

CONDENSED CLINICAL PRACTICE GUIDELINE
TREATMENT OF CLIENTS WITH SUBSTANCE USE DISORDERS (SUD)
Substance Abuse and Mental Health Services Administration. *Treatment of Adolescent With Substance Use Disorders: A Treatment Improvement Protocol (TIP) 32*

- I. General scope of TIP 32
 - A. Treatment decisions are based on a continuum reflecting the severity (severity continuum) of the SUD
 - B. Treatment defined as activities that might be undertaken to deal with problem(s) associated with substance involvement and SUD
 - C. Severity continuum interventions involve acute intervention, rehabilitation, and maintenance
 - D. The continuum reflects the treatment philosophies of providers, with less emphasis on settings and modalities
 - E. Three common types of treatment of SUD in youth: 12-step, therapeutic community (TC), and family therapy
 - F. TIP 32 offers guidelines for using the severity continuum to make treatment decisions and for providing three common models of treatment
- II. SUD and youth
 - A. Current trends indicate a major national problem with youth and SUD
 - 1. Perceived risk of harm from substance use is falling while the availability of drugs is climbing
 - 2. Onset of substance use is occurring at younger ages, resulting in more youth entering treatment for SUD with greater developmental deficits and perhaps greater neurological deficits than in the past
 - 3. Other consequences of substance use/abuse include alcohol- and drug-related traffic accidents, delinquency, high risk sexual behavior, and psychiatric disorders
 - B. Youth users differ from adults in many ways
 - 1. Substance use often stems from different causes
 - 2. They have more trouble anticipating consequences of their use
 - 3. In treatment, youth must be approached differently than adults because of unique developmental issues, differences in values and belief systems, and environmental considerations
 - 4. At a physical level, youth tend to have smaller body sizes and lower tolerances, leading to greater risk for alcohol-related problems
 - 5. Substance use may compromise a youth's mental/emotional development from youth to adulthood
- III. Tailoring treatment to youth
 - A. Youth substance use occurs with varying degrees of severity. The degree of substance involvement is an important factor in treatment, as are any coexisting disorders, family and peer environment, and individual stage of mental and emotional development.
 - B. Treatment interventions fall along a continuum that ranges from minimal outpatient contacts to long-term residential treatment. All levels of care should be considered in

- making an appropriate referral. Treatment should be consistent with the severity of involvement of drug involvement.
- C. While no explicit guidelines exist, the most intensive treatment services should be devoted to youth who show signs of dependency with the presence of multiple personal and social consequences and evidence of an inability to control or abstain from substances
 - D. SUD treatment must address nuances of each youth's experience, including cognitive, emotional, physical, social, and moral development
 - E. Regardless of the model used in treating youth, there are several points to remember when providing SUD treatment:
 - 1. Consider age, gender, ethnicity, disability status, stage of readiness to change, and cultural background
 - 2. Some delay in normal cognitive and social-emotional development is often associated with substance use during adolescence. Treatment for youths should identify such delays and their connections to academic performance and social interactions.
 - 3. Programs should involve the youth's family because of its possible role in the origins of the problem and its ability to change the youth's environment.
 - 4. Using adult programs for treating youth is ill-advised. If necessary, it should be done with alertness to complications that may threaten effective treatment for youth.
 - 5. Many youths have explicitly or implicitly been coerced into attending treatment. Coercive pressure to seek treatment is not generally conducive to the behavior change process. Treatment providers should be sensitive to motivational barriers to change at the outset of intervention.
 - F. It is useful to consider a substance use continuum with six anchor points:
 - 1. Abstinence
 - 2. Use: minimal or experimental use with minimal consequences
 - 3. Abuse: regular use or abuse with several and more severe consequences
 - 4. Abuse/Dependence: regular use over an extended period with continued severe consequences
 - 5. Recovery: return to abstinence, with a relapse phase in which some youths cycle through the stages again
 - 6. Secondary abstinence

IV. Assessment

- A. Assessment is an ongoing process. Decisions about level of care should be based on the youth's progress and changes in his environment. Youths should be able move into or through different treatment programs based on their progress and/or changes in the environment.
- B. Prior to each program change, reassessment must be completed and the results communicated between providers
- C. In making placement decisions, practitioners should choose the most intensive level of care indicated by any single assessment criterion. When an assessment indicates the need for a particular level of care that is not available, it is desirable

to refer the youth to the next higher level of care, unless the placement would be counterproductive.

