

SYSTEMS-BASED PRACTICE
SUBSTANCE USE TREATMENT SERVICES SYSTEM
Updated May, 2020

SYSTEMS-BASED PRACTICE: SUBSTANCE USE TREATMENT SERVICES SYSTEM OBJECTIVES*

Knowledge

The resident will demonstrate an adequate knowledge of:

- 1) Epidemiological trends in substance use in youth, and common negative outcomes.
- 2) Other mental health disorders: risk factors for substance use and co-occurring.
- 3) Service system challenges involving the substance use treatment services and mental health systems of care.
- 4) Sources of substance use services for youth, including community, federal, state, and other services.
- 5) Family treatments associated with better outcomes.
- 6) The basic elements of motivational interviewing, and its relevance to treatment.
- 7) The role of peer support and the pros/cons of Twelve Step groups for youth with substance use disorders and co-occurring mental health disorders and substance use disorders.
- 8) Potential roles of the child and adolescent psychiatrist.
- 9) The interface between the mental health system and other systems that provide services for substance abusing youths.
- 10) Cultural and LGBTQ issues that impact the development and treatment of substance use in a particular youth.
- 11) The principles of integrated treatment and how they apply to the operation of systems of care for youth with co-occurring substance use and other mental disorders.
- 12) Understand the range of substance use attitudes and behaviors from a developmental viewpoint.
- 13) Patient placement criteria for levels of care as they pertain to mental health and substance use treatment systems of care.
- 14) Risk factors for development of substance use disorders.
- 15) Evidence-based interventions for prevention of substance use disorder
- 16) Appropriate role and boundaries for interactions with legal system, such as juvenile justice system.
- 17) Evidence-based interventions for prevention of substance use disorder.
- 18) Healthcare needs for youth with substance use disorders, including screening and prevention of Hepatitis C and HIV.

Skills

The resident will demonstrate the ability to:

- 1) Act as an advocate for youth with substance use disorders involved in a variety of service systems.

**Appendix 1 describes the systems-based practice competency in the RRC Program Requirements.¹

- 2) Refer a youth for specific treatment services in their specific locality and develop a reasonable treatment plan in localities lacking youth treatment services.
- 3) Screen for and diagnose substance use in youth.
- 4) Evaluate and treat youth with substance use disorders and co-occurring disorders.
- 5) Identify and intervene with parental and sibling substance use.
- 6) Promote integrated treatment for youth with co-occurring disorders, and, in the absence of integrated care, be able to coordinate care between substance use services, mental health services treatment, and physical healthcare services.
- 7) Provide culturally competent care.
- 8) Provide appropriate consultation regarding drug and alcohol treatment and prevention to providers including pediatricians, primary care providers, therapist, school counselors, probation officers and faith-based treatment providers.
- 9) Promote coordination of care between service systems.
- 10) Apply patient placement criteria for levels of care as it pertains to mental health and substance use treatment services system.

Attitude

The resident will demonstrate the commitment to:

- 1) Provide treatment to youth with substance use and co-occurring disorders in youth-guided, family-focused, recovery-oriented, systems-based and community-based contexts.
- 2) Integration and collaboration between service systems when providing treatment to youth and their family.
- 3) Addressing both substance use disorders and co-occurring disorders simultaneously.
- 4) Maintain a collaborative, non-judgmental, and problem-solving approach in treating youth with substance use disorders and their families and in working with other systems of care.
- 5) Maintain a collaborative, non-judgmental, and problem-solving approach when working with professionals in other systems of care.
- 6) Offer and maintain hope as part of ongoing treatment, so that youth and family are helped to recognize that recovery is possible and achievable.

TABLE OF CONTENTS

Overview.....	3
Introduction.....	4
Understanding the landscape.....	6
Substance use in youth and potential multi-system involvement.....	9
Substance use disorders and special clinical considerations.....	12
Approaches to recovery.....	14
Roles for child & adolescent psychiatrists.....	17
Conclusion.....	19
Appendix 1.....	20
Appendix 2.....	21
Appendix 3.....	24
Appendix 4.....	25
References.....	26
Web Resources.....	28

OVERVIEW

Adolescence and young adulthood are a period of significant brain maturation with a vulnerability to the adverse consequences of substance use. During this developmental window the majority of psychiatric illnesses begin and it is a critical time period when many adults develop persistent substance use disorders (SUDs). Substance use and psychiatric disorders share many common etiological risk factors. The term “co-occurring disorders” or “dual diagnosis” is used when conditions co-exist in an individual. Youth with co-occurring disorders experience increased treatment utilization rates, higher service costs and a poorer prognosis compared to youth without co-occurring conditions. If one disorder is left untreated, the outcome is likely to be worse. Patients with co-occurring disorders may experience impaired motivation to engage in treatment and have less social and community support for intervening with their illness which exacerbates their impairment.

Historically, SUDs and psychiatric disorders have been treated separately, in different care systems, with limited communication between treatment providers, creating multiple barriers to using an integrated approach. Thus, individuals with co-occurring disorders often fall through the cracks between systems and struggle to navigate the different care settings on their own. Growing evidence suggests that integrated care models where organizational fragmentation and referrals are minimized have the best treatment outcomes. Youth with SUD and co-occurring disorders often require long-term involvement of healthcare practices (primary and specialty care settings), education, community, peer and family support.

Primary care and other health care settings such as emergency rooms are often the first point of contact for substance using adolescents. An important advance of the last two decades has been the development and testing of a system for identification of youth with or at risk of SUD in these settings. Broad dissemination of SBIRT (Screening, Brief Intervention, and Referral to Treatment—see appendix 4) should be promoted to improve access to services. Child and adolescent psychiatrists and other mental health providers can promote the use of this practice,

receive referrals, and support integration of services across systems of care to treat identified youth.

In this module substance use refers to substances that include tobacco, alcohol, marijuana, other illicit substances, synthetic drugs, and the misuse of prescribed and over-the-counter (OTC) drugs.

