

Practice Improvement Protocol 10
SUBSTANCE ABUSE TREATMENT IN CHILDREN¹



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services**

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¹ For the purposes of this Practice Improvement Protocol, the terms “child” or “children” refer to individuals below the age of 18.

Issue

ADHS encourages the development of substance abuse interventions for children that are unique and specific to younger populations. Successful approaches for children consider the individual's developmental level, family strengths and culture, gender, co-existing disorders, and social and community factors that increase risks of substance involvement.

Purpose

To promote evidence-based, best practice approaches in the assessment and treatment of substance abuse in children.

Target Populations

All children referred to the behavioral health system with substance use disorders.

Protocol

WHICH CHILDREN ARE MOST LIKELY TO ABUSE SUBSTANCES?

Substance use can frequently be predicted through known risk factors and “red flags” in a child’s life. The greater the number of red flags, the greater the concern should be about the presence of unidentified substance use issues. Indicators that reflect a heightened likelihood of substance abuse include:

- Involvement in the juvenile justice system;
- Distinctive changes in psychological state;
- Sudden changes in functioning (family, school, behavioral, emotional);
- Physical changes (sleep patterns, agitation or depression, personal hygiene, etc.);
- Relationships (loss of friends, association with known gang members, friends with substance involvement);
- Possession of drug paraphernalia;
- Aggressive behavior or behavior which is frequently at odds with family and authorities;
- Running away, homeless;
- Parental incarceration;
- History of neglect or physical, emotional, or sexual abuse;
- Signs of family conflict and dysfunction;
- History of family drug and alcohol abuse;
- Prenatal complications and brain damage;
- Maternal drug use during pregnancy;
- Alienation from the dominant values of society, low religiosity, or rebelliousness.

WHAT IS A COMPREHENSIVE ASSESSMENT FOR SUBSTANCE USE DISORDERS?

A comprehensive assessment considers the child's or family's substance involvement across biological, psychological and social domains, such as existing medical problems or medical complications of substance use, emotional changes, family or peer relationships and academic performance. Assessment practices should be consistent with the Intake, Assessment and Service Planning section of the ADHS/DBHS Provider Manual, the ADHS Behavioral Health Assessment and Service Planning Process, and the ADHS Child and Family Team Practice Improvement Protocol.

The family and others identified by the child and family as important and supportive are invited to participate in the Child and Family Team and are actively involved in the initial and ongoing assessment. Children are evaluated with consideration of the child's and family's strengths and resources.

The unique social and cultural context of the family provides a basis for understanding how these factors influence family and individual relationships, decision-making and substance use behaviors, as well as how substance involvement impairs healthy family functioning. Parental attitudes and behavior toward their own substance use, parental limit setting and disciplinary style and the family history of substance use and addiction all influence the assessment and treatment process.

The assessment should initiate a "conversation" with the client and family that, over time, should identify the risk factors for substance abuse, the repercussions of substance use in the child's life, co-existing medical and mental health problems, and the individual's personal, family and community strengths and resources. The assessment also begins the process of engagement and responding creatively to any ambivalence about addressing substance use in the family. Finally, the assessment is considered an ongoing process that is continually updated with Child and Family Team involvement as needs, resources and conditions change.

If a substance use disorder is suspected, the diagnosis is based upon criteria of the *Diagnostic and Statistical Manual of Mental Disorders-IV- TR* (DSM-IV-TR) with due consideration given to the child's unique developmental stage. Appropriate v-codes may be used for levels of substance involvement that do not rise to the level of abuse/dependence but for which support services may be offered.

HOW SHOULD SERVICE PLANS BE DEVELOPED?

Service planning should be consistent with the new ADHS Behavioral Health Assessment and Service Planning Process and the ADHS Child and Family Team Practice Improvement Protocol. While abstinence remains the explicit, long-term goal of treatment, a realistic view recognizes both the chronic nature of substance use disorders in some children, and the self-limiting nature of substance use and related problems in others.

Effective treatment often begins by developing an interim goal focused on gradual reductions in substance use over time. Included in this concept is an expectation of reducing levels of substance involvement and reduced negative consequences, a reduction in the severity and frequency of relapse events, increasing competencies and skills that support and promote a drug free life style and improvement in one or more domains of child and family functioning.