- V. General program characteristics
 - A. Program design, a policies and procedures manual, ongoing evaluation, and a planned approach to legal concerns make up the framework for a treatment program
 - B. Within this framework, issues to consider include staff recruitment and training, treatment components, treatment planning, and client services.
 - C. Staffing
 - 1. Cultural competence
 - a. Staff members should represent the cultural diversity of the program's client population
 - b. Facility forms, books, videos, and other materials should reflect the culture and language of the clientele
 - c. Innovative and intensive continuing education, staff development, and outreach efforts during staff recruitment may be needed to improve cultural competence among staff. If a significant part of the client population is non-English-speaking, at least one staff member should be bilingual and bicultural.
 - d. Someone on staff should be familiar with disability issues/culture
 - 2. Training
 - a. Staff training should be scheduled periodically throughout the year
 - b. Training should address a range of specialty topics:
 - 1. Treatment approaches specific to youth/families
 - 2. Family dynamics and family therapy
 - 3. Adolescent growth and development
 - 4. Sexual and physical abuse
 - 5. Gender issues
 - 6. Mental health problems
 - 7. Different cultural and ethnic values
 - 8. Psychopharmacology
 - 9. Referral and community resources
 - 10. Cognitive impairments
 - 11. Legal matters
 - 3. When recovering individuals are hired, they should have the same level of expertise and training required of other staff members in the same position. Recovering individuals must have clear evidence of abstinence from alcohol and drugs for 2 to 5 years.
 - D. Program components
 - 1. The core components of many youth treatment programs, regardless of their therapeutic orientation, include the following:
 - a. Orientation, the first step in treatment, clarifies what treatment is, the youth's role in treatment, and program expectations
 - b. Daily scheduled activities of school, chores, homework, and positive recreational activities
 - c. Peer monitoring

- d. Conflict resolution
 - e. Youth contracts (e.g., behavioral contracts, including substance-free contracts) are negotiated and signed by both the youth and primary counselor; they lay out concrete treatment goals, expectations, time frames, and consequences that are mutually acceptable to the youth and counselor
 - f. Schooling, which generally focuses on substance use and basic education. Whether the schooling is provided on or off site, it should be fully integrated into the program. Teaching staff should be considered part of the treatment team. For youth who attend public schools, a liaison between the school and treatment program should be designated.
 - g. Vocational training. Appropriate interventions include prevocational training, career planning, and job-finding skills training.
 - 2. The intensity of these components varies from outpatient to residential treatment
- E. Treatment planning
- 1. Treatment plan should identify the following:
 - a. Problems of the youth and the family, including substance use, psychosocial, medical, sexual, reproductive, and possible psychiatric disorders
 - b. Goals that help youths to recognize their SUD and to acknowledge responsibility for the resulting problems
 - c. Strengths/resources of youth/family and application in treatment
 - d. Objectives/interventions that are attainable, realistic, measurable
 - e. Educational, legal, and external support systems
 - 2. Interagency agreements should be developed that describe payment policies, funding problems, and intra- and interagency contracts. These documents should include how releases of information will be obtained and exchanged.
- VI. 12-Step-based programs
- A. In programs like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), sobriety is maintained by employing a 12-Step philosophy
 - B. Use of sharing experiences, sponsorship, and group therapy is well suited to youth, who tend to rely heavily on peer examples and approval
 - C. The principles of recovery outlined by AA/NA provide effective and proactive tools for continuing recovery from substance involvement
 - D. Most 12-Step-based programs for youths focus on the first five steps during primary treatment, while the remaining ones are attended to during aftercare
- VII. Therapeutic communities (TC)
- A. As a social-psychological form of treatment for addictions and related problems, the TC is often used to treat youth with the severest problems and for whom long-term care is indicated
 - B. TCs have two unique characteristics
 - 1. The use of the community as therapist/teacher in treatment process

