact on the long-term well being of the adolescent
- *Family interventions can result in beneficial effects long after the "treatment" phase is over.* The amount of time for the addiction treatment phase is typically brief, although current understanding is that recovery from addiction is not a linear process- still it can be a long process. When parents develop skills to guide their child through the process the positive impact may continue for many years to come
- *Family interventions can be used to bring an adolescent to treatment for the first time or can help to retain the adolescent in treatment.* With the family members serving as allies, the likelihood that an adolescent will continue to participate in treatment is greatly increased

**Service Expectations:**

**The caregiver should be actively included in the adolescent's treatment planning whenever possible in order to maximize outcomes.**

#### **4. Developmentally Appropriate Treatment**

The period of adolescence is a period of cognitive, emotional, social and physical growth. Adolescence is characterized by rapid physical growth including sexual maturation and development of secondary sexual characteristics. It is also characterized by motivational and emotional changes. Cognitive development includes maturation of impulse control, judgment, and planning. Due to this unique and rapid development, it is important that substance use disorder programs are specifically designed for adolescents rather than merely modified from adult programs.

Children and adolescents who present with substance use disorders often manifest with significant changes in mood, cognition, and behavior.<sup>1</sup> Behavioral changes may include disinhibition, lethargy, hyperactivity, agitation, somnolence, and hyper vigilance. Changes in cognition may include impaired concentration and perceptual disturbances in thinking. Mood changes can range from depression to euphoria. The manifestations of substance use and intoxication vary with the type of substance(s) used, the quantity used

during a given time period, the setting and context of use, and a host of characteristics of the individual such as experience with the substance, expectations of drug effect, and the presence or absence of other psychopathology.

A hallmark of substance use disorders in adolescents is impairment in psychosocial and academic functioning.<sup>14</sup> Impairment can include family conflict or dysfunction, interpersonal conflict, and academic failure. Associated characteristics include deviant and risk-taking behavior and comorbid psychiatric disorders such as conduct, attention-deficit/hyperactivity, mood, anxiety, and learning disorders.<sup>36 37 38</sup> Almost all psychoactive substances, including alcohol and nicotine, are illegal for adolescents to obtain, possess, and use; this can result in legal implications such as involvement with the juvenile justice system.

Recent research by scientists at the National Institute of Mental Health (NIMH) using magnetic resonance imaging (MRI) has found that the adolescent brain is not a finished product, but rather a work in progress. Until recently, most scientists believed that the major wiring of the brain was completed by as early as three years of age and that the brain was fully mature by the age of twelve. New findings indicate that the greatest changes to the parts of the brain that are responsible for functions such as self-control, judgment, emotions, and organization occur between puberty and adulthood. This may help to explain certain adolescent behavior, such as poor decision-making, recklessness, and emotional outbursts.<sup>39</sup>

Regardless of the specific model used when treating adolescents, the following are some recommendations provided by SAMSHA/CSAT:<sup>40</sup>

- Adolescents must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and unique environmental considerations such as peer pressure
- Not all adolescents who use substances are, or will become, dependent. Programs and counselors must be careful not to prematurely diagnose or label adolescents or otherwise pressure them to accept that they have a disease. This may do more harm than good in the long run
- Programs should be developed to take into account the different developmental needs based on the age of the adolescent; younger adolescents have different needs than older adolescents
- Some delay in normal cognitive and social-emotional development is often associated with substance use during the adolescent period. Treatment for these adolescents should identify such delays and their connections to academic performance, self-esteem, and social considerations
- In addition to age, treatment for adolescents must also take into account gender, ethnicity, disability status, stage of readiness to change, and cultural background.
- Programs should make every effort to involve the adolescent's family because of its possible role in the origins of the problem and its importance as an agent of change in the adolescent's environment
- Although it may be a necessity in certain geographic areas where availability of adolescent treatment programs is limited, using adult programs for treating

- adolescents is not advised. If this must occur, it should be done only with great caution and with alertness to the inherent complications that may threaten effective treatment for adolescents
- Many adolescents have explicitly or implicitly been coerced into attending treatment. However, coercive pressure to seek treatment is not readily conducive to the behavior change process. Consequently, treatment providers must be sensitive to motivational barriers to change at the outset of intervention. There are several strategies suggested by Miller and Rollnick for encouraging reluctant clients to consider behavioral change.