I. INTRODUCTION

Systems Challenges for Youth with Substance Use Disorders

Individuals with SUDs and co-occurring psychiatric illnesses have “been recognized to be system misfits in systems of care that have been designed to treat one disorder only or only one disorder at a time. Thus, instead of being prioritized for attention, these individuals with challenging problems are made more challenging, because the system of care in which they present have significant regulatory, licensing, and reimbursement barriers to the implementation of successful treatment.”²

A. PREVALENCE RATES: THE SCOPE OF THE PROBLEM

- The past year prevalence of any illicit drug use for students in grades 8, 10, and 12 combined was 27.1% per the Monitoring the Future (MTF) survey in 2018. There was a rising popularity of marijuana and a decline in use of the other illicit drugs. The study also showed substantial and significant increase in vaping among students.³
- Adolescents with psychiatric symptoms and disorders are at risk for substance use. Studies have shown that more than 60% of adolescents who use substances suffer from at least one psychiatric disorder. Active substance use may delay or confound the identification and treatment of psychiatric disorders. Adolescents who use substances are likely to suffer from psychiatric disorders or exacerbation of pre-existing medical and psychiatric illnesses. Therefore, co-occurrence/comorbidity of substance use and psychiatric symptoms/ disorders are the rule rather than the exception.⁴
- Untreated co-occurring disorders have profound implications for youth, families, and communities, resulting in increased suicide attempts, greater lethality from suicide attempts, increased non-suicidal self-harm injuries (NSSI), poor academic performance, and trouble with the law. Due to their greater impairment, youth with co-occurring disorders are, as a group, at greater risk for negative clinical and functional outcomes than those with either a mental health or substance use disorder alone. Less than half of

adolescents who have three or more co-occurring disorders (including substance use) receive specialty care.⁴

B. THE SUBSTANCE USE TREATMENT SERVICES SYSTEM FOR CHILDREN AND ADOLESCENTS: CORE THEMES

- **The need for integrated behavioral health and substance use treatment.** The therapeutic approach that emphasizes integrating substance use and co-occurring psychiatric disorder treatments is an important mandate for systems of care. This integration is often multi-disciplinary involving physicians, social workers, psychotherapists, counselors, and case managers.
- **The need for screening and assessment by each system.** It is essential that providers in the mental health system routinely screen for substance use, and that providers in the substance use treatment services system routinely screen for mental health disorders. Positive screens should be followed by appropriate assessment, with treatment as indicated. These screens need to be valid, reliable and time-efficient. (See Appendix 2 for suggested screening tools)
- **The need to understand the specific state and local structures involved in the provision of mental health and substance use treatment services.** Substance use treatment services for youth often have administrative structures and funding streams separate from those of mental health, even though in many states both types of services are provided (and referred to as “behavioral health”) within behavioral health managed care to Medicaid enrolled members.
- **The need for coordination among child-serving systems.** The frequent lack of coordination between mental health and substance use treatment services, and among these and other child-serving systems (e.g., primary care, juvenile justice, child welfare, education, etc.), results in system silos and fragmented care for youth with the most challenging problems. Whether or not other systems provide some substance use treatment services, the treatment planning process should be multi-system and collaborative.
- **The need for a multi-level commitment in order to achieve integrated treatment.** Integrated treatment must be supported at the policy, administrative, and funding levels, with adequate training of the provider community, in order for service delivery to consistently involve integrated treatment.
- **The need for substance use and co-occurring disorders competence by the child and adolescent psychiatrist.** In order to provide leadership, knowledge about the current trends in substance use is a key component to basic training as a child and adolescent psychiatrist (CAP). The CAP must understand the substance use treatment services system, gain clinical competence in the diagnosis and treatment of SUDs and co-occurring mental health and SUDs, and be able to communicate about SUDs in youth to appropriate stakeholders.

II. UNDERSTANDING THE LANDSCAPE

A. SYSTEMS CONSIDERATIONS REGARDING THE SUBSTANCE USE SERVICES TREATMENT SYSTEM

1. Federal Programs:

- National Institute of Drug Abuse (NIDA). NIDA's mandate is "to lead the nation in bringing the power of science to bear on drug abuse and addiction." This is accomplished through support and conduct of research and through dissemination of results to effect change in prevention, treatment and policy. (<http://www.drugabuse.org>)
- National Institute of Alcohol Abuse and Alcoholism (NIAAA). The mandate states: "NIAAA supports and conducts research on the impact of alcohol use on human health and well-being." (<http://www.niaaa.nih.gov/about-niaaa>)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
 - SAMHSA describes its mission as building resilience and facilitating recovery for people with or at risk for mental or substance use disorders. (<http://www.samhsa.gov>)
 - SAMHSA is involved in supporting and implementing treatment and policy for the treatment of mental illness and SUDs in adults and youth.

2. Federal Laws relating to substance use disorders

- The 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) mandates that insurance plans that offer coverage for behavioral health services, including substance abuse treatment, provide the same amount of coverage that medical/surgical services receive.⁵
- The 2010 Affordable Care Act extended parity to Medicaid managed care plans, Medicaid benchmark and benchmark equivalent plans, and state health insurance exchange plans. Under the ACA, substance abuse treatment is categorized as part of the essential health benefits package which states must provide to newly eligible Medicaid enrollees.⁵

3. State Initiatives

- At the state level, there is no single template for the organization of the substance use treatment services system and the provision of substance use services. In fact, variability is the rule rather than the exception.
- The substance use treatment services system in each state develops a state plan that is submitted to the federal government, but this state plan is distinct from the mental health state plan.

- The state substance use services are housed within different parts of the state government, depending on the state. Some states house substance use services within the Department of Mental Health and Substance Use Services (e.g. Alabama) or Department of Human Services (e.g. Colorado).
- The National Association of State Alcohol and Drug Abuse Directors is a private, non-profit organization that includes representatives from the states' substance use disorder entities (<https://nasadad.org/ssa-web-sites/>), and provides information about policy, prevention, and treatment in different state systems.
- Each state receives federal “block grants” (a sum of money dedicated for a specific purpose) for substance use services that are separate from the block grants received for mental health programs.
- Federal requirements for the substance use treatment services state plan, and regulations governing use of block grant funds, differ from those applicable to mental health.
- Substance use services covered by Medicaid can be provided through behavioral health benefits (as in Pennsylvania) or through physical health benefits (as in Maryland).
- Within states that have implemented “behavioral health” managed care for Medicaid members, the managed care organization is responsible for providing medically necessary substance use as well as mental health services for Medicaid-enrolled individuals. The full continuum of care is not always consistently reimbursed.
- Commercial insurance companies provide variable substance use services, depending on the nature of the coverage.
- While there have been a number of initiatives in other states to integrate mental health and substance use services for adults, integrated youth services lag behind.²

4. Local Initiatives

- States have different systems for the provision of substance use services at the local level.
- For example, in Pennsylvania, there are, “single county authorities,” which are responsible for local oversight of substance use services that are external to Medicaid. In some cases, single county authorities also offer services themselves. In some states, such as Texas, there is a high level of variability in regards to availability of services.

