SYSTEMS-BASED PRACTICE
SUBSTANCE ABUSE TREATMENT SERVICES SYSTEM

SYSTEMS-BASED PRACTICE: SUBSTANCE ABUSE TREATMENT SERVICES SYSTEM

OBJECTIVES

Knowledge
The resident will demonstrate an adequate knowledge of:
1) Epidemiological trends in substance abuse in youths, and common negative outcomes. (1-4,9-11)
2) The problem and pervasiveness of co-occurring disorders in youth. (1-4,9-11)
3) Service system challenges involving the substance abuse treatment services and mental health systems of care. (1-12)
4) Sources of substance abuse services for youth, including the community, federal, state, and other services. (1-12)
5) Treatment involving the family is associated with better outcomes. (1-4,9-11)
6) Stages of change theory, and its relevance to treatment. (1-4,9-11)
7) The basic elements of motivational interviewing, and its relevance to treatment. (1-4,9-11)
8) The role of peer support and Twelve Step groups, as well as potential pitfalls, for youth with substance use disorders and co-occurring mental health disorders and substance use disorders. (1-4,9-11)
9) Potential roles of the child and adolescent psychiatrist with regards to substance abuse treatment for youth, including advocate, member of the child and family team, consultant to other service providers, and clinician. (1-12)
10) The interface between the mental health system and other systems that provide services for substance abusing youths. (1-12)
11) Cultural and gender issues that impact the treatment of substance abuse in a particular youth. (1-4,9-11)
12) 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. (1-10,12)
13) Differentiate between the principles of recovery and discovery from a developmental viewpoint when treating substance abusing youth and their families. (1,2,4,11)
14) Patient placement criteria for levels of care as they pertain to mental health and substance abuse treatment systems of care. (2)

Skills
The resident will demonstrate the ability to:
1) Act as an advocate for youth with substance abuse disorders involved in a variety of service systems. (1-12)
2) Refer a youth for specific treatment services in their specific locality. (1-4,9-11)
3) Screen for and identify substance abuse in youth with psychiatric illness, and to screen for and identify psychiatric illness in youth with substance abuse. (1-4,9-11)

* Parentheses refer to systems-based practice competencies in the RRC Program Requirements. See Appendix 1 for complete list of competencies.
4) Evaluate and treat youth with substance abuse disorders and co-occurring disorders. (1-4,9-11)
5) Promote integrated treatment for youth with co-occurring disorders, and, in the absence of integrated care, be able to coordinate care between substance abuse services and mental health treatment. (1-12)
6) Provide cultural competence as part of service provision and treatment. (4,5,9)
7) Provide appropriate consultation regarding drug and alcohol treatment and prevention to providers and other service systems. (1-12)
8) Promote coordination of care between service systems. (2,4,5,10)
9) Apply patient placement criteria for levels of care as it pertains to mental health and substance abuse treatment systems of care. (2,4,8,10)

Attitude
The resident will demonstrate the commitment to:
1) Provide treatment to youths with substance abuse and co-occurring disorders in youth-guided, family-focused, recovery-oriented, systems-based and community-based contexts. (4,5,7-9,11)
2) Integration and collaboration between service systems when providing treatment to youth and their family. (2-6,10,12)
3) Addressing both substance use disorders and co-occurring disorders simultaneously. (1-4,9-11)
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. (1-4,9-11).
5) Maintain a collaborative, non-judgmental, and problem-solving approach when working with other systems of care. (1-3,5-8,10,12)
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. (1-4,9-11)
OVERVIEW

Historically, there has been variability in the training received by child and adolescent psychiatrists in substance use disorders (also referred to as SUDs). This variability has been mirrored by the myriad organizational and fiscal relationships between mental health and substance abuse treatment services in state and local structures, and the frequent fragmentation between these two service systems at the clinical level. Fortunately, with the adoption of systems of care perspectives and the increased recognition of co-occurring mental health and substance use disorders, this fragmentation is starting to be addressed. It is important for child and adolescent psychiatrists to understand that the substance abuse treatment services system has a different culture and in some cases a different terminology than mental health. The child and adolescent psychiatrist needs to learn about SUDs and the identification and treatment of youth with co-occurring disorders, and become familiar with the substance abuse treatment services system, so that genuine collaboration with the goal of integration can occur. The trainer should highlight the range of roles for child and adolescent psychiatrists in addressing the needs of adolescents with substance abuse and co-occurring disorders and their families.