**Service Expectations:**

**Treatment must be tailored to address the unique cognitive, social, emotional and developmental needs of the adolescent**

## **5. Gender and Culturally Competent Treatment**

Adolescent substance use disorder treatment programs should provide services appropriate for the adolescent's age, gender, ethnicity, sexual orientation and culture. According to SAMHSA/CSAT Treatment Improvement Protocol 47<sup>41</sup>, culture is important to consider when providing substance use disorder treatment as the adolescent's experiences of culture precede and influence their clinical experience. Culture is a broad concept that refers to a shared set of beliefs, norms, and values among any group of people, whether based on ethnicity or a shared affiliation and identity. Therapeutic alliance should be informed by the clinician's understanding of the adolescent's cultural identity, social supports, self-esteem, and reluctance about treatment resulting from social stigma. The treatment provider is responsible for ensuring that treatment is effective for diverse clients.

SAMHSA/CSAT Treatment Improvement Protocol 47 provides guidelines for steps programs should take to ensure culturally competent treatment for their clients which includes:

- Assess the program for policies and practices that might pose barriers to culturally competent treatment for diverse populations. Removing these barriers could entail something as simple as rearranging furniture to accommodate clients in wheelchairs or as involved as hiring a counselor who is from the same cultural group as the population the program serves.
- Ensure that all program staff receives training about the meaning and benefits of cultural competence in general and about the specific cultural beliefs and practices of client populations that the program serves.
- Provide program materials on audiotapes, in Braille, or in clients' first languages. All materials should be sympathetic to the culture of clients being served.
- Ensure that client materials are written at an appropriate reading level.
- Include a strong outreach component. People who are unfamiliar with U.S. culture may be unaware that substance abuse treatment is available or how to access it.

- Hire counselors and administrators and appoint board members from the diverse populations that the program serves.
- Incorporate elements from the culture of the populations being served by the program (e.g., Native-American healing rituals or Talking Circles).
- Partner with agencies and groups that deliver community services to provide enhanced services, such as child care, transportation, medical screening and services, parenting classes, English-as-a-second-language classes, substance-free housing, and vocational assistance. These services may be necessary for some clients to be able to stay in treatment.

**Service Expectations:**

**Adolescent substance use disorder treatment programs implement specialized programming that reflects the unique needs of the individuals they serve.**

## **6. Engagement and Retention in Treatment**

Adolescents are far more likely to seek assistance for problems with employment, relationships, and family than they are for mental health issues including substance use disorders. Entities that can act as resource centers and offer a variety of services are more likely to be sought after by adolescents. Successful outcomes often depend upon retaining the person long enough to gain full benefits of treatment. Because adolescents often leave treatment prematurely, programs should employ evidence based strategies to engage and keep adolescents in treatment such as motivational interviewing.

Listed below are some recommendations included in Treatment Improvement Protocol 31 by SAMSHA/CSAT of ways mental health professionals can increase the likelihood that an adolescent will attend the first session and continue in treatment:<sup>27</sup>

- Orientation. This initial stage in treatment is very important to the adolescent. Many new activities may be threatening to the adolescent, and initiating treatment can intensify feelings of fear and self-consciousness. Moreover, adolescents frequently have incomplete and inaccurate information about the nature of substance use disorders and treatment programs. A non-confrontational approach in explaining the treatment program is the most effective method in clarifying the expectations and role of the adolescent in treatment.
- Make reminder calls. Call the adolescent's home prior to the appointment and speak with both the adolescent and their caregiver. Inform them that you look forward to meeting them; discuss the importance of arriving at the sessions on time; mention a couple of success stories; and ask about any anticipated obstacles
- Be especially welcoming at the first session. Praise the adolescent and family for making it to the first session.
- Be culturally aware and sensitive. When engaging adolescents and their caregivers, it is essential to be aware of cultural values and expectations that guide social interaction, mental health/substance abuse treatment, and salient themes in their communities. Establishing the trust of adolescents and their families from

diverse backgrounds is an important factor in determining whether they will continue in treatment. If staff members are not familiar with the cultural background of the adolescent and the families they are assisting, they must receive training in cultural competence