B. PRINCIPLES OF SUBSTANCE USE TREATMENT

1. Prevention efforts within each system look at protective and risk factors for youth and their families.
2. Mental health disorders and substance use disorders share many risk factors. Each system has an array of services and seeks to use the least restrictive service to address the needs of a specific youth.
3. In both positive and negative ways, the family can have a significant impact on youth.
 - Family protective factors include: parental supervision, a child's attachment to the parent, a parent's attachment to child, and parents' involvement in child's activities.⁶
 - Family risk factors include: parental substance use, poor parent-child relationships, low perceived parental support, and poor supervision, parental attitudes approving substance use, excessive and sporadic discipline, constant criticism, and an absence of parental praise or approval are all associated with higher rates of substance use in adolescents.⁶
4. Evidence Based Treatment interventions involving the family include: Brief Strategic Family Therapy, Family Behavior Therapy, Functional Family Therapy, Multidimensional Family Therapy and Multisystemic Therapy.⁷
5. Treatment that is individualized and developmentally appropriate for the youth is more likely to be effective than a generic, one-size-fits-all approach.
6. Treatment needs to build on the strengths of the youth and seek to promote resilience.
7. Treatment needs to take into account the culture of the youth and family, and be culturally competent.
8. Systems need to recognize the importance of natural supports and promote the use of natural and community supports.
9. Motivating youth and determining the degree of readiness for change are important components of effective treatment.
10. Effective intervention requires the creation of trusting relationships with an adequate therapeutic alliance between the youth and involved professionals. Trust is also essential in relationships between youth and non-professional support persons.
11. Substance use treatment makes use of specific support systems that rely heavily on peer support.
12. Co-occurring substance use and mental health disorders:
 - For guidance regarding the approach to co-occurring mental health and substance use disorders, SAMHSA has sponsored the Co-Occurring Center for Excellence (www.coce.samhsa.gov).
 - Youth with co-occurring disorders are likely to be involved with multiple systems, including the legal system, and to benefit from collaboration among child-serving systems and the use of a child and family team guided by wraparound principles.
 - Youth with co-occurring disorders have better clinical outcomes when their treatment is integrated (e.g., provided by the same providers or by an integrated team of providers with co-occurring competence). When

integration is not possible, coordinated care by providers with co-occurring knowledge should occur.

- In the past, substance use providers looked unfavorably on the use of psychotropic medication. However, as the awareness of co-occurring disorders has increased within substance use treatment services and the culture of co-occurring treatment has developed, this gap has also narrowed. Historically providers from the mental health sector were either not aware of co-existing substance use issues, immediately referred such patients to the substance use sector, or divided the care between the two sectors leading to fragmented care.
- All mental health and substance use providers need to become co-occurring capable. They should also become familiar with the structure of the other's service system, including its mandates, regulations, and culture.
- Appropriate treatment interventions for each disorder will vary according to the individual's degree of readiness to change with respect to each disorder.
- Medical interventions take place as needed, whether it involves drug detoxification for an individual dealing with substance dependence or withdrawal, or the use of psychotropic medication for a treatable mental health disorder.

III. SUBSTANCE USE IN YOUTH AND POTENTIAL MULTI-SYSTEM INVOLVEMENT

A. Juvenile Justice and Substance Use disorders

- Nearly half of juvenile detainees in the US had one or more SUDs and over 21% had two or more SUDs. The most prevalent combination of SUDs was alcohol and cannabis use disorders (17.25% females, 19.42% males). Substance use treatments need to target detainees with multiple SUDs who, upon release, return to communities where services are often unavailable.⁸
- Evidence shows that these complex youth often respond best to intensive community-based treatments and family-based interventions rather than incarceration.⁹
- Other initiatives, funded through the Department of Justice, SAMHSA, and private foundations like the Robert Wood Johnson Foundation, are working to develop "juvenile drug courts" where alternatives to juvenile detention are considered an option (see www.ojjdp.gov/programs under Juvenile Drug Courts/Reclaiming Futures program for details).
- In some states, a Child in Need of Services (CHINS or CINS) petition can be submitted to the court by a parent or an agency when a youth is refusing school, truant, disregarding curfew, running away from home or grossly oppositional and defiant towards a parent. A petition can also be used when a youth has a serious substance use problem, and is at risk of self-harm. A youth who has a CHINS is often referred to a CAP for evaluation. By identifying mental health disorders, SUDs, or co-occurring

disorders, the CAP can recommend appropriate treatment and at times divert youth from out-of-home placements.

B. Child Welfare

- Youth and families with SUDs may receive mandated services via the Child Welfare system.
- There is significant variability among and within states regarding the types of substance use interventions provided by the child welfare systems. Substance use disorders are often multi-generational within families. Children of parents who use substances are more likely to experience abuse and neglect, and are more likely to use substances themselves.
- For information regarding the interface between substance use disorders and child welfare, see the Child Welfare League of America Web site at <http://www.cwla.org/programs>.

C. Education System

- A CAP may be asked to provide school-based consultation to assess problem behavior, which may be due to substance use, a co-occurring disorder or both.
- Substance use is associated with poor academic functioning and lower rates of high school completion.¹⁰
- There are federal and state initiatives targeting drug use in the schools. For example, the Office of Safe and Drug-Free Schools, through the Department of Education, works to reduce substance use, alcohol use, and violence in the schools (for details, see http://www.ed.gov/about/offices/list/om/fs_po/osdfs/home.html?src=oc).
- School based Substance Abuse Counselors:¹¹
 - 1) With 50% of high school seniors admitting to having tried drugs, the need for substance abuse counseling in schools is evident.
 - 2) Substance abuse counseling in schools can manifest in different ways:
 - a. School Counselor
 - The school counselor receives substance abuse education enabling him/her to provide services.
 - b. Student Assistance Coordinator
 - Currently used in New Jersey.
 - They provide substance abuse education, prevention, intervention, counseling and mental health services.
 - c. Substance Abuse Prevention and Intervention Specialist
 - Currently used in New York.
 - They provide prevention programs, intervention services, and counseling.
 - d. Student Assistance Programs
 - Currently used in California and Pennsylvania.
 - They focus on offering substance abuse education to school personnel to help identify at risk students.

- “Zero tolerance” initiatives across the nation have resulted in many youth being prosecuted through the court system for substance use-related problems. In some school districts, youth caught with illegal substances are barred from extracurricular activities and are considered for expulsion. A CAP may be asked to evaluate a youth who has been removed from school for behavior or substance-related issues for safety and appropriateness of being allowed to return to school.

D. Primary Care

- Screening for substance use is considered a vital element of well-child care. The primary care physician (PCP) can often be the first professional to identify this problem.¹²
- SAMHSA advocates for integrated substance use treatment and primary care ([http://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care#integrating SU](http://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care#integrating%20SU)).
- A number of models in adult primary care have been introduced but require further development in pediatric and young adult populations.
- PCPs can also screen for parental substance use and refer, as appropriate, an effective prevention or intervention strategy for the child. Barriers to screening in primary care settings include time constraints, inadequate reimbursement for preventive services, fear of alienating patients and families, inadequate education and training about screening, and lack of adequate information about available services.
- Careful coordination between the CAP and the PCP can reduce the likelihood of competing treatment plans, diversion of medication, and misuse of prescribed medications.
- Adolescents with substance use disorders are at risk of poor access and/or use of primary care resources. Coordination between the CAP and a PCP is important for identifying and treating physical health conditions, particularly those that may result from high risk behaviors, such as HIV, hepatitis, and other blood- and sexually-transmitted diseases and consequences of traumatic brain injury.