I. INTRODUCTION

Systems Challenges for Youth with Substance Use Disorders

Individuals with SUDs and co-occurring psychiatric illness “long 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.”

A. EPIDEMIOLOGY: THE SCOPE OF THE PROBLEM

- Untreated substance use, abuse and addiction have profound implications for youth, families, and communities, resulting in increased crime, suicide rates, health care utilization, and poor academic outcomes.
- In 2007, just under half of American students tried an illicit substance by the 12th grade and almost three-quarters consumed alcohol.3
- “The lifetime prevalence of drug abuse and dependence has ranged from 3.3% in 15 year-olds to 9.8% in 17 to 19 year-olds (Kashani et al., 1987; Reinherz et al., 1993).”4
- Substance use disorders are associated with psychosocial and academic impairment (Martin and Winters, 1998), and include family dysfunction, interpersonal conflict, and academic failure.4
- SUDs are associated with increased risk-taking and deviant behaviors (Lewinsohn et. al. 1993; King et al., 2000, Bukstein et al., 1989).4
- Substance abuse in adolescents is associated with higher numbers of suicide attempts, greater suicidal ideation, greater lethality of attempts, and greater frequency of attempts.5
There are high rates of co-occurring mental health disorders with youth who have substance use disorders. 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.

B. THE SUBSTANCE ABUSE TREATMENT SERVICES SYSTEM OF CARE FOR CHILDREN AND ADOLESCENTS: CORE THEMES

- **The need for integrated treatment.** Despite the frequency and morbidity of co-occurring mental health and substance use disorders, integrated treatment services for youth with co-occurring disorders remains the exception rather than the rule in most communities.

- **The need for screening and assessment by each system.** It is essential that the mental health system routinely screen for substance abuse, and that the substance abuse 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.

- **The need to understand the specific state and local structures involved in the provision of mental health and substance abuse treatment services.** Substance abuse 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 medical assistance enrolled members.

- **The need for coordination among child-serving systems.** The lack of coordination between mental health and substance abuse 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 abuse 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 abuse and co-occurring disorders competence by the child and adolescent psychiatrist.** In order to provide leadership, the child and adolescent psychiatrist needs to gain more than just mental health competence. There is a need to understand the substance abuse treatment services system and gain clinical competence in the diagnosis and treatment of SUDs and co-occurring mental health and SUDs.

- **Multiple roles for the child and adolescent psychiatrist.** As discussed later, there are many potential roles for a child and adolescent psychiatrist with co-
occurring competence and a commitment to integrated treatment approaches. Child and adolescent psychiatrists (CAPs) need to appreciate that traditional treatment approaches will require modification in order to be effective with youth.

II. UNDERSTANDING THE LANDSCAPE

A. SYSTEMS CONSIDERATIONS REGARDING THE SUBSTANCE ABUSE SERVICES TREATMENT SYSTEM

1. Federal Initiatives
   - National Institute of Drug Abuse (NIDA)
     - NIDA’s mandate is in supporting and promoting research in the area of SUDs, and it also has a role in disseminating results in order to effect change in prevention, treatment, and policy. For details regarding NIDA’s policies and programming, see www.nida.nih.gov.
   - 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 abuse disorders. For details see, 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.
     - SAMHSA consists of four centers, including the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT), the Center for Substance Abuse Prevention (CSAP), and the Office of Applied Studies (OAS).
     - 3 of the 12 SAMHSA priority areas involve the following: children and families, substance abuse treatment capacity, and co-occurring disorders.
     - In addition, four other SAMHSA priority areas relate to negative outcomes to which untreated youth with SUDs and co-occurring disorders are extremely vulnerable, including: risk of suicide, homelessness, criminal activities, and HIV/AIDS and hepatitis.
     - SAMHSA has also sponsored a program known as the Co-Occurring Center for Excellence (COCE). The COCE mission is to provide technical assistance, training, products, and resources in support of dissemination and adoption of best practices in systems and programs serving individuals with co-occurring disorders. For details see www.coce.samhsa.gov.