- Reach out to the family. Make intense outreach efforts beginning with the first session. Obtain several ways to contact the adolescent and caregiver and obtain contact information for those involved in their care. Make follow-up phone calls, letting them know that you care and that you want to continue to see them. This is particularly important for adolescents who are court-mandated for treatment
- Stay “at their level” when making the first contact. Showing the adolescent that you understand his or her language and culture will facilitate engagement. Let him or her know that you are knowledgeable about the issues faced by adolescents
- Present treatment options in a non-threatening, appealing manner. Avoid asking personal questions, and stress that adolescents similar to him or her have participated in and benefited from the program
- Avoid blaming. Reframe current situations (e.g., drug behavior, living in a shelter) in terms of relational factors rather than personal failure
- Convey hope and empowerment. Communicate that change is possible and that the adolescent will have control over his or her participation in treatment
- Respect his or her concerns, such as those surrounding confidentiality and engaging primary caregivers. Be open to negotiation

Addressing relapse is also critical in engaging and retaining adolescents in treatment. Relapse is currently understood as part of the recovery process and therefore: 1) Programs should address relapse in the treatment and aftercare plans; 2) Program ejection policies should not be based on relapse.

Areas of confidentiality should be reviewed with the adolescent during all phases of assessment and treatment. Adolescents are more likely to be forthcoming if they believe that their information will not be shared. Prior to conducting the first interview with the adolescent, the provider should review all confidentiality issues, including exactly what information the mental health professional is obliged to share and with whom.<sup>1</sup> These confidentiality discussions should continue during the course of treatment.

**Service Expectations:**

**Programs must employ strategies to engage and keep adolescents in treatment.**

## **7. Treatment Outcomes**

A process which evaluates a program’s treatment effectiveness and outcomes is essential in assuring the quality of services provided; program improvements should be targeted to address the findings of these evaluations. Examples of methods employed to measure outcomes during and after adolescent substance disorder treatment include the use of

standardized tools at the beginning of treatment and at regular intervals during and after treatment, exit surveys and post-treatment telephone surveys.

**Service Expectations:**

**Programs should evaluate treatment effectiveness and outcomes and implement program improvements to address the findings of these evaluations.**

## 8. Continuing Care

The adolescent's Child and Family Team (CFT) should be involved in all stages of substance disorder treatment including aftercare. For example, if an adolescent is receiving substance disorder treatment through a Residential Treatment Center (RTC), the CFT should be involved throughout the course of treatment in this setting. The coordination of care between the substance disorder treatment team and the adolescent's CFT will maximize the adolescent's success when transitioning to after-care services (see [Out of Home Services Practice Protocol](#) for additional information).

Participation in after-care services following treatment in a program is related to improved outcomes.<sup>42</sup> Greater attendance during the first three months of continuing care has been significantly related to more days of abstinence during that period.<sup>43</sup> Adolescents attending more intensive aftercare programs involving case management and community reinforcement were more likely than those who did not receive these services to be abstinent from marijuana and reduce their alcohol use at 3 months post-discharge.<sup>44</sup>

Having a history of relapse is common for adolescents in treatment for substance use disorders.<sup>45</sup> Because an adolescent who has relapsed in the past is at greater risk for further relapses, it is important to evaluate precipitants for relapse and to adjust aftercare/continuing care plans to address these precipitants. The aftercare should also include plans for addressing relapse if it should occur. Components of effective relapse prevention consists of comprehensive discharge planning including:

- Referrals to community resources, including twelve-step programs specifically designed for adolescents
- Active coordination of care with outpatient providers and all involved agencies
- Arrangements for therapy and other applicable psychiatric services provided in a timely manner after discharge

**Service Expectations:**

**Methods are implemented by adolescent substance disorder treatment programs to maximize successful outcomes for youth after treatment completion, including plans for addressing relapse.**

## **Training and Supervision Expectations**

It is the expectation of ADHS/DBHS that behavioral health staff who complete evaluations and provide interventions for the treatment of adolescents with substance use disorders be adequately trained and clinically supervised in the tenets of this protocol. Additional specialty training topics can be found in [Attachment D: Recommended Specialty Topics for Trainings](#). Each T/RBHA shall establish their own process for ensuring that clinical staff working with this population follows the recommended process and procedures and whenever this Practice Protocol is updated or revised ensures that their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes.

## **Anticipated Outcomes and How They Will Be Measured**

### **Anticipated Outcomes include:**

- Improved recognition of substance use disorders in adolescents through the use of standardized screening instruments leading to improved outcomes
- Improved treatment of substance use disorders in adolescents through the use of standardized assessment instruments and EBP leading to improved outcomes

### **How Will Outcomes/Fidelity Be Measured?**

- Facilities providing adolescent substance disorder treatment will be monitored with the T/RBHA Adolescent Substance Abuse Treatment Program Evaluation Tool.

## **Guidelines for Comprehensive Assessment and Treatment for Substance Use Disorder in Children and Adolescents Desktop Guide**

### **Service Expectations:**

- Substance use disorder screening must be employed with all adolescents entering the behavioral health system using standardized screening instruments
- Adolescent substance use disorder treatment providers/programs must conduct comprehensive assessments that include the following:
  - Comprehensive substance use assessment and diagnosis using standardized assessment instruments and interview with the adolescent and caregiver
  - Screening and assessment of medical issues
  - STD screening (including HIV, Hepatitis B and C) if clinically indicated
  - TB screening if clinically indicated
  - Assessment of the need for detoxification if clinically indicated
  - Toxicology evaluation, through the collection of bodily fluids or specimens
- The ISP must comprehensively address the adolescent's substance use, medical, psychiatric, psychosocial, vocational/educational, and legal issues
- The ISP must be updated to reflect the changing needs of the adolescent and to ensure progress is being made
- Programs must be able to demonstrate which EBP is implemented, how training is conducted, and how fidelity is monitored
- The caregiver should be actively included in the adolescent's treatment planning whenever possible in order to maximize outcomes.
- Treatment must be tailored to address the unique cognitive, social, emotional and developmental needs of the adolescent.
- Adolescent substance use disorder treatment programs implement specialized programming that reflects the unique needs of the individuals they serve.
- Programs must employ strategies to engage and keep adolescents in treatment.
- Programs should evaluate treatment effectiveness and outcomes and implement program improvements to address the findings of these evaluations.
- Methods are implemented by adolescent substance disorder treatment programs to maximize successful outcomes for youth after treatment completion, including plans for addressing relapse.

- ❖ Key elements to remember about this best practice:
  - Adolescent substance use disorders have far-reaching neurological, developmental, social and economic ramifications
  - A hallmark of substance use disorders in adolescents is impairment in psychosocial and academic functioning <sup>14</sup>
  - Because of the unique challenges faced by adolescents with substance use disorders, including the potentially damaging and long-term consequences of substance use, it is critical that treatment programs be tailored to effectively screen, diagnose, and treat this population
  - A matching of treatment settings, interventions, and services to the strengths and needs of each adolescent and their family is imperative, given that a single treatment approach will not adequately address the complex needs of all adolescents.
  - Psychiatric disorders that are co-occurring with substance use disorders should be treated; specific psychotherapeutic interventions, depending on the co-occurring psychiatric condition, should be employed <sup>1</sup>
  - As adolescents often leave treatment prematurely, programs should employ strategies to engage and keep adolescents in treatment. Engaging both the adolescent and caregiver, as well as maintaining close links with the adolescent's family, community, school, and other involved systems, ensures greater success in treatment
  - Relapse is currently understood as part of the recovery process and therefore: 1) Programs should address relapse in the treatment and aftercare plans; 2) Program ejection policies should not be based on relapse
  