Service plans should incorporate the following:

- Recognizing that a period of “discovery” services and activities may be necessary to work through any ambivalence expressed by the child and/or family regarding the problematic nature of drug/alcohol involvement and their willingness to participate in treatment.
- Identifying issues of focus for the child and the family, including the level of substance involvement, the role of substance use in the family and associated psychosocial, medical, and behavioral issues.
- Developing goals that address the interpersonal and social context – peers, family, community, and culture -- in which the substance use occurs and which remain after the substance use is gone.
- Developing goals that are realistic, practical and attainable and can help young people recognize their substance use as a problem for them and those around them. Ideally, treatment goals are crafted as immediate, specific steps that adolescents and their families can act upon over a short period of time.
- Integration of the unique culture, strengths, and resources of the individual and the family, and the incorporation of these factors into the goals of treatment.
- Encouraging the participation of educational, judicial and other community support systems involved with the child and family that may assist in reinforcing and promoting change.
- Understanding that some delay in normal cognitive and social-emotional development is a common characteristic of adolescent substance abuse. Treatment should identify such delays and their relationship to academic performance, self-esteem, and socialization.
- Providing education, training and opportunities to practice the specific skills necessary to build confidence and competence to remain drug-free.
- Use of drug testing methods as appropriate

WHAT OVERRIDING TREATMENT CONCEPTS GUIDE SERVICES?

Services are developed and provided through a Child and Family Team process, consistent with the ADHS Child and Family Team Practice Improvement Protocol. The Child and Family Team determine the needs, type, intensity, and frequency of supports necessary for successful outcomes and works with the behavioral health representative to secure these outcomes.

Ongoing assessment and service planning helps the Child and Family Team identify and capitalize on the strengths, resources, priorities and resiliency of the family system. Behavioral health providers should understand the unique perspective of the family and services provided should be linguistically and culturally relevant, sensitive and useful. The following general principles should be incorporated into all care provided:

I. Engagement:

When individualizing treatment to the specific needs of the child and family, it is important to assess and understand the youth's readiness for and motivation to change. Time spent in "discovery" strategies that assist youth in recognizing the complex interactions between peer and family influences, their environment, their feelings and their use of substances is time well spent and enhances overall retention and involvement in treatment. An initial focus on engaging the youth in their own change process is a vital first step in assisting the adolescent to understand their motivators and take responsibility for his/her treatment, health and recovery.

The child and family are encouraged to explore substance use patterns, the reasons for drug use, and the consequences of substance use in a non-judgmental fashion. Staff should remain aware that substance use gratifies some unidentified or unexplored needs of the child and should avoid mandates to suddenly cease all substance use as a condition of involvement in treatment.

Treatment engagement should include identifying the adolescent's readiness for change, respecting his/her ambivalence about making real change, being supportive and empathetic, and understanding any discrepancy between personal goals and actual behavior.

II. Orientation and Education:

This initial phase of treatment is essential to building trust, clarifying expectations, roles, and allaying fears and misconceptions about substances and substance use disorder treatment in a non-confrontational style and tone. Elements of this initial phase of treatment include explaining what treatment is and what it is not, defining terms and outlining the process of treatment in understandable language, and establishing a therapeutic alliance.

III. Building a Social Context:

For Family:

The most successful substance use interventions in children are offered in the context of the social environment in which they exist. Treatment should proceed from a biopsychosocial model that directly addresses the relationship between substance use and interpersonal issues. The primary goal of substance use cessation should be built on the foundation of healthy relationships with family and friends, skill development in the areas of problem solving, conflict and stress management, and the promotion of resiliency and long-term healthy lifestyles.

Children are part of a complete family system. Changes in family functioning, the level and intensity of substance use, and other problem behaviors are often closely linked. Family health and stability – including substance use by parents, siblings and other family members – and the family's ability to provide emotional support and parental monitoring are important components of adolescent substance abuse treatment.

Families should be assisted in accessing supportive services and natural community supports that bolster resiliency and reduce risks in their children. Where indicated, family therapy methods should be initiated to help stabilize and support children in their family environment. Interventions should be focused on overcoming family conflict and improving problem-solving abilities, while enhancing family strengths and values.

With Peers:

The significance of peers cannot be over emphasized. In adolescence especially, the most important and influential relationships, besides family, are with those of similar age and interests. Peer pressure can promote recovery as well as continued substance use. Children that use substances need encouragement and opportunities to interact with other healthy young people in order to begin developing a realistic alternative life style to the drug culture.

As part of a well-considered service plan, peer influence, in the context of one on one peer support or group therapy, can help strengthen the child's ability to resist negative peer pressure. Peer relationships can support treatment when constructive feedback is given about progress and lack of progress, when a youth's unwillingness to examine the personal consequences of substance use in his/her life is challenged, and when vicarious experiences lead to positive behavioral change.

Peers can also re-enforce, encourage, and teach negative behaviors. When children are treated in groups, attitudes tend to migrate toward the group norm. Including a focus on health in the group introduces a more pro-social norm and the group can then provide modeling, feedback, and "peer pressure" to foster success. In a group environment, it is essential to ensure that the group is composed of a majority of members that are role models for successful reduction of substance use and strong maintenance skills and have aligned with the facilitator in supporting the program to the larger group. Services should be designed to facilitate bonding with social groups that

encourage self-acceptance, healthy self-esteem, positive values, and expectations of success.

IV. Developing Competencies and Pro-social Activities:

Preoccupation with the use of substances frequently leads to the exclusion of participation in positive recreational activities and the development of basic social and living skills. Service plans should consider the development of age-appropriate interactive and daily living skills through a prescribed schedule of school, chores, homework, and recreation. Recreational activities can serve as an essential element for learning new skills and interests to replace the role that substances played in their lifestyle.

Deficits in social skills, goal setting, problem solving, feeling regulation and impulse control are associated with use of substances. Programs to enhance social skills and self-regulation build confidence and the competencies needed to remain drug-free.

V. Considering and Treating Co-Morbid Conditions:

- Mental Health and Substance Abuse:

The co-occurrence of mental or behavioral disorders with substance abuse is relatively common. Interventions that identify and treat problematic early childhood behavioral issues can significantly mitigate the severity of substance abuse problems in youth. Treatment needs are best served by approaching co-occurring disorders in an integrated and coordinated manner by clinicians and support providers who are skilled in assessment and intervention of both disorders.

- Developmental Disabilities:

Approximately 13% of school age children are disabled. This group reports using alcohol and drugs at the same or higher levels than their peers. Interventions should be designed to address the cognitive level of the adolescent.

- Chronic Physical Problems:

Young people with chronic physical illnesses are at high risk for substance use disorders. This is particularly the case for those with pain-related syndromes for which treatment with opioid analgesics may be required. Distinguishing between appropriate treatment for pain and an individual's abuse of analgesic drugs is often difficult. Communication, collaboration, and care coordination among treatment providers is essential.

VI. Providing Trauma-Focused Services:

Risks for substance abuse problems rise dramatically among individuals with a history of physical or sexual abuse, emotional abuse or neglect, or among children who have been exposed to other traumatic stresses. In addition, children who have experienced

the loss of a caregiver through abandonment or death may be more prone than their peers to develop problems related to substance abuse. Effective treatment for these youth should address the substance abuse related problems and any issues related to trauma, abuse, neglect, or loss concurrently.

VII. Integrating Culture, Spirituality and Self-Discovery:

All forms of treatment should be capable of addressing and accommodating a child's unique sense of culture, spirituality and self-discovery. Twelve-Step groups frequently pose challenges for adolescents struggling with the developmental tasks of independent thinking, self-identity, and self-sufficiency. The unique individual needs, cultural identification, and spiritual orientation of each child should be carefully considered before any specific intervention is implemented. Nevertheless, Twelve Step programs are common support mechanisms that may be successfully used and are widely available in the community. Youth may also find encouragement and support from their own religion, or choose alternative cultural or spiritual practices, such as culturally related traditional practices, meditation, vegetarianism, or even exercise/health programs. Community based supportive services that engage these universal concerns should be included in service plans.

WHAT SPECIFIC TREATMENT APPROACHES HAVE BEEN FOUND TO BE EFFECTIVE IN TREATING CHILDREN?

I. Cognitive Behavioral and Psycho-Educational Strategies:

Youths enter substance abuse treatment with varying degrees of coping strategies, interpersonal skills and other protective attitudes, skills and behaviors. The goal of cognitive behavioral strategies is to teach youth to make desired changes in their behavior by identifying and accentuating those things they do well. Specific training or psycho-educational methods can be implemented to build the confidence and competence to remain substance free, and can include focused attention, education and practice time on specific skill areas.

II. Behavioral Contracting and Drug Testing:

Behavioral health contracts can give children a sense of control and a degree of personal investment in the treatment process, providing a reference point from which to monitor change. Contracts are developed in the context of a Child and Family Team to provide a clear sense of mutually acceptable expectations. Behavioral health contracts can be supported and reinforced by the judicious use of drug testing. Laboratory assessment of recent drug use can be used to overcome denial, to connect an individual's use with potential health risks, and to rate the effectiveness of skills learned. Drug testing should not be used as a punitive measure, and should be conducted with the knowledge and consent of the juvenile and legal guardian.

III. School and Vocational Training:

Realistic goal setting is related to positive functional outcomes of treatment. For children, this should include components of treatment that can address achieving success in school and beginning adult vocational development. Increasing competence and confidence in the work and school arena is a powerful protective factor against future substance use.

IV. Multi-Systemic Therapy (MST):

This is a family-oriented, home-based program that may be appropriate with chronically violent, substance-abusing juvenile offenders 12 to 17 years old. It uses methods that promote positive social behavior and decrease antisocial behavior, including substance use, to change how youth function in their natural settings (i.e., home, school, and neighborhood). Based on the philosophy that the most effective and ethical route to help children is through helping their families, MST views parents or guardians as valuable resources, even when they have serious and multiple needs of their own.

MST also recognizes that these children are involved in a network of interconnected systems that encompass extra-familial (e.g., peer, school, neighborhood) factors, and recognizes that it is often necessary to intervene in more than one of these systems. MST addresses these factors in an individualized, comprehensive, and integrated manner. The primary goals of MST are to reduce youth criminal activity, reduce antisocial behavior, including substance abuse, and to achieve these outcomes by decreasing incarceration and out-of-home placement rates.

V. Brief Strategic Family Therapy (BSFT):

This is an effective, problem-focused, and practical approach to the elimination of substance abuse risk factors. It successfully reduces problem behaviors in children, 6 to 17 years, and strengthens their families. BSFT provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill building strategies that strengthen families.

The program fosters parental leadership, appropriate parental involvement, mutual support among parenting figures, family communication, problem solving, clear rules and consequences, nurturing, and shared responsibility for family problems. In addition, the program provides specialized outreach strategies to bring families into therapy. It targets associations with anti-social peers, conduct problems, early substance use, and problematic family relations.

VI. Motivational Enhancement Treatment:

This intervention is modeled after the landmark research on health belief and motivation and readiness to change. This method describes a series of stages that mark the progress of an individual toward cessation of substance abuse including:

- **Pre-contemplation:** The person does not think about stopping and does not recognize any problems with substance abuse
- **Contemplation:** This stage is marked by ambivalence in which the person goes back and forth between reasons to changes and reasons not to change
- **Preparation:** The person increases commitment to change
- **Action:** The person takes active steps to change.
- **Maintenance:** The person develops a lifestyle to avoid relapse.

Motivational Treatment involves individual sessions with the adolescent and helping him/her to move along the stages of change. Direct feedback and advice is given in a non-confrontational manner that respects the person's personal responsibility for making decisions and assists in building specific skills to reduce substance use and avoid relapse.

Intervention workbooks based on the motivational enhancement model have been developed to help engage the child through concrete, simple questions that explore various areas of their life that may have been negatively affected by alcohol or other drugs.

VII. Family Strengthening:

This is an early intervention/treatment model for drug-involved parents with young children age 6 to 12. The program is structured around family skills training sessions that occur around the family meal. Family Strengthening uses family systems and cognitive-behavioral approaches to increase resilience and reduce risk factors within families with extensive parental substance involvement. The model has been evaluated with successful outcomes in the following areas improving family relationships, improving parenting skills, and increasing social and life skills competencies among children.

VIII. Community Reinforcement Approach for Adolescents:

CRA is a comprehensive behavioral program for treating substance abuse problems. CRA is based on the belief that environmental contingencies can play a powerful role in encouraging or discouraging drinking and drug use. The model utilizes social, recreational, familial and vocational reinforcers, with a goal of making a sober lifestyle more rewarding than use of substances. Therapists maintain active roles in initiating activities, and are encouraged to think of themselves as cheerleaders. Their enthusiasm helps motivate the child. CRA makes extensive use of modeling, role-playing and shaping with positive reinforcements used at every sign of progress. In this model, substance use and abuse are viewed as intertwined with all aspects of the juvenile's life and the context in which substance use occurs is used to support new methods of thinking and behaving.

IX. Relapse Prevention and Management:

Strategic relapse prevention and management is a critical element of effective substance abuse treatment. Substance abuse and dependence reflect chronic patterns of behavior that are highly influenced by environmental and personal stressors. Educational and support components that are conveniently located near the youth/family and provide on-going support can help reduce the risk of relapse and assure continuity of treatment goals as youth transition back to the community.

When counseling during a lapse, it is important that staff minimize guilt and shame and emphasizes the event as a teaching tool to avoid future relapse. Equally important are efforts to involve family members in understanding relapse stressors, including those that involve behaviors and relationships within the family.

A successful treatment program recognizes that relapse is part of recovery and a signal to redesign, rather than terminate, services. Specific relapse management strategies are a core component of ongoing treatment that are revised over time, rather than a one-session “tract” as the client is leaving the service setting.

Effective relapse prevention and management strategies include a variety of training, therapeutic and environmental change procedures including:

- Coping skills training which focuses on immediate and practical skills such as:
 - Understanding recovery and relapse as a process
 - Identifying and effectively handling high risk situations
 - Coping with urges and cravings
 - Implementing damage control procedures during a lapse to minimize negative consequences
 - Staying engaged in treatment even after a relapse and
 - Learning how to create a more balanced lifestyle.
- Cognitive therapy procedures that are designed to provide clients with ways to reframe the habit change process and develop alternative thinking patterns.
- Lifestyle modification strategies such as exercise, leisure and spiritual activities that are designed to strengthen overall coping skills.
- Crisis planning that anticipates relapse and develops an organized and therapeutic strategy that can be put into place with expedience.

For further information see <http://www.samhsa.gov/>