2. State Initiatives
   - At the state level, there is no single template for the organization of the substance abuse treatment services system and the provision of substance abuse services. In fact, variability is the rule rather than the exception.
• The substance abuse 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.
• Each state receives federal “block grants” (a sum of money dedicated for a specific purpose) for substance abuse services that are separate from the block grants received for mental health programs.
• Federal requirements for the substance abuse treatment services state plan, and regulations governing use of block grant funds, differ from those applicable to mental health.
• Substance abuse 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 Medical Assistance (MA) members, the managed care organization is responsible for providing medically necessary substance abuse as well as mental health services for MA-enrolled individuals. Individuals not enrolled in MA may receive a substance abuse services benefit that is provided in accordance with the state plan. The services can be quite far from reimbursing a full continuum of care, as well as case management services and alternatives to care. They tend to reimburse for select care based on diagnosis rather than on services that promote recovery, wellness, and relapse prevention. Reimbursement of residential programs for substance abuse treatment or co-occurring disorders are typically defaulted to public sector funding at the state level. Assertive management of “high-end users” of care is given a low priority or is absent.
• Private insurance provides variable substance abuse 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 abuse services for adults, integrated youth services lag behind.

3. Local Initiatives
• States have different systems for the provision of substance abuse services at the local level.
• For example, in Pennsylvania, there are, “single county authorities,” which are responsible for local oversight of substance abuse services that are external to Medicaid. In some cases, single county authorities also offer services themselves.

B. GENERAL PRINCIPLES SHARED BY SUBSTANCE ABUSE TREATMENT AND MENTAL HEALTH SERVICES
1. Prevention efforts within each system look at protective and risk factors for youth and their families.

2. The presence of multiple risk factors renders a youth more vulnerable to develop a mental health and/or SUD, typically both.

3. Each system has an array of services and seeks to use the least restrictive service to address the needs of a specific youth.

4. Given the importance of the family in the lives of youth, treatment with a family-based approach has a much greater likelihood of success than non-family based approaches.
   - In both positive and negative ways, the family can have a significant impact on youth.
   - On the one hand, a number of protective family factors can play an important role in prevention and recovery. These include: parental supervision, a child’s attachment to the parent, a parent’s attachment to child, and parents’ involvement in child's activities.7
   - On the other hand, multiple family factors have been shown to be risk factors for youth SUDs, including parental substance abuse or use, poor parent-child relationships, low perceived parental support, and poor supervision.4 In addition, excessive discipline, constant criticism, and an absence of parental praise or approval are all associated with higher rates of substance abuse in adolescents. Parental substance use and parental attitudes approving substance use appear to predispose children to use.
   - Family-supported treatments have the greatest evidence of effectiveness.4
   - Treatment interventions involving the family include: functional family therapy, brief strategic family therapy, multisystemic therapy, family systems therapy, cognitive behavioral therapy (for details and specific references, see AACAP, 2005).
   - Outside of the treatment environment, family members also play a vital role in supporting recovery for youth.

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. Many youth in each system are likely to have a co-occurring disorder, either previously identified or disclosed through careful history-taking and use of screening tools.

9. 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.

10. Youth with severe mental health or substance abuse – and those with co-occurring mental health and substance use disorders – are at high risk of entry into multiple systems, including the legal system, and benefit from
collaboration among child-serving systems and the use of a child and family team guided by wraparound principles.

11. Both systems recognize the importance of natural supports and the use of community resources/natural supports. Both systems have relied, to varying degrees, on the use of natural, non-professional supports.

12. Motivating youth and determining their degree of readiness for change are important components of effective treatment.

13. Effective intervention requires the creation of trusting relationships between the youth and involved professionals. Trust is also essential in relationships between youth and non-professional support persons.

C. DIFFERENCES BETWEEN SUBSTANCE ABUSE TREATMENT SERVICES AND MENTAL HEALTH APPROACHES

1. Substance abuse treatment makes use of specific support systems that rely heavily on peer support:
   - Peer support is typically organized around Twelve Step Programs, which are lay programs by design.
   - 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.
   - In addition, the individual typically obtains a sponsor, a person in recovery who becomes an ongoing volunteer resource over time.
   - 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. Youth typically have not experienced many of the severe consequences of substance abuse that adults have, and this difference in experiences can contribute to youth denial.
   - For similar reasons, for some youth the goal of abstinence and sobriety may create an additional barrier.
   - For this reason, use of youth-specific groups may be more effective for this population, and youth participation in traditional adult-only groups can be counter-productive. Matching of youth with a much older adult population, in contrast, can stimulate a grandparent-like relationship and be beneficial.