- ❖ Benefits of using this best practice:
  - Improved recognition of substance use disorders in adolescents through the use of standardized screening and assessment instruments leading to improved outcomes
  - Improved treatment of substance use disorders in adolescents through the use of standardized assessment instruments and EBP leading to improved outcomes

## Bibliography

---

- <sup>1</sup> American Academy of Child and Adolescent Psychiatry (2004), Practice parameters for the assessment and treatment of children and adolescents with substance use disorders, AACAP)
- <sup>2</sup> Dembo, R.; Williams, L.; Schmeidler, J.; Wish, E.D.; Getreu, A.; and Berry, E.. Juvenile crime and drug abuse: A prospective study of high risk youth. *Journal of Addictive Diseases*. 11:5-31,:1991
- <sup>3</sup> Hansell, S., and White, H.R. Adolescent drug use, psychological distress, and physical symptoms. . *Journal of Health and Social Behavior*. 32(2):288-301,:1991.
- <sup>4</sup> National Institute of Justice. . Drug Use Forecasting: 1993 Annual Report on Juvenile Arrestees/Detainees: Research in Brief. Washington, DC: National Institute of Justice. 1994
- <sup>5</sup> DiClemente, C.The emergence of adolescents as a risk group for human immunodeficiency virus infection. *Journal of Adolescent Research*. 5:7-17 :1990
- <sup>6</sup> Substance Abuse and Mental Health Services Administration.. National Household Survey on Drug Abuse: Population Estimates 1995. Rockville, MD: SAMHSA, Office of Applied Studies, 1996
- <sup>7</sup> Children's Defense Fund. . The Adolescent and Young Adult Fact Book. Washington, DC: Children's Defense Fund, 1991
- <sup>8</sup> Martin CS, Winters KC (1998), Diagnosis and assessment of alcohol use disorders among adolescents. *Alcohol Health Res World* 22: 95-105
- <sup>9</sup> Havighurst, R.J. Nurturing the cognitive skills in health. *Journal of School Health*. 42(2):73-76,:1972; Baumrind, D., and Moselle, K.A. . A development perspective on adolescent drug abuse. *Advances in Alcohol and Substance Abuse*. 4:41-67:1985
- <sup>10</sup> Newcomb, M.D., and Bentler, P.M. . Substance use and abuse among children and teenagers.*American Psychologist*. 44(2):42B248, :1989
- <sup>11</sup> MacKenzie, R.G. . Influence of drug use on adolescent sexual activity. *Adolescent Medicine: State of the Art Reviews* 4(2):112-115, 1993
- <sup>12</sup> Brook DW, Brook JS, Rubenstone E, Zhang C, Singer M, Duke MR: Alcohol use in adolescents whose father abuse drugs. *J Addict Dis* 22:11-34, 2003) (Brook JS, Whiteman M, Brook DW, Gordon AS: Sibiling influences on adolescent drug use: older brothers on younger brothers, *J Am Acad Child Adolesc Psychiatry* 958-66, 1991
- <sup>13</sup> Schulenberg JE, Maggs JL; A developmental perspective on a alcohol use and heavy drinking adolescence and the transition to young adulthood. *J stud alcohol Suppl* 54-70, 2002
- <sup>14</sup> Hopfer CJ, Crowley TJ, Hewitt JK: review of twin and adoption studies of adolescent substance use. *Jam Acad Child Psychiatry* 42:710-19, 2003
- <sup>15</sup> Young SE, Stallings MC, Corley RP, Krauter KS, Hewitt JK: Genetic and environmental influences on behavioral disinhibition, *Am J med gene* 684-95,2000
- <sup>16</sup> Crowley, T.J., and Riggs, P.D. . Adolescent substance use disorder with conduct disorder and comorbid conditions. In: Rahdert, E., and Czechowicz, D., eds. *Adolescent Drug Abuse: Clinical Assessment and Therapeutic Interventions*. National Institute on Drug Abuse (NIDA) Research Monograph Series, Number 156. Rockville, MD: National Institute on Drug Abuse, 1995. pp. 49-111

