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Treatment of Adolescents With Substance Use Disorders

Treatment Improvement Protocol (TIP) Series 32

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DHHS Publication No. (SMA) 99−3283
Printed 1999

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This publication was written under contract number 270−95−0013 with The CDM Group, Inc. (CDM). Sandra Clunies, M.S., I.C.A.D.C., served as the CSAT government project officer. Rose M. Urban, M.S.W., J.D., C.S.A.C., served as the CDM TIPs project director. Other CDM TIPs personnel included Y−Lang Nguyen, production/copy editor, Raquel Ingraham, M.S., project manager, Virginia Vitzthum, former managing editor, Mary Smolenski, Ed.D., C.R.N.P., former project director, and MaryLou Leonard, former project manager.

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance use disorders, provided as a service of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). CSAT's Office of Evaluation, Scientific Analysis and Synthesis draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private treatment facilities for substance use disorders as substance use disorders are increasingly recognized as a major problem.

The TIPs Editorial Advisory Board, a distinguished group of substance use disorder experts and professionals in such related fields as primary care, mental health, and social services, works with the State alcohol and drug abuse directors to generate topics for the TIPs based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content of the TIP. Then recommendations are communicated to a Consensus Panel composed of non−Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP. The members of each Consensus Panel represent treatment programs for substance use disorders, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Panel Chair (or Co−Chairs) ensures that the guidelines mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the TIP is prepared for publication, in print and online. The TIPs can be accessed via the Internet on the National Library of Medicine's home page at the URL: http://text.nlm.nih.gov. The move to electronic media also means that the TIPs can be updated more easily so that they continue to provide the field with state−of−the−art information.

Although each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance use disorder treatment is evolving, and published research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front−line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either Panelists' clinical experience or the literature. If there is research to support a particular approach, citations are provided.

This TIP, *Treatment of Adolescents With Substance Use Disorders*, updates TIP 4, published in 1993, and presents information on substance use disorder treatment for adolescent clients. Adolescents differ from adults both physiologically and emotionally as they make the transition from child to adult and, thus, require treatment adapted to their needs. The onset of substance use is occurring at younger ages, resulting in more adolescents entering treatment for substance use disorders than has been observed in the past. In order to treat this population effectively, treatment providers must address the issues that play significant roles in an adolescent's life, such as cognitive, emotional, physical, social, and moral development, and family and peer environment. This TIP focuses on ways to specialize treatment for adolescents, as well as on common and effective program components and approaches being used today.

Chapter 1 details the scope and complexity of the problem; Chapter 2 presents factors to be considered when making treatment decisions; and Chapter 3 discusses successful program components. Chapters 4, 5, and 6 describe the treatment approaches used in 12−Step−based programs, therapeutic communities, and family therapy respectively. Chapter 7 discusses adolescents with distinctive treatment needs, such as those involved with the juvenile justice system. An explanation of legal issues concerning Federal and State confidentiality laws appears in Chapter 8. Appendix B is a table on the medical management of substance intoxication and withdrawal, which will appear in a forthcoming publication.

Other TIPs may be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729−6686 or (301) 468−2600; TDD (for hearing impaired), (800) 487−4889.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA/CSAT's mission to improve treatment of substance use disorders by providing best practices guidance to clinicians, program administrators, and payors. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non−Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advances in the substance use disorder treatment field.

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Executive Summary and Recommendations

This document, *Treatment of Adolescents With Substance Use Disorders,* is a revision and update of Treatment Improvement Protocol (TIP) 4, published in 1993 by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA). Like TIP 4, this document aims to help treatment providers design and deliver better services to adolescent clients with substance use disorders.

In 1992, CSAT convened a Consensus Panel of experts on adolescent substance use disorder treatment to produce guidelines for treatment programs on designing and delivering effective services to adolescent clients. The clients addressed in the TIP included, among others, young people involved with the juvenile and criminal justice systems. CSAT also intended for the Panel's guidelines to help governmental agencies and treatment providers establish, fund,

operate, monitor, and evaluate treatment programs for substance−using adolescents.

The result of that Panel's work was TIP 4, *Guidelines for the Treatment of Alcohol− and Other Drug−Abusing Adolescents.* In July 1997, CSAT convened a small Revision Panel to review TIP 4. The Panel recommended changes and developed content for this revised TIP.

Since the publication of TIP 4, the understanding of substance use disorders and its treatment among adolescents has advanced. More is known today about the immediate and long−term physiologic, behavioral, and social consequences of use, abuse, and dependency. New research attention has begun to examine the effectiveness of various treatment methods and components that meet the specific treatment needs of substance−using adolescents, and this literature is reviewed. However, the literature is small. Fortunately, a large multisite, national study on the effectiveness of treatment for adolescent substance users is underway with funds from the National Institute on Drug Abuse. CSAT is also conducting studies on adolescents, focusing on marijuana treatment, diversion programs in the juvenile justice system (JJS), and exemplary treatment programs. The field will likely mature greatly by the knowledge advanced from these studies.

The structure of the earlier TIP of separate inpatient and outpatient treatment chapters, which represented a continuum of service intensity, was viewed by the Revision Panel to be less central to treatment decisions than a continuum based on the severity of the substance use disorder. This shift in focus better reflects clinical experience, extant treatment research, and the recent changes regarding reimbursement by health care payors for treatment. However, the Revision Panel retained a broad definition of treatment. Treatment is defined in this TIP as those activities that might be undertaken to deal with problem(s) associated with substance involvement and with individuals manifesting a substance use disorder. Although the Panel recognizes that primary or secondary prevention of substance use are included in expanded definitions of treatment, the Panel limited the continuum of interventions to what is traditionally viewed as acute intervention, rehabilitation, and maintenance. The elements of the continuum primarily reflect the treatment philosophies of providers, with less emphasis on settings and modalities.

In addition to defining the treatment needs of adolescents and providing a full description of the use of the severity continuum, the Revision Panel focused attention on three common types of treatment for adolescents today: 12−Step−based treatment, treatment in the adolescent therapeutic community, and family therapy. The 12−Step model lies at the heart of many adolescent treatment programs. Therapeutic communities (TCs) are an intensive type of residential treatment that is attracting attention as a preferred approach for substance−using juveniles incarcerated in the justice system. Clinicians have found that effective treatment of the adolescent almost always involves the family, and the effectiveness of family therapy has been documented extensively, particularly among those substance−using adolescents who are normally the most difficult to treat.

This revision of the earlier TIP, then, offers guidelines for using the severity continuum to make treatment decisions and for providing three common models of treatment for adolescents with substance use disorders. Recommendations of the Revision Panel, supported by extensive clinical experience and the literature, are summarized below. The organization of this TIP reflects the core facets of initiating, engaging, and maintaining the change process for youths with substance use disorders. Chapter 1 details the scope and complexity of the problem. Chapter 2 covers factors considered in making treatment decisions, and Chapter 3 details the features of successful programs. Chapters 4, 5, and 6 introduce and describe the treatment approaches used in 12−Step−based treatment, therapeutic communities, and family therapy, respectively. Chapter 7 discusses adolescents with distinctive treatment needs, such as youths involved in the juvenile justice system, homeless and runaway youth, and youth with coexisting disorders. Chapter 8 describes the legal and ethical issues that relate to diagnosis and treatment of adolescents.

This new TIP derives from CSAT's intention to provide protocols that reflect the work now being done by providers of high−quality treatment. As with other TIPs, this document brings the best knowledge from the field to State and local treatment programs. In order to avoid awkward construction and sexism, this TIP alternates between "he" and "she" for generic examples. The companion document, TIP 31, *Screening and Assessing Adolescents for Substance*

Use Disorders, a revision of TIP 3, has also been published (CSAT, 1999).

Substance Use Disorder Treatment and Adolescents

In 1997, substance use among 12− to 17−year−old children rose to 11.4 percent with illicit drug use among 12− and 13−year−olds increasing from 2.2 to 3.8 percent, according to the *1997 National Household Survey on Drug Abuse* conducted by the Substance Abuse and Mental Health Services Administration. Moreover, perceived risk of harm from substance use is falling while the availability of drugs is climbing. These trends indicate a major national problem, especially as the social and economic costs of adolescent substance use are becoming better understood. The onset of substance use is occurring at younger ages, resulting in more adolescents entering treatment for substance use disorders with greater developmental deficits and perhaps much greater neurological deficits than have been observed in the past. Other consequences of substance use and abuse include alcohol− and drug−related traffic accidents, delinquency, sexually risky behavior, and psychiatric disorders.

Adolescent users differ from adults in many ways. Their drug and alcohol use often stems from different causes, and they have even more trouble projecting the consequences of their use into the future. In treatment, adolescents must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and environmental considerations (e.g., strong peer influences). At a physical level, adolescents tend to have smaller body sizes and lower tolerances, putting them at greater risk for alcohol−related problems even at lower levels of consumption. The use of substances may also compromise an adolescent's mental and emotional development from youth to adulthood because substance use interferes with how people approach and experience interactions.

The treatment process must address the nuances of each adolescent's experience, including cognitive, emotional, physical, social, and moral development. An understanding of these changes will help treatment providers grasp why an adolescent uses substances and how substance use may become an integral part of an adolescent's identity.

Regardless of which specific model is used in treating young people, there are several points to remember when providing substance use disorder treatment:

- In addition to age, treatment for adolescents must take into account gender, ethnicity, disability status, stage of readiness to change, and cultural background.
- Some delay in normal cognitive and social−emotional development is often associated with substance use during adolescence. Treatment for adolescents should identify such delays and their connections to academic performance, self−esteem, or social interactions.
- Programs should make every effort to involve the adolescent client's family because of its possible role in the origins of the problem and its ability to change the youth's environment.
- Although it may be necessary in certain geographic areas where availability of adolescent treatment programs is limited, using adult programs for treating youth is ill−advised. If this must occur, it should be done only with great caution and with alertness to inherent complications that may threaten effective treatment for these young people.
- Many adolescents 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. Several strategies can be used for engaging reluctant clients to consider behavioral change.

Tailoring Treatment to The Adolescent

Adolescent substance use occurs with varying degrees of severity. The degree of substance involvement is an important determinant of treatment, as are any coexisting disorders, the family and peer environment, and the individual's stage of mental and emotional development. This information should be used to refer the client to

appropriate treatment.

It is useful to consider a substance use continuum with these six anchor points:

- *Abstinence*
- *Use:* Minimal or experimental use with minimal consequences
- *Abuse:* Regular use or abuse with several and more severe consequences
- *Abuse/Dependence: R*egular use over an extended period with continued severe consequences
- *Recovery:* Return to abstinence, with a relapse phase in which some adolescents cycle through the stages again
- *Secondary abstinence*

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. Any response to an adolescent who is using substances should be consistent with the severity of involvement. While no explicit guidelines exist, the most intensive treatment services should be devoted to youth who show signs of dependency−−that is, a history of regular and chronic use−−with the presence of multiple personal and social consequences and evidence of an inability to control or stop using substances.

Assessment

The guidelines below show how the continuum can be used in making a decision regarding the placement of the adolescent. The Revision Panel created the guidelines based on clinical experience.

- 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 adolescent to the next higher level of care, unless the assessment indicates that such a placement would be counterproductive. Naturally, a higher level of care may not be practical or available.
- Assessment is an ongoing process. Decisions about level of care should be based on the adolescent's progress and changes in his environment. Clients should have the opportunity to move back and forth across the level of care continuum based on changes in these factors.
- Assessors should have an indepth knowledge of available services and their quality and intensity.
- Adolescents may move into or through different treatment programs based on their progress and/or changes in the environment. Prior to each program change, indepth reassessment must be completed and the results communicated between providers.

General Program Characteristics

Program design, a policies and procedures manual, ongoing evaluation, and a planned approach to legal concerns make up the framework for a treatment program. Within this framework, issues to consider include staff recruitment and training, treatment components, treatment planning, and client services.

Staffing

Staff members should represent the cultural diversity of the program's client population. In addition, the facility's forms, books, videos, and other materials should reflect the culture and language of the clientele. 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. Someone on staff should be familiar with disability issues

and disability culture: For example, people who are deaf who use American Sign Language have their own culture.

Most important is to schedule staff training periodically throughout the year. This is greatly preferable to training presented in ad hoc situations to address crises or acute situations. Ongoing training should address a range of specialty topics, including the following:

- Treatment approaches specific to adolescents and their families
- Family dynamics and family therapy
- Adolescent growth and development
- Sexual and physical abuse
- Gender issues
- Mental health problems
- Different cultural and ethnic values
- Psychopharmacology
- Referral and community resources
- Cognitive impairments
- Legal matters

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.

Program Components

The core components of many adolescent treatment programs, regardless of their therapeutic orientation, include the following:

- *Orientation, the first step in treatment,* clarifies to the adolescent what treatment is, her role in treatment, and the concept of program expectations. Orientation should be conducted in a nonconfrontational style and tone in order not to raise the adolescent's anxiety, which may already be heightened by other aspects of the treatment program.
- *Daily scheduled activities* of school, chores, homework, and positive recreational activities can help adolescents learn new skills and provide them with an alternative to their substance−using behavior and can help ensure that adolescents remain sober after treatment.
- *Peer monitoring* in a group setting can help the client build the strength necessary to override peer pressure and harness the influence of the peer group in a positive manner.
- *Conflict resolution* is often necessary given that there is a high potential for conflict between young clients and program staff. Such conflicts can arise from a staff member's inexperience in working with adolescents or a client's inability or unwillingness to meet program expectations, in which case the treatment plan should be modified. In any event, staff should take a proactive stance in resolving conflicts.
- *Client contracts* (e.g., behavioral contracts, including substance−free contracts) are negotiated and signed by both the adolescent and primary counselor; they lay out concrete treatment goals, expectations, time frames, and consequences (if the contract is not followed) that are mutually acceptable to the client and counselor. They can help identify the current level of the adolescent's functioning and developmental markers, providing a baseline from which to monitor change. They also give to adolescents a sense of control in going through treatment and a degree of investment in their well−being.
- *Schooling,* which generally focuses on substance use and basic education, is one of the most important factors in an adolescent's recovery. Whether the schooling is provided on or off site, it should be fully integrated into an adolescent's program. Teaching staff should be considered part of the treatment team. For adolescents who attend public schools, a liaison between the school and treatment program should be designated.

- *Vocational training* is an important intervention and should be part of an adolescent's treatment. Appropriate interventions include prevocational training, career planning, and job−finding skills training. Without these skills, many youths may be more likely to support themselves through illegal activities and thus be more prone to relapse.

The level of intensity of these components will vary considerably from outpatient to residential treatment.

Treatment Planning

At a minimum, a treatment plan should identify the following:

- Problems of the client and the family, including substance use, psychosocial, medical, sexual, reproductive, and possible psychiatric disorders
- Goals that are attainable and help clients to recognize their involvement with substances and to acknowledge responsibility for the problems resulting from substance use
- Strengths and resources of the individual and the family and ways to apply them to address treatment goals
- Objectives that are realistic and measurable steps for achieving each goal
- Interventions such as treatment strategies and services that are needed to achieve the objectives
- Educational, legal, and external support systems

The treatment plan should include pre−established times for evaluation and adjustment of goals as necessary. Treatment programs also should work closely with other entities that are involved in the treatment of adolescents, such as school systems, child welfare, and juvenile justice agencies. Interagency agreements, also known as memoranda of understanding, should be developed that describe payment policies, funding problems, mutual goals for clients, and intra− and interagency contracts. In addition, it is important to have an established practice of exchanging signed releases of information from each shared client, insofar as the client agrees to the sharing of information, so that the involved staff members can more freely exchange confidential information about the client's progress.

12−Step−Based Programs

In programs like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), sobriety is maintained by carefully employing a 12−Step philosophy and by sharing experiences with others who have suffered similar problems with substance abuse and dependency. Many clients who are involved with AA/NA find another member who will serve as a sponsor and provide guidance and help in times of crisis when the urge to return to drinking or drug use becomes overwhelming.

Providers treating adolescents in a 12−Step−based program should bear the following in mind:

- Substance use disorders are primary, multifaceted illnesses that exist in people of all ages, including adolescents.
- Persons with substance use disorders are individuals who share a common problem but have unique and separate needs and therefore should be treated with respect and dignity.
- Once substance−using adolescents are informed about addiction in an understandable way, they are capable of helping others, as long as they receive some guidance.
- Use of group therapy is well suited to adolescents, who tend to rely heavily on peer examples and approval.
- The principles of recovery outlined by AA/NA provide effective and proactive tools for continuing recovery from substance involvement.
- Once a person has lost control over his use of substances as an adolescent, returning to *responsible* and *legal* use as an adult may require additional help and support.

Most 12−Step−based programs focus on the first five steps during primary treatment, while the remaining ones are attended to during aftercare. Below are ways to present the first five steps to adolescents so that their specialized developmental needs can be addressed.

- *Step 1: We admitted we were powerless over alcohol−−that our lives had become unmanageable.* With adolescents, the primary goal of this step is to assist them in reviewing their substance use history and to have them associate it with harmful consequences.
- *Step 2: We came to believe that a Power greater than ourselves could restore us to sanity.* To convey this message, allow new clients to interact with those who have been successful in treatment and are leaving the program. Providers must help adolescents with coexisting mental illnesses or cognitive disabilities to understand that Step 2 refers to obtaining help to stop drug seeking and use behavior.
- *Step 3: We made a decision to turn our will and our lives over to the care of God as we understood Him.* This step can be simplified by saying, "Try making decisions in a different way; take others' suggestions; permit others to help you." Using the phrase "Helping Power" instead of "Higher Power" can benefit some.
- *Step 4: We made a searching and fearless moral inventory of ourselves; Step 5: We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.* Steps 4 and 5 provide an opportunity to be accepted by another person in spite of one's past behaviors and to take a "personal inventory" of those past behaviors.

Therapeutic Communities

As a social−psychological form of treatment for addictions and related problems, the TC has been typically used in the United States to treat youth with the severest problems and for whom long−term care is indicated. TCs have two unique characteristics:

1. The use of the community itself as therapist and teacher in the treatment process
2. A highly structured, well−defined, and continuous process of self−reliant program operation

The community includes the social environment, peers, and staff role models. Treatment is guided by the substance use disorder, the person, recovery, and right living.

Traditionally in the therapeutic community, job functions, chores, and other facility management responsibilities that help maintain the daily operations of the TC have been used as a vehicle for teaching self−development. The day is highly structured, with time designated for chores and other responsibilities, group activities, seminars, meals, and formal and informal interaction with peers and staff. The use of the community as therapist and teacher results in multiple interventions that occur in all these activities.

For the adolescent, the community may be even more crucial than for adults since the TC functions as family. This is an exceedingly significant function, since many youth in TCs come from dysfunctional families.

Modifications that are generally made in the TC model for treatment of adolescents can be summarized as follows:

- The duration of stay is shorter than for adults.
- Treatment stages reflect progress along behavioral, emotional, and developmental dimensions.
- Adolescent programs are generally less confrontational than adult programs.
- Adolescents have less say in the management of the program.
- Staff members provide more supervision and evaluation than they do in adult programs.
- Neurological impairments, particularly learning disabilities and related disorders, such as attention deficit/hyperactivity disorder (AD/HD), must be assessed.
- There is less emphasis on work and more emphasis on education, including actual schoolwork, in the

adolescent program.

- Family involvement is enhanced in adolescent programs and ideally should be staged, beginning with orientation and education, then moving to support groups, therapy groups, and therapy with the adolescent. When parental support is nonexistent, probation officers, social workers, or other supportive adults in the youth's life can participate in therapy.

Clinical wisdom suggests that the ideal duration of treatment for adolescents in a TC is 12 to 18 months and that adolescents with very deep and complicated disorders cannot be treated effectively in 28 days.

Staffing in TCs continues to include non−degreed, recovering individuals as adjunctive staff, as well as professionally trained, degreed specialists. Having a nurse on site is ideal, in part to provide cross−training for the counselors, particularly regarding the symptomatology of addiction. The nurse should be well−versed in sexuality, reproductive health, and sexually transmitted diseases (STDs), including diagnosis, treatment, and issues surrounding partner notification. Teachers in a TC program for adolescents must have an understanding of substance use disorders among youth.

TC residents move through stages of increasing responsibility and privileges. To advance to the next level, the adolescent must demonstrate responsibility, self−awareness, and consideration for others. In adult TCs, the final stage is taking some responsibility for operating the TC; this is not appropriate for adolescents, for whom the staff plays the role of effective parents.

Ideally, TCs should provide their own schools with licensed teachers as well as satellite aftercare programs in the communities where the residents live. For adolescents, aftercare programs should include a family therapy component. Programs should develop cooperative working agreements with their local juvenile probation departments to coordinate the referral, screening, and followup and to ensure this population's access to appropriate treatment. Prevocational and vocational training should be incorporated whenever possible.

A TC environment should help clients come to terms with 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 clients should be prohibited. Boys' and girls' living spaces should be separated. The longer term stay and increased contact make TCs a good environment for counseling and education on other issues such as smoking and STDs.

Family Therapy

Substance use disorder treatment programs can employ family therapists to apply therapeutic approaches that have proven effective with adolescents and their families. A therapist who practices a family−based approach should have formal, professional training in this method. Family therapy fits well into the regimen of treatment where case management is used; it also has been proven effective in home−based treatment.

Contemporary family therapy approaches understand the importance of treating individuals as subsystems within the family system and as units of assessment and intervention; in other words, each member of the family is capable of being assessed and can act as a unit of intervention, for example, by changing his interactional patterns. Family−based treatments work with multiple units, including individual parents, adolescents, parent−adolescent combinations, and whole families, as well as family members vis−_−vis other systems. Contemporary family approaches also target extended systems, most notably an adolescent's peers, school, and neighborhood, which are believed to contribute to dysfunctional interactions in families.

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 presumably, healthier) ones. The therapist should help family

members appreciate how the values and perspectives of each family member may differ from their own, but that differences do not have to be a source of conflict. Helping the family members solve problems together in the therapeutic setting enables them to learn strategies that can be applied with the adolescent in the home. Such maneuvers in therapy decrease family conflicts and improve the effectiveness of communication.

Family treatment also equips parents with the skills and resources necessary to address the inevitable difficulties that arise in raising teenagers. The family therapist's job is to help parents regain their optimism and motivate them to continue to help their teenager. Family therapists should bolster the parents' self−confidence as parents while at the same time helping them improve their parenting skills. Parents are taught how to provide age−appropriate monitoring of their teenager (e.g., to know their friends, to know how they spend their time), set limits (e.g., negotiate with the youth about reasonable curfews, schedules, and family obligations), establish a system of positive and negative consequences, rebuild emotional attachments, and take part in activities with the adolescent outside the home.

Family therapy can include discussion of the effects of the teenager's actions in extrafamilial systems−−such as skipping an appointment with a probation officer or hanging out with peers late at night on unsafe street corners where drugs are bought and sold. Then the therapist might meet with the probation officer or ask the adolescent to bring a peer to a session to review the problem from the youth's perspective.

Family therapists should be acutely aware of the complex of behaviors and systemic interactions associated with recovering from a substance use disorder. They also must be aware of cultural differences in family patterns and typical attitudes toward therapy. Adolescent substance involvement should be considered within the context of other problem behaviors such as delinquency and school problems, necessitating new frameworks of diagnosis and assessment, as well as treatment.

Adolescent clients 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 substance use disorder treatment setting. When they have this understanding, the treatment team members can best support the efforts of the therapist and coordinate their components of treatment with family therapy.

Most important in family therapy is the therapeutic alliance between the therapist and adolescent. It is crucial for the therapist to emphasize to the client and family members that the purpose of the therapy is to help the client.

Youths With Distinctive Treatment Needs

Young people who have distinct concerns related to coexisting psychiatric conditions, sexual orientation, involvement with the criminal justice system, physical health, or displaced living conditions may not do well in traditional treatment programs. Therefore, treatment providers should offer individualized treatment, paying particular attention to the events and circumstances that contributed to the client's current situation. Problems that often accompany substance use disorders include illegal activity, homelessness, shame surrounding sexual orientation, and coexisting physical and mental disorders.

Youth in the Juvenile Justice System

Every young person involved in the juvenile justice system should undergo thorough screening and assessment for substance use disorders, physical health problems, psychiatric disorders, history of physical or sexual abuse, learning disabilities, and other coexisting conditions. Juvenile probation officers can be helpful partners in the system of care. For their part, providers should educate the local juvenile justice system about the importance of early intervention and the resources available to it. It is almost impossible to intervene here unless the youth is removed from the environment that brought him into conflict with the juvenile justice system in the first place (e.g., the home neighborhood). Early intervention is critical in working with adolescents who have come into contact with the juvenile

justice system.

Homeless Youth

Research shows that homeless youths are at high risk for a wide range of problems, including substance use disorders. Effective treatment for this population hinges on recognizing these young people's readiness for treatment. For adolescents who are living on the streets, outreach becomes 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 the various obstacles that may be potential barriers to services. Street outreach workers should focus on developing trusting relationships with youths that, over time, can influence a young person to access treatment services for substance use disorders. Service providers must meet with, talk to, and develop relationships with young people on the street to engage them in treatment. Returning homeless or runaway youth to their homes is not always in their best interest because less than optimal conditions may exist in these homes. Treatment providers should explore the appropriateness of other transitional living options for homeless youth if necessary.

Once a homeless youth has entered the system, the next step is establishing a case management plan that is based on a thorough assessment of her needs. Possible services should include finding housing, dealing with family problems, entering substance use disorder and/or HIV−related treatment, and providing schooling, sexual and reproductive health care, and job training. It may be necessary to prioritize the needs for services according to the individual's problems.

Homosexual, Bisexual, and Transgendered Youth

Adolescence is a very lonely, high−risk time for many youths who have sexual identity issues. Many gay, bisexual, and transgendered youths have no one in whom they can confide, and most communities lack gay−identified services. Gay−specific 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. Effective treatment for these youths involves helping them to feel comfortable with, and to take pride in, their sexual identity.

Coexisting Disorders

Any adolescent who is being treated for substance use disorders and is also taking psychoactive medications for a coexisting psychiatric disorder requires careful psychopharmacological management. These adolescents should also be given routine urine testing as part of their treatment plan. Close scrutiny of adolescents with AD/HD is particularly important for those who are receiving substance use disorder treatment. Treatment providers and mental health authorities should develop programs together to treat youth with coexisting disorders. Cross−training can help staff of both programs develop the sensitivity and the clinical skills to understand coexisting disorders and to identify the presence of either problem or both. Youths who have coexisting disorders and are not on psychoactive medications do better in programs that provide both substance use disorder and mental health treatment together than in separate programs. For more information on coexisting psychiatric conditions and substance use disorders, refer to TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*.

Legal and Ethical Issues

Because of the complexity of the consent issue, programs in States with laws that do not clearly allow admission of adolescents without parental consent or notification should develop a special admissions policy. This policy should be based on these variables:

- State law regarding treatment of adolescents (i.e., whether parental consent and/or notification is required)
- State law regarding program liability if adolescent clients in need are turned away

- The family circumstances as related by the adolescent (the adolescent's view of his family may be verified, with his consent, by contacting an adult who knows the family well)
- The adolescent's age and emotional, cognitive, and social maturity
- The kind of treatment the program provides
- The program's financial capacity to provide treatment without reimbursement from family
- Potential for exposure to a lawsuit should the program admit the adolescent

With the above factors in mind, the program should assess its potential liability if the adolescent is admitted without parental consent in a State where such consent is required.

Programs Governed by Federal Confidentiality Regulations

Any program that specializes, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for adolescents with substance use disorders must comply with the Federal confidentiality regulations (42 C.F.R. _2.12(e)). Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid such as tax−exempt status or State or local government funding coming (in whole or in part) from the Federal government.

Coverage under the Federal regulations does not depend on how a program labels its services. Calling itself a "prevention program" does not excuse a program from adhering to the confidentiality rules. It is the kind of services, not the label, that will determine whether the program must comply with the Federal law.

Information that is protected by the Federal confidentiality regulations may be disclosed only after the adolescent has signed a proper consent form. In some States, parental consent must also be obtained. The adolescent may revoke consent at any time, and the consent form must include a statement to this effect. The form must also contain a date, event, or condition on which it will expire if not previously revoked. Once the consent form has been properly completed, there remains one last formal requirement. Any disclosure made with patient 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 adolescents who are involved in the criminal justice system or juvenile justice system (juvenile court) must also follow the Federal confidentiality rules.

Duty to Warn

If an adolescent's counselor thinks the teenager poses a serious risk of violence to someone, there are at least two questions that must be answered:

1. Does a State statute or court decision impose a duty to warn in this particular situation?
2. 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?

The first question can only be answered by an attorney familiar with the law in the State in which the program operates. If the answer to the first question is "no," it is advisable to discuss the second question with a knowledgeable lawyer, too. A similar dilemma also arises when providers know that an adolescent they are treating is infected with HIV or if the adolescent has committed a criminal act.

Reporting Child Abuse and Neglect

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. 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. 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.

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. Families should never be abandoned because of suspected abuse or neglect, and health care providers should be wary of making judgments until a comprehensive assessment has been completed by State authorities.

Chapter 1−−Substance Use Among Adolescents

Substance use by young people is on the rise, and initiation of use is occurring at ever−younger ages. Patterns of substance use over the past 20 years have been documented by two surveys−−the National Household Survey on Drug Abuse conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Monitoring the Future Study conducted by the National Institute on Drug Abuse (NIDA). Data released in 1996 indicated that in the early to mid−1990s, the percentage of 8th graders who reported using illicit drugs (i.e., drugs illegal for Americans of all ages) in the past year almost doubled, from 11.3 percent in 1991 to 21.4 percent in 1995 (NIDA, 1996a). Drug use by high school students also has risen steadily since 1992. The survey also indicates that 33 percent of 10th graders and 39 percent of 12th graders reported the use of an illicit drug within the preceding 12 months (NIDA, 1996a). These estimates are probably low because the statistics are gathered in schools and do not include the high−risk group of dropouts. Most of the recent increase is attributed to marijuana use, which rose significantly during this period.

An estimated 15 percent of 8th graders, 24 percent of 10th graders, and 30 percent of 12th graders reported having had five or more drinks within the preceding 2 weeks (Johnston et al., 1995). Slightly more than half of high school students (grades 9 through 12) reported having had at least one drink of alcohol during the 30 days preceding a 1995 Centers for Disease Control and Prevention (CDC) survey (CDC, 1996). It is further estimated that 9 percent of adolescent girls and up to 20 percent of adolescent boys meet adult diagnostic criteria for an alcohol use disorder (Cohen et al., 1993). Furthermore, the proportion of daily smokers among American high school seniors remains disturbingly high at about 20 percent.

The surveys have found that the perceived risk of harm from drug involvement has been declining while the availability of drugs has been rising (NIDA, 1996a; SAMHSA, 1998a). Particularly in the case of marijuana, sharp declines in harm perception have been observed among 8th, 10th, and 12th graders (see Figure 1−1). This shift has occurred at the same time that marijuana use has spread (NIDA, 1996a). Since 1991, the percentage of students who thought that regular marijuana use carries a "great risk" of harm has dropped from 79 percent to 61 percent among 12th graders, from 82 percent to 68 percent among 10th graders, and from 84 percent to 73 percent among 8th graders (NIDA, 1996a). During the same period, reported use of marijuana within the preceding year rose for all these grades by an average of 11 percent (NIDA, 1996a).

Household products are abused as well as illegal drugs: The percentage of youths 12 to 17 years old who tried inhalants rose from 1.1 percent in 1991 to 2.2 in 1994 (NIDA, 1996a). "Heroin chic" as exemplified by rock stars and fashion models has boosted the popularity of that drug among young people. Panel members reported that in some areas, the adolescent use of heroin mixed with water and then inhaled has increased. Clearly, drug use trends among young people are a major national concern. Within the context of national surveys of frequency of use, the prevalence of those meeting criteria for a diagnosis is becoming clearer. A 1996 statewide Minnesota survey provided the first systematic look at the rate of substance use disorders in a large student population: 11 percent of 9th grade students and 23 percent of 12th grade students met formal diagnostic criteria as established in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994) for drug abuse or drug dependence disorder

(Harrison and Fulkerson, 1996).

The Consequences

In terms of public health, adolescent substance use disorders have far−reaching social and economic ramifications. The numerous adverse consequences associated with teenage drinking and substance use disorders include fatal and nonfatal injuries from alcohol− and drug−related motor vehicle accidents, suicides, homicides, violence, delinquency (Dembo et al., 1991), psychiatric disorders, and risky sexual practices (Jainchill et al., in press). Longitudinal studies have established associations between adolescent substance use disorders and (1) impulsivity, alienation, and psychological distress (Hansell and White, 1991; Shedler and Block, 1990), (2) delinquency and criminal behavior (National Institute of Justice, 1994), (3) irresponsible sexual activity that increases susceptibility to HIV infection (DiClemente, 1990), and (4) psychiatric or neurological impairments associated with drug use, especially inhalants, and other medical complications (SAMHSA, 1996).

Substance use disorders that begin at an early age, especially when there is no remission of the disorder, exact substantial economic costs to society (Children's Defense Fund, 1991). The trend toward early onset of substance use disorders has increasingly resulted in adolescents who enter treatment with greater developmental deficits and perhaps much greater neurological deficits than have been previously observed. Moreover, the risks of traumatic injury, unintended pregnancy, and sexually transmitted diseases (STDs) are high in adolescents in general. Drug involvement that is superimposed on these already high risks has numerous potentially adverse consequences that have not yet been the subject of indepth study beyond basic population studies.

Mortality

Alcohol−related motor vehicle accidents exact a heavy toll on society in terms of economic costs and lost productivity. Nearly half (45.1 percent) of all traffic fatalities are alcohol−related, and it is estimated that 18 percent of drivers 16 to 20 years old−−a total of 2.5 million adolescents−−drive under the influence of alcohol. According to the Youth Risk Behavior Surveillance System conducted by the CDC, which monitors health risk behaviors among youths and young adults, unintentional injuries, including motor vehicle accidents, are by far the leading cause of death in adolescents, causing 29 percent of all deaths. An estimated 50 percent of these deaths are related to the consumption of alcohol (CDC, 1998).

Sexually Risky Practices

Adolescents are at higher risk than adults for acquiring STDs for a number of reasons. They are more likely to have multiple (sequential or concurrent) sexual partners and to engage in unprotected sexual intercourse. They are also more likely to select partners who are at higher risk for STDs. Among females, those 15 to 19 years old have the highest rates of gonorrhea, while 20− to 24−year−olds have the highest rate of primary and secondary syphilis (CDC, 1996).

Adolescents who use alcohol and illicit drugs are more likely than others to engage in sexual intercourse and other sexually risky behaviors. A positive correlation has been demonstrated between alcohol use and frequency of sexual activity. In a 1990 Massachusetts survey of adolescents 16 to 19 years old, two−thirds reported having had sexual intercourse, 64 percent reported having sex after using alcohol, and 15 percent reported having sex after using drugs (MacKenzie, 1993).

Substance use among adolescents is associated with early sexual activity, an important factor in the prevalence of STDs and HIV infection. The use of substances combined with sexual activity significantly decreases the likelihood that a condom will be used during sex. Substance use also can decrease an individual's discrimination in the selection of sexual partners and can increase the number of partners and the likelihood of risky sexual practices (including anal

intercourse), thereby heightening the risk of STDs (MacKenzie, 1993).

The CDC conducted its school−based Youth Risk Behavior Survey among a representative sample of 10,904 high school students in grades 9 through 12. Among the survey's findings were the following:

- More than half−−53.1 percent−−of the students had sexual intercourse at some time. Of these, 9 percent had initiated sexual intercourse before the age of 13.
- An estimated 17.8 percent of students had sexual intercourse with four or more sexual partners during their lifetimes.
- Among the students, 6.9 percent reported that they had been pregnant or impregnated someone.
- Of the currently sexually active students, 24.8 percent reported that they had used alcohol or drugs prior to their last sexual intercourse (CDC, 1994).

Another drug use consequence related to sexual behavior is unwanted pregnancy. Each year, an estimated 4.9 percent of females under age 18−−nearly 200,000 young women−−give birth to a live infant (NIDA, 1996b). The live birth rate among 18− to 24−year−olds is 34.7 percent (1.4 million women). Among both of these age groups, an estimated 12.4 percent used alcohol, and 21.9 percent smoked cigarettes during their pregnancies (NIDA, 1996b). Some 5.7 percent used illicit drugs (marijuana or cocaine) while they were pregnant. The risks of fetal alcohol syndrome, miscarriage, and restricted fetal growth that accompany substance use during pregnancy result in substantial economic and health costs each year.

The prevalence of early sexual activity among adolescents emphasizes the need for treatment programs to gather sexual histories and to perform HIV and STD testing in this population. Adolescents should be appropriately counseled about these tests, especially the implications of positive test results. They should be assured that the results will remain strictly confidential (see Chapter 8 for confidentiality issues).

Juvenile Delinquency and Crime

The link between adolescent substance use and juvenile delinquency is complex. There is a strong and consistent association between conduct disorder and substance use among teenagers (Crowley and Riggs, 1995). Many young people entering the juvenile justice system have a host of problems ranging from impaired emotional, psychological, and educational functioning to physical abuse, sexual victimization, and substance use disorders (Dembo, 1996). A growing trend is that most of the teenagers entering residential treatment for substance use disorders have been criminally active and mandated to treatment by the criminal justice system (Jainchill, 1997).

Drug testing data collected on male juvenile arrestees through the National Institute of Justice (NIJ) confirm a strong and continuing relationship between the extent of drug use and juvenile crime (NIJ, 1997). An additional finding from the data is that the median positive rate for marijuana use among male juvenile arrestees increased from 41 percent in 1995 to 52 percent in 1996.

Developmental Problems

Substance use can prevent an adolescent from completing the developmental tasks of adolescence, such as dating, marrying, bearing and raising children, establishing a career, and building rewarding personal relationships (Havighurst, 1972; Baumrind and Moselle, 1985; Newcomb and Bentler, 1989). Because substance use changes the way people approach and experience interactions, the adolescent's psychological and social development is compromised, as is the formation of a strong self−identity. Adolescents' use of alcohol or drugs may also hinder their emotional and intellectual growth. Some adolescents may use substances to compensate for a lack of rewarding personal relationships. Instead of developing a sense of empowerment from healthy personal development, the substance−using adolescent is likely to acquire a superficial and false self−image as he becomes more deeply

entrenched in the drug experience (MacKenzie, 1993). Naturally, treating an adolescent with substance use disorders as early as possible maximizes the opportunity to stem these initially short−term, but potentially long−term, ill effects.

Treatment Needs

A recent study conducted by SAMHSA reveals that treatment for substance use disorders significantly reduces substance use and criminal activity (SAMHSA, 1998b). Administering treatment to adolescents, then, could greatly prevent future substance use related−problems as the adolescent transitions into adulthood. Understanding the relationship between substance use and adolescent development is crucial for designing effective interventions and treatment strategies. Treatment efforts that approach young people as "little adults" are bound to fail. Rather, the treatment process must incorporate the nuances of the adolescent's experience−−including cognitive, emotional, moral, and social development−−so that treatment providers can begin to grasp why substance use becomes a part of the identity of these young people.

Adolescence is a time when interpersonal relationships are transformed and new cognitive abilities emerge. The adolescent is for the first time forming an individual sense of self. The psychosocial changes associated with the passage into adult society occur within the context of the significant physiological changes of puberty. Social relationships move from a predominant attachment to family to an increased bonding and identification with peers. Teenagers also begin joining and identifying with institutions outside the family−−schools, churches, Boy and Girl Scouts, political groups, and fan clubs. The extrafamilial bonding often has a very pluralistic character, with peer groups being only a visible and influential part.

Adherence to the family's values evolves into independent thinking and the development of a personal belief and value system. Abstract thinking, propositional logic (the ability to form hypotheses and consider possible solutions), and metacognition (the ability to think about the thought process itself) are essential abilities that develop during the adolescent years. It stands to reason that these cognitive functions are vital to the process of establishing therapeutic relationships between therapist and client, and for the client to gain insight into the adverse course of substance use, as well as to engage in behavioral change strategies.

Not all young people who experiment with substances develop clinical problems. In fact, some degree of experimentation with drugs is technically normative; that is, most adolescents have tried alcohol or illicit drugs at least once by the time they turn 18 (Johnston et al., 1995). The formidable task faced by every adolescent−−to become an independent and responsible adult−−is undertaken with strategies that may include exploration, experimentation, risk taking, limit testing, and questioning of established rules and sources of authority. Experimentation with substances may be among these usually functional strategies, despite the potential harm and hazard associated with this behavior. However, substance use can lead to an abusive and addictive pattern that requires more active, firm, and constant intervention.

Risk Behaviors of Adolescents

It is useful to consider substance use during adolescence within the context of the more general spectrum of risk behaviors that mark this developmental period. Problem behavior theory provides a useful conceptual framework for understanding risk behaviors during the adolescent period. Problem behavior theory defines *risk behavior* as behavior that can interfere with successful psychosocial development (e.g., having deviant peers), whereas *problem behaviors* are risk behaviors that lead to either formal or informal social responses designed to control them (e.g., substance use) (Jessor and Jessor, 1977). In other words, risk behaviors increase the adolescent's vulnerability to a problem, whereas problem behaviors incur consequences, such as discipline at home or school. As Jessor and his colleagues observed in several investigations, problem behaviors tend to cluster in an individual; for example, those who experiment with substance use also tend to engage in risky sexual practices and illegal behavior (Jessor, 1991).

Risk behaviors can become a "risk behavior syndrome" (DuRant et al., 1995a, 1995b) in that problem behaviors serve a common social or psychological developmental goal, such as separating from parents, achieving adult status, or gaining peer acceptance. These behaviors may also help an adolescent cope with failure, boredom, social anxiety or isolation, unhappiness, rejection, and low self−esteem. One example of a risk behavior syndrome is an adolescent's reported use of substances as a means of gaining social status and acceptance from peers and, at the same time, counteracting dysphoria and feelings of low self−worth.

Tailoring Treatment to Adolescents

As noted above, treatment for adolescents with substance use disorders works best when it is provided and implemented with their particular needs and concerns in mind. In this TIP, the Revision Panel used a broad definition of treatment. Treatment is defined as those activities that might be undertaken to deal with problem(s) associated with substance involvement and with individuals manifesting a substance use disorder. Although the Panel recognizes that primary or secondary prevention of substance use is included in expanded definitions of treatment, the Panel limited the continuum of interventions to what is traditionally viewed as acute intervention, rehabilitation, and maintenance. The elements of the continuum primarily reflect the treatment philosophies of providers, with less emphasis on settings and modalities.

Regardless of which specific model is used in treating young people (e.g., 12−Step−based programs, family therapy, therapeutic communities), there are several points to remember when providing treatment for adolescents.

- Adolescents must be approached differently than adults because of their unique developmental issues, differences in their values and belief systems, and unique environmental considerations (e.g., strong peer influences).
- Not all adolescents who use substances are, or will become, dependent. Programs and counselors must be careful not to prematurely diagnose or label adolescents or otherwise pressure them to accept that they have a disease: This may do more harm than good in the long run.
- Programs should be developed to take into account the different developmental needs based on the age of the adolescent; younger adolescents have different needs than older adolescents.
- Some delay in normal cognitive and social−emotional development is often associated with substance use during the adolescent period (Newcomb and Bentler, 1989). Treatment for these adolescents should identify such delays and their connections to academic performance, self−esteem, and social considerations.
- In addition to age, treatment for adolescents must also take into account gender, ethnicity, disability status, stage of readiness to change, and cultural background.
- Programs should make every effort to involve the adolescent client's family because of its possible role in the origins of the problem and its importance as an agent of change in the adolescent's environment.
- Although it may be a necessity in certain geographic areas where availability of youth treatment programs is limited, using adult programs for treating adolescents is ill−advised. If this must occur, it should be done only with great caution and with alertness to the inherent complications that may threaten effective treatment for these young people.
- Many adolescents have explicitly or implicitly been coerced into attending treatment. However, coercive pressure to seek treatment is not readily conducive to the behavior change process. Consequently, treatment providers must be sensitive to motivational barriers to change at the outset of intervention. There are several strategies suggested by Miller and Rollnick for encouraging reluctant clients to consider behavioral change (Miller and Rollnick, 1991). Figure 1−2 provides an overview of several of these strategies.

The rest of this document guides providers through the process of treating adolescents with substance use disorders. Chapter 2 covers factors to consider in making treatment decisions. Chapter 3 details the features of successful programs. Chapters 4, 5, and 6, respectively, introduce and describe the treatment approaches used in 12−Step−based programs, in therapeutic communities, and in family therapy. Chapter 7 discusses adolescents with distinctive treatment needs, such as homeless and runaway youth, youth with coexisting disorders, and youth involved in the

juvenile justice system. Chapter 8 describes the legal and ethical issues that relate to diagnosis and treatment of adolescents.

Chapter 2 −− Tailoring Treatment to the Adolescent's Problem

Determining the appropriate level of treatment for an adolescent is no small task. In addition to factors normally considered when placing an individual in treatment for a substance use disorder, such as severity of substance use, cultural background, and presence of coexisting disorders, treatment programs must also examine other variables such as age, level of maturity, and family and peer environment when working with adolescents. Once these factors are assessed and the problems are understood, the treatment program can then match the adolescent with the proper type of treatment.

Understanding the Problem

The Severity Continuum

Researchers and treatment professionals have found it useful to characterize adolescent substance use behavior on a continuum of severity. *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* (American Academy of Pediatrics, 1996) views substance use disorders as occurring on a continuum that extends from the developmental variation of experimentation with substances through problem use, to the disorders of abuse and dependence. The degree of substance involvement is an important determinant of treatment, as are any coexisting disorders, the family and peer environment, and the individual's stage of mental and emotional development. This information should be used to refer to the appropriate treatment.

It is useful to consider a substance use continuum with these six anchor points (Knight, in press):

- *Abstinence*
- *Use:* Minimal or experimental use with minimal consequences
- *Abuse:* Regular use or abuse with several and more severe consequences
- *Abuse/Dependence:* Regular use over an extended period with continued severe consequences
- *Recovery:* Return to abstinence, with a relapse phase in which some adolescents cycle through the stages again
- *Secondary abstinence*

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 (see Figure 2−1). Any response to an adolescent who is using substances should be consistent with the severity of involvement. Although no explicit guidelines exist, it stands to reason that the most intensive treatment services should be devoted to youths who show signs of dependency−−that is, a history of regular and chronic use, with the presence of multiple personal and social consequences and evidence of an inability to control or stop using substances.

Factors Affecting Treatment Placement

Developmental Stages

Youth treatment providers should be sensitive to the developmental differences among adolescents and make the necessary adjustments to accommodate such differences. The treatment of a 13−year−old should not be identical to

that of an 18−year−old. Figure 2−2, below, provides some general developmental features that tend to distinguish younger from older adolescents, as well as some guidelines pertaining to professional behavior and attitudes that reflect these differences. This is an adaptation of the Adolescent Development Table created by the Advisory Council of Adolescent Health and the Colorado Department of Public Health and Environment (1998).

Ethnicity

Understanding substance use and abstinence within the client's cultural context will flow most naturally from a broad base of knowledge about the client. The provider will be better prepared, however, with some specific information about that culture. First, the provider should find out if the client's parents are first generation immigrants. Any intervention with a teenager from an immigrant family will be enhanced by the provider's knowledge about the background of the youth and his family. Norms, values, and health beliefs may differ across cultures, and these factors can have a significant impact on treatment; for example, people from some cultural groups may see therapy as invasive, and others may want the extended family included in family therapy sessions.

Programs to which non−English speakers are referred should be able to provide services in the language of clients and their families. This includes bilingual staff and written materials on topics ranging from program policies to bibliotherapy (a self−learning procedure by which the client reads and studies appropriate self−help material). Cultural competence is far more than bridging language barriers, however. Treatment settings and providers should incorporate cultural traditions (e.g., special holidays) into their treatment regimens. Also, cultural concerns should be addressed in clinical staff meetings, through interagency collaborations, and at all levels of the organization in order to enhance cultural sensitivity and competence.

Gender

Many gender−related factors have a bearing on the extent of the adolescent's involvement in treatment and on the treatment approach that is most likely to be effective and appropriate. Adolescent females, for example, may need more attention in regard to family problems; it has been found empirically that female adolescent substance users have often experienced severe parental rejection and sexual or physical abuse (Gross and McCaul, 1990−1991). Family dysfunction, therefore, may be a more critical component and indicator of substance use disorders in adolescent females and may require more attention in treatment. Females also often need highly specialized services, such as those for pregnant and parenting young women. Intervention for domestic abuse also may be required for females.

Coexisting Disorders

A *coexisting disorder* (also called a *dual diagnosis*) most commonly refers to the coexistence of a substance use disorder and a psychiatric disorder. Adolescents with substance use disorders are much more likely than their abstinent peers to have such psychiatric disorders (Kleinman et al., 1990; National Institute on Drug Abuse [NIDA], 1998). The behavioral or mental conditions of childhood most often associated with substance use disorders are conduct and oppositional disorders, attention deficit/hyperactivity disorder (AD/HD), affective disorders (unipolar and bipolar depression), and anxiety disorders, including posttraumatic stress syndrome from sexual or physical abuse (NIDA, 1998).

There is growing evidence that the presence of conduct and oppositional disorders in childhood are particularly predictive of later adolescent substance use (Crowley and Riggs, 1995). Also, the coexistence of more than one childhood psychiatric disorder greatly enhances the risk for later substance use. In particular, the coexistence of externalizing (behavioral) and internalizing (emotional) disorders constitutes a high risk for substance use (NIDA, 1998). Other disorders associated with a higher risk for substance use include learning disorders (Latimer et al., 1997) and eating disorders (Harrison and Hoffman, 1989). A complete assessment−−including a lifetime diagnostic evaluation, treatment trials, and clinical progress over time−−will help to establish whether an adolescent has such a

disorder in addition to the substance use disorder.

Coexisting disorders can interfere with treatment for substance use disorders, and if they are left untreated, the client is more vulnerable to relapse. The ability of treatment staff members to identify and either treat these disorders or provide appropriate referrals for treatment can help guard against this possibility. For example, a consultant may be needed to conduct mental health assessments and to evaluate the need for pharmacotherapy, and the adolescent may be referred to an outpatient mental health program. It is important for staff members to be aware of the distinctive problems of the young person who is diagnosed with substance use and other disorders. It is vital for the treatment team to perform the functions of gathering and sharing clinical data, formulating a diagnosis, and planning intervention for these clients with coexisting disorders.

To treat adolescents with coexisting disorders, substance use disorder treatment providers and mental health providers must develop programs together and ensure that staff members are cross−trained. Each program can maintain its individuality, but services should be provided in one location and arrangements made to accommodate each program's requirements (see Chapter 7 for more discussion on youths with coexisting disorders).

Pharmacotherapy

When treating adolescents with coexisting disorders, it is paramount for programs to consider the client's need for appropriate medication. For example, substance use disorder treatment facilities should suspend "no−medication" rules for depressed adolescents who have been prescribed antidepressants. Of course, medication, whether for detoxification or the treatment of psychiatric disorders, must be prescribed and dispensed under the direction of a physician. It is recommended that youths with coexisting disorders receive supplemental counseling regarding their psychiatric medication. Discontinuation of any medication is a decision that should be made only in consultation with a medical doctor. Abrupt discontinuation of certain psychotropic medications can be extremely dangerous. However, if the patient continues to use illicit substances, the medication regimen should be reassessed. The relative risks and benefits of a temporary discontinuation of pharmacotherapy (until abstinence is achieved) should be carefully considered.

The use of stimulant medication (for AD/HD) or minor tranquilizers (for anxiety disorders) is still controversial for adolescents with substance use disorders. Some of these medications have significant potential for addiction or abuse. Nonaddictive medications, as well as behavioral and psychotherapeutic interventions, should be considered before medications with the potential for addiction or abuse are prescribed. For cases in which these medicines must be used, regular urine testing for substances of abuse, and/or serological determination of therapeutic drug levels, is usually indicated.

Family Factors

The risk of adolescent health and behavioral problems, including substance use disorders, rises with lack of parenting skills, high levels of family conflict, and poor bonding between parents and children. Recent national data of adolescent health identified the importance of connectedness to parents and family as a key factor that protects adolescents, in a cross−cutting manner, from many problem behaviors, including substance use (Resnick et al., 1997). When parents have unclear expectations of their children's behavior, apply discipline inconsistently, or fail to reward their children for positive or desirable behavior, their children's risk for substance use disorders increases. Both permissiveness and excessively harsh parenting practices can lay the groundwork for adolescent behavioral problems and substance use disorders (Patterson, 1982).

An adolescent's family also provides a crucial background to the child's substance use for reasons both genetic and environmental. Children of parents with substance use disorders are at increased risk of developing substance use disorders themselves compared with children with nonsubstance−abusing parents (Cotton, 1979; McGue et al., 1992; Schuckit, 1987). An assessment of the family's history of substance use will provide some insights into the possible

role of genetic factors in the family lineage. Perhaps even more relevant to the adolescent patient's immediate concern is the need to evaluate the family environment for risk and protective factors that pertain to substance use. Salient environmental factors include parental modeling of substance use behaviors, permissive parental attitudes toward substance use, and substance use by siblings (Hawkins and Fitzgibbon, 1993).

Clinicians working with adolescents with substance use disorders should consider the degree of stability and commitment in the patient's family in determining the most appropriate treatment type and approach for each individual. Ideally, the family should be involved in all phases of the adolescent's treatment, but in families characterized by extreme instability, conflict, physical or sexual abuse, and/or domestic violence, this may not be possible or even advisable. It is important for providers to remember that "family" may include a broad spectrum of members, such as grandparents, older siblings, and foster parents.

Social and Community Factors

School life, peer influences, the community, and the media may also exert an influence on the adolescent's risk to initiate and maintain substance use (Newcomb and Bentler, 1989). Understanding their influences on an individual can help a service provider pinpoint areas of intervention relevant to the client's recovery.

Peer influences

Association with peers who use alcohol and/or illicit drugs, including involvement in gangs, is a very prominent risk factor associated with adolescent substance use (Winters et al., in press). Adolescents in cohesive peer groups make substances available to each other, substance use is modeled by friends in the group, and peer group support and norms favor substance use (Oetting and Beavais, 1986). Also, because the role of substance use and other delinquency behaviors may influence the selection of friends, it is possible that substance use behavior may contribute to selecting peers who are delinquent and happen to already be using alcohol and/or illicit drugs as well (Farrell and Danish, 1993).

Environmental influences

The socioeconomic level of a young person's community is one important determinant for his risk of substance use. Rates of substance use are higher in areas where alcohol and/or illicit drugs are more easily available and where local norms are more tolerant of their use. Substance use in these areas is also more likely to be associated with crime. In addition, positive role models for young people are often scarce or lacking. Not surprisingly, youths who identify with individuals engaging in substance use and criminal activities are more likely to engage in these activities themselves. Youths who grow up in communities where there is little or no social cohesiveness and attachment, a high population density, and disorganized neighborhoods are at greater risk of using alcohol and illicit drugs, as well as developing other behavioral problems (Hawkins and Fitzgibbon, 1993).

School factors

No relationship has been found between intelligence level and the risk of substance use. Performance in school, however, does affect this risk (Friedman et al., 1985). Academic failure beginning in the late elementary grades increases the likelihood that substance use will develop in adolescence (Hawkins et al., 1992). This is true regardless of whether academic failure stems from learning or behavioral disorders, family conflict, or poor educational quality. Lack of success and academic commitment, as evidenced by problems such as truancy and insufficient time spent on homework, is predictive of later substance use, which in turn increases the risk of substance abuse (Newcomb and Bentler, 1989).

The Continuum of Treatment

The various types of treatment approaches for adolescents with substance use disorders are described in detail in upcoming chapters. Regardless of the modality or the setting in which it takes place, treatment can be seen as taking place on a continuum starting with outreach, screening, and assessment to identify youths who are at risk or who are already engaging in substance use. It continues through the stages of counseling and treatment to continuing care and support to reinforce abstinence.

Linking Assessment and Treatment Placement

The variety of options for the treatment of substance use disorders−−outpatient, inpatient, and residential, as well as services that support independent living−−can be subdivided into specific services for adolescents with substance use disorders. These services can be viewed as a continuum ranging from pretreatment services for at−risk adolescents and those in the early phases of substance use to more intensive treatment for youths already having substance use disorders.

The differences among these levels of treatment are both qualitative and quantitative; that is, the variation in intensity of service is only one aspect of the continuum. Treatment programs also may differ considerably in their individual philosophies and approaches to treatment, in the treatment components they offer, and in the types of professionals employed. Regardless of the specific elements, any program's services must match the needs of the adolescents it intends to serve, and the levels of treatment and service options must respond to the internal and environmental realities of at−risk or substance−using adolescents. To that end, the original Consensus Panel developed the continuum shown in Figure 2−3, Client Assessment Criteria, bearing the following in mind:

- Levels of treatment and service options must respond to the internal and environmental realities of an adolescent who is at risk for or who already has a substance use disorder.
- The table must be comprehensible to treatment providers with different levels of clinical sophistication.
- The table must be internally consistent and reliable in making placement decisions.

In the model presented in Figure 2−3, the following assessment criteria can be used to determine the level and type of service that is most appropriate for each individual. For example, assessment of an adolescent's recent substance use might indicate that she has a toxicity level that requires more than outpatient medical management but is not severe enough to require life support and intensive medication. This would suggest that the adolescent requires care as a medically monitored inpatient. On the other hand, her emotional well−being might reveal a great deal of distress, requiring 24−hour continuous psychiatric monitoring. The following areas can be evaluated in order to arrive at appropriate treatment placement decisions:

- *Use pattern:* Pressure of consequences and problems resulting from substance use, and level and recency of substance consumption
- *Medical concerns:* Toxicity, withdrawal, and other medical sequelae resulting from substance use, as well as medical problemsunrelated to substance use, such as pregnancy, HIV/AIDS, domestic violence, and child abuse and neglect
- *Intrapersonal−−Cognitive:* Substance−induced impairment in cognition and thinking, both chronic and acute, including neurological deficits as well as memory problems such as blackouts, short−term memory deficits, and poor concentration
- *Intrapersonal−−Emotional:* Emotional functioning, which may range from an inability to experience emotions to extremely negative emotional states
- *Interpersonal−−Social:* Interpersonal relationships, social development, and social concerns such as employment, family, friends, and legal matters

- *Environmental:* External influences, including living conditions, housing, gang influence, and family and school influences

The continuum of treatment underscores the importance of understanding all of the factors that bear on the adolescent's substance use. These factors must be included in a comprehensive assessment, which must in turn incorporate information collected from the adolescent's self−report, standardized assessments, reports from family members, and other collateral sources of information whenever possible in order to obtain a complete picture of the adolescent's social and environmental situation.

Placement Guidelines

The following guidelines indicate how the continuum can be used in making a decision regarding the placement of the adolescent. The Revision Panel created the guidelines based on clinical experience.

- In making placement decisions, practitioners should choose the most intensive level of care indicated by any single assessment criterion. For example, an adolescent who is not currently using substances but who is actively psychotic would require inpatient treatment.
- When an assessment indicates the need for a particular level of care that is not available, it is desirable to refer the adolescent to the next higher level of care, unless the assessment indicates that such a placement would be counterproductive. For example, if intensive outpatient treatment is indicated but unavailable, day treatment should be the next recommendation, unless it is contraindicated. Naturally, a higher level of care may not be practical or available.
- Assessment is an ongoing process. Decisions about level of care should be based on the adolescent's progress and changes in his environment. Clients should have the opportunity to move back and forth across the level−of−care continuum on the basis of changes in these factors.
- There is as much, if not more, variability among treatment programs within a single intensity level as there is across treatment intensity levels. The assessor should incorporate this understanding when making placement decisions. Assessors should have an indepth knowledge of available services and the intensity of any particular treatment or service option.
- The assessment criteria shown in Figure 2−3 are interrelated and can be viewed together as an integrated system. This point is important in considering the most appropriate treatment level and the ability of the adolescent to move along the level−of−care continuum as treatment progresses or regresses. Prior to each program change, indepth reassessment must be completed in order to update information on the client's status and to obtain a current clinical picture of his situation.

The American Society for Addiction Medicine is also in the process of developing placement guidelines for adolescents with substance use disorders.

Levels of Treatment

Outpatient treatment

Outpatient services provide a broad range of intensity−of−care levels without overnight accommodation. Some of these levels may be used subsequent to inpatient treatment. It is common for some levels of outpatient counseling to implement the same treatment strategies as in inpatient counseling. Outpatient counseling as a treatment option is composed of sublevels of treatment characterized by increasing levels of intensity.

Brief intervention

Brief intervention generally takes less time than more formal treatment approaches. It is usually delivered by nonspecialists or paraprofessionals, emphasizes self−help and self−management, reaches large numbers of individuals, and is considerably less expensive than conventional treatment. Brief interventions, notably those based on motivational enhancement theory, have proven successful with adult alcohol users (Institute of Medicine, 1990; see also Rollnick et al., 1992; Miller et al., 1993). Typically, a brief intervention would include brief screening, anticipatory guidance, and psychoeducational interventions. This option is primarily appropriate for adolescents in the low−to−middle range of the severity continuum (experimental, regular, and problem use). This approach has also been demonstrated to be very effective in the emergency medical care setting by significantly increasing the likelihood that clients will keep followup appointments for subsequent treatment (CSAT, 1995a). See the forthcoming TIP, *Brief Interventions and Brief Therapies for Substance Use Disorder Treatment*, for a description of brief interventions and therapies that can be used in various treatment settings(CSAT, in press).

Intervention in primary care settings

Within the health care sector, there is a growing interest in primary care providers to practice brief interventions. Primary care providers are well situated to practice primary prevention of substance use disorders and to intervene when they suspect the possibility of substance use by adolescents under their care for other medical problems. The developmental model of substance use disorder progression, diagrammed in Figure 2−1, is useful for understanding the development of substance use disorders in teenagers and the type of intervention that is most appropriate at each stage.

The time pressure in a managed care environment makes many primary care physicians reluctant to screen for substance use although health care guidelines recommend screening every adolescent patient for substance use disorders as part of routine medical care. Screening and intervention can be done in minutes−−for example, during an office visit−−using any of a number of screening instruments designed for adolescents (see the companion TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* [CSAT, 1999]).

In geographic areas where substance use is highly prevalent, it is often useful to bring substance abuse counselors in routinely to meet with adolescents as part of the screening. These workers can establish a rapport with young patients and can arrange subsequent meetings with those who screen positively for problems. This approach helps to bridge the gap between primary care and substance use disorder treatment programs, where the risk of losing patients to followup is greatest, and obviates the need to make referrals to a treatment center.

When substance use disorders are identified in an adolescent patient by a primary care provider, it is important to make the connection to a treatment program as quickly and directly as possible. Resources can be mobilized more immediately by having an established contact with a substance use disorder treatment provider who is willing to call or meet with adolescents, or even to visit those admitted to inpatient treatment. Making a direct and immediate contact with a treatment provider is highly preferable to merely giving an adolescent patient a referral card, name, or phone number, none of which may ever be used. However, making direct contact with a treatment provider requires the consent of the adolescent and may also require the consent of the parent. See Chapter 8 for information on legal and consent issues.

Physicians treating adolescents should become familiar with treatment resources in the community and their approaches to treatment. Programs vary in intensity and philosophy, but abstinence is normally the goal; it will also help if the physician is familiar with several therapeutic communities that may be available, even if they are a distance away (Knight, 1997).

The physician can recommend that the parents take part in treatment with the youth. Individual and family counseling may be needed, and the physician can refer the parents and youth to child−centered support groups, such as Alateen

and Alatot. Also, if parents have a substance use disorder, they should be referred for an assessment.

The physician should also inform the patient that she will continue to check the patient's progress in future visits and encourage the youth to discuss any substance use problems with her. Formal treatment interventions are generally indicated for adolescents who have progressed to abuse or dependency. Such problem users require more than a brief intervention during an office visit, and should be referred to a substance use disorder treatment specialist. The bottom line is that primary care staff members should be encouraged to consult with substance use disorder professionals about how they might best support treatment during ongoing contact with adolescents being seen for primary care. For a further discussion on brief interventions in primary care settings, see TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT, 1997).

Outpatient counseling

Outpatient counseling includes professionally directed evaluation and treatment typically for fewer than 9 hours per week in regularly scheduled sessions. In less intensive programs, 2 to 3 hours per week is common. Nonintensive outpatient treatment also may address related psychiatric, emotional, and social concerns. Intensive outpatient programs may be after−school or evening programs, often include some weekend programming, and may involve 9 to 20 hours of treatment per week.

Day treatment or partial hospitalization

Day treatment programs, sometimes referred to as partial hospitalization, provide professionally directed evaluation and treatment in a structured program. This is the most intensive of the outpatient treatment options and can be used for adolescents who demonstrate the greatest degree of dysfunction but do not require inpatient treatment. Day treatment may range from several hours per week to more focused and directed sessions for up to 5 days a week. Sessions may take place after school, in the evenings, or on weekends. The treatment provided may be some combination of individual, group, and family therapy.

Inpatient treatment

Inpatient treatment may include 24−hour intensive medical, psychiatric, and/or psychosocial treatment and residential care. The levels of the residential care continuum include a high level of supervision by professional staff members at the most intensive end and group home living with minimal professional involvement or supervision at the least intensive end.

Detoxification

Detoxification generally refers to a 3− to 5−day inpatient program with 24−hour intensive medical monitoring and management of withdrawal symptoms. Although physiological withdrawal symptoms are uncommon among adolescents, this level of care may be mandated by psychosocial circumstances, personal characteristics, or a history of using significant amounts of a substance associated with life−threatening withdrawal symptoms (e.g., benzodiazepines, barbiturates, heavy chronic alcohol use). Detoxification should be monitored by appropriately trained personnel under the direction of a physician or other personnel with specific expertise in management of addiction and abstinence syndromes. It is appropriate for adolescents with multiple problems, including those who need habilitation or with coexisting personality and substance use disorders. See Appendix B for information on medical management of substance use disorders.

Residential treatment

Residential treatment is a long−term treatment model that includes psychosocial rehabilitation among its goals. It may be directed by physicians or other professionals, and it is appropriate for adolescents with multiple problems,

especially those with coexisting personality and substance use disorders. The duration of residential treatment can range from 30 days to as much as 1 year in some cases (as in the case of therapeutic communities), although managed care requirements continue to chip away at the maximum length of treatment allowed.

Continuing Care

The period right after completion of a treatment program, when the youth returns to family, peers, and the neighborhood, is often the time of greatest risk for relapse. It is for this reason that all forms of treatment should include some provision for continuing care. A continuing care program often takes the form of a structured and time−limited outpatient program and planning process that can provide ongoing support to the adolescent. Many continuing care programs have specialized groups that focus on making the transition from intensive treatment to a lower level of care.

Most treatment programs also have specialized groups for relapse prevention. Having a history of relapse is common for adolescents in treatment for substance use disorders (Hoffman et al., 1993). If an adolescent in treatment experiences relapse, it is best viewed not as a failure of the treatment or the client, but rather as a common part of the early recovery process that needs to be factored into the treatment plan. As in chronic physical diseases such as leukemia or diabetes, relapse is an indication not for punishment or discontinuation of treatment, but for additional or intensified treatment. Relapse (or the lesser version known as a minor slip or lapse) should be viewed by treatment professionals as an opportunity for learning; for example, it can help teach young people that they do not have control over their substance use.

Because an adolescent who has relapsed in the past is at greater risk for further relapses, it is important to evaluate those factors that are precipitants for relapse and to adjust treatment accordingly. An adolescent's coping style (i.e., the use of skills gained through treatment) and social resources are among the known protective factors for alcohol relapse (Brown, 1993).

Self−help and peer support groups

Self−help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al−Anon, and Alateen are valuable adjuncts to outpatient services and residential programs for teenagers during the recovery process, both during and after primary treatment. Self−help groups offer positive role models, new friends who are learning to enjoy life free from substance use, people celebrating sober living, and a place to learn how to cope with stress and other relapse triggers. Teenagers should ideally be referred to youth−oriented groups, led by responsible individuals, with a membership that is appropriate for the age, gender, and culture of the client (see Chapter 4).

Group homes

Sometimes referred to as halfway houses or independent living, group home living is a transitional living arrangement with different levels of specificity of treatment planning and staff supervision. Residents may work and/or receive educational or training services or treatment outside the group home. House responsibilities are shared, and the youths are involved in the house governance. Therapeutic foster home placements, a type of group home, involve a small group of adolescents being placed in a family situation, often with foster parents, who themselves may be recovering from substance use disorders.

"Booster" sessions

In the cognitive−behavioral model of treatment, recovering adolescents periodically return to the treatment program to meet with clinicians and review their skills for relapse prevention, self−management, and independent living. Recommendations and supportive and encouraging feedback are provided during these monitoring sessions. Consistent with the need for continuing care, booster sessions, often known as aftercare sessions, are important for

any treatment experience.

Chapter 3 −− General Program Characteristics

The previous chapter examined the range of substance use disorders and related problems seen in adolescents. The chapter then applied those factors to treatment placement decisions. This chapter discusses how individual program components can best meet the needs of adolescent clients. Program design and administration, treatment components, client services, and a program's collaborative relationships are important considerations for practitioners or other staff members who are treating adolescents or referring them to an outpatient treatment setting.

Scope and Approach

A program's design, policy, evaluation, and legal approach are shaped by its underlying philosophies−−the core values and beliefs from which treatment decisions arise. Mapping out these program features can provide a strong and flexible framework for providing services that are implemented smoothly and effectively and yet are individualized to meet each client's needs. Much of this information shows up in a program's policy and procedures manual.

Although a program's funding and scope limit the number and depth of treatment components a program can provide, it is vital that the most critical components be identified and implemented with skill and timeliness. In addition, expectations for successfully completing treatment should be as clear and as objective as possible.

Policies and Procedures Manual

A program's policies and procedures manual provides guidelines for program operation. It also serves as a reference book for Federal, State, and local laws and regulations and for requirements for contract compliance. State licensing requirements may also include obligatory standards about what goes in a policy and procedures manual. Both the program staff and clients are protected by these regulations, which may include the following:

- A program mission statement identifying underlying program principles, including the program's commitment to a drug−free workplace
- Confidentiality procedures for clients as well as the staff
- Documentation guidelines and requirements for client charts, including reporting requirements for sexual and physical abuse and suicidal and violent behavior
- Personnel policies that describe
- Policies concerning critical incidents, such as involuntary commitment, emergency procedures (e.g., suicide, violence), and inappropriate behavior (e.g., drug use) during treatment

In addition, HIV guidelines and staff training should describe the universal precautions recommended by the Centers for Disease Control and Prevention, specify who should know the HIV status of clients and family members, and outline the policies and procedures for HIV testing of clients and staff members. Programs may wish to designate a staff person as the AIDS trainer. This training helps to raise awareness of the HIV−related needs and concerns of adolescents. Also, guidelines should address precautions about hepatitis B and C and tuberculosis. Some strains of hepatitis are easily transmitted and may be more prevalent than HIV in certain communities. Hepatitis B vaccinations may be considered for at−risk staff members with significant client contact.

Staffing

Staffing decisions are best made with attention to program needs, job descriptions, and educational and experiential requirements for each position. It also must be determined which services will be provided on site by program

personnel and which are to be provided by arrangement with an external agency, program, or professional. If volunteers or interns are to be an integral part of the program, specific policies must be established regarding their supervision, training, and responsibilities.

Staff members should represent the cultural diversity of the program's client population. In addition, the facility's forms, books, videos, and other materials should reflect the culture and language of the clientele. 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. Cultural differences should be addressed in clinical staff meetings, through interagency collaborations, and at all levels of the organization, with the goal of enhancing cultural sensitivity and cultural competence. For individuals with disabilities, the Americans With Disabilities Act of 1990 requires treatment facilities to be accessible to all clients, which may mean having a sign language interpreter and other specially trained personnel on staff. For more information on treating people with disabilities and coexisting disorders, see TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* (CSAT, 1998).

Core Staff

The type of program and the range of services offered within a program determine treatment staffing patterns. The following positions should comprise a core staff:

- Program or clinical supervisor
- Substance use disorder counselors
- Therapists (preferably at a master's level with a certification in substance abuse treatment)

The essential roles of core staff include

- Intake
- Screening
- Assessment (including a cultural assessment)
- Case management, including treatment planning and crisis intervention
- Substance use disorder treatment (individual, group, family)
- Providing specialized education on topics such as understanding substance use, HIV infection and AIDS, and other sexually transmitted diseases (STDs)
- Planning continuing care and treatment
- Record keeping and report writing

Optional Staff

As the intensity of the treatment increases, programs may require additional personnel. These professionals may be hired as part−time staff members or as consultants, or they may be provided by contract or through referral. They include:

- Psychiatrists
- Pediatricians, adolescent medicine specialists, internal medicine specialists, and/or family practitioners
- Psychologists
- Nurses
- Recreational therapists (leading activities in art, music, drama, wilderness outings, etc.)
- Occupational therapists
- Disabilities specialists, including sign language interpreters

- Outreach workers
- Home intervention workers
- Continuing care workers
- Cultural advisors or spiritual leaders
- Students, interns, and fellows (from local colleges and universities)
- Vocational specialists
- Case managers

Skills Development

The complexities of an adolescent's needs and concerns require that the clinical staff be supervised. However, high−level skill or expertise may not be necessary for all staff members in all areas. Most important is regularly scheduled training that occurs periodically throughout the year. This is greatly preferable to ad hoc training presented to address crises or acute situations. Training on specialty topics should be available in the following areas:

- Changes in diagnostic criteria for substance use disorders (e.g., DSM−IV criteria)
- New substance use disorder treatment approaches specific to adolescents and their families
- Family dynamics and family therapy
- Adolescent growth and development
- Sexual and physical abuse
- Gender issues, including gender and sexual identities (e.g., gay, lesbian, transgender)
- Mental health problems (particularly depression, anxiety disorders, and conduct disorders)
- Awareness of different cultural and ethnic values
- Recreational and prosocial activities
- Psychopharmacology
- Group dynamics and group therapy
- Suicidal behavior
- Grief and loss
- Referral and community resources
- Management of oppositional and violent behaviors
- Cognitive impairments (learning disabilities, cognitive disorders, and organic mental disorders)
- Legal matters (custody and juvenile justice concerns, child abuse and neglect reporting requirements, and duty−to−warn issues)
- Treatment planning and documentation
- HIV/AIDS
- Other health matters (STDs, tuberculosis, hepatitis, nutrition)
- Gangs
- Drug dealing

Staff Members in Recovery

Treatment programs often use recovering substance abusers as staff members. Staff members who are themselves in recovery can offer unique hope, role modeling, and insight into dependency, addiction, and recovery. 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 at least 2 to 5 years of recovery demonstrated by regular attendance at 12−Step meetings, a current sponsor, and continuous abstinence from substances other than those prescribed by a physician.

Certification and Credentials

Each State has different requirements for the certification of substance abuse counselors. Certification is available in many disciplines; for example, a nurse can be certified in chemical dependency, and a physician can become a certified addictions specialist. Records documenting these credentials are necessary. Programs should encourage all staff members to become certified and support their continuing education efforts to enhance their clinical competence in their specialty.

Supervision and Evaluation

A supervisory review of each staff member's performance should be conducted on a regular basis. Opportunities for self−evaluation and feedback from other staff and team members can be included in the evaluation process. The program's manual on policies and procedures should specify how the program deals with staff turnover, burnout, relapse, and related staff problems, as well as specific procedures for staff reviews.

Supervision should include training staff on program procedures and policies, developing clinical skills, monitoring performance and providing feedback, identifying clinical limitations, addressing transference and countertransference (such as relationships and identification between the adolescent and treatment personnel), and dealing with staff concerns.

Perspectives on Counseling Youth

Understanding how adolescents perceive and react to treatment is crucial in developing appropriate counseling techniques to address their substance use. Treating an adolescent like an adult will likely result in failure−−counseling adolescents requires sensitive yet firm approaches. An adolescent treatment program should have explicit and impartially administered standards for behavior. It should emphasize treatment of every participant in a personal, respectful, and hopeful manner. The program staff should maintain an optimistic tone and be dedicated to serving and helping its clients, while exercising authority without seeming authoritarian. The staff should also ensure that every participant is protected from possible harassment, such as teasing and hazing, by other program clients. When youths do not abide by the treatment program guidelines, they must be held responsible for their conduct, but in a manner that avoids a confrontational style or indicators of mistrust. It is also important that youth be helped in fulfilling their responsibilities in a way that would typically be inappropriate for adults. For example, if an adolescent does not show up on time for an outpatient program, he should be called immediately and reminded to attend.

Program Components

Many adolescent treatment programs, regardless of their therapeutic orientation, include significant shared components, some of which are described below. The level of intensity of these components will vary considerably in outpatient and residential treatment.

Orientation

This initial stage in treatment is very important to the adolescent. Many new activities may be threatening to the adolescent, and coming into treatment can intensify feelings of fear and self−consciousness. Moreover, adolescents frequently have incomplete and inaccurate information about the nature of substance use disorders and treatment programs. The client may have heard that very negative things happen in treatment and that "people really get on your case." The awkwardness experienced by adolescents may also be intensified. During adolescence, many situations can increase a young person's anxiety level. Anxiety can be acted out in many negative ways, including leaving or running away from the program. Sometimes, the acting−out behavior is so disruptive that the client may have to be discharged

by the staff. Thus, it is important that the orientation to treatment be structured to provide relief from anxiety.

One main component of orientation is explaining to adolescents *what treatment is*, as well as *what it is not*, in a nonconfrontational style and tone. If the youth has a mistaken notion about the nature of treatment, the chances for treatment success may be lowered. Young people come into treatment with many different expectations. It will help the adolescent to know the meanings of such terms as *chemical dependency*, *expectations*, and *unmanageableness*. But definitions must be clear and not too abstract, given that some adolescents may be unable to grasp complex concepts.

Orientation also provides an opportunity to clarify the adolescent's role. Videos of activities to be experienced in treatment can be shown. Orientation should include the concept of program expectations. This term is preferable to the term *rules*, which implies staff dictates or commands (Winters and Schiks, 1989). Having expectations implies ownership by the client and promotes responsibility from him. Communication of essential principles and expectations can start during orientation and continue throughout the treatment process.

Daily Scheduled Activities

Most adolescents who require treatment for substance use disorders have been preoccupied with the use of substances to the exclusion of participation in positive recreational activities and the development of basic living skills. When the substance use is removed, they may not know how to use their time appropriately. A prescribed daily schedule of school, chores, homework, and especially recreation can significantly help with this relearning process. In outpatient programs, staff members can work with adolescents and their families to schedule activities for the client during the hours away from treatment; in residential programs, scheduling can be more elaborate. A full schedule with many different group activities has been shown to work well with adolescents (Winters and Schiks, 1989).

Adolescents who have centered their leisure time on the use of substances may resist learning new skills and often equate staying clean with boredom. Youths who engage in thrill−seeking behaviors by using rock cocaine seem especially susceptible to anhedonia, an inability to experience pleasure, because of the boredom that sets in afterward. Encouraging the adolescent client to take advantage of community recreational resources and to develop socially appropriate recreational habits will help ensure that she remains sober following treatment. Adolescent treatment programs can provide many recreational opportunities to their clients with relatively little expense. For example, a program might establish an athletic period during which it takes groups of youths to the local "Y" to play basketball. Chess, ping pong, computer games, and other sports and games can be provided at the treatment site.

Peer Monitoring

Given the important influence of peers on an adolescent's behavior and attitudes, it stands to reason that pressure from peers often keeps the client from achieving treatment goals. Although this pressure occurs in social times rather than within structured program activities, it must be addressed during treatment. Group therapy can help the client build the strength needed to override peer pressure and harness the influence of the peer group in a positive manner. In a process guided by the clinician, clients can receive constructive feedback about their progress from their peers. The group can serve as an important source for addressing the client's denial about his substance use disorder, as well as promote positive behavioral changes. In addition, peers can indirectly influence change by way of clients' learning vicariously through others' stories and interactions (Stinchfield et al., 1994). When denial is strong, peer monitoring can be a relatively nonthreatening form of confrontation.

Conflict Resolution

Conflicts often arise among young clients or between clients and staff members. The treatment staff should take a proactive stance to resolve such conflicts. This may entail having extra staff meetings or addressing these issues

directly in team meetings. How the conflict is dealt with is critical. If staff members take an authoritarian approach, the conflicts may escalate, resulting in damaged rapport and a retreat from the treatment process.

Power struggles between a youth and a counselor can arise from the client's inability or unwillingness to meet program expectations. They also often arise when the staff is not trained in how to work with adolescents. When a youth is unable to meet program expectations, modifications in the treatment plan to better suit the client's abilities are desirable. It is important in power struggles to keep the focus on what the client can reasonably achieve rather than on staff policies. If it appears that numerous program expectations have to be modified for the client, this may signify that the program is not appropriate for that individual. In such cases, the client may have to be referred to a different level of care or to another treatment program.

For cases in which the client seems able to meet the program's expectations but does not do so, the clinician should directly address what is impeding the client's participation. It is most useful to encourage a resistant adolescent by telling her that she has the capabilities but is not working up to her level. This positive approach may help avoid unnecessary power struggles. An unwilling client may need the attention of staff members who are skilled in implementing motivational techniques such as building therapeutic rapport and in identifying and addressing specific sources of poor motivation, such as the client's having a learning problem, feeling shame or guilt about having his problems with substances come to light, and experiencing social discomfort by virtue of being in a new environment.

Client Contracts

Entering into a behavioral contract, including a substance−free contract, with an adolescent is a counseling tool that can help a provider identify the current level of the adolescent's functioning and developmental markers, providing a baseline from which to periodically monitor change. Contracts should include the following:

- Specific treatment goals organized around specific client target behaviors
- Concrete descriptions of the consequences to the client if the contract is not followed and the rewards if the contract is followed
- Specific outlining of situations to which the contract applies
- The time frame during which the contract is active
- Options regarding contract revisions
- A written reminder of boundaries and expectations

The contract should be composed and signed by both the client and the primary counselor and copies distributed to both parties. By involving the client in the process, the importance of the goals is emphasized, and a commitment to the plan is asked of the client and the therapist. Contracting provides a clear and concrete set of expectations that are mutually acceptable to both the client and counselor. It helps hold the client accountable for her behavior and undercuts manipulation. Some counselors also have the adolescent's family sign the contract, which communicates to the client that her family is also committed to the treatment process.

Contracts are especially useful to adolescents because they give them a sense of control in going through treatment and a degree of personal investment in their well−being, both of which are important to teenagers who have difficulties with authority or who are struggling to establish an identity. Moreover, contracts may represent the first time an adult has taken real interest in them. A successfully completed contract can give an adolescent a sense of self−fulfillment and responsibility that will be valuable after treatment is finished.

It is important to avoid written contracts that are inflexible and that pose unreasonable expectations for teenagers whom staff members would like to exclude from treatment programs. Clients who enter into a contract too quickly may come to believe that it is a form of coercion on the part of the counselor. Contracts should be made in the context of collaboration between the adolescent and counselor, in which clients have a role in defining problems, goals, and approaches that will be the focus of their individual treatment.

Schooling

Some States mandate that adolescents receive several hours of classroom schooling while in treatment, particularly if they are receiving residential care or day−long outpatient care. Helping adolescents have a successful experience in the classroom is one of the most important factors in their recovery. Regardless of whether the schooling is provided on site (by the program or through homebound public teachers) or off site (in public settings), the educational program must be fully integrated into the adolescent's clinical program. This is best accomplished when the teaching staff members are considered part of the treatment staff and when the behavioral program is extended into the classroom, as occurs in many residential programs. If adolescents attend local public schools, it is desirable to have a dedicated liaison at the school who can attend treatment team meetings at the program.

Educational activities generally focus on substance use disorders and recovery, as well as on basic school subjects. Conducting educational activities with this age group can be challenging. It is a common observation among treatment providers that many adolescents suffer from learning disabilities. Staff members must be able to deal with reading and attention span problems by modifying traditional education strategies and techniques. For example, group exercises in which the clients are required to read aloud may not be very productive. An alternative is to play an audiotape while adolescents follow along in a book; another is to assign reading to a designated reader group composed of clients who enjoy reading and can read well aloud.

Testing can be done to determine the client's reading ability and to rule out learning disabilities. Testing should also include an eye exam and an evaluation for blurred vision as a side effect of medications, because poor vision can confound test results. Special reading materials should be available for clients with reading and attention span problems. Another approach is to give lectures that allow for interaction among the clients in a group. The power of the personal story can also be a powerful teaching tool, particularly when an experienced patient recounts her experiences.

Questions to consider in developing a school program include the following:

- What are reasonable academic expectations for the adolescent client? By obtaining the client's school records, staff members can gauge appropriate educational goals.
- What criteria and procedures will be used to determine whether a client has special educational needs?
- To whom should the client be referred for specialized educational testing?
- What liaisons with the client's school can be developed? Issues that can be discussed include receiving appropriate academic credit for class work taken as part of the treatment program and re−enrollment planning.
- How are the client's treatment and educational needs coordinated, and if necessary, how will these needs be coordinated with juvenile justice and child welfare systems?

It is important to emphasize that schools are mandated to identify youngsters with learning disabilities and to develop an individualized education plan for each student with disabilities. All staff members working with adolescents must be sensitive to their educational needs. Staff members should advocate for their clients' continued participation in school.

Vocational Training

Career planning−−that is, education about different career possibilities−−is an important intervention for adolescents and should be a part of a treatment program's clinical plan. For example, having people in various professions come to a program and talk about their work and their careers is often of interest to adolescent clients. Other appropriate interventions include prevocational training (e.g., a program that emphasizes coming to work on time, the appropriate etiquette for interacting with a boss or supervisor, acting in the interest of an employer when on the job) and teaching job−finding skills (e.g., how to find a job, how to prepare a r_sum_, how to speak at an interview). Without these

skills, many youths may be more likely to support themselves through illegal activities and would be more prone to relapse.

Because many outpatient programs cannot directly address the vocational needs of their clients−−often because they lack vocational training resources and specialists−−it is important to attempt to develop collaborative agreements with local vocational programs.

Treatment Planning

A treatment plan should be developed by the primary therapists or treatment team in concert with the client, family, family collaterals, and, when possible, representatives of the referring agency. Engaging both the client and family in the treatment process can promote their willingness to participate in the actual intervention. All of these parties must obey the Federal confidentiality regulations (see Chapter 8). The treatment plan should be comprehensive, specific, and objective so that progress can be measured. Naturally, the plan should address the environmental factors that may have contributed to the youth's substance use disorder and that could be a hindrance to recovery. At a minimum, a treatment plan should identify the following:

- Target problems of the client and the family, including substance use and psychosocial, medical, and possible psychiatric disorders
- Goals that help clients recognize their involvement with substances and acknowledge responsibility for the problems resulting from substance use and that take into account what the adolescent wants to accomplish
- Objectives that are realistic and measurable steps for achieving each goal
- Time frames for the achievement of the stated objectives
- Appropriate interventions, that is, treatment strategies and services that are needed to achieve the objectives
- Assessment methods for measuring the extent to which goals, objectives, and interventions are fulfilled
- Educational, legal, and external support systems

The specified treatment strategies and services should include the identification of the persons who will be providing treatment, an expected timetable for achieving the objectives, the date the treatment plan will be reviewed, and where treatment is to take place (Beck et al., 1993; Berg, 1991). The treatment plan should be subject to frequent reassessments to determine whether the client is making therapeutic progress. If progress is not being made, the client, family, therapist, and key interested players should examine whether the therapist's goals and the client's goals match.

Linkages to the Community

Treatment programs must work closely with the other entities that are involved in the treatment of adolescents. Programs whose clients are often involved in multiple agencies (especially school systems, child welfare, and juvenile justice agencies) should write interagency agreements, also called memoranda of understanding, with other involved agencies. The agreements should describe payment policies, funding problems, mutual goals for clients, and intra− and interagency contracts. Moreover, guidelines for confidentiality must be established, and discussions should focus on potential problems or key concerns for which different agencies may have different policies (such as protocols for a student who is found to be carrying drugs). In addition to interagency memoranda of understanding, it is important to have an established practice of exchanging signed releases of information from each shared client, insofar as the client is willing to agree to share information and sign releases, so that the involved staff members can more freely exchange confidential information about the client's progress and difficulties (see Chapter 8).

Program managers should encourage and support staff members' involvement in community activities, a task that often goes "above and beyond" a person's official job description or title. Outpatient programs often must rely on staff members from other community programs to complement their services or to provide staff training. Community involvement by the program staff can empower the community to address local problems such as gangs or territorial

issues.

Recovering individuals in the community can serve as valuable role models and mentors for adolescents in treatment. Adolescents particularly need adults to whom they can relate and with whom they can identify. These may be young recovering adults who have achieved or are working toward their educational goals; who are doing well in their profession or employment, perhaps owning their own business; and who have generally been able to succeed despite their history of substance use. These individuals can offer advice, assistance, and support in tasks such as preparing r_sum_s, helping with schoolwork, or selecting and applying to colleges.

Also key are networking with community services, understanding the community's reaction to the program's presence, and establishing a community advisory board. It is advisable to include recovering adolescent clients on the advisory board. Building a broad community base can enhance the program's opportunity to provide effective treatment for youth in the community. It cannot be overstated that a commitment by the program to community involvement is vital for the success of an adolescent outpatient treatment program.

Program Evaluation

In recent years, there has been modest progress in addressing the question of whether adolescents improve after substance use disorder treatment (Catalano et al., 1990−1991; Friedman et al., 1986, 1994; Hoffmann et al., 1987, 1993). Continuing assessment of program efficacy can provide valuable information on which areas of a treatment program are functioning smoothly and which areas require modification. External licensing, accreditation, and funding agencies may carry out such an evaluation, often for the purpose of monitoring compliance with Federal, State, and private agency regulations. Alternatively, evaluation may be carried out internally by staff and clients. The value of such assessment depends more on the measures used than on whether it is accomplished externally or internally.

All too frequently, program evaluation is based on the number of clients seen, the maintenance of a desired census level, or adherence to regulations or protocols without regard to outcome measures. Many programs of high quality do not document their effectiveness in terms of client retention, posttreatment functioning, and use of aftercare services, for example. Although the cost of care, efficiency in treatment, provision of categorical services, and adherence to regulations are certainly important, the true worth of a treatment program must be measured by the success of its clients.

When evaluations involve making comparisons between programs, differences among clients must be considered. For example, some programs will not accept clients with coexisting disorders and will inevitably produce better "outcomes" than programs that admit regardless of coexisting disorders.

Evaluation of success must be ongoing and must apply both to adolescent clients who complete treatment and to those who left care prior to discharge. It is the obligation of the treatment program to provide for the continuing assessment of each client's progress, although obtaining accurate information on an adolescent's maintenance of abstinence and success in other life skills may be difficult, expensive, and time consuming. Such difficulties are pervasive within the field of substance use disorder treatment and remain an obstacle to assessing the efficacy of a specific program and to comparing the effectiveness of different treatment approaches. Nevertheless, each program has an obligation to monitor progress of the client during treatment and attempt to characterize the long−term success or failure of adolescents discharged from its care. The knowledge gained through these processes should be used to refine the treatment program. Monitoring the adolescent's progress during treatment typically includes receiving feedback from members of the treatment team, obtaining reports directly from the adolescent, and getting reports and feedback from family, school, and employers. Some evaluations include use of urinalysis and Breathalyzer_ results to provide a validity check against self−reports. For a complete discussion of the measurement of posttreatment outcomes, readers should refer to TIP 14, *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment*

(CSAT, 1995a).

Chapter 4 −− Twelve−Step−Based Programs

In the United States, many public and private substance use disorder treatment programs, including those for adolescents, subscribe to the 12−Step−based approach organized around the philosophy of Alcoholics Anonymous (AA) (Bukstein, 1994; Institute of Medicine [IOM], 1990). AA is an organization that began as a fellowship devoted to helping those who wish to stop drinking. From its original two members in 1935−−Bill W., a stockbroker, and Dr. Bob, a surgeon−−it has become an international organization consisting of more than 73,000 groups worldwide, with an estimated membership in the United States and Canada of approximately 800,000 (IOM, 1990). Certainly, any discussion of contemporary treatments for adolescents with substance use disorders must include a review of 12−Step models because of their great influence on substance use disorder treatment.

Interestingly, there is a notable lack of research on 12−Step−based programs, which have for nearly three decades been the most prevalent model of treatment (Bukstein, 1994). Yet family−based models, which are relatively new, have been impressively evaluated with controlled studies (see Chapters 5 and 6). This is partly because most 12−Step−based programs do not have a research tradition due to their emphasis on preserving the anonymity of their members.

Although AA does not view itself as a treatment modality (Laundergan, 1982), it plays a prominent role in the design and implementation of 12−Step−based programs in two important ways: (1) It fosters relationships with the local treatment facilities, and (2) its philosophy, methods, and materials are formally integrated into the treatment activities (Gallant, 1988). Practically speaking, some 12−Step−based treatment programs are headed by private physicians or affiliated with a hospital, whereas others, often led by mental health professionals, are "self−standing." Although generally characterized as aftercare, 12−Step−based programs are sufficient treatment for millions of people, young and old, around the world.

The 12 Steps

The 12 Steps were written in 1938 by the founders of the fledgling AA and originally appeared in what is known to legions of recovering adults as the Big Book (AA, 1976). In AA, sobriety is maintained by carefully applying this 12−Step philosophy and by sharing experiences with others who have suffered similar problems. Many clients who are involved with AA find another AA member who will serve as a sponsor and provide guidance and help in times of crisis when the return to substance use becomes overwhelming. This sharing and group support approach has spawned a number of self−help programs, such as Al−Anon (for families and friends of the alcoholic) and Narcotics Anonymous (NA) (for persons addicted to substances other than or in addition to alcohol). Learning and practicing the 12 Steps, which are listed below, is the main focus of AA and NA. NA programs change some wording in the first and last steps to make them appropriate to users of illicit drugs and other substances; these appear in parentheses.

1. We admitted we were powerless over alcohol (our addiction)−−that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God as we understood Him.
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take a personal inventory and when we were wrong promptly admitted it.

11. We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics (addicts) and to practice these principles in all our affairs.

Treatment effectiveness is believed to be maximized the more a client is able to personalize the concepts expressed by the steps into her own life.

From AA to the Minnesota Model

Different ways of incorporating the 12 Steps into treatment have evolved over the years. A major adaptation of the model initially developed at Willmar State Hospital in Minnesota has become known as the Minnesota model. By the 1980s, it was the linchpin of almost all programs treating alcoholic and other substance−dependent patients. The goals of the Minnesota model include moving away from the simple custodial care of alcoholics, clarifying the distinction between detoxification and treatment, and identifying a variety of elements of care within one program. The continuum of care components generally includes a diagnostic and referral center, a primary residential rehabilitation program, an extended care program, residential intermediate care (e.g., halfway houses), outpatient care (diagnostic, primary, and extended), aftercare, and a family program.

The Hazelden Foundation further modified this model of care, which preceded enrollment in a primary care program with several days of detoxification in a separate facility. The Minnesota model tried to develop an environment of recovery in a setting removed from daily life, often in the country, for a few months.

The approach that evolved was highly structured and included detoxification, psychological evaluation, general and individualized treatment tracks, group meetings, lectures, and counseling, as well as referral to medical, psychiatric, and social services, as needed. Group counseling was considered the main therapeutic technique. Emphasis was on using older, more advanced residents to share experiences and to pass on knowledge and values to patients. The 12 Steps were carefully studied, and AA meetings were held within the treatment framework. The primary care program was intended to last up to 60 days in a residential setting in the hope that a caring and low−stress environment removed from traditional daily life would facilitate the recovery process.

In the early 1960s, Hazelden developed a 21−day version; insurance companies then set 28 days as a reimbursement guideline in order to ensure sufficient coverage. This abbreviated version viewed intensive treatment as a multidisciplinary endeavor, in which the physician, nurse, psychiatrist, psychologist, counselor, and administrators were involved in a hospital setting. Rehabilitation was provided after intensive treatment by nonmedical staff and coordinated by the counselor. Participation in AA for patients and in Al−Anon for family members got started during treatment and ideally continued for 2 years after treatment. More specifically, treatment components included

- Strong AA orientation
- Skilled alcoholism counselors as primary therapists
- Psychological testing and psychosocial evaluation
- Medical and psychiatric support for coexisting disorders
- Therapists trained in systematized methods of treatment including Gestalt, psychodrama, reality therapy, transactional analysis, behavior therapy, activity therapy, and stress management
- Use of therapeutic milieu and crisis intervention
- Systems therapy, especially with employers, and later including a family component
- Family− and peer−oriented aftercare (Stuckey and Harrison, 1982)

For many years, some in the treatment field considered the Minnesota model the only "workable" method of treatment for substance use disorders. Then, as the nation's attention in the 1970s and 1980s focused on the use of illicit drugs

(e.g., cocaine), three trends in service delivery occurred. First, treatment programs expanded their curriculum to address substances other than alcohol. Second, new programs were developed that specifically addressed individuals with nonalcohol substance use disorders. Third, both types of programs eventually discovered that alcoholism and substance use disorders overlapped, and thus most programs oriented themselves to the treatment of both.

As the years passed, additional types of treatment approaches emerged, including social model programs and programs based in psychology, such as family−based therapy in its many forms. Parts of the 12−Step−based approach were incorporated into these treatment programs. Since the advent of managed care, outpatient programs of all approaches are becoming the norm. Residential programs within the public or private sector have become less common and often have diminished lengths of stay. Those that remain are often located within institutions, such as correctional institutions or hospital−based psychiatric units.

Incorporating the 12−Step−Based Approach

Although the Big Book contains stories of the drinking experiences and recovery of middle−aged adult alcoholics living in a very different time from today, its principles are relevant to adolescents (Winters and Schiks, 1989). Providers treating adolescents in a 12−Step−based program should bear the following in mind:

- Substance use disorders are primary, multifaceted illnesses that exist in people of all ages, including adolescents.
- Persons with substance use disorders are individuals with unique and separate needs who share a common problem and therefore should be treated with respect and dignity.
- Once substance−abusing and substance−dependent adolescents are given information about their disorder(s) in an understandable way, they are capable of helping others, as long as they receive some guidance.
- Use of group therapy is well suited to adolescents, who tend to rely heavily on peer examples and approval. Thus, mutual sharing in a peer group setting is vital to the rehabilitation process.
- The principles of recovery outlined by AA provide effective and proactive tools for continuing one's recovery from drug involvement.
- Once a person has lost control over his use of substances as an adolescent, returning to *responsible* and *legal* use as an adult may require additional help and support.

12−Step Principles in Treatment

Most 12−Step−based programs concentrate on the first five steps during primary treatment, whereas the remaining ones are attended to during aftercare. Below are ways to present the first five steps to adolescents so that their specialized developmental needs can be addressed (Winters and Schiks, 1989).

- *Step 1: We admitted we were powerless over alcohol−−that our lives had become unmanageable.* With adolescents, the primary goal of this step is to assist them in reviewing their substance use history and to have them associate it with harmful consequences. It helps them understand their need for support in not using.
- *Step 2: We came to believe that a Power greater than ourselves could restore us to sanity.* At a practical level, this step can be simplified to "There is hope if you let yourself be helped." A powerful way to convey this message involves allowing new clients to interact with those who have been successful and are leaving the program. The "goodbye" or graduation ritual for successful clients helps to instill hope in others. Providers must help adolescents with coexisting mental disorders or cognitive disabilities to understand that Step 2 refers to obtaining help to stop substance seeking and use and not "curing" their mental disorder. Providers should also spell out that depression or anhedonia after abstinence is common and can get better.
- *Step 3: We made a decision to turn our will and our lives over to the care of God as we understood Him.* This step can be simplified as well: "Try making decisions in a different way; take others' suggestions; permit others to help you." Using the phrase "Helping Power" instead of "Higher Power" can benefit some.

- *Step 4: We made a searching and fearless moral inventory of ourselves; Step 5: We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.* Steps 4 and 5 provide an opportunity to be accepted by another person in spite of one's past behaviors and to take a "personal inventory" of those past behaviors. These steps enable clients to put some of their past unpleasant substance use experiences behind them.

Some other aspects of the 12−Step model may also have to be modified for adolescents. For example, the tenet that newly abstinent members should have no major life changes for 1 year in order to concentrate solely on their recovery may be difficult for adolescents to internalize. A year has a different meaning in their world, and many changes are an inevitable aspect of adolescence. An advantage of using a 12−Step−based program and having a sponsor is that help is available 24 hours a day, not only when the staff is on duty. It is an empowering idea to know that help is "only a phone call away."

Obviously, an important goal of 12−Step−based programs is to build an affinity between the client and AA meetings. The goal is to teach the young client that continuing participation in these group meetings after treatment is important to his recovery. Young people are increasingly joining AA and NA groups; in some cities, regular AA and NA meetings exist that are attended by teenagers and young adults and that are supervised by an appropriate adult. This continuing support network is believed to be invaluable to the ongoing recovery process.

Individual Treatment Planning

All teenagers in treatment have some problems in common, and these can be addressed in groups. Clearly, group work is a hallmark of 12−Step−based treatment. However, many needs of individuals in this age group are best addressed in one−on−one or other specifically planned interventions in individualized treatment plans. For example, in 12−Step−based programs, such individualized planning often revolves around work on one or more of the steps, and many 12−Step plans address life problems and how the concepts of AA can be used as problem−solving strategies. Also, given that family is a core treatment component, it is common for the client's specialized plan to address family issues such as substance use norms in the family, familial abuse, and sibling relationships.

It is also common for individualized treatment plans to address the teenager's social anxiety. For example, patients with difficulty speaking in a group setting should meet with a counselor and work on strategies to address the source of the problem. The counselor and the client can discuss ways of setting ground rules with peers who use substances when social circumstances arise in the future. Also, some clients will want to discuss how to best develop a future relationship with an appropriate sponsor.

Research Studies

In recent years, there has been modest progress in addressing the question of whether adolescents improve after treatment of substance use disorders (e.g., Catalano et al., 1990−1991; Friedman et al., 1986, 1994; Hoffmann et al., 1987, 1993). It is perhaps ironic that the widely used Minnesota model approach has received relatively minimal research attention. When large−scale studies have been conducted, they have suffered from poor followup contact rates and usually do not include comparison groups. Hazelden's Youth and Family Center in Minnesota conducted a treatment outcome study of 480 clients who completed treatment in the mid−1980s. However, only 53 percent of the sample were contacted at 1 year after treatment. Almost half (46 percent) of those contacted reported no use of alcohol, and over two−thirds (68 percent) indicated no use of other substances during the followup period (Keskinen, 1986).

Harrison and Hoffmann reported outcome results from several residential treatment programs, many of which were based on the Minnesota model (Harrison and Hoffman, 1989). Data from 924 adolescents (49 percent of the eligible followup sample) were collected; 42 percent reported total abstinence during the followup period, and another 23

percent had used substances less than monthly. There are smaller scale evaluations of 12−Step−based programs that have better followup rates (e.g., Alford et al., 1991; Brown et al., 1989; Knapp et al., 1991; Richter et al., 1991); these studies report abstinence rates in the range of about 50 to 60 percent.

In a recent evaluation of a 12−Step−based approach, some of the methodological weaknesses of previous studies were addressed, namely, a high contact rate at followup was achieved and meaningful comparison groups were included (residential vs. outpatient, and no treatment vs. treatment) (Winters et al., in press). Six− and 12−month substance use outcomes were measured among 245 drug clinic−referred adolescents, 179 of whom received complete or incomplete treatment and 66 of whom were deemed to need treatment but did not receive any. The intent−to−treat adolescents showed significant reductions in substance use frequency when preintake levels were compared with followup levels. Fifty−three percent of them reported either abstinence or minor lapses (substance use only once or twice) during the 6 months following treatment, while 44 percent reported this status for the full year following treatment. Absolute and relative outcome measures indicated that completing treatment was associated with far superior outcomes when compared with those who did not complete treatment or received no treatment at all. The percentage of those completing treatment who reported either abstinence or minor relapses for the 12 months following treatment was 53 percent, compared with 15 percent and 27 percent for those who did not complete treatment or who did not receive treatment, respectively. There were no outcome differences between residential and outpatient groups, yet females tended to report better outcomes compared with males. Among the intent−to−treat subjects who relapsed, alcohol was the most commonly used substance during the followup period, despite marijuana being the preferred substance at intake. Until more rigorous research designs are applied, the most conclusive statements that can be made about the effectiveness of the 12−Step−based approach for adolescents is that many youths are improved after receiving this form of care. Although some preliminary data indicate that the 12−Step−based method yields outcomes that are superior to no treatment at all, there is a great need for controlled studies in this field.

Chapter 5 −− Therapeutic Communities

The therapeutic community (TC) is an intensive and comprehensive treatment model developed for use with adults that has been modified successfully to treat adolescents with substance use disorders. TCs for the treatment of addiction originated in 1958, a time when other systems of therapy, such as psychiatry and general medicine, were not successful in treating alcohol or substance use disorders. The first TC for substance users (Synanon) was founded in California by Chuck Dederich, one of the earliest members of Alcoholics Anonymous (AA), who wanted to provide a controlled (substance−free) environment in which alcohol and substance users could rebuild their lives, using the principles of AA along with a social learning model (De Leon, 1995a).

The core goal of TCs has always been to promote a more holistic lifestyle and to identify areas for change such as negative personal behaviors−−social, psychological, and emotional−−that can lead to substance use. Residents make these changes by learning from fellow residents, staff members, and other figures of authority. In the earliest TCs, punishments, contracts, and extreme peer pressure were commonly used. Partly because of these methods, TCs had difficulty winning acceptance by professional communities. They are now an accepted modality in the mainstream treatment community. The use of punishments, contracts, and similar tools have been greatly modified, although peer pressure has remained an integral and important therapeutic technique.

Originally, the large majority of residents served by TCs were male heroin addicts who entered 18− to 24−month residential programs. By the mid−1970s, a more diverse clientele was entering treatment; 45 percent used heroin alone or in combination with other substances, and most were primarily involved with a range of substances other than heroin, such as amphetamines, marijuana, PCP, sedatives, and hallucinogens. By the 1980s, the large majority of those entering treatment in TCs had primarily crack or cocaine problems. The percentage of women entering treatment grew, and they presented with different problems, including extremely dysfunctional lives and more psychopathology. Although several adolescent TCs have been in operation since the late 1960s, increasing numbers of younger people sought treatment during the 1980s, and many previously all−adult communities began admitting adolescents. With the

inclusion of youths in these adult TCs, education and family services were added as important program components.

The TC model has been modified over time to include a variety of additional services not provided in the early years, including various types of medical and mental health services, family therapy and education, and educational and vocational services. In the beginning, nearly all staff members were paraprofessionals recovering from addiction; over the years, increasing numbers and types of professionally trained specialists have been employed by TCs and are now serving in staff or consultant positions.

The Generic TC Model

As a social−psychological form of treatment for addictions and related problems, the TC has been typically used in the United States to treat youth with the severest problems and for whom long−term care is indicated. TCs have two unique characteristics:

- The use of the community itself as therapist and teacher in the treatment process
- A highly structured, well−defined, and continuous process of self−reliant program operation

The community includes the social environment, peers, and staff role models. Treatment is guided by the *substance use disorder*, *the person*, *recovery*, and *right living* (De Leon 1995a).

Right living emphasizes living in the present, with explicit values that guide individuals in relating to themselves, peers, significant others, and the larger society. *Recovery* is seen as changing negative patterns of behavior, thinking, and feeling that predispose one to substance use and developing a responsible substance−free lifestyle. It is a developmental process in which residents develop the motivation and know−how to change their behavior through self−help, mutual self−help, and social learning.

The theoretical framework for the TC model considers substance use a symptom of much broader problems and, in a residential setting, uses a holistic treatment approach that has an impact on every aspect of a resident's life. Residents are distinguished along dimensions of psychological dysfunction and social deficits. The community provides *habilitation*, in which some TC residents develop socially productive lifestyles for the first time in their lives, and *rehabilitation*, in which other residents are helped to return to a previously known and practiced or rejected healthy lifestyle (De Leon, 1994). A primary distinction between the TC approach and 12−Step−based programs is the belief that the individual is responsible both for his addiction and for his recovery. Where AA says "let go, let God," TCs take the view that "you got yourself here, now you have to get yourself out with the help of others."

Traditionally in the TC, job functions, chores, and other facility management responsibilities that help maintain the daily operations of the TC have been used as a vehicle for teaching self−development. Remaining physically separated from external influences strengthens the sense of community that is integral to the residential setting. Activities are performed collectively, except for individual counseling. Peers are role models, and staff members are rational authorities, facilitators, and guides in the self−help method. The day is highly structured, with time allocated for chores and other responsibilities, group activities, seminars, meals, and formal and informal interaction with peers and staff members. The use of the community as therapist and teacher results in multiple interventions that occur in all these activities.

Treatment is ordinarily provided within a 24−hour, 7−days−per−week highly structured plan of activities and responsibilities. Although recommended treatment tenures have generally shortened in recent years, averaging around 1 year, they may last as long as 18 months. The full−time approach is part of the ecological point of view held by proponents and leaders of TCs. The program is conducted in three stages: induction, primary treatment, and preparation for separation from the TC (De Leon, 1994).

Like many other substance use disorder treatment providers in today's health care market, TC personnel are committed to providing services to residents in shorter periods of time and with decreased resources than was the case in previous years. Modifications of the traditional residential model and its adaptation for special populations and settings are redefining the TC modality within mainstream and mental health services. Two new strategies have recently been suggested: focusing goals on moving the resident to the next stage of recovery in another, less expensive setting, or expanding aftercare opportunities in residential and day treatment programs following TC treatment (De Leon 1995a, 1995b; Rosenthal et al., 1971).

Adolescents in TCs

Jainchill and others have pointed out that only recently has cross−site information describing adolescents who enter TCs been compiled (Jainchill, 1997). One exception was the Drug Abuse Reporting Program (DARP), which in the 1960s and 1970s found that almost one−third of the TC sample was younger than 20 years old. (DARP was the nation's first comprehensive multimodality study of the treatment industry.) Those teenage TC residents typically were white males who used opioids (Rush, 1979). Data are sparse after the 1970s. However, new data reveal that adolescents make up 20 to 25 percent of the residents in TCs. Some 80,000 clients were admitted to TCs in 1994 (De Leon, 1995b).

Resident Characteristics

Adolescents who enter TCs tend to have serious substance use and behavioral problems that render them dysfunctional in many arenas (Jainchill, 1997). Common problems are truancy, conduct disorders, poor school performance, attention deficit/hyperactivity disorder (AD/HD), learning disabilities, and problems relating to authority figures. In terms of substance use history, adolescents entering TCs have begun substance use at an earlier age and have greater involvement with alcohol and marijuana and less use of opiates compared with adults.

A majority of youths in TCs have been referred by the juvenile justice system, family court, or child welfare (social service) systems and reflect an early involvement with illegal activities and family dysfunction. Conduct disorders and juvenile delinquency are common. In fact, some TCs are operated by criminal justice institutions, such as correctional agencies, and may be structured as minimum−security correctional facilities.

Less frequently, adolescents enter the TC under parental pressure. Thus, extrinsic pressures are usually required to coerce the adolescent into treatment and to keep her there. It is not uncommon for such residents to have little motivation to change their behavior.

Most adolescent residents are males mandated by the court, and problems of social deviance are commonplace. Because adolescent females commit fewer crimes and less violent ones than do adolescent males (Jainchill et al., 1995), they are not often mandated to a TC, although they may be brought to treatment by a family court. However, even those adolescent females with the same range and type of problems as the males generally do not enter TCs. One of the questions facing the TC movement is how to create and conduct effective outreach for adolescent females who need treatment. Very often, when females do enter TCs, their problems are found to be more severe than the problems of most of the males. When females are enrolled in the TC, sleeping quarters are separate but activities are very often coed (Jainchill et al., 1995).

Both adults and adolescents in TCs share many problems. There is little difference between the social histories of adult and adolescent users in residential treatment concerning onset and pattern of substance use, academic performance, and juvenile delinquency (De Leon, 1988).

TCs With Adolescents

A core feature of TC treatment for adults and adolescents alike is that the community serves as the primary therapist−−treatment is a community process, and it is not possible to identify a single individual as therapist. Although adolescents often have a primary counselor with whom they work individually, everyone in the community, including the adolescents themselves, has responsibility as a therapist and teacher. Peer−group meetings led by an adolescent with a staff facilitator are common.

The community's role is critical to the client's habilitation and rehabilitation. For the adolescent, the community may be even more crucial than for adults because the TC functions as the family. This is a significant function because many youths in TCs come from dysfunctional families. Being a member of the TC community gives them an opportunity to experience and learn how to have and maintain positive relationships with authorities, parents, siblings, and peers. Nearly all activities, even housekeeping responsibilities, are considered part of the therapeutic process. It is precisely because adolescent residents usually come from environments without structure, routine, rules, or regulations that the TC is ideally suited to providing their treatment.

Modifications that are generally made in the TC model for treatment of adolescents are summarized as follows:

- The duration of stay is shorter than for adults.
- Treatment stages reflect progress along behavioral, emotional, and developmental dimensions.
- Adolescent programs are generally less confrontational than adult programs.
- Adolescents have less say in the management of the program.
- Staff members provide more supervision and evaluation than they do in adult programs.
- Neurological impairments, particularly learning disabilities and related disorders (e.g., AD/HD), are assessed.
- There is less emphasis on work and more emphasis on education, including actual schoolwork, in the adolescent program.
- Family involvement is enhanced and ideally should be staged, beginning with orientation and education, then moving to support groups, therapy groups, and therapy with the adolescent. When parental support is nonexistent, probation officers, social workers, or other supportive adults in the youth's life can participate in therapy.

Additional modifications are made depending on the specific needs of the program's referral and funding sources (Rockholz, 1989). For example, some programs primarily serve protective services cases (e.g., abuse and neglect, homelessness) involving adolescents who often present with psychiatric needs that require medication. Others serve juvenile and criminal justice system−involved youths with behavioral disorders, who require anger management programming and who respond better to more traditional confrontation techniques. Still others operate college preparatory TCs, without the use of psychotropic medications, for emotionally troubled, upper−middle class youths.

Duration of Stay

In the past, TCs for adolescents were entirely residential programs lasting 18 months to 2 years−−the time required for behavior change to be internalized and practiced by the adolescent. The conservative funding policies that typify the 1990s have introduced complex issues for residential TCs because success in treatment is correlated positively with extended stay in the program. As with so many other issues in substance use disorder treatment today, final decisions often have to be based more on financial considerations than on therapeutic need, with the result that most programs can plan only for a course of treatment that lasts 6 to 12 months. A few programs are attempting to provide TC treatment in 6 months; this is a radical move. Clinical wisdom suggests that the ideal duration of treatment for adolescents in a TC is 12 to 18 months and that adolescents with very deep and complicated disorders cannot be treated effectively in 28 days. However, no research is available to compare treatment success in 28−day programs with treatment in the longer stay programs.

Staffing

Originally, only persons in recovery staffed TCs, and TC directors and staff were opposed to therapy by psychologists, psychiatrists, and other mental health personnel such as social workers or family counselors. TCs are now integrating the services of professionals with training in some area of mental health, and there is recognition that individual counseling can complement the group approach, which was the mainstay of treatment during the first two decades of TCs.

TC staffs today are a mixture of nondegreed frontline counselors and degreed professionals. The counselors who do not have degrees typically facilitate the daily TC activities and serve as role models for successful recovery; the degreed staff includes vocational counselors, nurses, psychologists, social workers, and substance abuse counselors.

Having an on−site nursing staff is important to monitor medications, provide health education, and provide cross−training for the counselors, particularly regarding the symptomatology of addiction. Teachers in a TC program for adolescents must understand substance use disorders among youths from disadvantaged families with severe dysfunction. Cross−training for the teachers is also important. It is essential that the counselor meet at least weekly with the teacher(s) to integrate schooling into the program. Psychiatrists are often involved because of the common presence of disorders such as depression or AD/HD. Pharmacological agents for coexisting disorders are now permitted and are used widely by some TCs serving adolescents with coexisting mental disorders.

Depending on the size and staffing of the TC, there will be some combination of administrative, legal, dietary, and maintenance staff. The people in these categories are often considered integral to the clinical process. For example, office personnel may actually have some clinical input in terms of hands−on management of a resident who has a job function under their supervision. It is essential that all employees who have any direct or indirect dealings with residents receive training that gives them a thorough understanding of the TC concept and its bearing on their specific duties.

Protocol

Most programs are designed so residents can progress through phases as they advance through treatment. Tied to the phases are increased responsibilities and privileges. One cannot advance to the next higher level until he demonstrates responsibility, self−awareness, and consideration for others (De Leon, 1995a). By moving through these structured phases, the adolescent acquires and benefits from psychological and social learning before proceeding to the next stage. Each stage prepares the resident for the next. After becoming a responsible member of the treatment community, the adolescent can move on to the outside community. In adult TCs, residents advance through developmental stages to a level of authority in which they become responsible for the TC's operation. However, this is not appropriate for adolescents, for whom the staff plays the role of effective parents.

Creating a Safe Environment

Part of the ecological approach to treatment in the TC is the creation of a safe and nurturing environment, within which adolescents can begin to experience healthy living. It is important for the staff of the TC to understand what type of home, neighborhood, and social environment from which each adolescent comes. Many adolescents enrolled in the TC come from unsafe physical and psychological environments; the characteristics of the home and neighborhood do not facilitate healthy living, and many risk factors may be environmental. For example, many of these adolescents are third−generation substance users who have grown up in an environment where substance use is an everyday activity. Often, physical or psychological violence accompanies the addictive practices, and children and adolescents may be physically and psychologically damaged.

Essential to creating a safe environment is the TC's strict adherence to "cardinal rules" that, at a minimum, prohibit substance use or possession, physical threats or violence, or sexual contact. It is also essential that the environment be psychologically safe by ensuring, for example, that adolescents are not verbally attacked and that they feel comfortable enough to disclose even the most sensitive of events (and associated feelings), such as sexual abuse.

Groups in the TC for Adolescents

Various types of counseling groups are provided in the TC. Groups constitute an important therapeutic technique, as they have since the earliest TCs were established. Typically, everyone attends at least one group session a day.

Today's TCs generally do not use the grueling encounter groups and all−night "marathons" of their earlier counterparts, but modified encounter groups still are common. Some programs have begun to move away from encounter groups and have included 12−Step work, as in the 12−Step model of treatment. Techniques such as confrontation, designed to help adolescents recognize and acknowledge their feelings and learn to accept personal and social responsibility, can be counterproductive by raising clients' defensiveness. Group meetings at advanced stages of the program are composed of peers, whereas other groups for adolescents are led by qualified counselors or therapists. Many of the TC programs for adolescents use a cognitive restructuring approach to change adolescents' thinking and to redirect the focus of their attention to healthier behavior.

There are various types of groups that deal with physical and sexual abuse, although it is very difficult to get adolescents to acknowledge that they have experienced abuse. Skill groups also exist in adolescent TCs to enhance existing skills or build new ones.

Education

Enabling residents to receive a good education and at least complete high school are critical goals for adolescent TCs. Comprehensive TCs provide their own schools, licensed as required, with full−time, salaried, or local educational agency−provided teachers. Others have a teacher who comes in part time to conduct classes. All teachers must be State−certified to provide special education or education in their specific subject area. Residents must receive a minimum of 5 hours of academic instruction per school day. It is critical that educational services be fully integrated into the TC program and that they be consistent with the TC process. Teaching staff should be active in the treatment planning process, and behavioral management programming should be integrated into the "house" procedures.

Because schooling replaces most of the work responsibilities common in adult TCs, the adolescent's workload is not as heavy as that of the adult. Each resident has assigned job responsibilities in the evening and on weekends, such as preparing dinner, washing dishes, mopping, dusting−−the important tedium of sober life. After dinner, there is study time and a group meeting. Lights−out is monitored at a specific time, such as 10:30 p.m.

Recreation

Recreational activities are important for teenagers in TCs who need help in learning to enjoy themselves and others without using substances. These activities help overcome boredom, a key problem with adolescents. Physical activities, such as outdoor sports, are necessary but difficult to provide in winter, particularly in programs that are housed in a limited amount of space. Some TCs have incorporated relationships with local public facilities or programs such as Outward Bound.

Aftercare

During the first two decades of the TC, residents spent 18 to 24 months in treatment and were essentially considered to be "cured" and not in need of formal aftercare services. As the average length of stay decreased, however, it became

necessary to return adolescents to their families or independent living situations with continuing treatment needs. Others required halfway houses, which were, and continue to be, scarce. In most cases today, adolescents are referred to outpatient programs, especially for continued family therapy. Some are served through alumni or other affiliated aftercare resources of TC agencies. Although Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are minimally included in many adolescent and adult TCs, most programs have experienced significant improvements in treatment outcomes when they introduce residents to AA/NA during the reentry phase of treatment and strongly encourage them to use these 12−Step programs as valuable and effective aftercare supports. Evaluative work documenting significant reductions in recidivism, substance use, and antisocial behavior through the use of dedicated TC residents in the community for aftercare is just beginning to emerge, primarily from researchers dealing with adult prison populations (Inciardi et al., 1997). Ideally, sophisticated satellite aftercare programs should be provided in the communities where the residents live. For adolescents, aftercare programs should include a family therapy component.

Involvement of the Adolescent's Family

In the early days of the adolescent TC, families were often viewed as the cause of the adolescent's problems and were kept away from the adolescent. Families were usually only involved with occasional parent support groups or Al−Anon and thus were kept away from their children. For cases in which the adolescent planned to return home, parents were usually brought in for a conference or two shortly before the adolescent left residence in the TC. In many cases, adolescents were older and tended to move out to independent living in the community near the TC program−−often with little or no family counseling.

Today, TCs often provide comprehensive family services programs, including such components as family assessments, family counseling and therapy including multifamily groups, parent support groups, and family education programs. Some TCs have well−established parent groups that provide program fundraising and scholarship assistance initiatives. Regular visitation remains limited in most TCs to weekly or monthly open houses and special events such as graduations.

The issues of accessibility and limited family supports are challenging to TCs, especially when they are located away from families. Many families lack the transportation or interest to be involved in regular family programming. In some cases, adolescents have no living parents or have a parent who is incarcerated. In cases such as these, teleconferencing and family counseling with the individual are necessary alternatives. Some programs develop agreements with other service providers where the family resides. These programs can help with parenting skills training and can provide support and guidance on how to help the youth maintain his recovery. The TC tends to provide a surrogate extended family for residents, which can provide a corrective experience resulting in more positive self−identity. Ideally, staff members and the community as a whole provide effective reparenting through a balance of discipline without punishment or shaming, along with love and concern without enabling.

Related to this is the issue of rural programs versus urban programs that are located closer to the homes of TC residents. Proponents of city programs argue that it is unfair to take adolescents away from their families for the duration of treatment. On the other hand, if the family is really dysfunctional, it is better to keep adolescents away from their family. Locating the adolescent in a rural area away from the environment in which she was involved with substances and away from her peers in that environment may strengthen the adolescent's resistance upon return to that environment. There is disagreement on this matter, however; some authorities believe there is no value in moving the adolescent to a rural area. Others take a middle ground by placing the adolescent in a rural TC initially and then returning the youth to treatment in her original environment.

Special Issues of the Adolescent TC Resident

TC staff members must be prepared to deal with many special issues of adolescents that will come to the fore in the treatment process. Three are particularly common and important: self−image, guilt, and sexuality (De Leon, 1988;

Jainchill, 1997).

Self−image

Adolescents are struggling to develop an identity, which is a critical and sometimes difficult task, even for those leading ordinary lives without the types of problems experienced by an adolescent in the TC. They often select images they want to assume, body postures, and an affected manner of speaking that may be inappropriate. Their images may be embedded in street culture and gang affiliation. Staff members can work with them and help them see how a healthy identity develops and is maintained; they are in a position to help the adolescent avoid the acquisition of a negative self−image that can be destructive. Once this stage of understanding has been reached, staff members can help adolescents develop self−monitoring methods to assess their own images as well as images of others and to suggest changes in behaviors, dress, speech, or even posture, when appropriate.

Guilt

Many experienced TC professionals view guilt as the fundamental feeling associated with self−defeating behavior, including substance use and acting out against others (such as by stealing). They frequently say to adolescents, "Guilt kills," which expresses their understanding that negative behavior produces guilt, which in turn, results in more negative behavior to escape guilty feelings. Adolescents can benefit from help with self−guilt (e.g., how their actions have hurt other people) and community guilt (e.g., breaking house rules or not confronting negative behavior and attitudes of other residents).

TC staff members regularly address guilt in encounter groups, seminars, counseling, and even in special guilt sessions, in which confession is the first step in counteracting the feeling of guilt. While it is necessary to disclose the act itself, the root issue in these sessions is the concealment of that act, which the adolescent must confess. Discussion of guilt is valuable for all adolescents, whether they are undergoing group, community, or individual therapy (DeLeon, 1995a). It is of critical importance that the residents understand the relationship between guilt and self−destructive behavior. Recognition and acceptance of the pain associated with guilt is the first step to an experiential basis for new social learning. Finally, it is hoped that the resident will understand that acknowledging past misdeeds can be a springboard for commitment to a changed future.

Sexuality

Sexuality, social behavior, and personal identity are interrelated in all human beings, but problems in these areas are intensified during adolescence. Staff members will encounter problems related to sexual feelings, sex roles, values, attitudes, and interpersonal relationships between the sexes. Some residents may be trying to cope with feelings related to sexual abuse. The adolescent must learn to manage strong sexual impulses. Sexual adjustment of adolescents with substance use disorders is complicated by other problems such as the lack of sex education at home or school or having poor role models. Altogether, there is a risk that the adolescent will develop distortions in attitude, values, and self−perceptions regarding sex.

TC professionals can best deal with these problems through management and rules (e.g., rules against sexual contact) and through providing sex education in seminars as well as dealing with sexual issues during encounter groups, one−on−one counseling, and special sessions that are focused on problem solving. Boys' and girls' living spaces should be separated. The longer term stay and increased contact make TCs a good environment for counseling and education on HIV infection, AIDS, and safe sex; the TC can make a real contribution to the young person's life by helping her understand and practice safe sex.

Research Studies

There is no consensus definition of successful treatment outcomes for adolescent TC programs. Some TCs believe they have been successful if, after treatment, the adolescent uses only marijuana. Others measure treatment success by reductions in the amount of substance use and in criminal and delinquent behavior. For some, the standard of abstinence from all substances and complete cessation of all delinquent behavior following treatment is the ultimate goal. Still others have looked at indicators such as improvements in the adolescent's self−esteem, quality of relationships with others, and improvement in academic performance and attendance (Rockholz, 1978).

Data on the TC approach to adolescent care come from recent reviews of the literature (e.g., Jainchill et al., 1995; Pompi, 1994) and current adolescent studies by Jainchill and associates at the Center for Therapeutic Community Research (CTCR) (Jainchill, in press). Other sources of information are earlier multimodality studies involving adolescents in TCs, funded by the National Institute on Drug Abuse (Hubbard et al., 1989) and large multiprogram studies of TC programs in Therapeutic Communities of America (De Leon, 1985).

Using data from these sources, it is possible to hypothesize that retention rates and post−treatment outcomes are similar to those among adults, with adolescents showing positive changes in the use of cocaine, opiates, and methamphetamine and reductions in criminal activity. The majority of adolescents admitted to TCs who drop out do so within the first 30 days. Dropout rates diminish after that time. Retention rates vary considerably among programs. The highest retention rates are found among adolescents who are legally mandated to treatment, probably because fulfilling the court requirement supports the adolescent while he undergoes compliance, which lays the groundwork for the retraining stages that occur in later therapy. Thus, a legal mandate can be a valuable tool in increasing adherence to and efficacy of treatment (De Leon, 1995b).

There has been a long−held clinical impression that younger clients are less motivated than adults to be in treatment, and this impression has recently been confirmed by empirical data from CTCR, although younger clients are likely to remain in treatment longer if they are highly motivated to be there. If motivation and readiness can be assessed at intake, treatment providers may be able to identify those youths who are at high risk for dropping out. Such information could guide the development of intervention strategies to enhance motivation and retention in treatment.

Outcome Studies

The relatively few studies that have reported on the effectiveness of long−term residential treatment indicate that residential treatment is generally more effective than outpatient modalities, that a client's length of stay in treatment is a critical factor, and that adolescents require a longer treatment tenure than adults (e.g., De Leon, 1985; Hubbard et al., 1985; Sells and Simpson, 1979). Among these studies the most consistent improvements were seen on measures of criminal involvement with marijuana, and there has been a notable lack of marijuana−specific treatment studies.

Jainchill and colleagues recently completed a 1−year posttreatment followup study of adolescents who were in residential therapeutic communities (Jainchill et al., in preparation). The majority (46 percent) indicated that marijuana was their primary drug of abuse. Followup interviews were completed on 485 adolescents of whom 31 percent graduated or completed the residential phase of treatment, 52 percent dropped out, and the remainder were terminated for a variety of other reasons. There were significant reductions in substance use, both in the percentage of adolescents reporting use of specific substances and in the extent or frequency of use. Those who completed treatment showed more positive outcomes than those who did not complete treatment. There were similar improvements obtained in the level of criminal activity. For both those who completed treatment and those who did not complete treatment, there were significant reductions in all areas of criminal activity (e.g., violent crimes, drug sales, property crimes); however, the reductions were greater for those who completed treatment. Continued research supported by the National Institute on Drug Abuse is investigating long−term outcomes (5 and 7 years after treatment) for those adolescents. The need for further studies is critical, particularly for those that address the issue of treatment duration

and tenure in relation to outcome.

Chapter 6 −− Family Therapy

The interconnected relationships within a family are widely recognized as crucial elements of substance use disorders and their treatment. Clinicians and researchers agree that interactions among family members can affect the emotional health of individual members and thus fail to prevent the development of substance use disorders. Although family factors have been implicated in the etiology of adolescent substance use, it is important to recognize that individual, environmental, and contextual factors also contribute to adolescent substance use behaviors. With that in mind, adolescent substance use disorders are commonly referred to as multidimensional disorders.

Through the years, many substance use disorder treatment programs have worked with family members in a component called *family−based therapy*, *family−centered therapy*, or simply *family therapy*. Just as these names differ, so have the services differed from one treatment program to another. They reflect that family−based interventions work at the level of family change (e.g., parenting practices, family environment, problem solving) and also aim to take into account the psychosocial environments in which the adolescent lives. In one situation, family therapy might refer to an educational session or a discussion of family problems with a substance abuse counselor. In others, it might consist of a few family conferences with members of the treatment team present to explore what family members can do to help the patient. Some programs may have very effective family counseling sessions, referred to as family therapy.

The distinctions among family−based therapy, family−centered therapy, and family therapy are not unimportant. They reflect different versions of family−based intervention. Some family−focused interventions assume that information about the 12−Step philosophy, delivered in the context of family treatment, is sufficient to affect the substance−using behaviors of the adolescent. Other approaches, as well as most family−based therapies, assume that the interaction within the family and between important family members and other extrafamilial individuals is critical to making change. Data support the link between changes in central aspects of family functioning and changes in the substance−using and problem behaviors of the adolescent (Schmidt et al., 1996).

Too often, however, the phrase "family therapy" is a "catch−all" name for any activity that brings family members together for discussion. Unfortunately, much of what has passed for family therapy throughout the development and history of substance use disorder treatment has not been the provision of services using a carefully learned and disciplined therapeutic approach. Nor has it been designed with a solid understanding of family dynamics or led by well−trained and experienced family therapists.

Fortunately, these old approaches have all but disappeared from treatment programs. It is now recognized throughout the substance use disorder treatment field that working with families is a huge responsibility that requires a clinical understanding of family interactions and pathologies. It is notable that one of today's leading texts on family therapy has concluded that much of the cutting edge research in the field at large is done in the context of a substance use disorders (Nichols and Schwartz, 1998).

Over the past two decades, much has been learned in carefully constructed and controlled research studies to indicate how a family therapist, working in conjunction with other members of the treatment staff or alone, can intervene constructively to help a family change behaviors (Stanton and Todd, 1979; Stanton and Shadish, 1997; Gurman et al., 1986; Liddle, 1992). These studies have been conducted in research−based settings, not within existing community−based programs. However, sufficient outcome data and experience now exist to transfer the research models to naturalized treatment settings. Family therapy programs may also be suitable sites of effective research on adolescents who have substance use disorders.

Family Therapy as a Recent Approach

Integrating Family Therapy

Substance use disorder treatment programs can use family therapists to apply therapeutic approaches that have been proven effective with adolescents and their families. Preparing for and integrating a therapist who will provide family therapy in a treatment program requires a considerable amount of time. Furthermore, a therapist who practices a family−based approach should have formal, professional training in this method. Family therapy fits well into the regimen of treatment in which case management is used; it has also been shown effective in home−based treatment (Comfort and Shirley, 1990; Thompson et al., 1984).

What Is Family Therapy?

Three approaches of family therapy are being applied in treatment settings today:

1. *The old−style paradigm* believes that something wrong in the family produced the substance use disorder. In other words, the family caused it. This view has been recently revised to reflect an increased understanding of family dynamics.
2. *The second paradigm* focuses on risk and protective factors by working with families to reduce the risk factors and increase the protective factors. It is commonly used in adolescent substance use prevention programs as well as treatment.
3. *The third paradigm of family therapy,* which is the concern of this chapter, takes a multisystemic or multidimensional perspective in the therapeutic process. Therapy includes all family members, and in some cases, peers (although their involvement would be limited to when the therapist believes their participation would be helpful). In effect, the family or the group is the patient. The justification for the multidimensional approach is that the two most important influences on the adolescent are his family and members of his peer group.

Multidimensional family therapy started sometime in the 1930s when social scientists began to understand that family members are interconnected and interdependent parts of a system. They constantly interact with and affect each other. When there is a change in any individual member of the family, others in the family system are affected. From a systems perspective, families are seen as organisms that continuously change and reconstitute themselves (Gladding, 1995). One study summarized family systems as a powerful and influential series of interconnected relationships among family members that provide for human behavior, emotion, values, and attitudes (Figley and Nelson, 1990).

Contemporary family therapy approaches understand the importance of treating individuals as subsystems within the family system and as units of assessment and intervention; in other words, each member of the family is capable of being assessed and can act as a unit of intervention−−for example, by changing her interactional patterns. The critical point is that family−based treatments work with multiple units, including individual parents, adolescents, parent−adolescent combinations, and whole families, as well as family members vis−_−vis other systems. It is the multiple systems approach that distinguishes current family−based therapies from older family therapy approaches (Liddle, 1995).

Applied appropriately, family therapy often can quickly cut through to the reality of a situation. This makes it an effective tool in treatment. When used with all of the members of the family, it can open and improve communications, often eliminating the family secrets that have enabled the client to continue practicing his addiction. It is important to note that some families with an adolescent with a substance use disorder do not need family therapy. These families function well and should not change in any substantive way. If the family system is effective overall, individual or group therapy for the member with the substance use disorder may be the focus of the therapy, with occasional family meetings to convey information, to help the family provide support to the substance−using member,

and to integrate the family into the long−term goal of relapse prevention.

Elaborations of the Family Systems Perspective

Within the systems approach, several types of family therapy strategies have been applied and studied with adolescents who have substance use disorders. These include

- Functional family therapy
- Structural ecosystems therapy
- Multisystemic family therapy
- Multidimensional family therapy
- Problem−based therapy

All of these are considered *integrative family therapies*, meaning that they draw from and build on a number of structural, strategic, and behavioral models of family therapy that have emphasized families as systems.

Engagement in Treatment

Engaging adolescent substance users in treatment is notoriously difficult (Szapocznik et al., 1988). Youths in these circumstances typically do not believe their substance use is a problem and rarely seek treatment. Instead they are brought into treatment by their parents or coerced into treatment by the criminal justice system. Thus, family therapy models specializing in engagement interventions were developed. Such specialized engagement interventions allow therapists to diagnose, join, and restructure a family from the first contact to the first family therapy session (Szapocznik et al., 1988).

Using the principles of family therapy to work with the family to engage them in treatment is a well−established component of family treatment of substance use disorders. The therapist uses the usual therapeutic tools of family therapy but uses them to deal first with the problem of engagement until resistance to participation is overcome. Henggeler further developed these ideas by emphasizing that therapists, along with the treatment team, must strive to engage the family in treatment and to reach treatment goals; if obstacles develop, the therapist should devise alternative strategies to attain desired outcomes (Henggeler et al., 1986).

Changing Interactions Among Family Members

The therapist's intervention aims to bring about change in the way family members relate to each other by examining the underlying causes of dysfunctional interactions and by encouraging new (and presumably healthier) ones. By creating a context in which families focus on revitalizing interpersonal bonds and acting in more adaptive ways within the family, the process helps members of the family change negative emotional and attributional components (especially blaming) of their interaction.

In doing so, the therapist helps family members appreciate how the values and perspectives of each family member may differ from their own, but that differences do not have to be a source of conflict. Helping family members solve problems together in the therapeutic setting enables them to learn strategies that can be applied with the adolescent in the home. Such maneuvers in therapy decrease family conflicts and improve the effectiveness of communication. Family members, both parents and youth, learn how to listen to one another and solve problems through negotiation and compromise.

For example, in family therapy sessions, the therapist may help the adolescent understand the origins of expressions of hostility toward him by family members. Take the situation in which the parents are upset about the teenage son playing the stereo in the family's apartment late at night and keeping other family members from sleeping. The

therapist might ask the parents if they ever played their radio too loudly when they were teenagers, thus helping them to identify with their son. This softening on the part of the parents may help the adolescent accept the fact that he will still be able to hear his favorite music even if he lowers the volume of the stereo. Then, an agreement may be negotiated in which the adolescent agrees to decrease the volume or use headphones after 9:30 p.m. or when others are watching television. This is a more productive resolution of the problem than having the teenager leave the family's apartment at night so he can play his stereo the way he really likes to.

Another method of improving communication between family members is to introduce the concept of "I" statements. "I" statements focus on the effect of an action on the speaker rather than on the action itself. Instead of saying "you always do (blank)_" a family member would say, "I feel (blank) when you (blank) because (blank)." These statements are often effective because people can disagree about what they "always" do, but it is more difficult for them to dispute what someone says she feels. Further expansion on this technique would involve a listening skills exercise. One member would paraphrase what she heard the other person say until the first speaker states that she got it exactly right.

Another goal in the family treatment of substance use disorders is to equip parents with the skills and resources needed to address the inevitable difficulties that arise in raising adolescents. Parents of youths who use substances typically aggravate small conflicts because their parenting practices are too extreme (e.g., too permissive, authoritarian, or inconsistent). Moreover, by the time parents seek therapy for their child they have "tried everything" and feel quite hopeless about being able to improve the situation. It is the family therapist's job to help parents regain their optimism and motivate them to continue to help their child. Family therapists, then, bolster the parents' self−confidence as parents and at the same time help them improve their parenting skills. Parents are taught how to provide age−appropriate monitoring of their child (e.g., to know their friends, to know how they spend their time), set limits (e.g., negotiate with the youth about reasonable curfews, schedules, and family obligations), establish a system of positive and negative consequences, rebuild emotional attachments, and take part in activities with the child outside the home.

The special case of multidimensional family therapy includes several core targets of assessment and change: the individual adolescent, the parent(s), the family interaction (parent−adolescent interactional patterns), and family members vis−_−vis extrafamilial persons and systems. Interventions within each of these core targets occur in a particular sequence. The theoretical framework underpinning the sequence of the interventions within each subsystem includes developmental theory and research, including attachment relations, family systems, and family therapy. Process studies on multidimensional family therapy indicate that certain aspects of behavior (proximal targets) must be changed before other target behaviors can change (more distal behaviors). In a sense, it is a moderator approach to change. For example, some aspects of a parent's behavior change before others (attachment increases before parenting practices can change) (Schmidt et al., 1996). In the therapeutic alliance with the adolescent, focusing on the client's life experiences and the capacity to tell his story in a therapeutic context to a therapist who will help him tell it to others (including his family, in the context of other parallel work with the parent and extrafamilial others), often facilitates improvements in initially poor therapist−adolescent alliances (Diamond and Liddle, 1996). Furthermore, interactional impasses within the context of family therapy sessions can be resolved if the interaction can be facilitated through certain stages (i.e., resist problem solving in enactments too early, focus on slowing down the pace of the communication, help the parent and adolescent share their experience of their situation) (Diamond and Liddle, 1996).

Beyond the Family

Contemporary family systems approaches have evolved to the point at which numerous systems, in addition to the youth and family, are targets of the intervention. These extended systems−−most notably peers, school, and neighborhood−−are believed to help maintain dysfunctional interactions in families and thus are important targets. For example, the therapist might focus on the system composed of interactions between the adolescent and her peers who engage in delinquent acts, or focus on the system consisting of interactions between the adolescent and an institution, such as school, that keep her from becoming engaged in schoolwork. The aim of family treatment, then, is to change

the dysfunctional systems within the core systems−−the family−−and between the family and social systems such as the peer group or the school.

These approaches may direct family members to join groups such as a church or civic group. In the area of peer relationships, therapists may discourage association with deviant peers and help establish parental sanctions for contact with these bad influences. In the forms of family therapy known as multisystemic therapy and structural ecosystems therapy, for example, the parents are supported by the counselor to implement effective parenting to address the problem of associations with deviant peers. The counselor also helps the parents develop strategies for monitoring and supporting the youth's school performance or vocational functioning.

As another example, the therapist within the multidimensional family therapy approach would identify and assess the negative consequences associated with taking part in these extrafamilial systems−−such as skipping an appointment with a probation officer or hanging out with peers late at night on unsafe street corners where illicit drugs are bought and sold. The therapist might meet with the probation officer or ask the adolescent to bring a peer to a session to review the problem from the youth's perspective.

The therapist then helps the adolescent and his family become aware of these consequences by identifying their long−term significance, such as the potential legal problems of missing appointments with the probation officer or being blamed for participating in drug deals. Conducting this type of session requires great skill to ensure that the participants in the discussion do not feel blamed for the problem or become defensive about their actions. When sessions are led skillfully by a therapist who has established a therapeutic alliance with the adolescent, the adolescent will ideally reach rational alternatives to his behavior.

Like other systemic therapies, these therapies are based on knowledge of the developmental aspects of families, primarily of adolescents, and the ecological environment in which they live. The therapist draws from this base of knowledge to assess and intervene with the adolescent, the family, or the community institutions with which the adolescent is involved, including such institutions as the juvenile justice system, a gang, a youth organization, or a public health clinic, as well as the school. These systems are assessed in terms of their past and present actions that contribute to family dysfunction.

The Therapeutic Alliance

Even with a systems perspective, family therapy models consider the therapeutic alliance between therapist and adolescent as the crucial component. It is important for the therapist to work hard to establish a therapeutic relationship with the adolescent. This relationship supports the adolescent in developing a personal agenda, such as ensuring that the family system of discipline does not deny the adolescent the opportunity to participate in social activities or impede personal growth. This qualifies the sense in which therapy is conducted with the whole family. It is also a chief task for the therapist to clarify to the client and other family members that the purpose of the whole exercise is to help the client. This often conflicts with the family's tendency to scapegoat the member who has been in trouble or to ignore the personal needs of the client.

What Should the Program Staff Know?

At a practical level, the duration of family−based treatment typically ranges from 2 to 6 months, decreasing in intensity toward the end of the period of treatment. This may translate into approximately 5 to 20 therapy sessions. Naturally, more difficult cases take longer. Henggeler and colleagues, using a family preservation model, reported a caseload size per counselor of 4 to 6 families (Henggeler et al., 1992). Other approaches have caseloads of 4 to 10 cases per counselor. Different groups of family members may attend different therapy sessions; for example, if the therapist is discussing poor parenting, the youth will not be included because the youth's presence might serve to undermine parental authority. Treatment can be relatively intense, with multiple sessions during a single week. It also

can be intense in terms of explicit goal setting and extensive homework assignments. Also, the setting does not have to be conventional and can occur in either home or community settings.

Family therapists should be acutely aware of the complex of behaviors and systemic interactions associated with recovering from a substance use disorder. They also should be aware of cultural differences in family patterns and typical attitudes toward therapy (McGoldrick et al., 1982). Adolescent substance involvement should be considered within the context of other problem behaviors such as delinquency and school problems, necessitating new frameworks of diagnosis and assessment, as well as treatment. Liddle and Dakof wrote that familial attitudes and behavior, family emotional environment, and parenting practices are dimensions consistently targeted by family−based interventions (e.g., parental substance use, parent−adolescent conflict, emotional disengagement) (Liddle and Dakof, 1995a).

Adolescent clients will benefit when the treatment team, including counselors, nurses, and doctors, working in conjunction with family therapists, has a general understanding of family therapy within the substance use disorder treatment setting. When they have this understanding, the treatment team can best support the efforts of the therapist and coordinate their components of treatment with family therapy. For example, when substance use disorder counselors know that the adolescent is going through an intense time in family therapy, they can reduce the intensity of substance use education with the adolescent. Likewise, the physician can include the provision of family therapy as a factor in her decisions about medication.

Research Studies

Increasing numbers of research−based trials are clearly defining and studying the use of family−based therapy among adolescents in treatment for substance use disorders. In 1980, the National Institute on Drug Abuse (NIDA) began to address adolescent substance use disorders systematically to find out if effective family−based therapy models could be applied to adolescents (Liddle et al., 1992). The role of family relationships in the creation and maintenance of substance use disorders has been understood for some time. The pioneering study on family therapy with adults with substance use disorders was a NIDA project (Stanton and Todd, 1979). Szapocznik and colleagues were the first to establish the effectiveness of family therapy in treating adolescent substance use disorders (Szapocznik et al., 1983, 1990). In subsequent research funded primarily by NIDA, and to a lesser degree by the National Institute on Alcohol Abuse and Alcoholism and other sources, great strides have been made in understanding and defining the types of family therapy that work best with adolescents with substance use disorders.

The great importance of these models to the substance use disorder treatment field is that as they have been carefully tested and documented over time in many different settings, including the home and outpatient programs, revisions have been incorporated as needed, thereby improving the effectiveness of the models. Thus, a program that applies one of the documented family therapy models can implement family therapy with some certainty that successful treatment of adolescents will result. In the public arena, State directors of alcohol and drug treatment agencies, as well as individual program directors, can be assured that funds invested in family therapy are wisely spent.

Driven largely by current efforts to reduce the costs of health care and provide documented evidence of the effectiveness of the care, the primary setting for adolescent substance use disorder treatment today is the outpatient program. For the first time, conclusions can now be drawn about some particular forms of family therapy that work effectively in this setting.

The documentation of family therapies in adolescent programs is particularly interesting because they have been used successfully among adolescents who are difficult to treat (Liddle and Dakof, 1995b; Stanton and Shadish, 1997; Henggeler et al., 1986). One of the most exciting aspects of this accumulating research and treatment evaluation is that the family therapies applied in these research settings have been shown to be especially effective with adolescent clients from the most disadvantaged backgrounds and with very severe substance use disorders.

Chapter 7 −− Youths With Distinctive Treatment Needs

Many adolescents who acutely need treatment for substance use disorders may be in circumstances that make early identification and treatment particularly difficult. Sometimes, legal, social, or health circumstances in a young person's life create unique problems that require attention. Youths in the child welfare and juvenile justice systems are at particularly high risk for developing a substance use disorder. More often than not, they have more risk factors than other children and fewer protective factors. For example, adolescents who have come into contact with the juvenile justice system can be expected to display severe problems surrounding family and social relationships, as well as coexisting mental, emotional, or physical difficulties (Dembo et al., 1991). Screening and intervention policies in primary care settings will help uncover both the substance use disorders and the problems that often accompany them: illegal activity, homelessness, shame surrounding sexual identity, and coexisting mental disorders.

Treatment in the Juvenile Justice System

Many young people who enter the juvenile justice system for relatively minor offenses, such as problems in school or at home, enter a cycle of failure reinforced by repeated instances of these problems. Most of the adolescents who come into contact with the juvenile justice system have already developed a number of functional problems. Many of these youths have had substance use disorders and other psychosocial concerns for some time, and many come from fractured or dysfunctional families. By the time these adolescents enter the juvenile justice system, they have developed serious substance use disorders and attendant psychosocial dysfunction.

For these reasons, early intervention is critical in working with adolescents who have had contact with the juvenile justice system. Every young person involved in the juvenile justice system, regardless of his charge, should undergo thorough screening and assessment for substance use disorders, physical health problems, psychiatric disorders, history of physical or sexual abuse, learning disabilities, and other coexisting conditions. Juvenile probation officers can be helpful partners in the system of care. For their part, treatment service providers should educate the local juvenile justice system about the importance of early intervention and what resources are available to them. Juvenile justice professionals should be required to have training in identifying and appropriately intervening with substance use in their clients. Having court−ordered treatment and monitoring may be the most effective approach to getting substance use disorder services to many adolescents. It is almost impossible to intervene unless the youth is removed from the environment that brought her into conflict with the juvenile justice system in the first place−−that is, the home neighborhood.

Diversion Programs

Because the justice system is overwhelmed with a high case volume and limited resources−−a judge in juvenile justice may handle thousands of cases a year−−increased emphasis has been placed on diversion programs (sometimes called dispositional alternatives) for juvenile offenders. These alternatives have been shown to be highly effective in relation to the minimal resources invested in them. Juvenile detention facilities are designed to provide short−term care for juveniles awaiting adjudication or disposition. However, juveniles placed in detention facilities are unlikely to receive the special programs necessary for treatment or reintegration into society. For these reasons, alternatives to placing juvenile offenders in secure facilities have increased dramatically in recent years. The range of transitional programs that help to prepare youths to return to their communities has widened as well. The use of alternative placement resources will likely involve multiple agencies. Therefore, it is vital to have a single case manager to coordinate services and be the central monitoring and tracking source for each adolescent. It is important for juvenile program administrators to be aware of the pros and cons of each program and to place youths in the programs that are likely to be of most benefit to them. A number of approaches and types of settings are now being used, and the many options that are available make it possible to select the setting most conducive to a juvenile's treatment needs. Some of the available alternatives are described below.

- *Intensive community supervision.* Under intensive community supervision, a youth remains in the community and must regularly report to an assigned probation counselor. This arrangement allows the adolescent to attend school and to maintain family relationships with minimal interruption. The planned frequency of the required contacts with the probation counselor may vary from several times a day to twice a week; less than twice a week is not considered intensive supervision. Telephone contact alone is not enough, although it may be used to supplement personal meetings.
- *Day reporting centers.* As part of community supervision programs, reporting centers can be set up in accessible locations in the community, such as schools and shopping centers. Youths then report regularly to these stations according to their case plans. Some centers provide education, recreation, or social services.
- *Day treatment.* Specialized day programs that include education and social services help youths develop social skills. They also provide supervision and control in a familiar setting. In many day treatment programs, youths take classes in the morning, participate in a group activity (such as playing sports) in the afternoon, and return home at night.
- *Evening and weekend programs.* Direct supervision and programming similar to day treatment are also offered during evening and weekend hours. Tutoring, recreation, employment, and treatment services can be provided to supplement an adolescent's regular educational or work programs. Like day treatment programs, evening and weekend programs provide supervision in addition to education and social skills development.
- *Tracking.* Tracking programs hire staff (usually part−time) to monitor youths and to report their compliance with specific requirements in areas such as school attendance, participation in counseling, and job performance. Whether working with other service providers or independently, trackers report regularly to the agency that has jurisdiction over the adolescent.
- *Electronic monitoring.* Some youths are now released under the condition that they wear an electronic device that monitors their movements. The efficacy of such systems is debated by professionals and technicians in the juvenile justice system, but all agree that electronic monitoring alone is insufficient and that, to be successful, such tracking must be part of a multifaceted effort.
- *Home detention.* Adolescents under home detention are supervised by their parents in their homes and are allowed to leave only to go to school or work. This type of treatment is well−suited for youths who do not require institutional security but need adult supervision and structure. Home detention is generally a short−term arrangement that is used until a detailed, long−range plan is developed.
- *Home tutoring.* Supplementing regular educational programs with home tutoring helps to remedy adolescents' educational deficiencies, establishes contact with an adult role model, and provides supervision.
- *Mentor tutoring.* Providing a trained adolescent tutor for a troubled youth can be extremely beneficial. In addition to educational tutoring, a mentor can offer advice, emotional support, and a respectful, caring relationship.
- *Work and apprenticeship.* Some local businesses provide jobs or apprenticeships for juvenile offenders, generally in conjunction with an educational program. Such programs instill a work ethic, a sense of responsibility, and a feeling of accomplishment while enhancing community relations.
- *Restitution.* Under court order, juveniles may be asked to try to rectify the damage they have caused their victims. Restitution may be in cash or in services amounting to a specific dollar value. Most frequently ordered in property crimes, restitution provides an alternative to incarceration, thereby reducing public costs while compensating victims.
- *Community service.* Some offenders are required to provide services that benefit the entire community, such as cleaning up parks or working in nursing homes. This is a form of restitution that allows juveniles to contribute routine but worthwhile services. Community service projects must be clearly identified, and the juveniles in these programs must be properly supervised.
- *Volunteer programs.* Volunteers are often available to tutor youths and to supervise work and recreational activities. They may also provide an additional service to youths as friends, role models, and listeners. Like regular employees, volunteers require training, specific job descriptions, and supervision.

For more information on alternatives for adolescents involved in the juvenile justice system, refer to TIP 21, *Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System* (CSAT,

1995d).

Juvenile Drug Courts

The caseloads of most juvenile courts in this nation have changed dramatically during the past decade. The increasingly complex nature of both delinquency among juveniles and substance use disorders has contributed to more serious and violent criminal activity and escalating degrees of substance use. Juvenile justice professionals recognize that the problems that bring a juvenile under the court's jurisdiction are affected by family factors, community factors, peer issues, and other individual and environmental variables.

The juvenile court traditionally has been considered an institution specifically established to address multiple needs of the juvenile. However, it is becoming clearer among juvenile justice practitioners that conventional practices are ineffective when applied to the problems of juveniles with substance use disorders. During the past 2 years, a number of jurisdictions have examined the experiences of adult drug courts to explore the possibility of adapting such systems for juvenile courts in the hopes of more effectively dealing with an increasing substance−using juvenile population. Interest in juvenile drug courts is developing rapidly across the country, with a number already operational or in the planning stage. The States of California, Florida, and Nevada have the greatest activity, but according to a recent report, 59 programs are underway or planned across 30 States (Drug Court Clearinghouse and Technical Assistance Project , 1997). See Figures 7−1 and 7−2.

Challenges

The process of developing and implementing juvenile drug courts must address several challenges, including

- Counteracting the negative influences of multiple risk factors, most notably the presence of coexisting psychiatric disorders, peer deviance, and poor family dynamics
- Addressing the needs of the family, especially families with substance use disorders and poor parenting practices
- Complying with confidentiality requirements for juvenile proceedings while at the same time obtaining necessary information to adequately assess and refer the substance−using juvenile
- Overcoming the typical lack of motivation to engage in the recovery process (since most youthful substance users have rarely hit bottom like long−term adult substance users)−−along with those traits that typify the conduct−disordered juvenile offender, including a sense of invulnerability, lack of concern for one's future, and disinterest in conventional values, all of which complicate this motivational hurdle
- Responding to numerous developmental changes that may occur in the adolescent during the course of extended supervision while under the court's jurisdiction

Characteristics

Although the importance of flexibility of juvenile court operations has been emphasized, several characteristics common to existing juvenile courts have been identified (Drug Court Clearinghouse and Technical Assistance Project, 1997):

- Early and comprehensive intake assessments, with an emphasis on the functioning of the adolescent's family and the adolescent throughout the court process
- A heavy emphasis on responding to the needs of the adolescent by coordinating the actions of the court, the school system, the treatment service provider, and other community agencies
- Use of the case management approach, in which active and continuous supervision of the adolescent occurs throughout the assessment, referral, and treatment processes
- Immediate use of both sanctions applied for noncompliance and incentives to recognize progress by the adolescent and the family

Homeless and Precariously Housed Youths

An estimated 750,000 to 1.3 million youths run away from their homes each year, and one−third of these are believed to become chronically homeless. A growing body of literature suggests that these young "street" people are at high risk for a wide range of problems, particularly substance use (Kipke et al., 1995, 1997).

Research among homeless youth in inner−cities indicates that most of these young people use multiple substances, although the types of substances used were found to vary among geographical areas of the country (Kipke et al., 1996). On the East Coast, for example, common substances of use were heroin and crack cocaine, whereas on the West Coast, the use of LSD, ecstasy, and methamphetamine was more common (Kipke et al., 1997). Substance use, defined according to DSM−IV criteria, has been found to be a pervasive problem among these youths. For example, 71 percent of inner−city homeless youths in Los Angeles were classified as having an alcohol and/or illicit substance use disorder (Kipke et al., 1997). In addition, as many as 30 percent of them reported intravenous drug use, and of these, 59 percent reported having shared needles and equipment on at least one occasion. Added to the risk of HIV posed by this practice are the additional risks associated with "survival sex"−−the trading of sex for food, shelter, or drug money. As many as 40 percent of street youths are estimated to engage in this activity (Kipke et al., 1995).

Most street youths also have a long history of abuse and neglect: Over 50 percent of homeless adolescents report having experienced physical, sexual, and/or emotional abuse and neglect (Sibthorpe et al., 1995). Not surprisingly, many homeless youth turn to substance use in an effort to numb their emotional pain and cope with the uncertainty and instability of their lives.

Effective treatment of substance use disorders in this population hinges on the necessity of recognizing the importance of these young people's readiness for treatment. Also, entering a substance use disorder treatment system is a complicated process, and displaced youths are likely to require help in gaining access to services. Outreach programs should have in place a "step−up" for homeless or inner−city youths to enter these programs, assisting them in negotiating the various obstacles that may be potential barriers to services. These adolescents may require several street contacts before they are willing to trust anyone. Street outreach workers should focus on developing trusting relationships with youths that, over time, can influence a young person to access substance use disorder treatment services. A wide array of services should be readily available, especially emergency shelter services, residential treatment services, or transitional living services, depending on the individual's needs. Furthermore, most of these youths do not believe that their primary problems are related to their substance use. For adolescents who may or may not be receiving services but who are living on the streets, outreach becomes a primary intervention strategy. Service providers must meet with, talk to, and develop relationships with young people on the street to engage them in treatment (see the Levels of Treatment subsection in Chapter 2).

Once a homeless youth has entered the system, the next step is establishing a case management plan that is based on a thorough assessment of her needs. Possible services may include finding housing, dealing with family problems, entering substance use or HIV−related treatment, and providing job training, schooling, and sexual and reproductive health care. It may be necessary to prioritize the needs for services according to the individual's severity of problems.

Returning homeless or runaway youths to their homes after treatment is not always in their best interest because less than optimal conditions may exist in these homes. Many of these youths have parents with serious substance use disorders who may have been the first to expose their children to intravenous drugs. Treatment providers must make efforts to assess whether family reunification is appropriate for these youths. Returning them to a chaotic home environment after treatment is frequently not an appropriate discharge option. In these cases, treatment providers should collaborate with child welfare professionals to explore the possibility of other transitional living options for homeless youths.

Homosexual, Bisexual, and Transgendered Youths

During the adolescent years, some young people explore a variety of sexual relationships with both the same and opposite sexes. It is during this time of experimentation that they begin to develop a sexual identity, including whether they see themselves as heterosexual, homosexual, bisexual, or transgendered (that is, biologically of one sex but identifying primarily with the opposite sex). Youths who begin to develop a nonheterosexual identity have a high risk of being ostracized by family and friends, leading many to become integrated into adult gay cultures in which substance use is greater (Cabaj, 1989; Myers et al., 1992). Rates of depression, anxiety, and suicidal ideation and attempts are high in these groups (Remafedi et al., 1991). Others may turn to substance use in response to having experienced physical or sexual abuse or as a result of homelessness.

Whatever scenario led to their current circumstances, these youths are at high risk for developing serious substance use disorders. It is often the case that these youths do not bring their problems and concerns to the attention of health care providers because it would mean disclosing their sexual identity and risking further alienation. Many of these youths have no one in whom they can confide, and most communities lack gay−identified services. Such services can be important in these situations because of issues of protecting client identity. Also, gay−specific services are likely to be more sensitive to the importance of not divorcing the issues of sexual identity from substance use disorders during the treatment process. Effective treatment for these youths incorporates helping them to feel comfortable with, and to take pride in, their sexual identity.

Youths With Coexisting Disorders

Substance−abusing and substance−dependent adolescents often have coexisting physical, behavioral, and psychiatric disorders. Traditional treatment for substance use disorders may not be effective in addressing the specific problems associated with these coexisting disorders. The following section discusses specialized and adjunctive services that may be needed for coexisting disorders.

Physical Health Problems

Adolescents with chronic physical illnesses are at high risk for substance use disorders. This is particularly the case for those with pain−related syndromes, such as sickle cell anemia, migraine headaches, and arthritis, for which treatment with opioid analgesics is often required. Other illnesses that require long−term, intensive medical intervention, such as cystic fibrosis and chronic renal failure, take a toll on both physical and emotional health. Clinicians should consider that this may, in turn, increase the risk for misuse of psychoactive substances. Chronic illness may also put teenagers at risk for substance use disorders because they may feel that using substances is the only way that they can relate to a peer group.

Distinguishing between appropriate treatment for pain and an individual's abuse of analgesic drugs is often difficult, particularly when individuals develop symptoms of tolerance to large doses of narcotics that are used as part of treatment. It is important to remember that addiction is defined as the use of substances despite adverse consequences, preoccupation with use, and the development of tolerance or withdrawal, and not tolerance or withdrawal alone. Many individuals undergoing treatment for chronic pain develop physiological tolerance to opioid medications and will suffer withdrawal if the medication is abruptly discontinued. This does not necessarily mean, however, that they are addicted. Clinicians must determine whether the narcotic treatment is improving or worsening the patient's quality of life and whether the patient is developing a preoccupation with obtaining and using the substance.

When this question does arise, however, frequent and open communication among all treatment professionals is essential. One physician should be assigned to write all prescriptions, and patients may be asked to sign a contract to this effect. In acute situations where a patient appears to be in pain and is requesting medication, it is best to err on the side of giving treatment. That is, administer the requested medication under controlled conditions (e.g., admit to the

hospital or treatment facility) and then consult with a physician who is specially trained in the treatment of pain and addiction. This approach prevents sudden, dangerous withdrawal and helps to build the patient's sense of trust. If a patient is exaggerating symptoms or reporting a fictitious illness, there will be ample time later to address these problems.

Whenever there is a suspicion of a coexisting substance use disorder and a medical illness, the treatment team must simultaneously assess and treat both problems. There may be a tendency for treatment professionals to focus on only one of the coexisting disorders; in other words, either the patient has a real pain syndrome or he has a substance use disorder. The treatment provider should recognize when the patient has a coexisting disorder and address both the real chronic pain or distress and the substance use disorder. When an individual is admitted to treatment, a complete physical assessment should be conducted; when new or recurrent physical complaints arise, a complete reassessment should be performed. See TIP 29, *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities,* for further discussion on this topic (CSAT, 1998)

Patients with severe or life−threatening illnesses, particularly HIV infection and AIDS, may require hospitalization and ongoing psychotherapy to deal with the physical and emotional effects of these conditions. HIV−infected patients who develop AIDS may escalate their substance use, with the rationalization that they now have nothing to lose. It helps to make these patients understand that their substance use is likely only to hasten the progress of their disease and that AIDS is being increasingly managed as a chronic rather than a fatal illness. (Refer to the forthcoming revised TIP, *Treatment of Persons with HIV/AIDS and Substance Use Disorders* [CSAT, in press].)

Emotional and Mental Disorders

The coexistence of adolescent substance use and mental or behavioral disorders is relatively common (Bukstein, 1997). Because these two sets of problems are integrally related and often difficult to disentangle, it is probably best to treat the cluster of disorders together. Attention to the treatment of only the substance use or only the other disorder may not result in optimal outcomes. Treatment providers and mental health authorities should develop programs together to treat youths with coexisting disorders. Cross−training can help staff of both programs develop the sensitivity and the clinical skills to understand the dual diagnosis and to identify the presence of either problem or both.

Substance use by adolescents with coexisting and behavioral disorders has received considerable discussion in the adolescent literature. Whereas the prevalence of diagnosable behavioral disorders among clinical adolescent populations has a solid empirical base (Kaminer, 1994), there are still questions about the extent to which the coexisting disorders are the cause or the effect of the substance use and how one may alter the course of the other (Meyer, 1986). However, studies among adolescents being treated for substance use disorders reveal a high prevalence of coexisting disorders, primarily mood disorders (particularly depression), conduct/oppositional defiant disorder, and attention deficit/hyperactivity disorder. In a recent review of this literature, Kaminer reported quite variable coexisting psychiatric rates among adolescents having substance use disorders, although various studies indicate a trend of over half of the subjects having at least one psychiatric disorder, with conduct disorder being the most prevalent (Kaminer, 1994).

Once a youth with a mental or behavioral disorder begins to use substances, both problems tend to worsen. Because it is believed that a major reason for substance use among emotionally disordered youths is to cope with negative affects (such as anxiety or depression), there may be a rebound effect on the coexisting disorder if the substance use is discontinued. For example, a youth who drinks heavily to self−medicate anxiety may become even more anxious when she reduces or quits drinking. The Panel recommends that any adolescent who is being treated for a substance use disorder and is also taking psychoactive medications for a coexisting mental or emotional disorder should have routine urine testing as a part of her treatment plan. For more information on coexisting psychiatric conditions and substance use disorders, refer to TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* (CSAT, 1994).

Attention Deficit/Hyperactivity Disorder: A Special Case

Attention deficit/hyperactivity disorder (AD/HD) has been diagnosed with increasing frequency over the past decade, perhaps owing partly to an increased awareness of the disorder. A growing body of literature indicates that youths with AD/HD are at high risk to develop a substance use disorder, particularly if AD/HD coexists with conduct disorder (e.g., Wilens et al., 1994; Windle and Windle, 1993). In addition, the persistence of AD/HD symptoms has been associated with elevated risk for substance use disorder in late adolescence and early adulthood (Biederman et al., 1995). Young people with AD/HD are impulsive and inattentive and so may require adjustment in the treatment regimen in order to address these problems. A significant percentage of adolescents with AD/HD also have specific learning disorders. Such information−processing problems can impair their ability to understand adequately the components of treatment that require listening and verbal skills. For example, such deficits may make group therapy a difficult and even painful process for AD/HD−afflicted youths.

AD/HD complicates the treatment of substance use disorders. Dextroamphetamine and methylphenidate, both of which are potential drugs of abuse, are currently the medications of choice and are sometimes the therapeutic approach of choice for treating childhood AD/HD. The increasing frequency with which AD/HD has been diagnosed over the last decade has brought with it concern over the increased potential for abuse of the AD/HD medications (Cantwell, 1996). The small body of literature that has focused on this issue has yielded mixed results, with some studies reporting both worsening of risk for substance use disorders and improvement in risk, depending on the variable and substance assessed (Weiss and Hechtman, 1993). There are anecdotal reports that a black market in schools has developed in which youths sell stimulants to their peers. Methylphenidate can be ground up and insufflated like cocaine, and in this form it can cause sudden cardiac arrest.

Any adolescent who is being treated for a substance use disorder and is also taking psychoactive medications for a coexisting psychiatric disorder should have routine urine testing as part of his treatment plan. Close scrutiny of the psychopharmacological management of AD/HD is particularly important in such youths who are receiving treatment for substance use disorders. The bottom line is that psychoactive agents often have a high potential for abuse, and they should be used with extreme caution in adolescents with substance use disorders.

Chapter 8 −− Legal and Ethical Issues

by Margaret K. Brooks, Esq.[1]

Providers of adolescent treatment for substance use disorders must sometimes grapple with these two questions:

1. Can the provider admit an adolescent into the treatment program without obtaining the consent of a parent, guardian, or other legally responsible person?
2. How can substance use disorder treatment programs communicate with others concerned about an adolescent's welfare without violating the stringent Federal regulations protecting confidentiality of information about clients?

The answers to these questions are especially complex for those who treat adolescents for substance use disorders because a mix of Federal and State laws govern these areas; "adolescence" spans a range of ages and competencies; and the answer to each question may require consideration of a matrix of clinical as well as legal issues.

This chapter will examine the factors treatment service providers should consider in deciding whether a particular adolescent may consent to treatment in the absence of parental consent or notification and how communications with other systems can be accomplished without violating the adolescent's right to privacy. The first section discusses the consent issue in the context of the legal constraints imposed by Federal and State law and the clinical issues that may have an impact on the decision.

The second section discusses how providers can communicate with others concerned about the adolescent's welfare without violating either the Federal confidentiality rules or the adolescent's heightened sense of privacy.

Consent to Treatment

Americans attach great importance to being left alone. They pride themselves on having perfected a social and political system that limits how far government and others can control what they do. The principle of autonomy is enshrined in the Constitution, and U.S. courts have repeatedly confirmed Americans' right to make decisions for themselves. This tradition is particularly strong in the area of medical decisionmaking: An adult with "decisional capacity"[2] has the unquestioned right to decide which treatment he will accept or to refuse treatment altogether, even if that refusal may result in death.

The situation is somewhat different for adolescents because they do not have the legal status of full−fledged adults. There are certain decisions that society will not allow them to make: Below a certain age (which varies by State and by issue), adolescents must attend school, may not marry without parental consent, may not drive, and cannot sign binding contracts. Adolescents' right to consent to medical treatment or to refuse treatment also differs from adults'. Whether a substance use disorder treatment program may admit an adolescent without parental consent depends on State statutes governing consent and parental notification in the context of substance use disorder treatment and a number of fact−based variables, including the adolescent's age and stage of cognitive, emotional, and social development. Although it may make clinical sense to obtain consent for treatment from an underage adolescent, it is relevant to consider the wide range of factors that contribute to a program's decision to admit an adolescent for treatment without parental consent.

State Laws

More than half the States, by law, permit adolescents less than 18 years of age to consent to substance use disorder treatment without parental consent. In these States, providers may admit adolescents on their own signature. (The important question of whether the provider can or should inform the parents is discussed below.)

In States that do require parental consent or notification, a provider may admit an adolescent when there is parental consent or (in those States requiring notification) when the adolescent is willing to have the program communicate with a parent. Presumably, a parent whose child seeks treatment will consent. (A parent or guardian who refuses to consent to treatment that a health care professional believes necessary for the adolescent's well−being may face charges of child neglect.)

The difficulty arises when the adolescent applying for admission refuses to permit communication with a parent or guardian. As is explained more fully below, with one very limited exception, the Federal confidentiality regulations prohibit a program from communicating with anyone in this situation, including a parent, unless the adolescent consents. The sole exception allows a program director to communicate "facts relevant to reducing a threat to the life or physical well−being of the applicant or any other individual to the minor's parent, guardian, or other person authorized under State law to act in the minor's behalf," when

- The program director believes that the adolescent, because of extreme youth or mental or physical condition, lacks the capacity to decide rationally whether to consent to the notification of her parent or guardian
- The program director believes the disclosure to a parent or guardian is necessary to cope with a substantial threat to the life or physical well−being of the adolescent applicant or someone else. __2.14(c) and (d)

Note that _2.14(d) applies only to applicants for services. It does not apply to minors who are already clients. Thus, programs cannot contact parents of adolescents who are already clients without the adolescent's consent even if counselors are concerned about adolescent's behavior.

This is the point at which things become more complicated. If the adolescent refuses to consent to communication with a parent in a State that requires parental consent or notification, and the situation does not fit within the exception in __2.14(c) and (d), the program has two clear choices: It can refuse to admit the adolescent,[3] or it can admit the adolescent despite what the law seems to require. In making this decision, the program should consider the following factors (see Figure 8−1).

Other Variables

The adolescent's age. Society accords adolescents increased autonomy as they get older. Although the details of the rules vary from State to State, adolescents in the middle age range may obtain a driver's license, often with limitations, and may work during their high school years, if they obtain work permits. It follows that a treatment provider that might refuse to admit a 14−year−old without parental consent in a State requiring it might have little concern admitting an 18−year−old in similar circumstances.

The adolescent's maturity. Chronological age is clearly not the only concern. There are 14−year−olds who have maturity beyond their years, and there are emotionally immature 18−year−olds with poor social skills and reasoning ability. Thus, a provider pondering whether to admit an adolescent without parental consent in a State requiring it should assess the adolescent's maturity as well as her chronological age.

The adolescent's family situation. This TIP has emphasized the importance of family involvement in treatment. However, involving an adolescent's parents or notifying them to obtain their consent may be impractical and clinically unwise in some cases. Adolescents who refuse to permit parental notification may have good reasons; requiring them to do so may not be ethical or very good clinical practice. Reconciliation with the family may be vital to an adolescent's recovery, but circumstances may dictate that it be abandoned or postponed until a later stage of treatment.

The kind of treatment to be provided. The more intrusive and intensive the proposed treatment would be, the more risk the program assumes in admitting the adolescent without parental consent. An outpatient program is on firmer ground admitting an adolescent without parental consent than an intensive outpatient or a residential program would be.

Federal confidentiality restrictions. As has already been mentioned, the Federal confidentiality regulations require substance use disorder treatment programs that wish to communicate with an adolescent's parents to obtain the adolescent's written consent.

The program's possible liability for refusing admission. State law may impose a duty on a program to treat clients in need.

The program's possible liability for treating the adolescent without parental consent. It is theoretically possible that a provider could be sued for treating an adolescent without obtaining parental consent in a State that requires it. It is, however, unlikely. If the treatment provided is uncontroversial and relatively nonintrusive, does not put the adolescent at risk, and is carried out in a responsible, nonnegligent manner, it would be hard for a parent to show that any harm was done. This is particularly so if the provider made a reasoned decision (relying on the factors discussed here) and acted in good faith and out of concern for the adolescent.

Of course, there is a slim possibility that a parent might sue a provider, claiming that treatment harmed the youngster or turned the adolescent away from the family. However, success in such a case would require proof that treatment harmed the adolescent or that family relationships were good prior to treatment and treatment caused the adolescent's alienation. These are extraordinarily difficult things to prove. Despite popular belief, most lawyers do not chase after cases that are complex, time−consuming, expensive, and difficult to win. Convincing an attorney to take on such a case would not be easy.

The program's financial condition. If the program admits an adolescent without parental consent, it may not be paid for its treatment services. Any effort to bill the parent over the objections of the adolescent would violate the Federal confidentiality regulations. If a program is publicly funded, support for services for adolescents who do not want their parents notified may not be a problem.

Because of the complexity of this issue, programs in States with laws that do not clearly allow admission of adolescents without parental consent or notification should develop an admissions policy. The policy should be based on the variables discussed above, vis−_−vis:

- State law regarding treatment of adolescents (i.e., is parental consent and/or notification required?)
- State law regarding program liability if adolescent clients in need are turned away
- The family circumstances as related by the adolescent−−verifying the adolescent's view of his family, with his consent, by contacting an adult who knows the family well
- The adolescent's age and emotional, cognitive, and social maturity
- The nature, severity, and complexity of presenting problems, and the kind of treatment the program provides
- The program's financial capacity to provide treatment without reimbursement from the family
- Potential for exposure to a lawsuit should the program admit the adolescent
- With the above factors in mind, an assessment of the potential liability of the program if the adolescent is admitted

The admission policy need not be rigid. For example, a provider could develop a policy permitting treatment of limited duration for adolescents of sufficient maturity who are in need of treatment and who refuse to consent to parental notification. During that period of time, the program would provide treatment of light or moderate intensity and, at the same time, work with the adolescent on the notification issue. If the adolescent consents to parental notification after a period of time, the problem may be resolved. If the adolescent remains adamantly opposed to communication with her parents and if the program is convinced there is ample justification, it could assist the adolescent in finding another adult relative to bring into the picture or help find legal assistance that would permit the adolescent to gain "emancipated minor" status or simply continue treatment.

If an adolescent's family situation poses a real threat to her well−being, it may be appropriate for the program to report that fact to child welfare officials.[4] This option is also available to the provider who determines that it is inappropriate to admit an adolescent to treatment without parental consent because of the youngster's age or maturity.[5] The entire decisionmaking process, including reasons for exceptions to the policy, should be noted in the client's medical records.

Privacy and Confidentiality

Those who treat adolescents with substance use disorders are naturally concerned about their clients' privacy and confidentiality. For an adolescent, disclosure of a substance use disorder may contribute to negative stigma. Disclosures of information about an adolescent's substance use disorder might result in his having to deal with inquisitive peers, who may feel uncomfortable around him or subject him to ridicule. Adolescents in recovery have much to overcome, without having to face their peers before they are ready.

Given the importance of respecting adolescent clients' privacy, how can a program that assesses and treats adolescents approach family, school, and other sources that have information it may need? Can the program contact a parent or guardian without an adolescent's consent? If an adolescent tells a program staff member that she has been abused, can the program report it? If the adolescent tells a counselor she has committed a crime, should the counselor notify the police? If the adolescent is threatening harm to herself or another, can the program call the authorities? Are there special rules regarding confidentiality for programs operating in the juvenile justice system or for child welfare programs?

This section attempts to answer these and related questions. It has five parts. First, there is an overview of the Federal law protecting a youth's right to privacy when seeking or receiving treatment services. Next is a detailed discussion of the rules regarding the use of consent forms to get an adolescent's permission to release information about his seeking or receiving substance abuse services. The third reviews the rules for communicating with others about various issues concerning a youth who is in treatment for a substance use disorder (including rules for communicating with parents, guardians, and other sources; reporting child abuse; warning others of an adolescent's threats to harm herself or another; and special rules for use within the criminal and juvenile justice systems). The next part discusses a number of exceptions to the general rule barring disclosure such as medical emergencies. This section ends with a few additional points concerning a youth's right to confidential services and the need for programs to obtain legal assistance.

Federal Law Protects Adolescents' Right to Privacy

Concerned about the adverse effects social stigma and discrimination have on clients in recovery and how that stigma and discrimination might deter people from entering treatment, Congress passed legislation, and the Department of Health and Human Services issued a set of regulations to protect information about clients' substance use disorder treatment. The law is codified at 42 U.S.C. _290dd−2. The implementing Federal regulations, *Confidentiality of Alcohol and Drug Abuse Client Records*, are contained in 42 C.F.R. Part 2 (Vol. 42 of the Code of Federal Regulations, Part 2).

The Federal law and regulations severely restrict communications about identifiable clients by "programs" providing substance use/abuse diagnosis, treatment, or referral for treatment (42 CFR _2.11). The purpose of the law and regulations is to decrease the risk that information about individuals in recovery will be disseminated and that they will be ostracized or subjected to discrimination.

The regulations restrict communications more tightly in many instances than, for example, either the doctor−client or the attorney−client privilege. Violating the regulations is punishable by a fine of up to $500 for a first offense and up to $5,000 for each subsequent offense (_2.4).[6] Some may view these Federal regulations governing communication about the adolescent and protecting privacy rights as an irritation or a barrier to achieving program goals. However, most of the nettlesome problems that may crop up under the regulations can easily be avoided through planning ahead. Familiarity with the regulations' requirements will assist communication. It can also reduce confidentiality−related conflicts among the program, adolescent client, parent, and outside agencies so that they occur only in a few relatively rare situations.

What Types of Programs Are Governed by the Regulations?

Any program that specializes, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for adolescents with substance use disorders must comply with the Federal confidentiality regulations (42 C.F.R. _2.12(e)). Although the Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid such as tax−exempt status or State or local government funding coming (in whole or in part) from the Federal Government.

Coverage under the Federal regulations does not depend on how a program labels its services. Calling itself a "prevention program" does not excuse a program from adhering to the confidentiality rules. It is the kind of services, not the label, that will determine whether the program must comply with the Federal law.

The General Rule: Overview of Federal Confidentiality Laws

The Federal confidentiality laws and regulations protect any information about an adolescent who has applied for or received any substance use/abuse−related assessment, treatment, or referral services from a program that is covered

under the law. Services applied for or received can include assessment, diagnosis, individual counseling, group counseling, treatment, or referral for treatment.[7] The restrictions on disclosure (the act of making information known to another) apply to any information that would identify the adolescent as having a substance use disorder either directly or by implication. The general rule applies from the time the adolescent makes an appointment. It also applies to former clients. The rule applies whether or not the person making an inquiry already has the information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant.

When May Confidential Information Be Shared With Others?

Information that is protected by the Federal confidentiality regulations may always be disclosed after the adolescent has signed a proper consent form. (As will soon become clear, parental consent must also be obtained in some States.) The regulations also permit disclosure without the adolescent's consent in several situations, including medical emergencies, reporting child abuse, and communications among program staff. Nevertheless, obtaining the adolescent's consent is the most commonly used exception to the general rule prohibiting disclosure. The regulations' requirements regarding consent are strict and somewhat unusual and must be carefully followed.

Consent: Rules about obtaining adolescent consent to disclose treatment information

Most disclosures are permissible if an adolescent has signed a valid consent form that has not expired or been revoked (_2.31).[8] A proper consent form must be in writing and must contain each of the items specified in _2.31:

- The name or general description of the program(s) making the disclosure
- The name or title of the individual or organization that will receive the disclosure
- The name of the adolescent who is the subject of the disclosure
- The purpose or need for the disclosure
- How much and what kind of information will be disclosed
- A statement that the adolescent may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
- The date, event, or condition upon which the consent will expire if not previously revoked
- The signature of the adolescent (and, in some States, her parent)
- The date on which the consent is signed (_2.31(a))

A general medical release form or any consent form that does not contain all of the elements listed above is not acceptable. (See sample consent form in Figure 8−2.) A number of items on this list deserve further explanation and are discussed under the following subheadings:

- The purpose of the disclosure and how much and what kind of information will be disclosed
- The adolescent's right to revoke his consent
- Expiration of the consent form
- The adolescent's signature and parental consent
- The required notice against re−releasing information

These topics are followed by a note about agency use of the consent forms.

The purpose of the disclosure and how much and what kind of information will be disclosed

These two items are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure (_2.13(a)). It would be improper to disclose everything in an adolescent's file if the recipient of the information needs only one specific piece of information.

The purpose or need for the communication of information must be specified on the consent form. Once the purpose or need has been identified, it is easier to determine how much and what kind of information will be disclosed, tailoring it to what is essential to accomplish the specified need or purpose. That, too, must be written into the consent form.

As an illustration, if an adolescent needs to have her participation in counseling verified in order to be excused from school early, the purpose of the disclosure would be "to verify treatment status so that the school will permit early release," and the amount and kind of information to be disclosed would be "time and dates of appointments." The disclosure would then be limited to a statement that "Susan Jones (the client) is receiving counseling at XYZ Program on Tuesday afternoons at 2 p.m."

The adolescent's right to revoke consent

The adolescent may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing, but the standard of practice is to document a verbal revocation with a dated note in the treatment record. If a program has already made a disclosure prior to the revocation, acting in reliance on the adolescent's signed consent, it is not required to try to retrieve the information it has already disclosed.

The regulations also provide that "acting in reliance" includes the provision of services while relying on a consent form permitting disclosures to a third−party payor. (Third−party payors are health insurance companies, Medicaid, or any party that pays the bills other than the adolescent's family.) Thus, a program can bill the third−party payor for services provided before the consent was revoked. However, a program that continues to provide services after a client has revoked a consent authorizing disclosure to a third−party payor does so at its own financial risk.

Expiration of consent form

The form must also contain a date, event, or condition on which it will expire if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" (_2.31(a)(9)). Depending on the purpose of the consented disclosure, the consent form may expire in 5 days, 6 months, or longer. Sound practice calls for adjusting the expiration date in this way, rather than imposing a set time period, say 60 to 90 days. When providers use uniform expiration dates, they can find themselves in a situation for which there is a need for disclosure, but the adolescent's consent form has expired. This means at the least that the client must come to the agency again to sign a consent form. At worst, the client has left or is unavailable, and the agency will not be able to make the disclosure.

The consent form does not have to contain a specific expiration date but may instead specify an event or condition. For example, if an adolescent has been placed on probation at school on the condition that he attend counseling at the program, the consent form can be drafted to expire at the completion of the probationary period. Or, if an adolescent is being referred to a specialist for a single appointment, the consent form should stipulate that consent will expire after he has seen "Dr. X."

The signature of the adolescent (and the issue of parental consent)

The adolescent must always sign the consent form in order for a program to release information even to her parent or guardian. The program must get the signature of a parent, guardian, or other person legally responsible for the adolescent in addition to the adolescent's signature only if the program is required by State law to obtain parental permission before providing treatment to the adolescent (_2.14).

In other words, if State law does not require the program to get parental consent in order to provide services to the adolescent, then parental consent is not required to make disclosures (_2.14(b)). If State law requires parental consent to provide services to the adolescent, then parental consent is required to make any disclosures. Note that the program

must always obtain the adolescent's consent for disclosures and cannot rely on the parent's signature alone.

Required notice against redisclosing information

Once the consent form has been properly completed, there remains one last formal requirement. 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 (_2.32). This statement, not the consent form itself, should be delivered and explained to the recipient of the information at the time of disclosure or earlier. (Of course, an adolescent may sign a consent form authorizing a redisclosure.)

Note on agency use of consent forms

The fact that an adolescent has signed a proper consent form authorizing the release of information does not force a program to make the proposed disclosure, unless the program has also received a subpoena or court order (__2.3(b)(1); 2.61(a)(b)). In most cases, the decision whether to make a disclosure authorized by a client's signed consent is up to the program, unless State law requires or prohibits a particular disclosure once consent is given. The program's only obligation under the Federal regulations is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or incorrect (_2.31(c)).

In general, it is best to follow this rule: Disclose only what is necessary, for only as long as is necessary, keeping in mind the purpose for disclosing the information.

Rules for Communicating With Others About Adolescents: Common Issues

Now that the rules regarding consent are clear, attention can turn to the questions that were introduced at the beginning of this section.

- How can a program seek information from collateral sources about an adolescent, coordinate care with other agencies serving the adolescent, and make referrals for the adolescent?
- How can programs communicate with parents?
- Are there special rules for adolescents who are involved in the juvenile or criminal justice systems?
- Do programs have a duty to warn potential victims or law enforcement agencies of threats by adolescents, and if so, how do they communicate the warning?
- What should a program do if an adolescent confesses to committing a crime?
- How should programs deal with adolescents' risk−taking behavior?
- Can programs report child abuse?

Seeking Information From Collateral Sources, Coordinating Care, and Making Referrals

Making inquiries of schools, doctors, and other health care providers might, at first glance, seem to pose no risk to an adolescent's right to confidentiality. But it does.

When a program that screens, assesses, or treats adolescents asks a school, doctor, or parent to verify information it has obtained from the adolescent, it is making a disclosure that the named adolescent has sought help for a substance use disorder. The Federal regulations generally prohibit this kind of disclosure unless the adolescent consents.

How then is a program to proceed? The easiest way is to get the adolescent's consent to contact the school, health care facility, and so on. In fact, the program can ask the client to sign a consent form that permits it to make this kind of

limited disclosure in order to gather information from any one of a number of entities or persons listed on the consent form. Note that this combination form must still include "the name or title of the individual or name of the organization" for each collateral source the program may contact. The program must also inform the party at the other end of the inquiry about the prohibition on redisclosure, orally at first if the communication is via telephone.

Note, however, if the information being disclosed is not about the adolescent's substance use disorder, then the answer may be different. For example, 14−year−olds may be able to authorize release of information about substance use disorder treatment, but a client may have to be 16 years old to consent to release a psychiatric record, and, in most jurisdictions, school systems will not release educational records if the client is less than 18 years old. Many programs have both child and parent sign to indicate that, even if only one signature is required by law, all parties involved agree to the release of the information.

Communications Among Agencies−−Making Periodic Reports or Coordinating Care

Programs serving adolescents may have to confer on an ongoing basis with other agencies, such as mental health or child welfare programs. Again, the best way to proceed is to get the adolescent's consent (as well as parental consent when State law so requires). Care should be taken in wording the consent form to permit the kinds of communications necessary. For example, if the program needs ongoing communications with a mental health provider, the "purpose of the disclosure" would be "coordination of care for Hector Velez" and "how much and what kind of information will be disclosed" might be "treatment status, treatment issues, and progress in treatment." If the program is treating a client who is on probation at school and whose future school attendance is contingent on treatment, the "purpose of disclosure" might be "to assist the client to comply with the school district's mandates" or to "supply periodic reports about attendance" and "how much and what kind of information will be disclosed" might be "attendance" or "progress in treatment." Note that the kinds of information that will be disclosed in these two examples are quite different. The program might well share detailed clinical information about a client with a mental health provider if that would assist in coordinating care. Disclosure to a school should be limited to a brief statement about the client's attendance or progress in treatment. Disclosure of detailed clinical information to the school would, in most circumstances, be inappropriate.

The program should also give considerable thought to the expiration date or event the consent form should contain. For coordinating care with a mental health program, it might be appropriate to have the consent form expire when treatment by either agency ends. A consent form permitting disclosures to a school might expire when the adolescent's probationary period ends.

Programs treating adolescents often refer clients to other health care or social service agencies. Giving an adolescent the name and telephone number of an outside gynecologist, tutoring service, or training program might not be effective unless the adolescent's treatment counselor calls to set up the appointment for the adolescent. However, such a call is a disclosure of confidential information that the adolescent has a substance use disorder and requires the counselor to get the client's consent in writing (as well as parental consent in States requiring it).

Communicating With Parents or Guardians

As has been noted above, programs may not communicate with the parents of an adolescent unless they get the adolescent's written consent. When the adolescent is willing to consent to a disclosure to her parents, the program should take the opportunity to discuss with the adolescent whether she (and the program) want communications between the program and his parent or guardian to occur just once or on a regular basis. This decision will affect how the program fills out the consent form.

If a program counselor and the adolescent jointly decide they want the counselor to confer with the parent or guardian only once, in order to obtain the parent's consent to treatment or to gather additional information, the purpose of the disclosure (which must be stated on the consent form) would be "to notify Mary's parents" or "to obtain information from Mary's parents in order to assist in the assessment process." The "kind of information" to be disclosed (in either of these instances) would be "Mary's application for services." The expiration date should be keyed to the date of parental notification or the date by which the counselor thinks the assessment process will be completed.

If the program and Mary decide they want the program's counselor to be free to talk to Mary's parent or guardian over a longer period of time, the program would fill out the consent form differently. The purpose of the disclosure might then be "to provide periodic reports to Mary's parents" and the kind of information to be disclosed would be "Mary's progress in treatment." Or, the purpose might be "to provide family counseling to Mary and her family" and the kind of information to be disclosed would be "Mary's treatment." The expiration of this kind of open−ended consent form might be set at the date the program and Mary foresee counseling ending or even "when Mary's participation in the program ends." (However, Mary can revoke the consent any time she wishes.)

What if Mary refuses to consent? Because the Federal confidentiality regulations forbid disclosures without Mary's consent, the program cannot confer with her parents. This issue was discussed above.

Special Consent Rules for Adolescents Involved in the Criminal or Juvenile Justice Systems

Programs assessing or treating adolescents who are involved in the criminal justice system (CJS) or juvenile justice system (JJS) (i.e., juvenile court) must also follow the Federal confidentiality rules. However, some special rules apply when an adolescent comes for assessment or treatment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of a criminal or juvenile justice proceeding.[9]

A consent form (or court order) is still required before a program can disclose information about an adolescent who is the subject of CJS or JJS referral. However, the rules concerning the length of time that a consent is valid and the process for revoking the consent are different (_2.35). Specifically, the regulations require that the following factors be considered in determining how long a CJS or JJS consent will remain in effect:

- The anticipated duration of treatment
- The type of juvenile or criminal proceeding
- The need for treatment information in dealing with the proceeding
- When the final disposition will occur
- Anything else the adolescent, program, or justice agency believes is relevant

These rules allow programs to draft the consent form to expire "when there is a substantial change in the adolescent's justice system status." A substantial change in justice status occurs whenever the adolescent moves from one phase of the JJS or CJS to the next. For example, for an adolescent on probation, a change in JJS or CJS status would occur when the probation ends, either by successful completion or revocation. Thus, the program could provide an assessment and periodic reports to the adolescent's probation officer and could even testify at a probation revocation hearing if it so desired, because no change in status would occur until after that hearing.

Moreover, the Federal regulations permit the program to draft the consent form so that it cannot be revoked until a certain specified date or condition occurs. The regulations permit the JJS or CJS consent form to be irrevocable so that an adolescent who has agreed to enter treatment in lieu of prosecution or punishment cannot then prevent the court, probation department, or other agency from monitoring his progress. Note that although a JJS or CJS consent may be made irrevocable for a specified period of time, that time period must end no later than the final disposition of the juvenile or criminal justice proceeding. Thereafter, the adolescent may freely revoke consent. A sample criminal

justice consent form appears in Figure 8−3.

Duty to Warn

For most treatment professionals, the issue of reporting a client's threat to harm another or commit a crime is a troubling one. Many professionals believe that they have an ethical, professional, or moral obligation to prevent a crime when they are in a position to do so, particularly when the crime is a serious one.

There has been a developing trend in the law to require psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a client presents a "serious danger of violence to another." This trend started with the case of *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976). In that case, the California Supreme Court held a psychologist liable for monetary damages because he failed to warn a potential victim that his client threatened to kill that person and then did so. The court ruled that if a psychologist knows that a client poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

Although the *Tarasoff* ruling, strictly speaking, applies only in California, courts and legislatures in other States have adopted *Tarasoff's* reasoning to hold therapists liable for monetary damages when they have failed to warn someone threatened by a client. In most instances, liability is limited to situations in which a client threatens violence to a specific identifiable victim; liability does not usually apply when a client makes a general threat without identifying the intended target.

If an adolescent's counselor thinks the youth poses a serious risk of violence to someone, there are at least two−−and sometimes three−−questions that must be answered:

1. Does a State statute or court decision impose a duty to warn in this particular situation?
2. 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?

The first question can only be answered by an attorney familiar with the law in the State in which the program operates. If the answer to the first question is "no," then it is advisable to discuss the second question with a knowledgeable lawyer, too.

If the answer to question 1 or 2 is "yes," then how can the program warn the victim or someone able to take preventive action without violating the Federal confidentiality regulations?

The problem is that there is a conflict between the Federal confidentiality requirements and the duty to warn imposed by States that have adopted the *Tarasoff* rule. Simply put, the Federal confidentiality law and regulations appear to prohibit the type of disclosure that the *Tarasoff* rule requires. Moreover, the Federal regulations make it clear that Federal law overrides any State law that conflicts with the regulations (_2.20). In the only case, as of this writing, that addresses this conflict between Federal and State law (*Hansenie v. United States*, 541 F.Supp. 999 (D. Md. 1982)), the court ruled that the Federal confidentiality law prohibited any report.

When an adolescent makes a threat to harm himself or another and the program is confronted with conflicting moral and legal obligations, it can proceed in one of the following ways:

- The program can go to court and request a court order authorizing the disclosure. The program must take care that the court abides by the requirements of the Federal confidentiality regulations (which are discussed below in detail).

- The program can make a disclosure that does not identify the adolescent who has threatened to harm another as a client. This can be accomplished either by making an anonymous report or−−for a program that is part of a larger nonsubstance use disorder treatment facility−−by making the report in the larger facility's name. For example, a counselor employed by a substance abuse program that is part of a mental health facility could phone the police or the potential target of an attack, identify herself as "a counselor at the New City Mental Health Clinic," and explain the risk. This would convey the vital information without identifying the adolescent as someone in substance use disorder treatment. Counselors at freestanding treatment programs cannot give the name of the program. (The "nonclient−identifying disclosure" exception is discussed more fully below.)
- If the adolescent has been mandated into treatment by the CJS or JJS, the program can make a report to the mandating CJS or JJS agency, so long as it has a CJS consent form signed by the adolescent that has been worded broadly enough to allow this sort of information to be disclosed. The CJS or JJS agency can then act on the information to avert harm to the adolescent or the potential victim. However, the regulations limit what the justice agency can do with the information. Section 2.35(d) states that anyone receiving information pursuant to a CJS consent may redisclose and use it only to carry out that person's official duties with regard to the client's conditional release or other action in connection with which the consent was given. Thus, the referring justice agency can use the disclosure to revoke the adolescent's conditional release or probation or parole. If the justice agency wants to warn the victim or to notify another law enforcement agency of the threat, it must be careful that it does not mention that the source of the tip was someone at a substance use disorder treatment program or that the adolescent making the threat is in treatment for a substance use disorder. However, the disclosure most likely cannot be used to prosecute the adolescent for a separate offense (such as making the threat). The only way to prosecute an adolescent based on information obtained from a program is to obtain a special court order in accordance with _2.65 of the regulations (which is discussed below).
- The program can make a report to medical personnel if the threat presents a medical emergency that poses an immediate threat to the health of any individual and requires medical intervention. (See the discussion of the medical emergency exception below.)
- The program can obtain the client's consent.

If none of these options is practical and if a counselor believes there is a clear and imminent danger to an adolescent client or another identified person, then it is probably wiser to err on the side of making an effective report about the danger to the authorities or to the threatened individual.

Although each case presents different questions, it is doubtful that any prosecution (or successful civil lawsuit) under the confidentiality regulations would be brought against a counselor who warned about potential violence when he believed in good faith that there was real danger to a particular individual. On the other hand, a civil lawsuit for failure to warn may well result if the threat is actually carried out. In any event, the counselor should at least try to make the warning in a manner that does not identify the individual as having a substance use disorder.

Duty−to−warn issues represent an area in which staff training, as well as a staff review process, may be helpful. For example, a troubled youth may engage in verbal threats as a way of "blowing off steam." Such threats may be the adolescent's cry for additional support services. Program training and discussions can assist staff in sorting out what should be done in each particular situation.

Is There a Duty to Warn of an HIV−Infected Adolescent's Threat to Others?

One more duty−to−warn issue needs to be discussed. Do providers have a duty to warn others when they know that an adolescent they are treating is infected with HIV? When would that duty arise? Even where no duty exists, should providers warn others at risk about an adolescent's HIV status? Finally, how can others be warned without violating the Federal confidentiality regulations and State confidentiality laws?

Is there a duty?

The answer to the first question is a matter of State law. Courts in some States have held that health care providers have a duty to warn third parties of the behavior of persons under their care if it poses a potential danger to others. In addition to these court decisions, some States have enacted laws that either permit or require health care providers to warn certain third parties. These persons may include sex partners at risk. Usually, these State laws prohibit disclosure of the infected person's identity, while allowing the provider to tell the person at risk that he may have been exposed. It is important that providers consult with an attorney familiar with State law to learn whether the law imposes a duty to warn, as well as whether State law prescribes the ways in which a provider can notify the person at risk. (For example, is the provider prohibited from disclosing the adolescent's name? Must the adolescent consent?) Because the law in this area is still developing, it is also important to keep abreast of changes.

When does the duty arise?

Two behaviors of infected persons can put others at risk of infection: unprotected sex involving the exchange of bodily fluids and needle−sharing. Because HIV is not transmitted by casual contact, the simple fact that an adolescent is infected would not give rise to a duty to warn the adolescent's family or acquaintances who are not engaged in sex or needle−sharing with the adolescent.

This still leaves open the question of when a duty arises. Would it be when an adolescent tells a counselor that he wants or plans to infect others? Or would it arise when an adolescent tells the counselor that he has already exposed others to HIV? These are two different questions.

The threat to expose others

A counselor whose adolescent client threatens to infect others should consider three questions in determining whether there is a duty to warn:

Is the adolescent making a threat or "blowing off steam"? Sometimes, wild threats are a way of expressing anger. Such threats may be the adolescent's cry for additional support services. However, if the adolescent has a history of violence or of sexually abusing others, the threat should probably be taken seriously.

Is there an identifiable potential victim? Most States that impose a duty to warn do so only when there is an identifiable victim or class of victims. Without an identifiable victim, it is difficult to warn anyone; and, unless public health authorities have the power to detain someone in these circumstances, there is little reason to inform them.

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?

Clearly, there are no definitive answers in this area. As with other duty−to−warn issues, each case depends on the particular fact pattern presented and on State law. If a provider believes that she has a duty to warn under State law or that there is real danger to a particular individual giving rise to a moral or ethical duty to warn that individual, she should do so in a way that complies with both the Federal confidentiality regulations and any State law or regulation regarding disclosure of medical or HIV−related information. Because a client is unlikely to consent to a disclosure to the potential victim, in an effort to comply with the Federal regulations, a provider could

- Seek a court order authorizing the disclosure. The provider should consult State law to determine whether it imposes requirements in addition to those imposed by the Federal regulations.
- Make an "anonymous" warning−−that is, a warning that does not disclose the adolescent's status as having a substance use disorder. The provider should also limit the way it issues the warning so as to expose the

adolescent's identity as HIV−positive to as few people as possible.

Reporting an exposure

Suppose an HIV−infected adolescent tells his counselor that he has had unprotected sex or shared needles with someone? If the counselor knows who the person is, does she have a duty to warn the person (or law enforcement)?

This is not a true duty−to−warn case because the exposure has already occurred. The purpose of the "warning" is not to prevent a criminal act, but to notify an individual so that he can take steps to monitor health status or begin drug therapy. Thus, it is probably not helpful to call a law enforcement agency. Rather, the counselor might want to let the public health authorities know, particularly in States with mandatory partner notification laws. Public health officials can then find the person at risk and provide appropriate counseling.

How can programs notify the public health department without violating the confidentiality regulations? In some areas of the country, programs have signed qualified service organization agreements (QSOAs) with public health departments that provide services to the program (for more information on QSOAs, see the subsection, Sharing Information With an Outside Agency That Provides Services to the Programs, below). This enables providers to report exposures to the department in situations like these. The public health department can then help not only the person the counselor believes was exposed, but can also trace other contacts the adolescent may have exposed. In doing so, the public health department often does not identify the person who has put his contacts at risk. Certainly, the public health department would not have to tell the contact that the person is in treatment for a substance use disorder, and the QSOA would prohibit it from doing so. (A treatment program must also make sure that reporting an exposure by a client through a QSOA complies with any State law protecting medical or HIV−related information.)

Notifying others without violating the law

If the provider does not have a QSOA with the public health department, it might try one of the following:

- *Consent.* The provider could inform the health department with the adolescent's consent. The consent form must comply with both the Federal confidentiality regulations and any State requirements governing client consent to release of HIV/AIDS information, as well as any State law governing consent by adolescents (i.e., whether a parent must also consent).
- *"Anonymous" notification.* If the program notifies the public health department in a way that does not identify the adolescent as having a substance use disorder it would be complying with the Federal regulations.
- *Court order*. Again, State law must be consulted to determine whether it imposes requirements in addition to those imposed by the Federal regulations.

One of these methods should enable the provider to alert the public health department, which is the most effective way to notify someone who may have been exposed.

The provider should document the factors that impelled the decision to warn an individual of impending danger of exposure or to report an exposure to the public health department. If the decision is later questioned, then notes made at the time the decision was made could prove invaluable.

Finally, the provider should remember that any time a program warns someone of a threat an adolescent makes without the adolescent's consent, the program may be undermining the trust of other adolescents and thus its effectiveness. This may be particularly true for a program serving HIV−positive adolescents. Other clients may learn of the disclosure, and the trust that the program worked so hard to build may be weakened. This is not to say that a disclosure should not be made−−particularly when the law requires it. It is to say that a disclosure should not be made without careful thought.

The circumstances in which a duty to warn or notify arises may change over time as scientists learn more about the virus and its transmission and as better treatments are developed. There is little doubt that the law will also change as States adopt new statutes and their courts apply statutes to new situations.

Programs should develop a protocol about duty−to−warn cases, so that staff members are not left to make decisions on their own about when and how to report threats of violence and threats or reports of HIV transmission. Ongoing training and discussions can also assist staff members in sorting out what should be done in any particular situation.

Reporting Criminal Activity

What should a program do when an adolescent tells a counselor that she intends to go shoplifting at the mall, something the counselor knows he has done before. Does the program have a duty to tell the police? Does a program have a responsibility to call the police when an adolescent discloses to a counselor that he participated in a serious crime some time in the past? What can a program do when a client commits a crime at the program or against an employee of the program? These are three very different questions that require separate analysis.

Reporting threatened criminal activity

By this time, the reader should know the answer to the first question: A program generally does not have a duty to warn another person or the police about an adolescent's intended actions unless the client presents a serious danger of violence to an identifiable individual. Shoplifting rarely involves violence, and the counselor may not know which stores are to be victimized. Petty crime like shoplifting is an important issue that should be dealt with therapeutically. It is not something a program should necessarily report to the police.

Reporting past criminal activity

Suppose, however, that an adolescent client admits during a counseling session that he killed someone 3 months ago. Here the program is not warning anyone of a threat, but serious harm did come to another person. Does the program have a responsibility to report that?

In a situation in which a program thinks it might have to report a past crime, there are generally three questions to consider:

1. Is there a legal duty to report the past criminal activity to the police under State law?

Generally, the answer to this question is no. In most States, there is no duty to tell the police about a crime committed in the past. Even those States that impose a duty to report rarely prosecute violations of the law.

1. Does State law permit a counselor to report the crime to law enforcement authorities if she wants to?

Whether or not citizens have a legal obligation to report past crimes to the police, State law may protect conversations between counselors of substance use disorder treatment programs and their clients and exempt counselors from any requirement to report past criminal activity by clients. State laws vary widely on the protection they accord communications between clients and counselors. In some States, admissions of past crimes may be considered privileged, and counselors may be prohibited from reporting them; in others, admissions may not be privileged. Moreover, each State defines the kinds of relationships protected differently. Whether a communication about past criminal activity is privileged (and therefore cannot be reported) may depend on the type of professional the counselor is and whether she is licensed or certified by the State.

Any program that is especially concerned about this issue should ask a local attorney for an opinion letter about whether there is a duty to report and whether any counselor−client privilege exempts counselors from that duty.

1. If State law requires a report (or permits one and the program decides to make a report), how can the program comply with the Federal confidentiality regulations and State law?

Any program that decides to make a report to law enforcement authorities about a client's prior criminal activity must do so without violating either the Federal confidentiality regulations or State laws. A program that decides to report a client's crime can comply with the Federal regulations by following one of the first three methods described above in the discussion of duty to warn:

- It can make a report in a way that does not identify the adolescent as a client in substance use disorder treatment.
- It can obtain a court order permitting it to make a report if the crime is "extremely serious" (_2.65(d)).
- If the adolescent is an offender who has been mandated into treatment by a criminal justice or juvenile justice agency, the program can make a report to that justice agency, if it has a CJS consent form signed by the adolescent that is worded broadly enough to allow this sort of information to be disclosed. (Note, however, that the regulations limit the actions law enforcement officials may take once they have received the information.)

Because of the complicated nature of this issue, any program considering reporting an adolescent's admission of criminal activity should seek the advice of a lawyer familiar with local law as well as the Federal regulations. Because past criminal activity may not indicate an emergency, the counselors do not have to decide immediately whether to report it. This issue can be addressed with the client as a treatment issue. With the support of a program and proper legal advice, the adolescent may report the crime himself.

Reporting crimes on program premises or against program personnel

The answer is more straightforward when an adolescent client has committed or threatens to commit a crime on program premises or against program personnel. In this situation, the regulations permit the program to report the crime to a law enforcement agency or to seek its assistance. In such a situation, without any special authorization, the program can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a client at the program (_2.12(c)(5)).

One crime that an adolescent might well commit on program premises is drug possession−−bringing drugs into the program either on her person or (if the program is residential) in her luggage. When a program finds drugs on a client or in a client's personal property, what should it do? Should the program call the police? What should it do with the drugs?

The answer to the first question has already been discussed above in the section dealing with reporting criminal activity. Generally, State law does not require programs to make such a report. As for the second question, State regulations often govern how a program may dispose of drugs, sometimes requiring that they be flushed down a toilet. Programs should check with their State substance abuse agency if they are unsure about State mandates.

Dealing With Adolescents' Risk−Taking Behavior

Adolescents in treatment for a substance use disorder may engage in risky activities such as renewed drug−taking, criminal behavior, risky sexual conduct, or other activity dangerous to themselves or others. If a counselor believes that the adolescent's conduct is dangerous and counseling seems not to be productive in reducing that behavior, what should he do?

This chapter has already examined what the counselor cannot do: He cannot call the adolescent's parents without the adolescent's consent and, unless there are unusual circumstances, he most likely cannot call law enforcement authorities. There are, however, some things he can do:

- If the adolescent has relapsed into substance use and the relapse has reached the point where it threatens her health and requires immediate medical intervention, the counselor could call the adolescent's family doctor under the "medical emergency" exception. Note that the situation must be a real medical emergency. The medical personnel that the counselor calls must "have a need for the information_for the purpose of treating" the adolescent's condition (_2.51). (For the other requirements of this section, see below.)
- Alternatively, the program could apply for a court order that would authorize it to inform the adolescent's parents or other responsible adults.

Neither of these alternatives is very satisfactory. A program can use the "medical emergency" exception only in very limited circumstances, and obtaining a court order is time−consuming and expensive.

There is a more satisfactory option: When a program admits an adolescent who has a history of risk−taking behavior, the program could ask the adolescent to sign a consent form that authorizes the program to tell an adult the adolescent trusts if the adolescent's behavior takes a dangerous turn. The adult named could be a parent or other relative, a minister or youth counselor, or anyone else with whom the adolescent has rapport. An adolescent entering treatment might consent to this arrangement because she may believe, as do many people entering treatment, that she will not suffer a relapse. An added benefit of this kind of request is that it demonstrates to the adolescent that the program respects her feelings and preferences, takes confidentiality seriously, and will not disclose information to others without the adolescent's consent.

Note that if a counselor notifies the person named in the consent form, that person is bound by the regulations not to disclose the information further without the adolescent's consent, unless he can do so without revealing the fact that the adolescent is in treatment for a substance use disorder. The adolescent can revoke her consent at any time.

Reporting Child Abuse and Neglect

All 50 States and the District of Columbia have statutes requiring reporting when there is reasonable cause to believe or suspect that child abuse or neglect is occurring. Although 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.

When a program makes such a report, it should generally 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. Families should never be abandoned because of suspected abuse or neglect, and health care providers should be wary of making judgments until a comprehensive assessment has been completed by State authorities.

Most States now require not only physicians but also educators and social service workers to report child abuse. Most States require an immediate oral (spoken) report, and many now have toll−free numbers to facilitate reporting. (Half of the States require that both oral and written reports be made.) All States extend immunity from prosecution to persons reporting child abuse and neglect. Most States provide penalties for failure to report.

Program staff will often need some form of training to review the State's child abuse and neglect laws and to clearly explain what the terms *abuse* and *neglect* really mean according to the law. A lay person's−−or a professional's−−idea of child neglect may differ greatly from the legal definition. For example, in some States, a child living with a parent involved in extensive substance abuse, perhaps surrounded by a culture of drugs and alcohol, is not considered to be abused or neglected unless certain other conditions are met. Such legal definitions may go against the grain of what some staff members consider to be in the best interest of the child, but these are safeguards that have developed over time to protect the child, the parent, and the family unit. A forthcoming TIP entitled *Responding to Child Abuse and Neglect Issues of Adult Survivors in Substance Use Disorder Treatment* (CSAT, in press) provides more information on this issue.

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.[10] Because many State statutes require that staff members report instances of abuse to administrators, who are then required to make an official report, programs should establish reporting protocols to bring suspected child abuse to the attention of program administrators. Administrators, in turn, should shoulder the responsibility to make the required reports.

The Federal confidentiality regulations permit programs to comply with State laws that require the reporting of child abuse and neglect. However, this exception to the general rule prohibiting disclosure of any information about a client applies only to initial reports of child abuse or neglect. Programs may not respond to followup requests for information or to subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report. The only situation in which a program may respond to requests for followup information is when the adolescent consents or the appropriate court issues an order under subpart E of the regulations.

Other Exceptions to The General Rule

Reference has been made to other exceptions to the general rule prohibiting disclosure regarding an adolescent who seeks or receives substance use disorder treatment services.

In the subsections that follow, six exceptions to the Federal confidentiality rules are examined in greater detail:

- Disclosures that do not reveal that the client as having a substance use disorder
- Disclosures authorized by court order
- Disclosures during medical emergencies
- Disclosures to an outside agency that provides a service to the program
- Disclosures of information within the program
- Disclosures of information to researchers, auditors, and evaluators

Communications That Do Not Disclose "Client−Identifying" Information

Federal regulations permit substance use disorder treatment programs to disclose information about an adolescent if the program reveals no client−identifying information. "Client−identifying" information is information that identifies someone as having a substance use disorder. Thus, a program may disclose information about an adolescent if that information does not identify him as having a substance use disorder or support anyone else's identification of the adolescent as having a substance use disorder.

There are two basic ways a program may make a disclosure that does not identify a client. The first way is obvious: A program can report aggregate data about its population (summing up information that gives an overview of the clients served in the program) or some portion of its population. Thus, for example, a program could tell the newspaper that, in the last 6 months, it screened 43 adolescent clients−−10 female and 33 male.

The second way has already been discussed: A program can communicate information about a specifically named adolescent in a way that does not reveal the adolescent's status as a substance use disorder treatment client (_2.12(a)(i)). Thus, a program that provides services to adolescents with other problems or illnesses as well as substance use disorders may disclose information about a particular client (e.g., in order to make a referral) as long as it does not reveal the fact that the client has a substance use disorder or is receiving treatment. A counselor employed by a program that is part of a general hospital could call the police about a threat an adolescent made, so long as the counselor did not disclose that the adolescent has a substance use disorder or is a client of the treatment program.

Programs that provide only substance use disorder services cannot disclose information that identifies a client under

this exception, because letting someone know a counselor is calling from the "XYZ Treatment Program" will automatically identify the adolescent as someone in the program. However, a free−standing program can sometimes make "anonymous" disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the adolescent's status as having a substance use disorder. Note that with the widespread use of caller identification, "anonymous" communications may not be so anonymous. Soon, it may no longer be possible for a freestanding program to use this kind of anonymous communication.

Court−Ordered Disclosures

A State or Federal court may issue an order that will permit a program to make a disclosure about an adolescent that would otherwise be forbidden. A court may issue one of these authorizing orders, however, only after it follows certain special procedures and makes particular determinations required by the regulations. A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose information (_2.61).[11]

Before a court can issue an order authorizing a disclosure about an adolescent that is otherwise forbidden, the program and the adolescent whose records are sought must be given notice of the application for the order and some opportunity to make an oral or written statement to the court.[12] Generally, the application and any court order must use fictitious (made−up) names for any known adolescent, not the real name of a particular client. All court proceedings in connection with the application must remain confidential unless the adolescent requests otherwise (__2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court can find "good cause" only if it determines that the public interest and the need for disclosure outweigh any negative effect that the disclosure will have on the client or the doctor−client or counselor−client relationship and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective (_2.64(d)).[11] The judge may examine the records before making a decision (_2.64(c)).

There are also limits on the scope of the disclosure that a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court should also take any other steps that are necessary to protect the adolescent's confidentiality, including sealing court records from public scrutiny (_2.64(e)).

The court may order disclosure of "confidential communications" by an adolescent to the program only if the disclosure

- Is necessary to protect against a threat to life or of serious bodily injury
- Is necessary to investigate or prosecute an extremely serious crime (including child abuse)
- Is in connection with a proceeding at which the adolescent has already presented evidence concerning confidential communications (e.g., "I told my counselor ...") (_2.63)

If the purpose of seeking the court order is to obtain authorization to disclose information to law enforcement authorities so that they can investigate or prosecute a client for a crime, the court must also find that (1) the crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury; (2) the records sought are likely to contain information of significance to the investigation or prosecution; (3) there is no other practical way to obtain the information; and (4) the public interest in disclosure outweighs any actual or potential harm to the client, the doctor−client relationship, and the ability of the program to provide services to other clients. When law enforcement personnel seek the order, the court must also find that the program had an opportunity to be represented by independent counsel. If the program is a government entity, it must be represented by counsel (_2.65(d)).

Medical Emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about [an adolescent] for the purpose of treating a condition which poses an immediate threat to the health" of the adolescent or any other individual. The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (_2.51).

The medical emergency exception permits disclosure only to medical personnel. This means that the exception cannot be used as the basis for a disclosure to the police or other nonmedical personnel, including parents. Under this exception, however, a program could notify a private physician or school nurse about a suicidal adolescent so that medical intervention can be arranged. The physician or nurse could, in turn, notify the adolescent's parents, so long as no mention is made of the adolescent's substance use disorder.

Whenever a disclosure is made to cope with a medical emergency, the program must document the following information in the adolescent's records:

- The name and affiliation of the recipient of the information
- The name of the individual making the disclosure
- The date and time of the disclosure
- The nature of the emergency

Sharing Information With an Outside Agency That Provides Services to the Program

If a program routinely needs to share certain information with an outside agency that provides services to it, then it can enter into what is known as a QSOA. (A sample QSOA is provided in Figure 8−4.)

A QSOA is a written agreement between a program and a person (or agency) providing services to the program, in which that person (or agency):

- Acknowledges that in receiving, storing, processing, or otherwise dealing with any client records from the program, she is fully bound by (the Federal confidentiality) regulations
- Promises that, if necessary, she will resist in judicial proceedings any efforts to obtain access to client records except as permitted by these regulations (__2.11, 2.12(c)(4))

A QSOA should be used only when an agency or official outside the program is providing a service to the program itself. An example is when laboratory analyses or data processing are performed for the program by an outside agency.

A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information that is needed by others so that the program can function effectively. A QSOA may not be used between different programs providing substance use disorder treatment and other services.

Internal Program Communications

The Federal regulations permit some information to be disclosed to staff members within the same program. The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of substance use disorders if the communications are (1) within a program or (2) between a program and an entity that has direct administrative control over that program (_2.12(c)(3)).

In other words, staff who have access to client records because they work for or administratively direct the program−−including full− or part−time employees and unpaid volunteers−−may consult among themselves or otherwise share information if their substance use work so requires (_2.12(c)(3)).

A question that frequently arises is whether this exception allows a program that treats adolescents and that is part of a larger entity, such as a school, to share confidential information with others who are not part of the assessment or treatment unit itself. The answer to this question is among the most complicated in this area. In brief, there are circumstances under which the substance use disorder treatment unit can share information with other units. However, before such an internal communication system is set up within a large institution, it is essential that an expert in the area be consulted for assistance.

Research, Audit, or Evaluation

The confidentiality regulations also permit programs to disclose client−identifying information to researchers, auditors, and evaluators without client consent, provided certain safeguards are met (__2.52, 2.53).[13]

Other Rules About Adolescents' Right to Confidentiality

Client notice and access to records

The Federal confidentiality regulations require programs to notify clients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to adolescents when they begin participating in the program or soon thereafter (_2.22(a)). The regulations contain a sample notice. Programs can use their own judgment to decide when to permit adolescents to view or obtain copies of their records, unless State law allows clients or students the right of access to records. The Federal regulations do not require programs to obtain written consent from clients before permitting them to see their own records.

Security of records

The Federal regulations require programs to keep written records in a secure room, a locked file cabinet, a safe, or other similar container.[14] Programs should establish written procedures that regulate access to and use of adolescents' records. Either the program director or a single staff person should be designated to process inquiries and requests for information (_2.16).

A Final Note

Substance use disorder treatment programs should try to find a lawyer who is familiar with local laws affecting their problems. As has already been mentioned, State law governs many concerns relating to treatment of adolescents. A practicing lawyer with an expertise in adolescent substance use concerns is the best source for advice on such issues. Moreover, when it comes to certain issues, the law is still developing. For example, programs' duty to warn of clients' threats to harm others is constantly changing as courts in different States consider cases brought against a variety of different kinds of care providers. Programs trying to decide how to handle such a situation need up−to−the minute advice on their legal responsibilities.

Endnotes

1 This chapter was written for the Revision Panel by Margaret K. Brooks, Esq., Montclair, New Jersey.
2 An adult with "decisional capacity" is one who is able to understand an explanation of her diagnosis, prognosis, and

choices of treatment, as well as their risks and benefits, and likely outcome should treatment be refused.

3 In States where parental consent is not required for treatment, the Federal confidentiality regulations permit a program to withhold services if the minor will not authorize a disclosure that the program needs in order to obtain financial reimbursement for that minor's treatment. The regulations add a warning, however, that such action might violate a State or local law (_2.14(b)).

4 Program staff may need training about what the State's child abuse and neglect laws require, including what conditions are considered reportable. See the discussion of child abuse reporting.

5 Of course, a provider may turn an adolescent away for clinical reasons, that is, because it has determined that no treatment is needed or that the treatment it offers is inappropriate for the particular adolescent. In this case, the program might want to make a referral to another type of counseling service or to another substance use disorder treatment program. The procedure for making a referral is discussed in section 2.

6 Citations in the form "_2..." refer to specific sections of 42 Code of Federal Regulations (C.F.R.) Part 2.

7 Only adolescents who have "applied for or received" services from a program are protected. If an adolescent has not yet been evaluated or counseled by a program and has not himself sought help from the program, the program is free to discuss the adolescent's substance use disorders with others, although it would not be wise to do so. But, from the time the adolescent applies for services or the program first conducts an evaluation or begins to counsel the youth, the Federal regulations govern.

8 Note, however, that no information that is obtained from a program (even if the client consents) may be used in a criminal investigation or prosecution of a client unless a court order has been issued under the special circumstances set forth in _2.65. 42 U.S.C. _290dd−2(c); 42 C.F.R. _2.12(a),(d).

9 Although the rules concerning CJS consent probably apply to proceedings in juvenile court involving acts that, if committed by an adult, would be a crime, there appear to be no cases on point. It is less likely that the special CJS consent rules would apply when an adolescent is adjudicated (found to be) in need of special supervision (e.g., "persons in need of supervision"), but not guilty of a criminal act.

10 If an attorney is not immediately available, and someone wants information about child abuse and neglect rules within a particular State, contact the social service or child welfare agency for that area. Nationally, the Child Welfare League of America can also be called at 202−638−2952. Definitions of terms can also be accessed on the Internet. State statute definitions are located at http://www.calib.com/nccanch/statutes.htm. Federal definitions, which appear in the Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C. _5106g, are available on the Internet at http://www.calib.com/ nccanch/pubs/whatis.htm

11 For information about how to deal with communications with lawyers, law enforcement officials and subpoenas, see TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians*, (CSAT, 1997), pp. 111−112. For information about dealing with search and arrest warrants, see TIP 19, *Detoxification from Alcohol and Other Drugs* (CSAT, 1995c), pp. 83−84. Additional information about dealing with subpoenas appears in *Confidentiality: A Guide to the Federal Laws and Regulations*, (New York: Legal Action Center, 1995 ed.).

12 However, if the information is being sought to investigate or prosecute a client for a crime, only the program need be notified (_2.65); and if the information is sought to investigate or prosecute the program, no prior notice at all is required (_2.66).

13 Outcome evaluation that assesses clients' behavior at set times after completion of treatment (the importance of which is mentioned in Chapter 2) poses particular problems under the Federal regulations. For a discussion of this issue and a more complete explanation of the requirements of __2.52 and 2.53, see TIP 14, *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment* (CSAT, 1995a), pp. 58−59.

14 Computerization of records greatly complicates efforts to ensure security. For a brief discussion of some of the issues computerization raises, see TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* (CSAT, 1996), pp. 52−53.

[Back Matter]

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Appendix B −− Medical Management of Drug Intoxication and Withdrawal

The following table was created by Dr. John Knight and reprinted with his permission. It will appear in the forthcoming publication, Knight, J.R. Substance use, abuse, and dependence. In: Levine, M.D.; Carey, W.B.; and Crocker, A.C., eds. *Developmental−Behavioral Pediatrics*, 3rd edition. Philadelphia: W.B. Saunders, in press.

A. Alcohol

A. Alcohol				
Names/Preparations	**Intoxication**		**Withdrawal**	
	Signs and Symptoms	**Treatment**	**Signs and Symptoms**	**Treatment**
Beer Wine Hard Liquor	**Mild−Mod**: lower level of consciousness, poor coordination, ataxia, nystagmus, conjunctival injection, slurred speech, stupor, GI bleed, orthostatic hypotension	Observation and supportive care, protect airway, position on side to avoid aspiration	**Mild−Mod**: restlessness, agitation, coarse tremor, higher sensitivity to sensory input, nausea, vomiting, anorexia, autonomic hyperactivity (tachycardia, hypertension, hyperthermia), anxiety/depression,	Thiamine 100 mg. IM, Benzodiazepine taper (chlordiazepoxide 25−50 mg. q6h X 24 hrs., then 25 mg. q6h X 48 hrs.; or diazepam, clonazepam, oxazepam), Multivitamins

			headache, insomnia	
	Severe: Respiratory depression, coma, death. (Chronic: pancreatitis, cirrhosis, are rare in adolescents)	Ventilatory support, intensive care	**Severe:** seizures, hallucinations, delirium, death	Seizures: benzodiazepines (diazepam 0.2−0.5 mg/kg/dose IV., Max. dose=10 mg., or 0.5 mg/kg/dose PR) Hallucinations: Haloperidol
	Pathological: belligerent, excited, combative, psychotic state (even after small amount in susceptible person)	Physical restraint, low dose benzodiazepine (lorazepam 1−5 mg. PO as needed), or haloperidol 1−5 mg. q4−8 hrs. IM or 1−15 mg/dose PO		
Miscellaneous Information: Alcohol is highly addictive, and withdrawal from it is associated with serious, potentially lethal, side effects which begin 6−24 hours after the last drink. Alcohol dependency is rare in adolescents, however, but alcohol−related deaths are not. Adolescents tend to be binge drinkers and are at high risk for alcohol−related accidents and acute alcohol poisoning.				

B. Cannabis

B. Cannabis				
Names/Preparations	**Intoxication**		**Withdrawal**	
	Signs and Symptoms	**Treatment**	**Signs and Symptoms**	**Treatment**
Marijuana *Pot, herb, grass, weed, reefer, dope, Buds, sinsemilla, Thai sticks*THC capsules Hashish Hashish Oil	**Acute:** Euphoria, sensory stimulation, pupillary constriction, conjunctival injection, photophobia, nystagmus, diplopia, greater appetite, autonomic dysfunction (tachycardia, hypertension, orthostatic hypotension) temporary bronchodilatation	Reassurance and observation		
	Chronic: gynecomastia, reactive airway disease,lower sperm count, weight gain, lethargy,	Discontinuation of use, symptomatic treatment/care (bronchodilators for wheezing)	**Chronic users**: mild irritability, agitation, insomnia, EEG changes.	Reassurance; symptoms disappear in 3−4 days

	amotivational syndrome			
	Pathological: panic, delirium, psychosis, flashbacks	Psychosis: Neuroleptic medication		
Miscellaneous Information: Cannabis derivatives have relatively low addictive potential. These drugs are commonly used by adolescents, however, and are associated with adverse psychological effects. The potency of marijuana has tripled over the past 25 years.				

C. Hallucinogens

C. Hallucinogens				
Names/Preparations	**Intoxication**		**Withdrawal**	
	Signs and Symptoms	**Treatment**	**Signs and Symptoms**	**Treatment**
Phencyclidine (PCP) *angel dust, super grass, peace weed* Lysergic acid diethylamide (LSD) *Acid, blotters, orange sunshine, blue heaven, microdot, sugar cubes* Mescaline *mesc* Peyote *buttons, cactus* Psilocybin *magic mushrooms, 'shrooms* Jimson weed *locoweed* Nightshade	**Acute**: Perceptual (visual, auditory) distortion and hallucinations, nystagmus, feelings of depersonaliza−tion, mild nausea, tremors, tachycardia, hypertension, hyperreflexia **Chronic**: flashbacks **Pathological**: panic, paranoia, psychosis	Reassurance and observation (For anticholinergics, i.e., jimson weed, nightshade, symptoms are more severe and may require gastric lavage, benzodiazepine sedation, and hospitalization.) Discontinuation of use Psychosis: close observation in a quiet room. benzodiazepines (Lorazepam 1−5 mg. PO). Use of neuroleptic medication is controversial.	Psychological	Reassurance
Miscellaneous Information: PCP may be sprinkled on marijuana and smoked. Exposure can thus occur without the user's knowledge.				

D. Inhalants

D. Inhalants				
Names/Preparations	**Intoxication**		**Withdrawal**	
	Signs and Symptoms	**Treatment**	**Signs and Symptoms**	**Treatment**

Nitrous Oxide, *laughing gas, whippets* Amyl Nitrite, *poppers, snappers* Butyl Nitrate, *rush, bullet, climax* Chlorohydrocarbons *aerosol spray cans* Hydrocarbons, gasoline, glue, solvents, White−out (typewriter correction fluid) Leaded Gasoline (not in US)	**Acute:** euphoria, disorientation, sedation, conjunctival injection, acute toxicity to CNS, liver, kidneys Nitrates: sudden hypoxemia, hypotension **Chronic:** peripheral nerve, CNS, liver, and kidney damage **Pathological:** cardiac arrhythmia and arrest	Symptomatic medical treatments Discontinuation of use, supportive therapies (dialysis, etc.) Plumbism: Chelation therapy Resuscitation, hospitalization	Psychological Physiological−unknown	Reassurance, support
Miscellaneous Information: Nitrous oxide is sometimes sold at rock concerts inside balloons. Nitrate compounds have been most popular among gay men, allegedly to enhance sexual experiences. The volatile hydrocarbon compounds are favored by younger adolescents and popular in some Latin−American countries, on Native American reservations, and in Latino communities within the United States.				

E. Stimulants

E. Stimulants				
Names/Preparations	**Intoxication**		**Withdrawal**	
	Signs and Symptoms	**Treatment**	**Signs and Symptoms**	**Treatment**
Cocaine *Coke, Snow, Flake, Blow, Nose Candy* Crack *Freebase, Rocks* Amphetamines *Speed, Black Beauties* Methamphetamine *Crank, Crystal Meth, Ice* Methylphenidate *Ritalin* Pemoline *Cylert* Rx Diet Pills *Didrex, Tenuate, Ionamin, Sanorex, etc.* "Legal speed" *OTC diet or stay awake pills*	**Acute:** exhilaration, euphoria, restlessness, irritability, insomnia, pupillary dilatation, tachycardia, arrhythmia, chest pain, hypertension, anorexia, hyperpyrexia, hyperreflexia **Chronic:** (if snorting: inflamed nasal mucosa, septal erosion or perforation) confusion, sensory hallucinations, paranoia, depression **Pathological:** sudden cardiac arrest,	Reassurance and observation Symptomatic care Agitation: high dose benzodiazepines (Diazepam 10−25 mg) Tachycardia, HTN: (controversial, see below) Hyperthermia: external cooling Discontinuation of use, symptomatic treatment/care. Psychosis: Neuroleptic medication Resuscitation, hospitalization	**Chronic users**: severe depression with suicidal/homicidal ideation, exhaustion, prolonged sleep, voracious appetite	Close observation, reassurance; symptoms disappear in 3−4 days

	hypertensive crisis, seizures	HTN crisis: beta−blockers, Phentolamine, Nitroprusside Seizures: IV Diazepam, (see alcohol section above), or Phenytoin 15−20 mg/kg slow IV push with cardiac monitor		

Miscellaneous Information: While use of cocaine and crack has declined somewhat in recent years, amphetamines have become more popular. Methamphetamine is more commonly available in California, the West, and Southwest. With the increased public awareness of AD/HD and the popularity of stimulant medications to treat it, Ritalin has now become a drug of abuse among some adolescents. It can be ground up and "snorted," and has been implicated in several reports of sudden cardiac arrest and death. So−called "legal speed," OTC preparations which are available in pharmacies and through mail order houses, can cause toxicity similar to more potent stimulants when taken in high doses.

F. Depressants

F. Depressants				
Names/Preparations	**Intoxication**		**Withdrawal**	
	Signs and Symptoms	**Treatment**	**Signs and Symptoms**	**Treatment**
Benzodiapines: *Valium, "V's," Librium, Serax, Klonopin, Tranxene, Xanax, Halcion, Rohypnol, "Ruffies"* **Barbiturates:** *Nembutal, Seconal, Amytal, Tuinal, downers, barbs, blue devils, red devils, yellows, yellow jackets* **Methaqualone:** *Quaaludes, ludes, sopors*	**Mild−Mod**: CNS sedation, pupillary constriction, disorientation, slurred speech, staggering gait **Severe:** Respiratory depression, hypothermia, coma, death **Pathological:** paradoxical disinhibition, hyperexcitability	Observation and supportive care, protect airway, position on side to avoid aspiration **Acute OD:** Gastric lavage. Supportive: ventilator, warming blanket, ICU care Symptoms pass in a matter of hours; physical restraint, low dose benzodiazepine rarely needed	**Mild−Mod**: restlessness, anxiety, agitation, tremor, abdominal cramps, nausea, vomiting, hyperreflexia, hypertension, headache, insomnia **Severe**: seizures, delirium, hyperpyrexia, hallucinations, death	Gradual reduction of the drug of dependency, or Phenobarbital substitution (calculate phenobarbital equivalent of daily dose, or give 3−4 mg/kg/day divided by q8h) with gradual taper. Or change short−acting benzodiazepine to longer−acting benzodiazepine and then taper Seizures: Diazepam Hallucinations: Haloperidol (see alcohol section above for doses)

Miscellaneous Information: These compounds are all similar to alcohol in effect and highly addictive. Withdrawal symptoms are severe and may begin 12−16 hours after last dose or may be delayed for up to a week.

G. Narcotics

G. Narcotics				
Names/Preparations	**Intoxication**		**Withdrawal**	
	Signs and Symptoms	**Treatment**	**Signs and Symptoms**	**Treatment**
Heroin, *smack, horse, junk, brown sugar, Big H, mud* Opium Rx Narcotics *Morphine, Meperidine* *Fentanyl, Oxycodone, Hydrocodone, Codeine* *Darvon, etc.*	**Acute:** Euphoria, pupillary constriction, depression of respirations and gag reflex, bradycardia, hypotension, constipation **Chronic:** complications of IV use include Hepatitis B, HIV/AIDS, SBE, brain abscesses **Pathological:** Acute OD may cause respiratory arrest and death	Airway protection, judicious use of naloxone Discontinuation of use, targeted medical care for infectious complications Intubation and ventilation, naloxone (IV, IM, SC, ETT): children < 20 kg: 0.1 mg/kg/dose q2−3 hrs. children > 20 kg: 2−5 mg/dose	**Chronic users:** restlessness, lacrimation, yawning, pupillary dilatation, rhinorrhea, sniffing, sneezing, sweating, flushing, tachycardia, hypertension, muscle cramps, abdominal cramps, nausea, vomiting, diarrhea	**Acute detoxification:** Methadone (PO) Children: 0.7 mg/kg/day divided by q4−6 hrs., or adult 30−40 mg./ day in 3−4 divided doses, with 5 mg/day taper. Clonidine (PO) Children: 5−7 mcg/kg/day divided by q6−12 hrs. (max = 0.9 mg/day) Adult: 0.1 mg. test dose, check postural BPs. If stable, 0.1−0.2 mg PO q4−6 hrs. **Long−term treatment:** Long−term therapeutic support. Methadone or LAAM maintenance (specialized clinics only)
Miscellaneous Information: Individuals who abuse narcotics seldom seek treatment for intoxication. They are more often found semi−comatose and brought to the hospital by friends or the EMS for treatment. When treating an overdose, remember that naloxone has a shorter duration of action than most narcotic drugs, and doses therefore should be repeated at fairly frequent intervals. These patients require lengthy (12−24 hours) periods of observation in hospital.				

H. Designer Drugs

H. Designer Drugs				
Names/Preparations	**Intoxication**		**Withdrawal**	
	Signs and Symptoms	**Treatment**	**Signs and Symptoms**	**Treatment**
Fentanyl analogs *Synthetic heroin, China White* Meperidine analogs *MPPP, MPTP*	Similar to narcotics (above)	Similar to narcotics (above)	Similar to narcotics (above)	Similar to narcotics (above)

Amphetamine analogs *MDMA, Ecstasy, Adam, EVE, STP, PMA, TMA, DOM, DOB, etc.*	Similar to amphetamines (above)	Similar to amphetamines (above)	Similar to amphetamines (above)	Similar to amphetamines (above)
PCP Analogs *PCPy, PCE*	Similar to PCP (above)	Similar to PCP (above)	Similar to PCP (above)	Similar to PCP (above)
Miscellaneous Information: More popular on the West Coast, designer drugs can be both stronger and cheaper than the parent compound. Quality is not controlled during illicit manufacturing, posing great danger to users. For example: MPTP, a contaminant of the Meperidine analog MPPP, causes irreversible Parkinson's Disease.				

Source:

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[Figures]

Figure 1−1: Perceived Risk of Harm From and Use of Marijuana Among High School Students, 1991 and 1995

Figure 1−2: Contrasts Between Confrontation of Denial and Motivational Interviewing

Figure 1−2
Contrasts Between Confrontation of Denial and Motivational Interviewing

Confrontation of denial approach	Motivational interviewing approach
Heavy emphasis on acceptance of self as having a problem; acceptance of diagnosis seen as essential for change	De−emphasis on labels; acceptance of "alcoholism" or other labels seen as unnecessary for change to occur
Emphasis on personality pathology, which reduces personal choice, judgment, and control	Emphasis on personal choice and responsibility for deciding future behavior
Therapist presents perceived evidence of problems in an attempt to convince the client to accept the diagnosis	Therapist conducts objective evaluation, but focuses on eliciting the client's own concerns
Resistance is seen as "denial," a trait characteristic requiring confrontation	Resistance is seen as an interpersonal behavior pattern influenced by the therapist's behavior
Resistance is met with argumentation and correction	Resistance is met with reflection
Goals of treatment and strategies for change are prescribed for the client by the therapist; client is seen as "in denial" and incapable of making sound decisions	Treatment goals and change strategies are negotiated between client and therapist, based on data and acceptability; client's involvement in and acceptance of goals are seen as vital

Source: Miller, W.R., and Rollnick, S. *Motivational Interviewing: Preparing People to Change Addictive Behavior*. New York: Guilford Press, 1991. p. 53. Reprinted with permission.

Figure 2−1: Treatment Stages and the Problem Severity Continuum

Figure 2−2: Adolescent Development: General Features of Early and Later Stages

Figure 2−2

Adolescent Development: General Features of Early and Later Stages		
	Early Adolescence	**Later Adolescence**
Cognitive Thinking	Concrete Thinking: ♦ Emphasizes immediate reactions to behavior ♦ May not be fully aware of later consequences	More Abstract Thinking: ♦ Greater use of inductive/deductive reasoning ♦ More introspective and more sensitive to later consequences
Task Areas 1. Family independence	♦ Beginning rejection of parental guidelines ♦ Ambivalence about wishes (dependence/independence)	♦ Insistence on independence, privacy ♦ May have overt rebellion or sulky withdrawal; limits are often tested
2. Peers−−Social and Sexual	♦ Most often "best" friend is same sex ♦ Boy−girl fantasies; little if any sexual experimentation	♦ Dating, intense interest in opposite sex; sexual experimentation normal ♦ Risk−taking common ♦ Need to please significant peers of either sex heightens
3. School and Vacation	♦ Structured school setting preferred	♦ Beginning to identify skills, interests ♦ Starting part−time job
4. Self−Perception Identity Social Responsibility Values	♦ Emphasis on "Am I normal?" ♦ Tendency to use denial ("It can't happen to me")	♦ Conformity−−behavior that meets peer group values ♦ Some continue to pursue group/peer acceptance ♦ Some are able to reject group pressure if not in self−interest
Professional Approach To retain sanity, staff should ♦ Like teenagers ♦ Understand development ♦ Be flexible ♦ Keep a sense of humor	♦ Provide firm, direct support ♦ Convey limits−−simple concrete choices ♦ Do not align with parents, but do be an objective caring adult ♦ Encourage transference (hero−worship) ♦ Sexual decisions−−directly encourage to wait ♦ Encourage parental presence in clinic, but interview teen alone	♦ Be an objective sounding board (but let adolescents solve own problems) ♦ Negotiate choices ♦ Be role model ♦ Don't get too much history ("grandiose stories") ♦ Confront gently−−about consequences, responsibilities ♦ Consider "What gives them status in the eyes of peers?" ♦ Use peer group sessions ♦ Adapt systems to crises, walk−ins, impulsiveness, testing ♦ Ensure confidentiality ♦ Allow teens to seek care independently

Figure 2−3: Client Assessment Criteria

Figure 2−3 Client Assessment Criteria					
Type of Treatment	**Use Pattern**	**Medical Concerns**	**Intrapersonal**	**Interpersonal**	**Environme**
Primary prevention	♦ No history of use ♦ No current use	♦ Not applicable	♦ Developmentally appropriate ♦ Effective coping skills ♦ Moderate−to−high emotional/cognitive functioning	♦ Demonstrates developmentally appropriate, prosocial interpersonal behavior ♦ Maintains responsible relationships with significant others	♦ May have significan
Anticipatory guidance and support	♦ Positive history of use ♦ No current use	♦ Not applicable	♦ Less effective coping skills, but competent emotional and cognitive functioning	♦ Demonstrates developmentally appropriate prosocial interpersonal behavior ♦ Maintains responsible relationships with significant others ♦ History of substance use and/or other risk−related behaviors that increase the potential for developing a psychoactive substance use disorder (PSUD) ♦ Able to function in a	♦ One or m environm factors th increase p vulnerabi (family hi substance disorders)

				nonstructured setting	
Brief office intervention	♦ Problem resulting from use ♦ Low−to−moderate current use	♦ No anticipated withdrawal	♦ High−risk peer group ♦ Still able to function in nonstructured setting	♦ Maintains responsible relationships with significant others	♦ One or m environm factors
Outpatient treatment	♦ Problem(s) resulting from use or low−to−moderate current use	♦ Low−to−moderate use without anticipated withdrawal	♦ Less effective coping skills ♦ Less competent emotional/cognitive functioning ♦ Still able to function in a nonstructured setting	♦ Identified deficiencies in relationships with significant others and history of substance use and/or other risk−related behaviors that increase the potential for developing a PSUD ♦ Able to function in a nonstructured setting	♦ Environm contextua affect the individua not warra removal f current liv situation ♦ Needs to supported minimal t
Intensive outpatient treatment	♦ Problem(s) resulting from use ♦ Moderate−to−heavy recent use	♦ Subacute toxicity ♦ Social support for detoxification ♦ Compliance regimen	♦ Ineffective but functional coping skills ♦ Less competent emotional/cognitive functioning ♦ Requires marginally structured setting	♦ Identified deficiencies in relationships with significant others and history of substance use and/or other risk−related behaviors that increase the poten−tial	♦ Environm contextua impact th individua not warra removal f current liv situation ♦ Needs to supported moderate

				for developing a PSUD ♦ Requires marginally structured setting	
Day treatment partial hospitalization	♦ Problem(s) resulting from use ♦ Moderate−to−heavy recent use	♦ Premorbid/sub−acute toxicity ♦ Compliant with detoxification regimen	♦ Ineffective but functional coping skills ♦ Less competent emotional/cognitive functioning ♦ Requires moderately structured setting	♦ Identified deficiencies in relationships with significant others and history of substance use or other behaviors that place individuals at risk for developing PSUD ♦ Requires moderately structured setting	♦ Environm contextua impact th individua not warra removal f current liv situation ♦ Needs to supported intensive
Medically monitored intensive inpatient	♦ Problem(s) resulting from use ♦ Moderate−to−heavy recent use	♦ Premorbid subacute toxicity requiring 24−hour medical monitoring ♦ Other medical concerns that cannot be handled with outpatient treatment	♦ Dysfunctional coping skills ♦ Emotional/cognitive/ psychiatric impairment requiring 24−hour structured setting	♦ Dysfunctional relationships and behaviors that *do not pose* an immediate threat to self and/or others but that require 24−hour structured care	♦ Environm contextua dictate in must be r from adv influence current liv situation
Medically managed intensive inpatient	♦ Problem(s) resulting from use	♦ Morbid, acute toxicity (overdose)	♦ Dysfunctional coping skills ♦ Emotional/cognitive/ psychiatric	♦ Dysfunctional relationships and behaviors	♦ Environm contextua dictate in must be r

	♦ Moderate−to−heavy recent use	that may require life support ♦ All medically complicating conditions, including those requiring life sup−port/intensive care	impairment requiring 24−hour structured care and continuous psychiatric monitoring	that *may pose* an immediate threat to self and/or others and that require 24−hour structured care and psychiatric management	from adve influence current liv situation
Intensive residential treatment	♦ Problems resulting from use ♦ No recent moderate−to−heavy use	♦ No detoxification required ♦ Medical conditions that cannot be handled with outpatient medical management and/or which do not require life support/intensive treatment services	♦ Dysfunctional coping skills ♦ Emotional/cognitive/ psychiatric impairment ♦ Requires long−term residential treatment, including psychiatric and activities of daily living (ADL) services	♦ Dysfunctional relationships and behaviors that *do not pose* an immediate threat to self and/or others but which require 24−hour structured care, including ADL services and possibly psychiatric services ♦ Behavior manageable within a structured setting	♦ Environm contextua dictate in must be r from adve influence current liv situation
Residential psychosocial care	♦ Problems resulting from use ♦ No recent moderate−to−heavy use	♦ Detoxification services not required ♦ No special medical services required on site	♦ Dysfunctional coping skills ♦ Emotional/cognitive/ psychiatric impairment ♦ Requires supervision in structured setting, ADL, and	♦ Dysfunctional relationships and behaviors that *do not pose* an immediate threat to self and/or others but which	♦ Environm contextua dictate in must be r from adve influence current liv situation

			other psychosocial rehabilitation	require behavior management within a structured setting which provides supervision, ADL, and other psychosocial rehabilitation	
Halfway house	♦ Problems resulting from use ♦ No recent moderate−to−heavy use	♦ Detoxification services not required ♦ No special medical services required on site	♦ Adequate coping skills ♦ Has moderate−to−high level of emotional/ cognitive functioning but requires some supervision	♦ Ability to establish prosocial relationships that support recovery ♦ Able to self−regulate behavior with minimal structure/supervision	♦ Environm contextua dictate in must be r from curr situation, adverse circumsta
Group home/ group living	♦ Problems resulting from use ♦ No recent moderate−to−heavy use	♦ Detoxification services not required ♦ No special medical services required on site	♦ Adequate coping skills ♦ Has moderate−to−high level of emotional/ cognitive functioning ♦ Able to live independently	♦ Ability to establish prosocial relationships that support recovery ♦ Self−regulates behavior consistent with standards of responsible group living without supervision	♦ Environm contextua dictate in must be r from curr situation, adverse circumsta

Figure 7−1: Status of Drug Courts in the United States

Figure 7−1 Status of Drug Courts in the United States		
	Adolescent Programs	Adult Programs
Estimated total number of individuals who have enrolled	850[a]	45,000[b]

Average retention rates	96 percent[c]	70 percent[c]

[a]Based on 13 active programs
[b]Based on 99 active programs
[c]Based on number of graduates and active participants in comparison with total participants enrolled

Figure 7−2: Number of Drug Court Programs Underway/Planned

Figure 8−1: Decision Tree

Figure 8−2: Sample Consent Form

Figure 8−2 Sample Consent Form
Consent for the Release of Confidential Information
I, _____, authorize XYZ Clinic to receive (name of client or participant)
from/disclose to _____ (name of person and organization)
for the purpose of _____ (need for disclosure)
the following information_____ (nature of the disclosure)
I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically on _____ unless otherwise specified below. (date, condition, or event)
Other expiration specifications:
_____ Date executed
_____ Signature of client
_____ Signature of parent or guardian, where required

Figure 8−3: Consent Form: Criminal Justice System Referral

Figure 8−3 Consent Form: Criminal Justice System Referral
Consent for the Release of Confidential Information

I, _____, hereby consent to communication
(name of defendant)

between _____ and
(treatment program)

_____
(court, probation, parole, and/or other referring agency)

the following information_____
(nature of the information, as limited as possible)

The purpose of and need for the disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program prognosis, and

I understand that this consent will remain in effect and cannot be revoked by me until:

_____ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment or

_____
(other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records and that recipients of this information may redisclose it only in connection with their official duties.

_____
(Date)

_____
(Signature of defendant/patient)

_____
(Signature of parent, guardian, or
authorized representative if required)

Figure 8−4: Qualified Service Organization Agreement

Figure 8−4
Qualified Service Organization Agreement

XYZ Service Center ("the Center") and the _____
(name of the program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide

(nature of services to be provided)

Furthermore, the Center:
(1) acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program

about the clients in the Program, it is fully bound by the provisions of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R. Part 2; and

(2) undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the Federal Confidentiality Regulations, 42 C.F.R. Part 2.

Executed this _____ day of _____, 199_____

_____
President
XYZ Service Center
[address]

_____
Program Director
[name of program]
[address]

−−−−−−−−−−−−−−−−−−−−−−−− End of Download Section −−−−−−−−−−−−−−−−−−−−−−−−