2. Substance abuse treatment, through its reliance on the Twelve Step Program, is more overtly spiritual in its orientation than most mental health treatment. There is reference to a “higher power,” although this is not necessarily linked to a specific religion or religion in general. While this spiritual component of substance abuse treatment can be reassuring to adults, it may create an additional barrier to participation for some youth.

3. Substance abuse treatment includes intervention by professionals, some of whom experienced substance abuse problems earlier in life and are now in recovery. In mental health, while a specific professional might have a mental
health disorder, this is usually not disclosed and is not viewed as an important component of the helping process.

4. In the past, substance abuse treatment was regarded as more confrontational, and mental health treatment was seen as more supportive. While this may continue to be the case in some places, substance abuse treatment now involves the provision of support and an awareness of the degree of readiness of the individual to change. Direct confrontation has been replaced by efforts to promote motivation, which is known as motivational enhancement.

5. Substance abuse treatment had traditionally tended to focus on the individual abusing substances, while mental health treatment for children and youth had focused simultaneously on the youth and the youth’s family, with an emphasis on family empowerment and “family-driven care.” Increasingly, however, substance abuse treatment involves the youth’s family. At times, this can even involve peer support for the family of a youth who is unwilling to participate in treatment. For substance abusing adolescents, there have been specifically designed evidence-based family-focused or family-included treatment models, such as brief strategic family therapy, the community reinforcement approach, multidimensional family therapy, and family support network.

6. Historically, the role of professionals in the two systems has been seen as different, with mental health providers doing more for the individual and family and substance abuse providers placing more responsibility on the individual. This difference has narrowed significantly within each system, as illustrated by:
   - Adoption of recovery principles within mental health, which upholds the importance of individual autonomy and responsibility.
   - Adoption of stage of change and motivational enhancement within both substance abuse and mental health treatment services upholds the need for the professional to actively engage the client.

7. In the past, substance abuse providers looked unfavorably on the use of psychotropic medication. However, as the awareness of co-occurring disorders has increased within substance abuse 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 abuse issues, immediately referred such patients to the substance abuse sector, or divided the care between the two sectors leading to fragmented care. The interest in developing the expertise to treat mentally ill patients with substance abuse disorders is a recent phenomenon.

8. Historically, there have been different connotations associated with the concept of recovery in each system. A deeper understanding of the Twelve Step process within substance abuse treatment services, however, reveals that there has always been a considerable convergence between recovery in the mental health system and recovery in the substance abuse treatment services system:
   - Recovery from substance abuse, as with mental health recovery, involves encouraging the individual to create a more balanced, personally meaningful life, not just to abstain from using substances.
The use of substances needs to be replaced by new, meaningful activities that help maintain recovery.

- Within both systems, the individual is encouraged to be active in the recovery process and is seen as having the right to make meaningful life decisions.

9. Rarely is the state public mental health sector able to measure with validity and reliability the treatment outcomes of care because is funded by an insurance reimbursement system without a requirement of a uniform medical record system. The state publicly-funded substance abuse sector has more instances of measured outcomes based on such an electronic record system, especially if the funds are distributed as grants to its counties and other jurisdictions with regulations that require reporting of admission, continued stay and discharge data. Without such outcome reports, it is difficult to make rational policy decisions about care or to determine how much of each level of care is needed. Nor can any city or jurisdiction determine what level of services it requires if it does not have such relevant real-time data.

10. To improve the delivery of care, the substance abuse treatment services system has formed Advancing Recovery (www.advancingrecovery.net), a collaboration between the Network for the Improvement of Addiction Treatment (NIATx), the Treatment Research Institute (TRI), the Robert Wood Johnson Foundation, and six payer-provider partnerships. Its mission is as follows:

   To impact the lives of people facing behavioral health issues by improving consumer access, retention and outcomes through better treatment delivery systems that utilize evidence-based practices (EBPs). We will accomplish this by:

   - Implementing system change through the use of process improvement methods and tools;
   - Designing, implementing, and sharing innovative solutions to systemic barriers;
   - Building alliances between treatment providers, payers, and policymakers; and,
   - Using a collaborative learning model that emphasizes peer networking and coaching.

D. THE CULTURE OF CO-OCCURRING DISORDERS TREATMENT – SPECIFIC ELEMENTS

1. All mental health and substance abuse providers need to become co-occurring capable (see V.B.3. below). They should also become familiar with the structure of the other’s service system, including its mandates, regulations, and culture.