2. A highly structured, well-defined, and continuous process of self-reliant program operation
- C. TC include the social environment, peers, and staff role models. Treatment is guided by the SUD, the person, recovery, and right living.
- D. TC should help youths address sexual issues (e.g., sexual identity, previous sexual abuse) through one-on-one counseling, encounter groups, sex education classes, and other special sessions. Dating and sexual contact between youths should be prohibited. Boys' and girls' living spaces should be separated.
- E. TC use job functions, chores, and other facility management responsibilities as a vehicle for teaching self-development. TC function as therapist and teacher leading to multiple interventions that occur in all these activities.
- F. Prevocational and vocational training should be incorporated if possible
- G. It is significant that the TC functions as family, since many youth in TCs come from dysfunctional families.
- H. Modifications from adult programs often made in TC model are:
 1. Duration of stay is shorter. Ideal duration of treatment is 12-18 months. Youth with deep and complicated disorders cannot be treated effectively in 28 days.
 2. Treatment stages reflect progress along behavioral, emotional, and developmental dimensions.
 3. TC are generally less confrontational than adult programs
 4. Youth have less say in the management of the program
 5. Staff members provide more supervision/evaluation
 6. Neurological impairments (e.g., learning disabilities, ADHD) are assessed
 7. There is less emphasis on work and more emphasis on education
 8. Family involvement is enhanced. When parental support is nonexistent, probation officers, social workers, or other supportive adults can participate in therapy.
 9. In adult TCs, the final stage is taking some responsibility for operating the TC. This is not appropriate for youth, for whom the staff plays the role of effective parents
- I. Staffing includes non-degreed, recovering individuals as adjunctive staff, as well as professionally trained, degreed specialists
 1. Nurse staff is ideal to provide cross-training for counselors. The nurse should be well-versed in sexuality, reproductive health, and sexually transmitted diseases (STDs), including diagnosis, treatment, and issues surrounding partner notification.
 2. TCs should provide their own schools with licensed teachers who have an understanding of SUD among youth
- J. Aftercare
 1. TC should provide satellite aftercare programs in communities where the residents live
 2. Aftercare should include a family therapy component
 3. Programs should develop cooperative working agreements with their local juvenile probation departments to coordinate the referral, screening, and follow-up and to ensure access to appropriate treatment

VIII. Family therapy

- A. SUD treatment programs can employ family therapists to apply therapeutic approaches that have proven effective with youth and their families. Family therapy fits well into the regimen of treatment where case management is used; it also has been proven effective in home-based treatment.
- B. Family therapy approaches treat individuals as subsystems within the family system and as units of assessment and intervention. Family-based treatments work with multiple units, including individual parents, youth, parent-youth combinations, and whole families, as well as family members in relation to other systems.
- C. Family approaches target extended systems, most notably a youth's peers, school, and neighborhood, which are believed to contribute to dysfunctional interactions in families.
- D. The therapist's intervention aims to change the way family members relate to each other by examining the underlying causes of current interactions and encouraging new and healthier ones. Helping family members solve problems together enables them to learn strategies that can be applied with the youth in the home. Parent skill training to help their youth address issues contributing to SUD is an important part of family therapy.
- E. Youth substance involvement should be considered within the context of other problem behaviors such as delinquency and school problems, necessitating new frameworks of diagnosis, assessment, and treatment
- F. Youth will benefit when the treatment team, including substance abuse counselors, nurses, and doctors, working in conjunction with family therapists, have a general understanding of family therapy within the SUD treatment setting. In this way the treatment team members can support the efforts of the therapist and coordinate their components of treatment with family therapy.
- G. Most important in family therapy is the therapeutic alliance between the therapist and the youth