IV. SUBSTANCE USE DISORDERS AND SPECIAL CLINICAL CONSIDERATIONS

A. POVERTY AND SOCIOECONOMIC STATUS

- Economically disadvantaged youth are exposed to multiple risk factors for substance use, including: higher availability of drugs, fewer alternative life opportunities, increased hopelessness, and higher rates of family adversity and conflict.¹³

B. MINORITY POPULATIONS

- Minority youth are at higher risk of substance use because of higher levels of poverty, higher risk of poor academic outcomes, and difficult environments.¹² There are no clear substance abuse prevalence differences between African-American and Hispanic youth compared to Caucasian youth. Prevalence of illicit drug use among persons aged 12 or older is highest among persons of two races (14.8%), followed by American Indians/ Alaskan natives (12.7%), African Americans (11.3%), Caucasians (9.2%), Hispanics (8.3%), Native Hawaiian/ Pacific Islands (7.8%), and Asians (3.7%).¹⁴

There is some variation in prevalence of substance abuse by race/ethnicity. Asian and African Americans aged 11-16 have lower life time and past week prevalence of alcohol use compared to their Caucasian and Hispanic counterparts; and African Americans aged 12-17 have lower lifetime prevalence of marijuana use compared to Hispanics and Caucasians.¹⁵

- Adverse effects of substance use disproportionately affect ethnic minorities compared to Caucasians. Minority groups who use drugs are at higher risk for HIV infection, and have lower retention, higher dropout and poorer compliance in substance abuse treatment.¹⁶
- Continued research is required to better understand the patterns of drug use among minority youth.
- Cultural factors may also impact substance use patterns. The CAP has an important role in understanding cultural factors in their local area that may impact substance use behavior for a particular youth. Cultural values, beliefs and practices may act as protective and risk factors in the use of drugs and alcohol.
 - Language barriers can mask identification of SUDs or the creation of trusting relationships that can facilitate entry into treatment.

C. LGBTQ YOUTH

- The CAP should be aware of gender issues, particularly the role of trauma, as it relates to the treatment of SUDs.
- Youth Risk Behavior Survey from 2017¹⁷

- Unlike the variations by sex and race/ethnicity, the 2017 Youth Risk Behavior Survey (YRBS) conducted by the Centers for Disease Control (CDC) documents that the differences are almost always in the same direction with sexual minority students having a higher prevalence of health risk behaviors compared with nonsexual minority students.
- Across the 19 risk behaviors related to alcohol and other drug use, the prevalence of 18 was higher among gay, lesbian, and bisexual students than heterosexual students and the prevalence of 16 was higher among students who had sexual contact with only the same sex or with both sexes than students who had sexual contact with only the opposite sex.

The prevalence for eight of these behaviors (having ever used synthetic marijuana, inhalants, heroin, methamphetamines, ecstasy, and hallucinogenic drugs; having ever taken steroids without a doctor's prescription, and having ever injected any illegal drug) was twofold or greater for gay, lesbian, and bisexual students compared with heterosexual students and the prevalence for eight of these behaviors (having ever used cocaine, inhalants, heroin, methamphetamines, ecstasy, and hallucinogenic drugs; having ever taken steroids without a doctor's prescription, and having ever injected any illegal drug) was twofold or greater for students who had sexual contact with only the same sex or with both sexes than students who had sexual contact with only the opposite sex.

D. DEVELOPMENTAL DISABILITIES

- Resources for youth with developmental disabilities are limited or unavailable in many areas. More research and programming is needed for individuals in this population.
- Youth with cognitive limitations may, out of naiveté or a desire for acceptance, use alcohol or substances to model other youths' behavior.
- Youth with cognitive limitations may be placed in inappropriate settings, such as juvenile justice, placing them at greater risk of ongoing difficulties, victimization, or both.
- Programs and professionals who are not sensitive to the varied disabilities may misinterpret their signs and symptoms as resistance to treatment and may not create appropriate therapeutic accommodations and methods.

E. TRAUMA

- There is evidence to show that childhood sexual abuse, more common in girls, or other traumatic life events may be risk factors the development of substance use disorders.¹⁸
- Trauma and substance use frequently co-occur: in one study, the rate of victimization among adolescents presenting for substance use treatment ranged from 40-80%.¹⁹

F. OTHER DEVELOPMENTAL CONSIDERATIONS

- As with mental health disorders, the earlier the onset and the more severe the SUD, the greater the degree of disruption on a child's normal psychosocial development.
- A child or adolescent may not accomplish, or accomplish incompletely, important developmental tasks, creating ongoing challenges to recovery.
- It can be difficult for youth with SUDs to transition to adult substance abuse services system when their age requires such a change.

V. APPROACHES TO RECOVERY

A. THE CAP SHOULD BE FAMILIAR WITH VARIOUS APPROACHES TO RECOVERY.

- **Stages of change.** The stages of change theory, initially used to guide substance use assessment and treatment, is based on the recognition that recovery is a gradual process that is marked by five sequential stages. Interventions need to match the stage of change of each individual. The concept has since been adapted to many change processes, including the assessment and treatment of co-occurring disorders.²⁰

The stages:

- **Precontemplation:** There is no acknowledgment of a behavior or problem to be changed. The individual defends the behavior (e.g., substance use) and resists externally applied pressure to change, whether by a family member or a professional.
- **Contemplation:** There is acknowledgment of a problem, but the individual is ambivalent and not ready to change. There is a willingness to consider the possible negative consequences of the behavior.
- **Preparation:** The individual has made a commitment to make a change, and is ready to take action.
- **Action:** The individual is making active efforts to change the behavior, using interpersonal support and a variety of different techniques.
- **Maintenance:** The individual is maintaining, and working to continue to maintain, the desired change. However, it is expected that individuals may relapse, which involves a return to the previous behavior. Relapse is seen as part of the cycle of change, not as failure.
- **Motivational interviewing.** A strategy that was used initially in the treatment of SUDs has now been applied to other fields within health care, including the treatment of co-occurring disorders.
 - Motivational interviewing involves a non-confrontational, non-judgmental, and collaborative approach by using four general processes.
 1. Engage youth in talking about issues, concerns, goals, and hopes to develop a rapport with the therapist.
 2. Focus on habits or patterns that youth may want to change.
 3. Evoke change by using the youth's motivation to sense the importance of change, feel confident about change, and being ready to change.

4. Plan to implement change using practical steps.

This technique is respectful of the client's ambivalence about change, attempts to understand the client's perspective, points out discrepancies between goals and behavior, and works to elicit the client's own self-motivational statements as an impetus for change.²¹

- **Twelve Step Programs:** The individual attends Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) or other Twelve Step-related group programs or other support groups, such as Rational Recovery and Smart Recovery.
 - a. Peer support is an important component of the 12 step process. The individual typically obtains a sponsor, a person in recovery who becomes an ongoing volunteer resource over time.
 - b. A barrier to participation for some youth can be the age difference between the youth and the majority of Twelve Step participants, who are typically older and in later developmental stages.
 - c. Twelve Step Programs are often overtly spiritual in their orientation, which may be more or less appealing to some youth
- **Cognitive Behavioral Therapy.** CBT is a time-limited, evidence-based treatment for adolescent substance use and multiple treatment manuals have been developed.
 - a. CBT can be integrated with motivational enhancement therapies to increase engagement and retention in treatment.
 - b. The therapist works with the youth to identify patterns between thoughts, feelings, situations, and drug use (functional analysis).
 - c. Youth are supported in developing and using effective skills to manage high risk situations and to replace drug use with healthy alternatives.
- **Family Therapies.** Families are extremely important to adolescent health. Several family therapy models have research support for improving substance use recovery. These include Multidimensional Family Therapy, Functional Family Therapy, Brief Strategic Family Therapy, and Multisystemic Therapy-Contingency Management, and Adolescent Community Reinforcement Approach.
 - a. Common elements are identifying and modifying problems contributing to adolescent substance use and improving parental monitoring and reinforcement of recovery.
 - b. Family therapy may be integrated with motivational enhancement therapy and cognitive behavioral therapy.
- **Abstinence and harm reduction.**
 - i. Abstinence: The term abstinence signifies that an individual is not using substances. While the pre-existing addiction continues to be present, with the attainment of abstinence the individual is taking control and moving

toward recovery. With substance use, abstinence is typically the long-term goal.

- ii. Harm reduction: Harm reduction focuses on the risks and consequences of substance use with the goal of decreasing the harm associated with use. In the case of youth, harm reduction as a goal for some is based on the recognition that some youth are unwilling to give up substances completely, and as a result abstinence may not be realistic.

B. SPECIFIC PROGRAMS FOR YOUTH WITH SUDS AND CO-OCCURRING DISORDERS.

1. To be effective, the CAP must be aware of the array of services available in his or her specific locality. For services by state, information can be obtained through the Substance Use and Mental Health Services Web site: <http://findtreatment.samhsa.gov/>.
2. The American Society of Addiction Medicine Patient Placement Criteria, has become the consensus document regarding the organization of substance use services.²² There are nine levels of care, specified for adolescents with specific admission, continuing care and discharge criteria. The least restrictive care is the preferable choice. These levels of care are as follows:

0.5: Early Intervention

I: Outpatient Services

II.1: Intensive Outpatient

II.5: Partial Hospitalization

III.1: Clinically-Managed Low-Intensity Residential

III.3: Clinically-Managed Medium-Intensity Residential

III.5: Clinically-Managed High-Intensity Residential

III.7-D: Medically-Monitored Intensive Inpatient

IV-D: Medically-Managed Intensive Inpatient

Choosing the specific level of care is determined by measuring the patient's status on the following six dimensions:

1. Acute Intoxication and/or Withdrawal Potential
 2. Biomedical Conditions and Complications
 3. Emotional/Behavioral/Cognitive Conditions and Complications
 4. Readiness to Change
 5. Relapse, Continued Use or Continued Problem Potential
 6. Recovery/Living Environment
3. In the mental health sector there is less uniform agreement concerning levels of care and associated criteria. The Child and Adolescent Service Intensity

Instrument (CASII)²³ is an example of a reliable and valid instrument with patient placement criteria for determining a level of service intensity.

4. In mental health and substance use services systems, there are three types of programs depending upon the presence or absence of the commensurate disorders. These services are paid for through a variety of means, including, private insurance, state and federal public funds, or out-of-pocket.
 - iii. Addiction or mental-health-only programs: These programs cannot accommodate patients with co-occurring disorders.
 - iv. Dual Diagnosis or Co-occurring Capable: These programs are geared towards either mental health disorders or SUDs, but staff has the capacity to address co-occurring disorders.
 - v. Dual Diagnosis or Co-occurring Enhanced: These programs place an emphasis on providing integrated treatment for individuals with co-occurring disorders.

VI. ROLES FOR CHILD AND ADOLESCENT PSYCHIATRISTS: THE EVOLVING STANDARD OF CARE

The CAP has multiple roles that can help youth with SUDs and those with co-occurring disorders, which include the following:

A. THE CAP AS A CLINICIAN PROVIDING EVALUATIONS AND TREATMENT OF YOUTH WITH SUDS.

- There are seven important principles in the clinical management of youth with SUDs:
 - Abstinence is a goal, but not a condition for treatment.
 - Both SUDS and co-occurring mental health issues should be viewed as primary disorders and should be addressed in the treatment plan. The treatment for these disorders should be integrated, although specific aspects of the interventions may focus on one of the disorders and sequencing of focus may need to occur based on factors such as safety, acuity, medical problems, or medication interactions.
 - The CAP should carry a higher index of suspicion for comorbidity in adolescents.
 - Screening for psychiatric problems and comprehensively assessing youth with SUDs are of utmost importance.
 - Similarly, the CAP should promote screening and consistently assess for SUDs in patients with other behavioral and mental health problems.
 - The judicious use of psychotropic medication when indicated for psychiatric disorders can be associated with better outcomes for those with co-occurring disorders. Psychopharmacologic intervention is one component of integrated treatment for youth with co-occurring disorders.

- Adolescents with substance use and/or mental disorders should be maintained within a system of care. Level of care should be determined by current need. Established guidelines for level of care should be used when possible.

B. THE CAP AS AN ADVOCATE FOR YOUTH WITH SUDS AND THEIR FAMILIES.

- While integrated treatment of co-occurring SUDs and mental health disorders is the goal, there are many barriers to such integration within current systems of care for youth with SUDs and mental health disorders.
- The CAP has the opportunity to play a role in bridging the gap between disparate systems of care for youth.
- Because youth with SUDs and those with co-occurring disorders often have contact with other service systems (e.g., education, juvenile justice, and child welfare), the CAP has the opportunity to advocate for appropriate treatment and prevention for youth in these systems.
- The CAP can also advocate at higher levels for improved service quality and access, for example, with managed care and the larger system of care. There are now available measures of the fidelity of professionals and programs that deliver either capable or enhanced care.

C. THE CAP AS A MEMBER OF THE CHILD AND FAMILY TREATMENT TEAM.

- Partner with families in supporting youth with SUDs. Family involvement correlates highly with recovery in youth with SUDs.
- Strive to support the participation of all team members and the cohesiveness of the child and family team.
- Act as a catalyst, participating in a collaborative way without taking over.
- Educate other team members about the needs of youth with co-occurring disorders as well as provide information about psychotropic medications being used or under consideration.
- Ensure that the treatment needs of youth and their families continue to be addressed when there are changes in services or levels of service intensity.

D. THE CAP AS A CONSULTANT TO PROVIDERS IN OTHER SERVICE SYSTEMS.

- Lack of training within other systems is a pervasive issue. Other providers may have had little training in the area of SUDs, making the CAP an important member of the team as an advisor regarding appropriate treatment and prevention.
- Coordination of care between service providers and among involved systems is particularly important.
- CAPs can serve as informal consultants to other systems, or develop formal consultative roles with various child-serving systems

VII. CONCLUSION

Despite overlap at both the systems and clinical level, in most localities, the substance use treatment services system for youth remains significantly separate from that of the mental health system. There is great variability in the structure and administration of substance use services from one state to another. Funding for substance use services comes from the federal government, the state, private insurance entities, foundations, and local communities. Youth with SUDs and co-occurring disorders are often involved in many systems external to substance use treatment services and mental health. These systems include education, child welfare, juvenile justice, and physical health. When multiple systems are involved, collaboration becomes especially important to support optimal outcomes and reduce family burden. Youth with co-occurring disorders typically experience higher rates of psychological and physical trauma, higher levels of involvement in crime as victim or perpetrator, and multiple family risk factors. Co-occurring SUDs and mental health disorders are best addressed in an integrated manner. Unfortunately, such clinical integration has not yet been achieved in most communities, but there is increasing recognition that integrated treatment is the standard and the goal for the future. CAPS can help their patients and families to negotiate barriers to obtaining the best available care and to remain engaged in treatment.

Given the particular challenges that youth with SUDs and co-occurring disorders face and the unmet needs of involved child-serving systems, CAPs have a number of meaningful roles within the system of care. In the future, improved integration of services for youth with SUDs and with co-occurring disorders can result in more effective care, with positive outcomes for youth and their families.

APPENDIX 1*

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

IV.B.1.f) Systems-based Practice. Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

* Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Child and Adolescent Psychiatry.

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405_ChildAdolescentPsychiatry_2019_TCC.pdf?ver=2019-03-28-161025-277. July 1, 2019.

*

APPENDIX 2 – Suggested Screening Tools

Brief Screening Tools

- BSTAD (Brief Screener for Tobacco, Alcohol, and other Drugs):** This recently published tool was tested in primary care settings, is specific and sensitive for use with adolescents. It consists of 6 screening questions plus additional items to identify specific drugs used and to assess frequency of use.²⁴

FRIENDS' USE	
Do you have friends who smoked cigarettes or used other tobacco products <u>in the past year</u> ?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have friends who drank beer, wine, or any drink containing alcohol <u>in the past year</u> ?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have friends who <u>in the past year</u> :	
- sniffed or "huffed" anything;	
- took illegal drugs like marijuana (weed, blunts), cocaine, etc;	
- took prescription medications that were not prescribed for them; or	
- took prescription or over-the-counter medications and took more than they were supposed to take?	<input type="checkbox"/> No <input type="checkbox"/> Yes
PERSONAL USE	
In the past year, have you smoked cigarettes or used other tobacco products?	<input type="checkbox"/> No <input type="checkbox"/> Yes
In the past year, have you had more than a few sips of beer, wine, or any drink containing alcohol?	<input type="checkbox"/> No <input type="checkbox"/> Yes
In the past year, have you:	
- sniffed or "huffed" anything;	
- taken illegal drugs like marijuana (weed, blunts), cocaine, etc;	
- taken prescription medications that were not prescribed for you; or	
- taken prescription or over-the-counter medications and took more than you were supposed to take?	<input type="checkbox"/> No <input type="checkbox"/> Yes
[IF DRUGS ARE ENDORSED IN THE PERSONAL USE QUESTION, ASK THE FOLLOWING:]	
Which of the following substances have you used in the past year? (check all that apply)	
<input type="checkbox"/> Marijuana or Hashish	
<input type="checkbox"/> Cocaine or crack	
<input type="checkbox"/> Heroin	
<input type="checkbox"/> Amphetamines or methamphetamine (nonpharmaceutical)	
<input type="checkbox"/> Hallucinogens (eg, Mushrooms, LSD)	
<input type="checkbox"/> Inhalants	
Which of the following medications have you used in the past year that were not prescribed for you or which you took more of than you were supposed to take? (check all that apply)	
<input type="checkbox"/> Prescription pain relievers (eg, morphine, percocet, vicodin, oxycontin, dilaudid, methadone, buprenorphine)	
<input type="checkbox"/> Prescription sedatives (eg, Valium, Xanax, Klonopin, Ativan)	
<input type="checkbox"/> Prescription stimulants (eg, Adderall, Ritalin)	
<input type="checkbox"/> Over-the-Counter Medications (eg, Nyquil, Benadryl, cough medicine, sleeping pills)	
[FOR EACH SUBSTANCE WHERE USE WAS ENDORSED, ASK:]	
In the <u>past 30 days</u> , on how many days have you...	
smoked cigarettes or used other tobacco products/used alcohol/used [SUBSTANCE]?	<input type="checkbox"/> <input type="checkbox"/> days
In the <u>past 90 days</u> , on how many days have you...	
smoked cigarettes or used other tobacco products/used alcohol/used [SUBSTANCE]?	<input type="checkbox"/> <input type="checkbox"/> days
In the <u>past year</u> , on how many days have you...	
smoked cigarettes or used other tobacco products/used alcohol/used [SUBSTANCE]?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> days

FIGURE 1

The BSTAD. Note: consistent with the NIAAA instrument, if respondent is aged 12 to 14, friends questions are asked first; if aged 15 to 17 (or 14-year-olds in high school), personal-use questions are asked first.

- CRAFFT:** This tool was developed for screening adolescents and has been widely used in primary care settings. The letters in “CRAFFT” represent the key words in the 6 questions: Car, Relax, Alone, Forget, Friends, Trouble.²⁵

https://craftt.org/wp-content/uploads/2019/02/CRAFFT-2.0_Clinician-Interview.pdf

The CRAFFT Interview (version 2.0)

To be orally administered by the clinician

Begin: “I’m going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential.”

Part A

During the PAST 12 MONTHS, on how many days did you:

1. Drink more than a few sips of beer, wine, or any drink containing alcohol? Say “0” if none.	<input style="width: 80%; height: 20px;" type="text"/> # of days
2. Use any marijuana (pot, weed, hash, or in foods) or “ synthetic marijuana ” (like “K2” or “Spice”)? Say “0” if none.	<input style="width: 80%; height: 20px;" type="text"/> # of days
3. Use anything else to get high (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff or “huff”)? Say “0” if none.	<input style="width: 80%; height: 20px;" type="text"/> # of days

Did the patient answer “0” for all questions in Part A?

Yes No

↓ ↓

Ask CAR question only, then stop	Ask all six CRAFFT* questions below
-----------------------------------------	--------------------------------------------

Part B

	No	Yes
C Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
R Do you ever use alcohol or drugs to RELAX , feel better about yourself, or fit in?	<input type="checkbox"/>	<input type="checkbox"/>
A Do you ever use alcohol or drugs while you are by yourself, or ALONE ?	<input type="checkbox"/>	<input type="checkbox"/>
F Do you ever FORGET things you did while using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
F Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
T Have you ever gotten into TROUBLE while you were using alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

*Two or more YES answers suggest a serious problem and need for further assessment. See back for further instructions →

FIGURE-2
THE CRAFFT SCREENING TEST IS A SHORT CLINICAL ASSESSMENT TOOL DESIGNED TO SCREEN FOR SUBSTANCE-RELATED RISKS AND PROBLEMS IN ADOLESCENTS

Comprehensive Assessment Tools

- **Global Appraisal of Individual Needs (GAIN):** This uses a semi-structured interview to assess substance use, legal issues, school functioning, and psychiatric symptoms. (see www.gaincc.org/publications)
- **Teen Addiction Severity Index (T-ASI):** Developed as a semi-structured interview, this tool is also available in computer assisted, internet, and telephone-based versions. It assesses substance use, school and family functioning, legal issues, peer-social relations, and psychiatric status. (see www.emcdda.europa.eu)
- **Personal Experience Inventory (PEI):** This is a well-researched, self-report measure that includes assessment of substance use, psychosocial risk, suicide, abuse, and parental substance use. (see www.wpspublish.com)
- **Substance Abuse Subtle Screening Inventory (SASSI):** This is a well-researched, self-report tool that was designed for use in people who are at high risk for substance abuse. Strengths include scales to detect defensive responding, insight, emotional pain, and legal risk.²⁶

Appendix 3 – Family Treatments⁷

- **Brief Strategic Family Therapy** – 12-16 sessions that work on targeted behavior in relation to unhealthy family dynamics, poor boundaries, and dysfunctional interactions.
- **Family Behavior Therapy** – goal to reduce alcohol, substance use, and behavior problems in youth 13 and older. This includes addressing depression, family problems, and disruptive behaviors. A behavioral contract is involved.
- **Functional Family Therapy** – short-term treatment strategy built on respect of individuals, families and cultures which motivates individuals and families to become more adaptive and successful in their own lives. This therapy addresses delinquency, substance abuse and violence.
- **Multidimensional Family Therapy** – 12 to 16 week program that works on addressing the core components of the youth's interpersonal functioning with caregivers and peers. This helps the youth work on relationships with family members and social systems
- **Multisystemic Therapy** – a home based approach that lasts about 4 months with a primary goal of fostering a healthier environment of the youth across multiple settings. This reduces risk factors and enhances resources.

Appendix 4—SBIRT

There are three core components of adolescent SBIRT (see: <https://www.mcpap.com/pdf/S2BI%20Toolkit.pdf>)

- **Screening** -- the key component of this stage is ‘ASK’. Unless asked, adolescents will not tell about their use of substances. Therefore screening is an important 1st step.
- **Brief intervention** –
 - **No Use:** If identified during screening stage that an adolescent is not using substances then provide immediate praise and positive reinforcement. Saying: *“It’s a great decision to avoid tobacco, alcohol, and drugs — it’s one of the best ways to protect your health.”*
 - **Use:**
 - During screening, the provider also notes the frequency of substance used. If the use is less than 2 to 3 times a year then physician delivered advice to discontinue the use combined with brief explanation of the negative impacts of substances use on health may encourage in substance use discontinuation.
 - If the screening indicates risky use then the provider should provide immediate feedback on how the use of substances may have health consequences. In addition, offer simple advice and ask if he or she is willing to make a change. A brief motivational interview technique can be utilized at this stage.
- **A referral to treatment and follow-up:** If the substance use is severe, complicated, and serious then more intensive and specialized services are required. Connecting the adolescent to a physician or license mental health professional for comprehensive assessment for substance use disorder is warranted. During follow-up stage the referring provider should always stay in contact with the patient and specialist to gather updates on the progress.

REFERENCES

1. Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Child and Adolescent Psychiatry. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405_ChildAdolescentPsychiatry_2019_TCC.pdf?ver=2019-03-28-161025-277. July 1, 2019.
2. Minkoff, K, Cline, C. Changing the world: the design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. *Psychiatr Clin N Am*. 2004; 27(4):727-743.
3. NIDA. Monitoring the Future 2018 Survey Results. <http://www.drugabuse.gov/related-topics/trends-statistics/infographics/monitoring-future-2018-survey-results>. Published Dec 2018. Accessed April 25, 2020.
4. Conway, K, Swendsen, J, Husky, M, Hej, P, Merikangus, K. Association of lifetime mental disorders and subsequent alcohol and illicit drug use: results from the National Comorbidity Survey: Adolescent supplement. *J Am Acad Child Adolesc Psychiatry*. 2016; 55(4): 280-288.
5. Wen, H, Cummings, J, Hockenberry, J, Gaydos, L, Druss, B. State parity laws and access to treatment for substance use disorder in the United States. *JAMA Psychiatry*, 2013, Dec 1;70(12):1355-62.
6. NIDA. Parenting programs lead to healthier behaviors. <http://www.drugabuse.gov/news-events/latest-science/parenting-programs-lead-to-healthier-behaviors>. Published July 25, 2019. Accessed April 25, 2020.
7. NIDA. Principles of adolescent substance use disorder treatment: A research-based guide. Family-based approaches. <http://www.drugabuse.gov/publications/principles-substance-use-disorder-treatment-research-based-guide/evidence-based-approaches-to-treating-adolescent-substance-use-disorders/family-based-approaches>. Published January 2014. Accessed April 25, 2020.
8. McClelland, G, Elkington, K, Teplin, L, Abram, K. Multiple substance use disorders in juvenile detainees. *J Am Acad Child Adolesc Psychiatry*. 2004; 43(10):1215-1224.
9. SAMHSA. Criminal and Juvenile Justice. <http://www.samhsa.gov/criminal-juvenile-justice>. Published May 15, 2019. Accessed April 25, 2020.
10. Bryant AL, Schulenberg JE, O'Malley PM, Bachman JG, Johnston LD. How academic achievement, attitudes, and behaviors relate to the course of substance use during adolescence: a 6-year, multiwave national longitudinal study. *J Research Adolesc*. 2003; 13(3):361-397.
11. School Based Health Alliance. Substance Use Prevention in SBHC. http://www.sbh4all.org/current_initiatives/sbirt-in-sbhcs. Published on September 2019. Accessed April 25, 2020.
12. Kulig J. Tobacco, alcohol, and other drugs: the role of the pediatrician in prevention, identification, and management of substance abuse. *Pediatrics*. 2005; 115(3):816–821.
13. MacDonald, R, March, J. Crossing the rubicon: Youth transitions, poverty, drugs and social exclusion. *International Journal of Drug Policy*. 2002; 13(1):27-38.
14. SAMHSA. Results from the 2012 national survey on drug use and health: Summary of national findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. 2013.

15. Shih, R, Miles, J, Tucker, J, Zhou, A, D'Amico, E. Racial/Ethnic differences in adolescent substance use: Mediation by individual, family, and school factors. *Journal of Studies on Alcohol and Drugs*. 2010; 71(5):640-651.
16. McCaul, M, Srikis, D, Moore, R. Predictors of outpatient treatment retention: Patient versus substance use characteristics. *Drug and Alcohol Dependence*. 2001; 62(1):9-17.
17. CDC. Youth Risk Behavior Survey. <http://www.cdc.gov/healthyyouth/data/yrbs/data.htm>. Published 2017. Accessed April 26, 2020.
18. Kloos, A, Weller, R, Chan, R, Weller, E. Gender differences in adolescent substance abuse. *Curr Psychiatry Rep*. 2009; 11:120-126.
19. Ford, J, Hartman, J, Hawke, J, Chapman, J. Traumatic victimization, posttraumatic stress disorder, suicidal ideation, and substance abuse risk among juvenile justice-involved youth. *Journal of Child & Adolescent Trauma*. 2008;1:75-92.
20. Prochaski J, DiClemente C. *Stages of Change in the Modification of Problem Behaviors*. Newbury Park, CA: Sage; 1992.
21. Miller WR, Rollnick S. *Motivational Interviewing: Preparing People To Change Addictive Behavior*. New York, NY: Guilford Press; 1991.
22. American Society of Addiction Medicine. American Society of Addiction Medicine Patient Placement Criteria. <http://www.asam.org/publications/the-asam-criteria>. Published Oct 2013. Accessed April 26, 2020.
23. American Academy of Child and Adolescent Psychiatry. *Child and Adolescent Service Intensity Instrument User's Manual (4.1 ed.)*. 2018.
24. Kelly, S, Gryczynski, J, Mitchell, S, Kirk, A, O'Grady, K, Schwartz, R. Validity of Brief Screening Instrument for Adolescent Tobacco, Alcohol, and Drug Use. *Pediatrics*. 2014 Apr 21 [Epub ahead of print].
25. Pilowsky, D, Wu, L. Screening instruments for substance use and brief interventions targeting adolescents in primary care: a literature review. *Addict Behav*. 2013 May;38(5):2146-2153.
26. Lazowski, L, Miller, F, Boye, M, Miller, G. Efficacy of the Substance Abuse Subtle Screening Inventory-3 (SASSI-3) in identifying substance dependence disorders in clinical settings. *Journal of Personality Assessment*. 1998; 71(1):114-128.

WEB RESOURCES

American Academy of Addiction Psychiatry

www.aaap.org

American Academy of Child and Adolescent Psychiatry (AACAP)

www.aacap.org

American Psychiatric Association

www.psychiatry.org

American Society for Adolescent Psychiatry

www.adolescent-psychiatry.org

Child Welfare League of America

www.cwla.org

CORK Bibliography: Adolescents and Psychopathology (Dual Diagnosis)

[http://www.projectcork.org/bibliographies/data/Bibliography_Adolescents_and_Psychopathology_\(Dual_Diagnosis\).html](http://www.projectcork.org/bibliographies/data/Bibliography_Adolescents_and_Psychopathology_(Dual_Diagnosis).html)

National Alliance for the Mentally Ill

www.nami.org

National Clearinghouse for Alcohol and Drug Information

www.ncadi.samhsa.gov

National Institute on Drug Abuse (NIDA)

www.drugabuse.gov

National Institute of Mental Health (NIMH)

www.nimh.nih.gov

Pennsylvania State Co-Occurring Initiative

www.pccd.pa.gov

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.samhsa.gov/

Substance Use Treatment Services System –

Discussion Vignette I – Trainee Version

Trevor is a 16 year old Caucasian male who stands 5’11” and weighs 200 lbs. He is in the 10th grade, has a D average and very poor school attendance. When Trevor was 5, his parents divorced and since then he has lived with his mother and has had no contact with his father, who lives about 30 minutes away. At the insistence of his mother, he is seeking help for “feeling depressed” and for “getting crazy when I get mad.”

He admits to smoking marijuana daily with his friends, and has not attended 16 out of the last 30 school days. He was previously suspended from school for 3 days after making threats to beat up a teacher, and was recently arrested for possession of marijuana and is scheduled to appear in court next week. He had a part-time job washing cars at a local dealership, but was recently fired after missing several days of work.

His mother is frustrated and worried over her son’s behavior and attitude, and she describes how Trevor’s behavior is getting worse, as his outbursts are more frequent and more destructive. Her greatest concern is over statements her son made over the last few days when he said he “thought about ending it all.” Last year at this time, he had a B average in school, his attendance was very good. Trevor’s mother fears that he will fail the school year, and may also be placed in Department of Youth Services (juvenile justice) custody due to his drug charges.

Trevor appears disinterested, oppositional and sullen during the evaluation. He reports that he does not want to be in your office, and states that he has no interest in stopping his substance use. He denies feeling suicidal or homicidal during the assessment. When asked about his anger, Trevor states that when he gets disappointed or frustrated, he impulsively breaks things and punches walls and feels unable to stop himself.

1. What is a strategy to use during Trevor’s evaluation to encourage a collaborative approach?

2. What diagnosis would you consider, given Trevor’s story? If more than one diagnosis, what is the primary diagnosis?

3. Based on your diagnosis, how might you proceed with treatment?

4. You have determined that Trevor needs treatment for both mental health and substance use problems. Describe the three types of programs identified by the American Society of Addiction Medicine Patient Placement Criteria.

5. Which types of programs are available for youth in your area?

6. Although you have recommended a dual diagnosis program, Trevor states that he does not see a problem with his substance use, and says that he would only like help for his mood. How would you proceed?

7. The same day you receive a call from Trevor's probation officer who wants your recommendation regarding whether incarceration would be the best treatment alternative. What does the evidence suggest?

8. You advocate for the child and family team process and are willing to participate. Who else would you suggest participate in the child and family team?

Substance Use Treatment Services System - Discussion Vignette II – Trainee Version

Maya is a 16 year old AA girl who is admitted to the medical floor of the hospital after she was found unresponsive in her school bathroom. Her medical history includes frequent hospitalizations for sickle cell crisis the last one being 3 months ago. She also takes opioids for sickle cell related episodes. She also has ADHD and takes stimulants. She admits to abusing the stimulants periodically. Maya lives with her foster mother who is in the process of adopting her. Foster mother notes that she thinks that Malaya's pain from sickle cell is not treated well and she is often unable to sleep or do well in school because of that. Maya tells the consulting psychiatrist that she does not abuse her pain pills because her foster mother monitors her pills and she feels that she should have more control over her pain management.

1) What primary diagnoses would you consider for Maya?

2) What level of care do you think Maya needs after stabilization on the medical unit?

3) Who will comprise of Maya's treatment team?

4) What role does a CAP play in the treatment team?

Substance Use Treatment Services System - Discussion Vignette III – Trainee Version

Ashley is a 17 y.o. Caucasian female who was referred to you for irritability and insomnia. In the course of your evaluation, she reveals to you that she smokes marijuana daily. She reports that the marijuana “calms me down,” and states that she does not see a problem with using marijuana “because it’s natural.” She also reports that she has episodic binge drinking and has experienced sexual assault at a party when intoxicated. At this time, she reports that she is not interested in reducing marijuana use, and does not see her use as a problem. She would just like a medication to sleep and to “help me when I’m about to lose it.”

1) What would your initial approach be with Ashley’s treatment?

2) Which level of ASAM criteria would Ashley be appropriate for?

3) What resource can you use to guide treatment of co-occurring disorders?

4) How would Ashley’s substance use treatment be funded in your area?