2. It is important to anticipate, and screen for, co-occurrence, regardless of where the individual first presents.
3. When co-occurring disorders are present, each is regarded as primary, and each is treated without a prior requirement that one be treated as a prerequisite for addressing the other.

4. There is need to determine an individual’s readiness to change with regard to each disorder separately.

5. Appropriate treatment interventions for each disorder will vary according to the individual’s degree of readiness to change with respect to each disorder.

6. Motivational enhancement approaches have been successful in helping individuals accept the need for treatment and be willing to change in general.

7. Treatment involves interest in the whole person, not just concern about the individual’s abstinence from substances and the management of mental health symptoms.

8. 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 ABUSE IN YOUTH AND POTENTIAL MULTI-SYSTEM INVOLVEMENT

A. Youth with a substance use disorder or a co-occurring mental health and substance use disorder are at high risk for multi-system involvement.

B. The CAP can play an important role as an advocate for substance abuse treatment services for youth who have involvement with other agencies, including juvenile justice, child welfare, medical and education systems.

C. Whether or not the service system in question provides substance abuse and mental health treatment, each system should at a minimum screen for substance use and psychiatric disorders, make appropriate referrals, and coordinate care.

D. There is significant variability between states, regions, or jurisdictions in the operations of child welfare, juvenile justice, education, and primary care systems for having predictable processes for screening, identification, applying level of care utilization criteria, referral, interagency coordination, and follow up of youth and families who would be eligible for behavioral services. As a result, these populations can be under-identified and underserved.

E. Specific child-serving systems that often interface with youth in the mental health and substance abuse treatment services systems are discussed below:
1. Juvenile Justice
• From 1986 to 1996, drug-related juvenile incarcerations increased nearly threefold. In 2002, about 60% of detained boys and nearly half of the girls tested positive for drug use. One study found that about one-half of both male and female juvenile detainees met criteria for a substance use disorders.
• Evidence shows that these complex youth often respond best to intensive community-based treatments and family-based interventions rather than incarceration.
• 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 [http://ojjdp.ncjrs.org/programs](http://ojjdp.ncjrs.org/programs) 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 abuse problem, and is at risk of self-harm. A youth who has a CHINS is often referred to a child and adolescent psychiatrist 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.

2. 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 abuse interventions provided by the child welfare systems.
• Problems with substance use disorders are often multi-generational – children of parents who abuse substances are more likely to experience abuse and neglect, and are more likely to abuse 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/bhd/aoddefault.htm](http://www.cwla.org/programs/bhd/aoddefault.htm).

3. Education System
• A child and adolescent psychiatrist may be asked to provide school-based consultation to assess problem behavior, which may be due to substance abuse or a co-occurring disorder or both.
• Substance abuse is associated with poor academic functioning and lower rates of high school completion.
• 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 abuse, 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](http://www.ed.gov/about/offices/list/om/fs_po/osdfs/home.html?src=oc)).
• “Zero tolerance” initiatives across the nation have resulted in many youth being prosecuted through the court system for substance abuse-related problems. In some school districts, youth caught with illegal substances are barred from extracurricular activities and are considered for expulsion. A psychiatrist 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.

4. Primary Care
• Screening for substance abuse is considered a vital element of well-child care. The primary care physician (PCP) can often be the first professional to identify this problem.
• PCPs can also screen for parental substance use and refer, as appropriate, an effective prevention or intervention strategy for the child.
• However, according to a periodic survey conducted by the American Academy of Pediatrics (AAP) in 1995, fewer than 50% of pediatricians screen for substance use disorders in youth.12
• Careful coordination between the child and adolescent psychiatrist and the primary care provider can reduce the likelihood of competing treatment plans, diversion of medication, and misuse of prescribed medications.
• 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. Primary care providers may also not be aware of the research demonstrating the importance of screening for substance use disorders and the positive outcomes of substance abuse treatment.12

IV. SUBSTANCE USE DISORDERS AND SPECIAL CLINICAL CONSIDERATIONS

A. POVERTY AND SOCIOECONOMIC STATUS
• Economically disadvantaged youth are exposed to multiple risk factors for substance abuse, including: higher availability of drugs, fewer alternative life opportunities, increased hopelessness, and higher rates of family adversity and conflict.13

B. MINORITIES
• Minority youth are at higher risk of substance abuse because of higher levels of poverty, higher risk of poor academic outcomes, and difficult environments.13
• Greater research is required to better understand the patterns of drug use among minority youth.
• There are variations in rates of substance abuse among youth of different ethnic and racial backgrounds by locality. The CAP should be aware of patterns of substance abuse among youth in their area.
• For example, in North Carolina, the rates of inhalant use among Caucasian youth are higher than the rates of African-American youth (16.5% lifetime use versus 7.6%, respectively). Among Latino youth in North Carolina, rates of cocaine use were higher than among African Americans or Caucasians (10.6% lifetime use among Latino youth, 2.3% among African-American youth, and 2.3% among Caucasian youth). (From State Center for Health Services, December 2, 2004, www.schs.state.nc.us/SCHS, accessed December 2, 2004.)

• Cultural factors may also impact substance use patterns.
  - The CAP has an important role in understanding cultural factors in his or her 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.
  - NIDA purports that “cultural influences, unique economic situations, and social networks” result in variable patterns of use among minority populations.14
  - Language barriers can mask identification of SUDs or the creation of trusting relationships that can facilitate entry into treatment.

C. GENDER

• The CAP should be aware of gender issues, particularly the role of trauma, as it relates to the treatment of SUDs.
• Rates of substance abuse may vary by gender – males tend to have greater rates of substance abuse at a younger age, while girls have slightly higher rates of abuse in older adolescence.
• Among youth aged 12 to 17, the rate of current illicit drug use was similar for boys (9.8%) and girls (9.7%). In 2006, male and female adolescents had similar rates of current marijuana use (6.8% and 6.4%) (Figure 2.9)15 and nonmedical use of prescription-type psychotherapeutics (3.1% and 3.5%, respectively).
• In 2006, 57.0% of males aged 12 or older were current drinkers, higher than the rate for females (45.2%). However, among youths (12 to 17 years old), the percentage of males who were current drinkers (16.3%) was similar to the rate for females (17.0%).15
• 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.16
• Trauma and substance abuse frequently co-occur: in one study, the rate of victimization among adolescents presenting for substance abuse treatment ranged from 40-80%.17 This is in marked contrast to the estimate that 3-12% of adolescents between ages 12-17 in the general population have been victimized.17
D. DEVELOPMENTAL DISABILITIES

- Resources for youth with developmental disabilities are limited or unavailable in many areas. More research and programming is required 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. 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.

V. APPROACHES TO RECOVERY

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

1. Stages of change. The stages of change theory, initially used to guide substance abuse assessment and treatment, is based on the recognition that recovery is a gradual process that is marked by 5 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. The stages of change are:
   - Precontemplation: There is no acknowledgment of a behavior or problem to be changed. The individual defends the behavior (e.g., substance abuse) 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.

2. 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, collaborative approach in which the clinician is respectful of the client’s ambivalence, attempts to understand the client’s perspective, “rolls with” the patient’s resistance, points out discrepancies between goals and behavior, and works to elicit the client’s own self-motivational statements as an impetus for change.¹⁹

• Motivational interviewing, by relating to and empathizing with clients at their levels of bio-psycho-social-spiritual development, can effectively create and sustain a meaningful helping relationship.

3. Abstinence and harm reduction.

• 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.

• Harm reduction: Harm reduction focuses on the risks and consequences of substance abuse rather than on the use per se, 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.

• The goal in working with youth is often determined pragmatically, based on the severity of the use or abuse, the presence of drug dependence, the youth’s stage of change, the functional analysis of substance-related and pro-social behaviors, agreed upon goals and objectives, the enhancing of practical skills such as problem-solving and communication, the building of family and community supports, and his/her response to treatment. Family therapy and cognitive behavior therapy treatments have also demonstrated efficacy in adolescent substance abuse treatment.⁴

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 Abuse and Mental Health Services Web site: http://findtreatment.samhsa.gov/.

2. The American Society of Addiction Medicine Patient Placement Criteria, Second Edition has become the consensus document regarding the
organization of substance abuse services. 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. Treatment Acceptance/Resistance  
5. Relapse/Continued Use Potential  
6. Recovery 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) is an example of reliable and valid instrument with patient placement criteria for determining a level of service intensity.

4. In mental health and substance abuse systems of care, 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.
   - Addiction or mental-health-only programs: These programs cannot accommodate patients with co-occurring disorders.
   - 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.
   - 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 comorbid mental health issues are to be viewed as primary disorders and should be approached simultaneously.
  - 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.
  - 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 and placed at the appropriate level based on specific admission criteria.