IX. Youths with distinctive treatment needs

- A. Youth in the juvenile justice system
 1. Early intervention is critical in working with youth who have come into contact with the juvenile justice system
 2. Youth involved in the juvenile justice system should undergo thorough screening and assessment for SUD, physical health problems, psychiatric disorders, history of physical or sexual abuse, learning disabilities, and other coexisting conditions
 3. Providers should work with the local juvenile justice system to educate about the importance of early intervention and the resources available to it, as well as to enlist the help of juvenile probation officers
- B. Homeless youth
 1. Homeless youths are at high risk for a wide range of problems, including SUD
 2. Effective treatment for this population hinges on recognizing readiness for treatment

3. For youth living on the streets, outreach is a primary intervention strategy. Outreach programs should have in place a "step-up" for homeless or inner-city youths to enter these programs, assisting them in negotiating potential barriers to services.
 4. Street outreach workers should focus on developing trusting relationships with youths that can promote access to treatment services for SUD
 5. Once a homeless youth has entered the system, the next step is establishing a case management plan that is based on thorough needs assessment. Possible services should include finding housing, dealing with family problems, entering SUD and/or HIV-related treatment, and providing schooling, sexual and reproductive health care, and job training.
- C. Homosexual, bisexual, and transgendered youth
1. Adolescence is a high-risk time for many youths who have sexual identity issues
 2. Many communities lack specialized services for this population, and these services are likely to be more sensitive to the importance of not divorcing the issues of sexual identity from substance use problems during the treatment process
- D. Co-existing disorders
1. Youths who have coexisting disorders and are not on psychoactive medications do better in programs that provide both SUD and mental health treatment together than in separate programs
 2. Any youth treated for SUD and also taking medications for a coexisting psychiatric disorder requires careful medication management. Routine urine testing should occur as part of treatment.
 3. Treatment providers and mental health authorities should develop programs together to treat youth with coexisting disorders. These programs should focus on helping staffs develop the sensitivity and the clinical skills to identify and understand coexisting disorders.
- X. Legal and ethical issues
- A. General policy considerations
1. Because of the complexity of the consent issue, programs should develop a special admissions policy that clearly reflects State laws dealing with admission of youth without parental consent or notification
 2. This policy should be based on these variables:
 - a. State law regarding treatment of youth
 - b. State law regarding program liability if youth in need are turned away
 - c. The family circumstances as related by the youth
 - d. The youth's age and emotional, cognitive, and social maturity
 - e. The kind of treatment the program provides
 - f. The program's financial capacity to provide treatment without reimbursement from family
 - g. Potential for exposure to a lawsuit should the program admit the youth
- B. Programs governed by federal confidentiality regulations

1. Any program that specializes in providing treatment/counseling/assessment/referral services for youths with SUD must comply with Federal confidentiality regulations (42 C.F.R. _2.12(e))
2. Federal regulations apply to programs that receive Federal assistance including indirect forms of Federal aid such as tax-exempt status or State or local government funding from the Federal government
3. The kind of services, not the label, determines whether the program must comply with the Federal law
4. Information protected by Federal confidentiality regulations may be disclosed only after the youth has signed a proper consent form. In some States, parental consent must also be obtained. The youth may revoke consent at any time, and the consent form must include a statement to this effect. The form must contain a date, event, or condition on which it will expire if not previously revoked. Any disclosure made with client consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the recipient cannot further disclose or release such information unless permitted by the regulations. Programs assessing or treating youths who are involved in the criminal justice system or juvenile justice system must also follow Federal confidentiality rules.