- 
- <sup>17</sup> Jainchill, N. Therapeutic communities for adolescents: The same and not the same. In: De Leon, G., ed. *Community as Method: Therapeutic Communities for Special Populations and Special Settings*. Westport, CT: Praeger, 1997. pp. 161-177
- <sup>18</sup> National Institute of Justice. *Drug Use Forecasting: 1993 Annual Report on Juvenile Arrestees/Detainees: Research in Brief*. Washington, DC: National Institute of Justice. 1994
- <sup>19</sup> Center for Substance Abuse Treatment. . *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities*. Treatment Improvement Protocol (TIP) Series, Number 29. DHHS Pub. No. (SMA) 98-3249. Washington, DC: U.S. Government Printing Office, 1998
- <sup>20</sup> MacKenzie, R.G. . Influence of drug use on adolescent sexual activity. *Adolescent Medicine: State of the Art Reviews* 4(2):112-115, 1993.
- <sup>21</sup> National Institute on Drug Abuse. *National Pregnancy and Health Survey: Drug Use Among Women Delivering Live Births 1992*. Rockville, MD: National Institute on Drug Abuse. Division of Epidemiology and Prevention Research. 1996b
- <sup>22</sup> Giaconia, R. M., Reinherz, H. Z., Paradis, A. D., and Stashwick, C. K. (2003). Comorbidity of substance use disorders and posttraumatic stress disorder in adolescents. In Oimette, P. and Brown, P. J. (Eds.), *Trauma and substance abuse: Causes, consequences, and treatment of comorbid disorders* (pp. 227-242). Washington, DC: American Psychological Association
- <sup>23</sup> (Kilpatrick, D. G., Saunders, B. E., and Smith, D. W. (2003). *Youth Victimization: Prevalence and Implications*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice. Retrieved April 16, 2008 from <http://www.ncjrs.gov/pdffiles1/nij/194972.pdf>
- <sup>24</sup> Funk, R. R., McDermeit, M., Godley, S. H., and Adams, L. (2003). Maltreatment issues by level of adolescent substance abuse treatment: The extent of the problem at intake and relationship to early outcomes. *Child Maltreat*, 8(1), 36-45)
- <sup>25</sup> Deykin, E. Y., and Buka, S. L. (1997). Prevalence and risk factors for posttraumatic stress disorder among chemically dependent adolescents. *Am J Psychiatry*, 154(6), 752-7
- <sup>26</sup> Clark, D. B., Lesnick, L., and Hegedus, A. M. (1997). Traumas and other adverse life events in adolescents with alcohol abuse and dependence. *J Am Acad Child Adolesc Psychiatry*, 36(12), 1744-51
- <sup>27</sup> D. M. (2000). Comorbidity of substance use and post-traumatic stress disorders in a community sample of adolescents. *Am J Orthopsychiatry*, 70(2), 253-62
- <sup>28</sup> Perkonig, A., Kessler, R. C., Storz, S., and Wittchen, H. U. (2000). Traumatic events and posttraumatic stress disorder in the community: Prevalence, risk factors and comorbidity. *Acta Psychiatr Scand*, 101(1), 46-59
- <sup>29</sup> Saladin, M. E., Drobles, D. J., Coffey, S. F., Dansky, B. S., Brady, K. T., and Kilpatrick, D. G. (2003). PTSD symptom severity as a predictor of cue-elicited drug craving in victims of violent crime. *Addict Behav*, 28(9), 1611 -29
- <sup>30</sup> Coffey, S. F., Saladin, M. E., Drobles, D. J., Brady, K. T., Dansky, B. S., and Kilpatrick, D. G. (2002). Trauma and substance cue reactivity in individuals with comorbid posttraumatic stress disorder and cocaine or alcohol dependence. *Drug Alcohol Depend*, 65(2), 11 5-27

- 
- <sup>31</sup> SAMHSA/CSAT Treatment Improvement. Screening and Assessing Adolescents for Substance Use Disorders Treatment Improvement Protocol (TIP) Series 31. DHHS Publication No. (SMA) 99-3282. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999
- <sup>32</sup> Beck, A.T.; Wright, F.D.; Newman, C.F.; and Liese, B.S. *Cognitive Therapy of Substance Abuse*. New York: Guilford Press.1993
- <sup>33</sup> Berg, I.K. *Family Preservation: A Brief Therapy Workbook*. London: B.T. Press.1991
- <sup>34</sup> Marsch LA, Bickel WK, Badger GJ, Stohart ME, Quesnel KJ, Stanger C, Brooklyn J. Comparison of pharmacological treatments for opioid-dependent adolescents: a randomized controlled trial. *Archives of General Psychiatry*. 62(10):1157-64, 2005 Oct.
- <sup>35</sup> Daniel Santisteban , *Engaging Family Members Into Adolescent Drug Treatment Florida Certification Board/Southern Coast ATTC Monograph series #3*
- <sup>36</sup> Bukstein OG, Brent DA, Kaminer Y (1989), Comorbidity of substance abuse and other psychiatric disorders in adolescents. *Am J Psychiatry* 146: 1131-1141
- <sup>37</sup> King RD, Gaines LS, Lambert EW, Summerfelt WT, Bickman L (2000), The co-occurrence of psychiatric substance use diagnoses in adolescents in different service systems: Frequency, recognition, cost, and outcomes. *J Behav Health Serv Res* 27: 417-430
- <sup>38</sup> Lewinsohn PM, Hops H, Roberts RE, Seeley JR (1993), Adolescent psychopathology: I. Prevalence and incidence of depression and other *DSM-III-R* disorders in high school students. *J Abnorm Psychol* 102: 133-144
- <sup>39</sup> Lenroot RK, Giedd JN. Brain development in children and adolescents: insights from anatomical magnetic resonance imaging. [Review] [94 refs] *Neuroscience & Biobehavioral Reviews*. 30(6):718-29, 2006
- <sup>40</sup> Center for Substance Abuse Treatment. *Treatment of Adolescents with Substance Use Disorders*. Treatment Improvement Protocol (TIP) Series 32. DHHS Publication No. (SMA) 99-3283. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999
- <sup>41</sup> Center for Substance Abuse Treatment. *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment*. Treatment Improvement Protocol (TIP) Series 47. DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006
- <sup>42</sup> William RJ, Chang SY (1000), A comprehensive and comparative review of adolescent substance abuse treatment outcome. *Clin Psychol: Sci Pract* 7: 38-166
- <sup>43</sup> McKay JR: Studies of factors in relapse to alcohol and drug use: a critical review of methodologies and findings. *Journal of Studies on Alcohol* 60:566-576, 1999
- <sup>44</sup> The Assertive Aftercare Protocol for adolescent sub-stance abusers. In: *Innovations in adolescent substance abuse interventions*, Wagner EF, Waldron HB, eds., pp 313-331 and Godley MD, Godley SH, Dennis ML, Funk R, Passetti LL (2002), Preliminary outcomes from the Assertive continuing care experiment for adolescents discharged from residential treatment. *J Subst Abuse Treat*, 23: 21-32
- <sup>45</sup> Hoffman, N.G.; Mee-Lee, D.; and Arrowhead, A. Treatment issues in adolescent substance abuse and addictions: Options, outcomes, effectiveness, reimbursement and admission criteria. *Adolescent Medicine: State of the Art Reviews*. 4:371-390,:1993.