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 TEAM.

- The CAP can partner with families in supporting youth with SUDs. Family involvement correlates highly with recovery in youth with SUDs.
The CAP should strive to support the participation of all team members and the cohesiveness of the child and family team. The CAP needs to act as a catalyst, participating in a collaborative way without taking over. The CAP can 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. The CAP needs to 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. SUMMARY

Despite overlap at both the systems and clinical level, the substance abuse treatment services system of care for youth remains significantly separate from that of the mental health system. There is great variability in the structure and administration of substance abuse services from one state to another. Funding for substance abuse services comes from the federal government, the state, and local communities. Although there are cultural differences between the two systems, there is also increasing convergence of values and practices. Nevertheless, the reliance of treatment on Twelve Step programs and on voluntary peer support is notable, and should be understood and respected by CAPs.

Youth with SUDs and co-occurring disorders are often involved in many systems beyond substance abuse 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. Youth with multiple co-occurring disorders typically have higher rates of trauma, higher crime rates, and greater family risk factors. Co-occurring SUDs and mental health disorders are best addressed in an integrated manner, with each disorder treated at the same time by a provider (or team of providers) with enhanced co-occurring competence, within the context of a child and family team process. 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. The final challenge for the treating CAP is maintaining the child and family in the system of care and preventing either dropping out or systemic rejection.
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. The CAP can serve as a clinician, advocate, child and family team member, and consultant. 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 and for providers.
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:

1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
2) coordinate patient care within the health care system relevant to their clinical specialty;
3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;
4) advocate for quality patient care and optimal patient care systems;
5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,
6) participate in identifying system errors and implementing potential systems solutions.
7) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care cost, assuring quality, and allocating resources;
8) practice cost-effective health care and resource allocation that does not compromise quality of mental health care for children and adolescents;
9) advocate for quality patient care and assisting patients in dealing with system complexities, including disparities in mental health care for children and adolescents;
10) work with health care managers and health care providers to assess, coordinate, and improve health care;
11) know how to advocate for the promotion of health and the prevention of disease and injury in populations; and,
12) instruct in the practice of utilization review, quality assurance and performance improvement.

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http://www.mayatech.com/cti/jmate2005/pdfs1/MichaelDennisAddressingVictimizationandT 


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OTHER RESOURCES


WEB RESOURCES

Advancing Recovery
www.advancingrecovery.net

American Academy of Addiction Psychiatry
www.aaap.org

American Academy of Child and Adolescent Psychiatry (AACAP)
www.aacap.org

American Psychiatric Association
www.psych.org

American Society for Adolescent Psychiatry
www.adolpsych.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

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.nida.nih.gov/

National Institute of Mental Health (NIMH)
www.nimh.nih.gov

Pennsylvania State Co-Occurring Initiative
PA-Co-occurring.org

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov/
findtreatment.samhsa.gov/
Substance Abuse 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 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 and taking Oxycontin 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 abuse 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 court counselor 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?
Tashy is a 13 year old African American female who has been diagnosed with bipolar I disorder. She has increasingly severe mood swings, and is extremely oppositional to her adoptive parents, who are Caucasian and who adopted Tashy when she was 3 months old. She attends an almost exclusively Caucasian school and her teachers have reported that for several months Tashy has been missing classes, has stopped turning in homework and has been found “hanging out” in the school bathroom, frequently alone. Tashy has been running away from home for days at a time recently. Recently, Tashy was caught with marijuana on school grounds. Her parents were called and asked to come and remove Tashy from school. As her clinician, you were not aware of her marijuana use. Upon questioning, Tashy admits to using marijuana with escalating frequency over the past two months.

1. What primary diagnosis would you consider for Tashy?

2. What types of special clinical considerations would the child/adolescent psychiatrist be cognizant of in this situation?

3. Describe the components of a youth-guided, family-focused treatment approach for Tashy

4. What are roles for the CAP that evaluates Tashy and her family?
5. Each state receives federal block grants for both substance abuse and mental health programs. How are these programs organized and integrated in your state? How do they address the issue of youth substance abuse? How are they organized for clinicians to refer for care and for patients and families to access care?

6. Describe peer-guided substance use programs that Tashy could become involved in. What would be the pros and cons of referring Tashy to such programs? Are there any risks involved?