C. Duty to warn

1. If a counselor thinks the client poses a serious risk of violence to someone, there are at least two questions that must be answered:
 - Does a State statute or court decision impose a duty to warn in this particular situation?
 - Even if there is no state legal requirement that the program warn an intended victim or the police, does the counselor feel a moral obligation to warn someone?
2. The first question can only be answered by an attorney familiar with the law in the state in which the program operates
3. If the answer to the first question is "no," it is advisable to discuss the second question with a knowledgeable lawyer
4. A similar process arises when providers know that a youth they are treating is infected with HIV or if the youth has committed a criminal act

D. Reporting child abuse and neglect

1. All 50 States and the District of Columbia have statutes requiring reporting when there is reasonable cause to believe or suspect child abuse or neglect
2. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made
3. Because of the variation in State law, programs should consult an attorney familiar with State law to ensure that their reporting practices are in compliance

4. When a program makes such a report, it should notify the family, unless the notification would place the child in further danger. The program should also endeavor to continue to work with the family as the State investigates the complaint and the child protective process unfolds.

References

- American Psychiatric Association: *Practice guideline for the treatment of clients with substance use disorders*. 2nd Ed. Arlington (VA). (August 2006).
- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders - Fifth Edition (DSM-V)*. Arlington, VA: American Psychiatric Publishing, Inc.; 2013.
- Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.R., Griffith, J.H. (eds): *ASAM Client Placement Criteria for the Treatment of Substance-Related Disorders*, 2nd ed., revised. Chevy Chase, MD, American Society of Addiction Medicine, 2001.
- Substance Abuse and Mental Health Services Administration. *Treatment of Youth With Substance Use Disorders: A Treatment Improvement Protocol 32*. U.S. Department of Health and Human Services (April 2008).
- VA/DoD Clinical Practice Guideline. *Management of Substance Use Disorders*. VA/DoD Evidence Based Practice. Veterans Health Administration/Department of Defense. Version 2.0 (2009).

Other Resources

The full VA/DoD SUD guideline can be accessed at www.healthquality.va.gov/ and <https://www.qmo.amedd.army.mil/substance%20abuse/substance.htm>

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
[www.niaaa.nih.gov/Publications/
EducationTrainingMaterials/Pages/guide.aspx](http://www.niaaa.nih.gov/Publications/EducationTrainingMaterials/Pages/guide.aspx)

On the NIAAA website, providers can find resources that include: clinical guides and videos on alcohol screening and brief intervention, alcohol use disorder screening instruments and assessment support materials, medication wallet cards and client materials. For additional resources, visit www.RethinkingDrinking.niaaa.nih.gov

National Institute on Drug Abuse (NIDA)
www.drugabuse.gov/nidamed/

NIDA provides resources that include: screening tools, charts of commonly abused drugs, drug abuse reports, multilingual education packets and client-physician conversation posters.

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.dpt.samhsa.gov/providers/providerindex.aspx

SAMHSA provides resources for provider training on substance abuse, addiction, prescribing and risk management, as well as resources on addiction treatment forums, treatment protocols and drug interactions.

Medical and Non-Medical Addiction Specialists

American Academy of Addiction Psychiatry

(www.aaap.org) 401-524-3076

American Psychological Association

(<http://apa.org>) 800-964-2000

American Society of Addiction Medicine

(www.asam.org) 301-656-3920

The Association for Addiction Professionals

(www.naadac.org) 800-548-0497

National Association of Social Workers

(www.socialworkers.org or www.helpstartshere.org)

Alcoholics Anonymous

(www.aa.org) 212-870-3400 or check your local phone directory under “Alcoholism”

Secular Organizations for Sobriety

(www.cfiwest.org/sos/index.htm) 323-666-4295

Al-Anon/Alateen

(www.al-anon.alateen.org) 888-425-2666 for meetings

Adult Children of Alcoholics

(www.adultchildren.org) 310-534-1815

Veterans Crisis Line

(www.mentalhealth.va.gov/suicide_prevention/index.asp)

800-273-8255 and press 1

Substance Abuse Treatment Facility Locator

(www.findtreatment.samhsa.gov) 800-662-HELP

(4357)www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp

