CHAPTER 2

Determining the Need for Substance Use Treatment

THERAPIST GOALS

1. **Determine the extent to which the youth is using substances.**
2. **Determine the impact of the youth's drug use and need for treatment.**

The purpose of this chapter is to provide therapists with information concerning how to assess youth for substance use and determine whether a clinical intervention is warranted.

OVERVIEW OF DETERMINING WHETHER THE YOUTH NEEDS SUBSTANCE USE TREATMENT

This chapter describes how therapists can assess whether a youth currently has a substance use problem that warrants clinical interventions (i.e., CM). First, however, a frame of reference is provided for understanding the important distinctions among substance use, abuse, and dependence and the role of the "referral problems" in facilitating these determinations.

A Continuum of Drug Use: From Abstinence to Dependence

Winters, Latimer, and Stinchfield (2001) provide an excellent framework for conceptualizing the continuum from substance abstinence to dependence and for understanding the factors that must be considered in placing a particular youth along this continuum. Drawing from a report by the Center for Substance Abuse Treatment (1999), the 5-point continuum includes:

1. *Abstinence*—no substance use.
2. *Experimental use*—typically minimal use in the context of recreational activities.
3. *Early abuse*—more established use, greater frequency of use, often more than one drug used, negative consequences of use beginning to emerge.
4. *Abuse*—history of frequent use, negative consequences have emerged.
5. *Dependence*—continued regular use in spite of negative consequences, considerable activity devoted to seeking and using drugs.

As noted in epidemiological studies, the majority of adolescents have used substances. Hence, substance use by itself is rarely a criterion for intervention. Rather, treatment should be reserved for youth at the early abuse, abuse, and dependence points on the continuum. Importantly, Winters and colleagues noted that several additional factors should be considered in deciding whether interventions are warranted.

1. Use of some drugs (e.g., heroin) is sufficiently dangerous as to merit intervention even if negative consequences have not emerged.
2. Age should be considered. For example, a 12-year-old experimenting with marijuana may present a very different profile than a 17-year-old with similar use.
3. Acute ingestion of large quantities of a substance at any age is sufficiently risky as to call for interventions.
4. Use of substances in inappropriate settings (e.g., at school, while driving) might justify interventions.

Thus, the general rule for deciding whether interventions for substance use are needed is based on an observed link between substance use and negative life outcomes or high risk for such outcomes. For example, youth whose substance use puts them at risk for arrest, probation, poor school performance, or family difficulties would be candidates for intervention.

Substance Use Is an Identified Referral Problem

The most obvious indicator that a youth might have a drug problem is that he or she was referred specifically for substance abuse treatment. Once in a great while, a youth might voluntarily seek treatment for substance use. More often, however, youth are referred for treatment because a caregiver suspects or has confirmed that the youth uses drugs, or because another agency involved in the life of the youth and family, such as the juvenile court, suspects or has confirmed such use. Even when the youth is referred specifically for substance use treatment, however, it is important to assess whether drug use is currently ongoing and problematic. The impact of the drug use on the youth's functioning should be assessed in key domains of life—at home, in school, with peers, and in the broader community. A worksheet is provided (*Domains of Functioning* [Form 2.4]) later in this chapter to assist with this process.

Substance Use Is Not an Identified Referral Problem

Youth receiving mental health or juvenile justice services are at increased risk for co-occurring substance abuse or dependence. Thus, many youth with behavioral or emotional problems also have undetected drug use problems. When treating youth referred for problems other than drug use, several kinds of experiences might prompt therapists to assess whether the youth is also using drugs, among them:

1. You hear, see, or smell something that makes you wonder whether the youth uses or has friends who use drugs (e.g., you smell marijuana on a youth's jacket, youth seems "spacey" and tired).
2. Someone else thinks the youth or his or her friends use drugs (e.g., in a family session, the parent expresses disapproval of a new boyfriend, saying she thinks he uses drugs).
3. Treatment goals are not being met, and you suspect drug use is one factor contributing to the lack of progress.

Aims and Time Frame of the Following Task

The primary goals for this chapter are to determine the extent to which a youth is using substances and the impact of that substance use on the youth's functioning. Based on this information, the therapist then helps the youth and caregiver determine the need for further treatment. The amount of time needed to accomplish these goals will vary greatly depending on the severity of substance use and the family's conceptualization of its impact on youth and family functioning. Families for whom drug use is not a primary presenting problem may need a full-hour session or more with the therapist to determine whether a substance abuse intervention is needed, while others might already be aware of the severity of the problem and complete the assessment form (*Substance Use Chart* [Form 2.3]) within a few minutes.

THERAPIST TASK 2.1: ASSESSING YOUTH SUBSTANCE USE AND THE NEED FOR TREATMENT

Objectives

1. Determine the extent to which the youth is using substances.
2. Determine the impact of the youth's drug use and need for treatment.

Materials

- *Therapist Flowchart and Checklist 2.1: Determining the Need for Substance Use Treatment*
- *Modified CAGE Questionnaire* (Form 2.1)
- *Client Substance Index—Short Form* (Form 2.2)

- *Substance Use Chart* (Form 2.3)
- *Domains of Functioning* (Form 2.4)
- *Common Symptoms of Drug Use* (Handout 2.1)
- *Commonly Abused Drugs Chart* (Handout 2.2)

Accomplishing the Objectives

The primary goal is to determine whether the youth's substance use is linked with problems functioning in family, peer, school, or community contexts and thus indicates a need for substance abuse treatment.

Assess Substance Use.

As presented in *Therapist Flowchart and Checklist 2.1: Determining the Need for Substance Use Treatment*, the first step is to clarify whether the presenting problems include substance use. If substance use is a presenting problem, the therapist proceeds to gather information on the youth's substance use. If drug use is not a presenting problem but is suspected as a contributing factor to other presenting problems (e.g., arrests, school difficulties), suggestions are made for determining whether more extensive substance use evaluation is needed.

When trying to determine whether a youth has substance abuse problems, it is important to obtain current and past information from multiple informants in the youth's ecology. This might include observing and interviewing the youth as well as getting information from the caregivers and other potential sources such as teachers or school records, past clinical notes, and probation officers. Several tools are provided to help the therapist and caregivers identify the extent of adolescent substance use.

- *Common Symptoms of Drug Use* (Handout 2.1) presents a list of symptoms that can be associated with substance use. The most salient symptoms are highlighted in boldface and pertain to associating with friends who are known drug users or at very high risk for substance abuse.
- Produced by NIDA, the *Commonly Abused Drugs Chart* (Handout 2.2) supplies information about drugs of abuse, their commercial and street names, routes of administration, intoxication effects, and potential health consequences. Therapists might find it helpful to have this chart in hand when completing the *Substance Use Chart* (Form 2.3) with youth. A website link to the *Commonly Abused Drugs Chart* (Handout 2.2) can be found, along with other helpful information, on the NIDA website (*www.nida.nih.gov/drugpages.html*; follow the link for *Commonly Abused Drugs Chart* or go directly to *www.nida.nih.gov/DrugPages/DrugsofAbuse.html*).
- The *Substance Use Chart* (Form 2.3) is a resource for obtaining and organizing drug use information that is used by several service provider agencies within the

South Carolina substance abuse treatment system. This tool can be used by therapists to record a complete history of substance use.

- As detailed in Chapter 7, valid measures of drug and alcohol use can be obtained relatively easily through urine drug screens and alcohol breath scans. These indices of substance use are extremely valuable in supplementing information obtained by self-report methods.

Determine the Impact of Substance Use and Possible Need for Treatment.

Assuming it has been determined that the youth is using drugs or alcohol, the next task for the therapist is to differentiate between experimental substance use, which is common for many youth during adolescence, and problematic substance use, which usually indicates a need for treatment. Screening tools can be used to help determine whether a particular youth has a substance use problem, and two of the most efficient are described and provided here.

- The *CAGE Questionnaire* (Mayfield, McLead, & Hall, 1974) is easy to use, and its four items can be asked by interview or in a paper-and-pencil questionnaire format. Therapists should also ask caregivers to respond to the CAGE questions concerning the youth. A "yes" response to any of the CAGE questions by either the youth or the caregiver indicates an increased likelihood that the adolescent's substance use is problematic. A *Modified CAGE Questionnaire* (Form 2.1) is provided to facilitate this assessment process.
- The *Client Substance Index—Short Form* (Form 2.2; Thomas, 1990) is another useful screening tool with 15 yes—no questions for the youth to complete. A "yes" response to any of the questions indicates that the youth's substance use warrants serious consideration as indicative of abuse or dependence.

Even when a youth has been referred specifically for substance use treatment, and the youth and caregiver already acknowledge that treatment is needed, therapists should still assess the extent to which drug use is ongoing and problematic. The impact of the drug use on the youth's functioning should be assessed in key domains of life—at home, in school, with peers, and in the broader community. The *Domains of Functioning* worksheet (Form 2.4) is provided to assist with this purpose. Although it might be apparent to the therapist that drug use is illegal and, therefore, puts the youth at risk, it is usually very helpful to talk about the linkages the therapist finds between drug and alcohol use and functional impairments the youth and family members might be experiencing (i.e., poor grades, arrests, probation, family arguments). Again, the general rule for deciding whether interventions for substance use are needed is based on an observed link between substance use and negative life outcomes or high risk for such outcomes.

If the therapist establishes a link between the youth's substance use and negative life outcomes, the next step is to ascertain the youth's and caregiver's appreciation of that link. Engaging an individual in treatment is easier when he or she sees a clear connection

between the presenting problems, or what resulted in referral to therapy, and the intervention the therapist is seeking to implement. At this point in the assessment, the therapist will want to revisit youth and caregiver treatment goals (i.e., getting off probation, finding a job, improved school performance) and demonstrate how these goals can be better reached if the youth and family participate in substance abuse treatment. The most common challenge faced by the therapist attempting to engage families in substance abuse treatment is one in which the youth or the caregiver will not acknowledge that the youth has a substance abuse problem. Steps for addressing this challenge are outlined in the Troubleshooting Tips section of this chapter. The reader is encouraged to review the Family Engagement section in Chapter 3 for suggestions concerning how to address other engagement challenges that frequently arise during the assessment and early intervention process.

TROUBLESHOOTING TIPS

Objective

The purpose of this section is to help therapists anticipate common challenges to obtaining youth and caregiver participation in the *Determining the Need for Substance Use Treatment* component of CM and to suggest strategies to address these difficulties.

Challenges and Solutions

Neither Youth nor Caregiver Acknowledges Drug Problem.

If both the youth and the caregiver deny that the youth uses drugs when evidence suggests she or he is using drugs, or if they deny that such drug use is problematic when the therapist believes otherwise, the therapist should not attempt to implement the CM protocol. Instead, we recommend using drug screens for 4 to 6 weeks to gather evidence that the youth is or is not using drugs. If the drug screens are "clean" throughout this time, meaning no drugs are detected, then the drug screening procedures should be suspended. On the other hand, if the screens are "dirty," the inconsistency between the drug results and the clients' contentions should be addressed clinically. Likewise, the therapist should stay attuned to evidence that the youth's drug use is associated with problems in his or her life.

Youth Denies Drug Problem but Caregiver Acknowledges Drug Problem.

This is a common scenario. Assuming that the caregiver wishes to address the problem in spite of the adolescent's denial, we recommend that the therapist and the caregiver implement CM with the youth. If the adolescent is not having a problem with drug use, the screens will be clean and he or she will earn rewards. On the other hand, if the adolescent is having a problem with drug use, an appropriate intervention will be in place.

Youth Is Reluctant to Reveal Information to His or Her Caregiver.

The CM program presented in this manual strongly relies on caregiver involvement. Thus, therapists are encouraged to be creative in working with youth to secure their consent to involve their caregivers in treatment. Yet, given the concerns adolescents might have about revealing substance use information to their caregivers at the onset of treatment, it might make sense to conduct one or two of the early assessment sessions alone with the youth. To avoid subsequent problems in sharing adolescent drug use information with caregivers, however, therapists must obtain a signed consent from the youth allowing disclosure to caregivers. Therapists might want to use a one-to-one assessment session to help the adolescent determine how he or she would like to tell the caregiver about the drug use. It often helps if therapists find out what factors are driving the youth's difficulty in sharing information with the caregiver (i.e., shame, fear of consequences, concern about caregiver's feelings or reaction) and try to address these with the youth and caregiver prior to putting them in a session together.

A Note about Confidentiality. When a diagnosis of alcohol or drug abuse or dependency is made for the purpose of substance abuse treatment or referral for treatment, the client is protected under the federal confidentiality law 42 C. F. R Part 2. Additionally, all clients are protected under the Health Insurance Portability and Accountability Act (HIPAA). Both HIPAA and 42 C.F.R Part 2 protect minors as well as adults from unconsented disclosures in most situations. Thus, therapists generally cannot disclose information even to parents without the minor's consent. Clinicians are advised to become familiar with these two federal laws as well as the laws pertaining to confidentiality and disclosure specific to their state.

THERAPIST CHECKLIST, FORMS, AND HANDOUTS FOR CHAPTER 2: DETERMINING THE NEED FOR SUBSTANCE USE TREATMENT

THERAPIST FLOWCHART AND CHECKLIST 2.1

Determining the Need for Substance Use Treatment

Case number: _____ **Session date:** _____

Clarify presenting problems

Drug use is a presenting problem

Drug use is NOT a presenting problem

Determine if drug use problems might be present

___ Drug and alcohol use problems are often found in youth who present to clinics with other problems.

___ Therefore, I would like for us to work together to try and determine if (*youth's name*) might be using drugs or alcohol. Once we know if this is happening, we can then see if the drug use is causing problems that suggest she/he needs further treatment.

___ I would like to find out more from both of you about whether (*youth's name*) has had problems related to drug or alcohol use either recently or in the past. I am interested in knowing about any problems he/she may have had at home, in school, with friends, or with the law that might have involved drug or alcohol use.

___ [If clinically helpful, review a copy of *Common Symptoms of Drug Use* (Handout 2.1) with the caregiver and youth to elicit more information.]

___ [Remember to consider your experience with the youth, the caregiver's experience with the youth, how treatment is progressing, and information gathered from other informants (i.e., teachers, probation officer).]

Drug use concerns exist

Gather information on youth's drug use and severity of use

[CONTINUED ON NEXT PAGE]

Drug use problems are not elicited

___ [If substance use problems or potential problems are not elicited, but caregiver or therapist continues to have concerns, consider collecting random urine drug screens or alcohol breath scans to further determine if problems are present.]

[STOP]

[CONTINUED FROM PREVIOUS PAGE]

Drug use concerns exist

Gather information on youth's drug use and impact of use

___ The next step is for us to better understand what drugs (*youth's name*) is using, how they are being used, and how they may be causing him/her problems.

___ I have some handouts that can help us with this process [dispense copies of the *Commonly Abused Drugs Chart* (Handout 2.2) and the *Substance Use Chart* (Form 2.3) to both youth and caregiver].

___ Now, I'd like to fill in the *Substance Use Chart* (Form 2.3) with information that (*youth's name*) tells us. It may also help if we look at the *Commonly Abused Drugs Chart* (Handout 2.2) so that we can see what some of the common names are for these drugs and what some of the consequences of their use can be. [Complete *Substance Use Chart* (Form 2.3) with youth and caregiver present.]

___ Now that we have a better sense of the drugs (*youth's name*) is using, I would like to step back a minute and talk with both of you about how you see (*youth's name*)'s drug use impacting his or her life. [Use *Domains of Functioning* (Form 2.4) to elicit information from both youth and caregiver about concerns they might have about the impact of drug use on youth and family functioning.]

___ [To gather more information on the existence of the youth's substance problems, administer the *Modified CAGE Questionnaire* (Form 2.1) to caregivers concerning their child. This measure may also be administered to youth.]

___ [To gather more information on the existence of the youth's substance use problems, administer the *Client Substance Index—Short Form* (Form 2.2) to the youth.]

___ [Remember to consider the youth's age, drug of choice, whether incidents of acute ingestion of large quantities of the substances have occurred, and if drug use takes place in inappropriate settings (e.g., school).]

Substance use problems identified and linked to youth functional impairment

Caregiver and youth willing to engage in treatment

____ [Go to Chapter 3—Therapist Task 3.1: Introducing CM to Families.]

Caregiver or youth NOT willing to engage in treatment

____ [Go to Troubleshooting Tips section in this chapter and Family Engagement section in Chapter 3.]

Substance use NOT linked to youth functional impairment based on therapist and family opinion

___ Substance use interventions are not indicated at this time. Consider continuing to assess or collect information (i.e., random drug screens) about potential use and its impact on functioning.

[STOP]

FORM 2.1

Modified CAGE Questionnaire

QUESTIONS FOR YOUTH

1. Have you ever felt you ought to cut down on drinking or drug use? ..... Y / N
2. Have people annoyed you by criticizing your drinking or drug use? ..... Y / N
3. Have you ever felt bad or guilty about your drinking or drug use? ..... Y / N
4. Have you ever had a drink or used drugs first thing in the morning ..... Y / N
   to steady your nerves or get rid of a hangover?

QUESTIONS FOR CAREGIVER

1. Have you ever felt your child ought to cut down on drinking or drug use? ..... Y / N
2. Have you and other people annoyed your child by criticizing his/her drinking ..... Y / N
   or drug use?
3. Has your child ever felt bad or guilty about his/her drinking or drug use? ..... Y / N
4. Has your child ever had a drink or used drugs first thing in the morning ..... Y / N
   to steady his/her nerves or get rid of a hangover?

From Mayfield, McLead, and Hall (1974). Copyright 1974 by the American Medical Association. Reprinted by permission.

FORM 2.2

Client Substance Index—Short Form

Please read carefully and circle the appropriate response.

1. Have you ever done something crazy while high and had to make excuses for your behavior later? Y / N
2. Have you ever felt really burnt out for a day after using drugs? Y / N
3. Have you ever gotten out of bed in the morning and really felt wasted? Y / N
4. Did you ever get high in school? Y / N
5. Have you gotten into a fight while you were high, including drinking? Y / N
6. Do you think about getting high a lot of the time? Y / N
7. Have you ever thought about committing suicide when you were high? Y / N
8. Have you run away from home, partly because of an argument over drug use? Y / N
9. Did you ever try to stick to one drug after a bad experience mixing drugs? Y / N
10. Have you gotten into a physical fight during a family argument over drugs? Y / N
11. Have you ever been suspended because of something you did while high? Y / N
12. Have you ever had a beer or some booze to get over a hangover? Y / N
13. Do you usually keep a supply of drugs for emergencies, no matter how small? Y / N
14. Have you ever smoked some pot to get over a hangover? Y / N
15. Have you ever felt nervous or cranky after you stopped using for a while? Y / N

The Client Substance Index—Short Form was developed and evaluated as part of a larger Substance Abuse Screening protocol through the National Center for Juvenile Justice. From Thomas (1990).

FORM 2.3

Substance Use Chart

Interview the client to fully complete the grid.

Psychoactive Substance Use History					
Drug[a]	Age at first use	Frequency of use over past 12 months	Typical quantity of use	Date of last use	Route of use[b]
Alcohol					
Amphetamine					
Caffeine					
Cannabis					
Cocaine					
Hallucinogen					
Inhalant					
Nicotine					
Opioid					
PCP					
Sedative–hypnotic					
Other					

[a]Use the Commonly Abused Drugs Chart (Handout 2.2) for assistance in identifying examples for each drug category and slang words, as the youth might not always know the formal drug names.

[b]For example, smoked, ingested, injected, inhaled through nose, or absorbed via skin patch.

FORM 2.4

Domains of Functioning

HOME

1. How is the youth's communication with parents, siblings, and other family members? (Example: cooperative, quiet, withdrawn, moody, angry, agitated, defiant)

2. Does the youth fulfill responsibilities at home and follow family rules? (Example: chores, homework, routines, curfew, use of profanity)

(cont.)

3. How are responsibilities completed at home? (Example: well, on time, incompletely, avoids or refuses)

SCHOOL

4. How are the youth's grades in each subject in school? (Example: improving, stable, deteriorating, incomplete)

5. How is the youth's behavior in school? (Example: generally minds and is compliant, argumentative, gets suspensions or expulsions, on time, tardy, skipping class, truant from school)

(cont.)

PEERS

6. How would the youth's peers be described? Name key peers and their qualities. (Example: does peer attend school, have a job, obey the law, get arrested, use drugs, have problems in school or community?)

7. How is the youth's relationship with peers? (Example: positive, supportive, distant, argumentative, fighting; leader, follower)

COMMUNITY

8. How is the youth's behavior in the community? (Example: participates in sports, clubs, positive activities; has few activities, has problems with the law, formal legal charges, on probation)

HANDOUT 2.1

Common Symptoms of Drug Use

Things others might see:

- ***Friends who use drugs or have problems in school***
- ***Friends who have been arrested***
- ***Older friends who are not working or going to school***
- Rapid or unusual changes in mood
- Poor coordination
- Slowed or rapid speech
- Inability to remember recent events
- Fast or slowed behavior and reaction times
- Changes in appetite
- Sleepiness
- Apathy
- Being silly for no reason
- Bloodshot eyes
- Poor sports performance
- Poor school performance
- Lingering odors of marijuana or attempts to cover up odors
- Clothing or property that promotes drug use

Things the youth might report (in addition to the above symptoms):

- ***Hanging out with friends who use drugs or do poorly in school***
- ***Hanging out with friends who get in trouble with the law***
- ***Hanging out with older friends who are not working or going to school***
- Racing or slowed thoughts
- Racing heart rate (stimulants, cocaine)
- Unusual thoughts or paranoid beliefs
- Feeling disconnected from reality
- Lack of motivation

Bold italics denote important clinical factors that are frequently linked with youth drug use and relapse.

HANDOUT 2.2

NIDA
NATIONAL INSTITUTE ON DRUG ABUSE

Commonly Abused Drugs

Visit NIDA at www.drugabuse.gov

National Institutes of Health
U.S. Department of Health and Human Services

Substances: Category and Name	Examples of Commercial and Street Names	DEA Schedule*/ How Administered**	Acute Effects/Health Risks
Tobacco			
Nicotine	Found in cigarettes, cigars, bidis, and smokeless tobacco (snuff, spit tobacco, chew)	Not scheduled/smoked, snorted, chewed	*Increased blood pressure and heart rate/chronic* lung disease; cardiovascular disease; stroke; cancers of the mouth, pharynx, larynx, esophagus, stomach, pancreas, cervix, kidney, bladder, and acute myeloid leukemia; adverse pregnancy outcomes; addiction
Alcohol			
Alcohol (ethyl alcohol)	Found in liquor, beer, and wine	Not scheduled/swallowed	*In low doses, euphoria, mild stimulation, relaxation, lowered inhibitions; in higher doses, drowsiness, slurred speech, nausea, emotional volatility, loss of coordination, visual distortions, impaired memory, sexual dysfunction, loss of consciousness/increased risk of injuries, violence, fetal damage (in pregnant women); depression; neurologic deficits; hypertension; liver and heart disease; addiction; fatal overdose*
Cannabinoids			
Marijuana	Blunt, dope, ganja, grass, herb, joint, bud, Mary Jane, pot, reefer, green, trees, smoke, sinsemilla, skunk, weed	I/smoked, swallowed	*Euphoria; relaxation; slowed reaction time; distorted sensory perception; impaired balance and coordination; increased heart rate and appetite; impaired learning, memory; anxiety; panic attacks; psychosis/cough; frequent respiratory infections; possible mental health decline; addiction*
Hashish	Boom, gangster, hash, hash oil, hemp	I/smoked, swallowed	
Opioids			
Heroin	*Diacetylmorphine:* smack, horse, brown sugar, dope, H, junk, skag, skunk, white horse, China white; cheese (with OTC cold medicine and antihistamine)	I/injected, smoked, snorted	*Euphoria; drowsiness; impaired coordination; dizziness; confusion; nausea; sedation; feeling of heaviness in the body; slowed or arrested breathing/constipation; endocarditis; hepatitis; HIV; addiction; fatal overdose*
Opium	*Laudanum, paregoric:* big O, black stuff, block, gum, hop	II, III, IV/swallowed, smoked	
Stimulants			
Cocaine	*Cocaine hydrochloride:* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/snorted, smoked, injected	*Increased heart rate, blood pressure, body temperature, metabolism; feelings of exhilaration; increased energy, mental alertness; tremors; reduced appetite; irritability, anxiety; panic; paranoia; violent behavior; psychosis/weight loss; insomnia; cardiac or cardiovascular complications; stroke; seizures; addiction* **Also, for cocaine**—nasal damage from snorting **Also, for methamphetamine**—severe dental problems
Amphetamine	*Biphetamine, Dexedrine:* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/swallowed, snorted, smoked, injected	
Methamphetamine	*Desoxyn:* meth, ice, crank, chalk, crystal, fire, glass, go fast, speed	II/swallowed, snorted, smoked, injected	
Club Drugs			
MDMA (methylenedioxymethamphetamine)	Ecstasy, Adam, clarity, Eve, lover's speed, peace, uppers	I/swallowed, snorted, injected	***MDMA**—mild hallucinogenic effects; increased tactile sensitivity, empathic feelings; lowered inhibition; anxiety; chills; sweating; teeth clenching; muscle cramping/ sleep disturbances; depression; impaired memory; hyperthermia; addiction* **Flunitrazepam**—*sedation; muscle relaxation; confusion; memory loss; dizziness; impaired coordination/addiction* **GHB**—*drowsiness; nausea; headache; disorientation; loss of coordination; memory loss/ unconsciousness; seizures; coma*
Flunitrazepam***	*Rohypnol:* forget-me pill, Mexican Valium, R2, roach, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted	
GHB***	*Gamma-hydroxybutyrate:* G, Georgia home boy, grievous bodily harm, liquid ecstasy, soap, scoop, goop, liquid X	I/swallowed	
Dissociative Drugs			
Ketamine	*Ketalar SV:* cat Valium, K, Special K, vitamin K	III/injected, snorted, smoked	*Feelings of being separate from one's body and environment; impaired motor function/anxiety; tremors; numbness; memory loss; nausea* **Also, for ketamine**—*analgesia; impaired memory; delirium; respiratory depression and arrest; death* **Also, for PCP and analogs**—*analgesia; psychosis; aggression; violence; slurred speech; loss of coordination; hallucinations* **Also, for DXM**—*euphoria; slurred speech; confusion; dizziness; distorted visual perceptions*
PCP and analogs	*Phencyclidine:* angel dust, boat, hog, love boat, peace pill	I, II/swallowed, smoked, injected	
Salvia divinorum	Salvia, Shepherdess's Herb, Maria Pastora, magic mint, Sally-D	Not scheduled/chewed, swallowed, smoked	
Dextromethorphan (DXM)	Found in some cough and cold medications: Robotripping, Robo, Triple C	Not scheduled/swallowed	
Hallucinogens			
LSD	*Lysergic acid diethylamide:* acid, blotter, cubes, microdot, yellow sunshine, blue heaven	I/swallowed, absorbed through mouth tissues	*Altered states of perception and feeling; hallucinations; nausea* **Also, for LSD and mescaline**—*increased body temperature, heart rate, blood pressure; loss of appetite; sweating; sleeplessness; numbness; dizziness; weakness; tremors; impulsive behavior; rapid shifts in emotion* **Also, for LSD**—Flashbacks, Hallucinogen Persisting Perception Disorder **Also, for psilocybin**—*nervousness; paranoia; panic*
Mescaline	Buttons, cactus, mescal, peyote	I/swallowed, smoked	
Psilocybin	Magic mushrooms, purple passion, shrooms, little smoke	I/swallowed	
Other Compounds			
Anabolic steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise:* roids, juice, gym candy, pumpers	III/injected, swallowed, applied to skin	**Steroids**—*no intoxication effects/hypertension; blood clotting and cholesterol changes; liver cysts; hostility and aggression; acne; in adolescents—premature stoppage of growth; in males—prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females—menstrual irregularities, development of beard and other masculine characteristics* **Inhalants** *(varies by chemical)—stimulation; loss of inhibition; headache; nausea or vomiting; slurred speech; loss of motor coordination; wheezing/cramps; muscle weakness; depression; memory impairment; damage to cardiovascular and nervous systems; unconsciousness; sudden death*
Inhalants	*Solvents (paint thinners, gasoline, glues); gases (butane, propane, aerosol propellants, nitrous oxide); nitrites (isoamyl, isobutyl, cyclohexyl):* laughing gas, poppers, snappers, whippets	Not scheduled/inhaled through nose or mouth	

(cont.)

Substances: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Acute Effects*/Health Risks
Prescription Medications			
CNS Depressants Stimulants Opioid Pain Relievers	For more information on prescription medications, please visit http://www.nida.nih.gov/DrugPages/PrescripDrugsChart.html.		

** Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a written ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Some Schedule V drugs are available over the counter.*

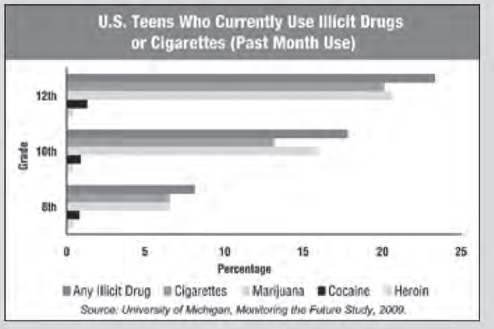
*** Some of the health risks are directly related to the route of drug administration. For example, injection drug use can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.*

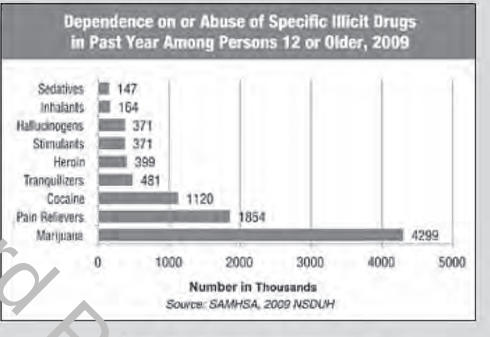
**** Associated with sexual assaults.*

Principles of Drug Addiction Treatment

More than three decades of scientific research show that treatment can help drug-addicted individuals stop drug use, avoid relapse and successfully recover their lives. Based on this research, 13 fundamental principles that characterize effective drug abuse treatment have been developed. These principles are detailed in *NIDA's Principles of Drug Addiction Treatment: A Research-Based Guide*. The guide also describes different types of science-based treatments and provides answers to commonly asked questions.

1. **Addiction is a complex but treatable disease that affects brain function and behavior.** Drugs alter the brain's structure and how it functions, resulting in changes that persist long after drug use has ceased. This may help explain why abusers are at risk for relapse even after long periods of abstinence.
2. **No single treatment is appropriate for everyone.** Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success.
3. **Treatment needs to be readily available.** Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible.
4. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems.
5. **Remaining in treatment for an adequate period of time is critical.** The appropriate duration for an individual depends on the type and degree of his or her problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment.
6. **Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment.** Behavioral therapies vary in their focus and may involve addressing a patient's motivations to change, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problemsolving skills, and facilitating better interpersonal relationships.
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** For example, methadone and buprenorphine are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Also, for persons addicted to nicotine, a nicotine replacement product (nicotine patches or gum) or an oral medication (buproprion or varenicline), can be an effective component of treatment when part of a comprehensive behavioral treatment program.
8. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure it meets his or her changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation and/or social and legal services. For many patients, a continuing care approach provides the best results, with treatment intensity varying according to a person's changing needs.
9. **Many drug addicted individuals also have other mental disorders.** Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.
10. **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.** Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification.
11. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.
12. **Drug use during treatment must be monitored continuously, as lapses during treatment do occur.** Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.
13. **Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases.** Targeted counseling specifically focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Treatment providers should encourage and support HIV screening and inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations.





NIDA DRUGPUBS RESEARCH DISSEMINATION CENTER

Order NIDA publications from DrugPubs:
1-877-643-2644 or 1-240-645-0228 (TTY/TDD)

This chart may be reprinted. Citation of the source is appreciated.

Revised October 2010

Sample Dialogue: Determining the Need for Substance Use Treatment

INTRODUCTION TO TONY AND HIS MOTHER, MS. SMITH

Tony, a 16-year-old Caucasian male, was referred to the clinic by the Department of Juvenile Justice because he was arrested for possession of a small amount of marijuana. His records indicate that he has a history of truancy and has been suspended from school once this year for fighting. He risks expulsion from school if further problems occur. At intake, Tony denied symptoms of anxiety, depression, posttraumatic stress disorder, mania, or psychosis as well as current or past suicidal or homicidal ideation. Tony lives with his mother and stepfather in an apartment situated in a working-class neighborhood. His mother works as an administrative assistant and his stepfather is a mechanic. Tony has not seen his biological father in 10 years.

The therapist met with Tony and his mother, Ms. Smith, the week prior to complete the necessary intake paperwork and obtain consents for treatment. During that session the caregiver endorsed Items 1 and 2 of the caregiver section of the *Modified CAGE Questionnaire* (Form 2.1) as a concern and Tony endorsed Items 5 and 11 of the *Client Substance Index—Short Form* (Form 2.2), indicating that he had gotten into a fight while high and was subsequently suspended from school for that behavior. On the *Domains of Functioning* (Form 2.4) Tony's mother described some history of antisocial behavior, including minor theft and fighting in a group. She stated that Tony enjoys playing basketball and does well in history class. He is functioning at grade level in all subjects except math and is getting C's in most classes. Tony has a few close friends who also use drugs and a girlfriend whom the mother believes gets good grades and does not use drugs.

This week the therapist is meeting with the family to try and better understand their presenting problems and goals for treatment.

CLARIFY PRESENTING PROBLEMS

Therapist: Hi, welcome back. It is good to see you again.

Caregiver: Thank you, good to see you too.

Therapist: Tony, why don't you sit down over here, where we can see you better?

Tony: I don't see why I need to be here. I'm gonna just sit here. How long til we're done?

Therapist: Okay, your mom and I can just pull our chairs to you. Sounds like you would prefer not to be here.

Tony: You got that right.

Caregiver: Tony, you better show some respect!

Therapist: It's okay, Ms. Smith. That is a very normal response. It takes most of the young men I work with a little while to get used to treatment.

Tony: Treatment? I don't need treatment! What kind of place is this?

Therapist: This is a clinic where we help young people who are having problems of some kind.

Tony: I don't have any problems, except that my mom made me come here. That is my only problem.

Therapist: Ms. Smith, can you tell me more about what has brought you here?

Caregiver: Well, like I told you last week, Tony got caught with a bag of pot by a policeman about a month ago. He was arrested and put on probation.

Tony: It wasn't my stuff. I was just holding it for somebody.

Caregiver: Please, Tony, I know you have been using and I also know that the probation officer keeps getting dirty screens on you. That is why we are here. You are going to get in trouble if you don't get clean.

Tony: That PO is just bluffing. He likes to scare people.

Caregiver: Well, I am afraid he might lock you away.

Tony: Maybe, but at least then I wouldn't have to go to school.

Therapist: So, Ms. Smith, it sounds like you are here because you would like for Tony to stay out of prison.

Caregiver: Right.

Therapist: Are you worried about Tony using? Do you want him to get off drugs?

Caregiver: Of course! I want him to quit. I would want him to quit even if he had not been arrested.

Therapist: Okay, good. One of the first things I like to do is find out why a family has come to me. It helps if I understand what each person wants to get out of treatment, what their goals are.

Tony: Well, my goal is to get out of here.

Therapist: All right, so getting released from treatment is your goal.

Tony: I guess.

Therapist: What do you think it will take to be released from treatment?

Tony: I don't know.

Caregiver: Oh please, you know you have to get clean. This therapist has to tell your PO you are participating or you may end up in prison.

Tony: Okay, I guess my goal is to get off probation. So my goal is to get clean so I can get off probation.

Therapist: Do you have any other goals?

Tony: What do you mean?

Therapist: Well, lots of teens whom I help get off drugs also find that they do better in school and in sports once the drugs are out of their system. Do you think that getting off drugs might help you in any way?

Tony: Well, I like basketball. I'd like to be better at basketball, so I guess that's a goal.

Caregiver: Don't forget school, son. You used to get A's and B's; now you get C's.

Tony: I know, I don't like school, it's boring and stupid.

Therapist: Do you want to graduate?

Tony: Of course. I'm no dropout.

Caregiver: He better graduate.

Therapist: Do you know what you want to do when you grow up?

Tony: Play basketball, NBA.

Therapist: Wow, you have big aspirations. That would be wonderful. Something tells me you will really want to get off pot if you hope to play ball. Even high school basketball can be pretty strenuous.

Caregiver: He has other, more reasonable plans too. Tony, tell her what else you might want to do.

Tony: I have an uncle who owns some trucks. He told me that I can drive for him when I get older if I get my trucking license.

Therapist: That sounds like a good plan too. So, to summarize, I hear that you, Tony, have a number of good reasons to get off drugs. These reasons include not wanting to go to prison, wanting to get off probation, hoping to be in good physical health so that you can play basketball, and trying to get your license so that you can drive trucks one day.

Tony: Yeah, I guess that sums it up.

Therapist: Ms. Smith, you would like for Tony to get off probation, stay out of prison, go to school, and get a good job one day.

Caregiver: Yes, that is correct. I think Tony also needs to start thinking about his future more. He is already in the 10th grade. He will be grown up before he knows it.

Therapist: Right, hopefully as we help Tony get off drugs, we can also in effect be helping him to mature and grow up.

GATHER INFORMATION ON THE YOUTH'S DRUG USE AND IMPACT OF USE

Therapist: Now that we all seem to be in agreement that it makes sense for us to work together to help Tony get off drugs, I have a few more things I need to find out before we can get started in treatment.

Tony: Now what?

Therapist: Don't worry, it's not very hard. I just need to make sure that I understand what drugs you are using. I need to know what drugs you use to be able to help you stop using them. [Gives each participant a copy of *Substance Use Chart* (Form 2.3) and *Commonly Abused Drugs Chart* (Handout 2.2).] All right, now I would like to use this chart [Form 2.3] to help me assess the drugs you may have used in the past as well as the ones you are using now.

Tony: I told you, I only use pot.

Therapist: Okay, let's start there. The technical term for pot is cannabis. How old were you the first time you tried pot?

Tony: Do I have to tell you this? My mom is sitting right here.

Therapist: Does that bother you?

Tony: Yeah, makes me feel weird. It's creepy talking about drugs in front of your mom.

Therapist: I know it takes a little while to get used to, but, yes, it is important that she be here.

Tony: Why?

Therapist: If your mom is not here with us, then she can't hear what we say and so she might miss out on important information that she needs to know in order to help you.

Tony: Can't you just tell her what I say?

Therapist: Well, I could try, but I might forget something, and it would not be a very efficient way to do this. It would take me twice as much time. I'm too busy to meet twice. Plus, I've found that doing it this way works better.

Caregiver: I'll try not to say anything. I'll just listen.

Therapist: That may help. I've found that after a few sessions, most teens get used to having their parents participate. It just takes a little while to adjust.

Tony: Whatever.

Therapist: So, let's get back to the form. Can you tell me how old you were when you first used?

Tony: I think I was 13, maybe 14.

Caregiver: What? Who were you with?

Tony: See what I mean? My mom is going to make me not want to say anything.

Caregiver: Sorry, I had no idea. I just feel like such a bad parent, and it makes me so mad.

Therapist: Those are all very normal feelings. Not to worry. The fact that you are here working on this shows me that you are a good, caring parent. It's hard for us to control all of the things that come into our kids' lives. So I'm glad you are able to step back and listen.

Tony: Okay, I was 13. That's all I'm going to say.

Therapist: That's enough about the past. Let's focus on the present. How much pot do you typically use in a day?

Tony: Well, some days I don't use any.

Therapist: Think about the last week. When did you last use?

Tony: Two days ago, on Saturday.

Therapist: Okay. Before that?

Tony: I think I used two other times last week, once on Wednesday, then again on Friday and Saturday.

Therapist: How much?

Tony: About one to two blunts, sometimes three each time.

Therapist: Did you share with anyone?

Tony: Yeah, each time I smoked the blunts with one or two, maybe three other people.

Therapist: Okay, let me fill that information in [*Substance Use Chart* (Form 2.3)].

Tony: What is this other paper for [*Commonly Abused Drugs Chart* (Handout 2.2)]?

Therapist: I like to use this sort of like a cheat sheet. It helps me remember the various street names of the drugs. That way, if one of the young adults I'm working with calls a drug something unusual, I can look it up.

Tony: Yeah, I've never seen the names of half these things either.

Therapist: Let's go down the list so I can find out what other drugs you may have tried.

Tony: I haven't done anything else on this list. [Holds up *Commonly Abused Drugs Chart* (Handout 2.2).]

Therapist: Please look at the other chart. How about that one [*Substance Use Chart* (Form 2.3)]?

Tony: Well, I tried cigarettes once, but hated it. They made me feel sick. Oh, and I drink caffeine sometimes.

Therapist: How much?

Tony: I dunno, I like energy drinks every once and awhile. But they cost too much.

Caregiver: He drinks iced tea and coffee sometimes. I'm more worried about alcohol. My brother has an alcohol problem, so I know it runs in my family. That really makes me worry.

Therapist: Tony, can you tell me about your alcohol use?

Tony: Well, I used some when I was younger.

Therapist: How young?

Tony: Thirteen, about the time I first had pot.

Therapist: When was the last time you drank?

Tony: Oh, a couple of months ago. I got tipsy at my friend's party. They were straight, didn't have any blunts, so I had to drink.

Therapist: How much did you drink?

Tony: Three or four beers.

Therapist: How about the time before last? When was that?

Tony: Can't remember. I think I average drinking about four, maybe five, times a year. Mostly on special occasions like holidays. I prefer pot.

Caregiver: That still concerns me.

Therapist: Tony, any idea why your mom is concerned?

Tony: Because she is afraid I will be a drunk like Uncle Henry.

Caregiver: I am also afraid you will drink and drive or drink and do something stupid like fight or steal.

Therapist: Those sound like valid concerns, mom. I noticed from the forms you both completed that Tony has been suspended from school for fighting while high. He has also been arrested for possessing marijuana and his grades have fallen from A's and B's to C's at school for the past 18 months. Are there other ways that either of you can think of that drugs are affecting Tony negatively?

Tony: I think you are exaggerating a little. It's not as bad as it sounds.

Caregiver: Can you believe that? He is in total denial.

Therapist: That is very normal and we will be looking at Tony's drug use so carefully in treatment

that you won't have to worry about denial. Are there other ways that Tony's drug use is causing problems?

Caregiver: Yes, my husband and I fight more when Tony uses.

Therapist: Okay, good to know. I would like for your husband to come in sometime so that I can meet him. We can include him in some sessions.

Caregiver: I don't know if he can. He works long hours.

Therapist: Well, the door is always open for him to attend and I will be glad to talk to him on the phone sometime with you if you like.

Caregiver: Thanks, I'll keep that in mind.

Therapist: All right, let me stop us here for a minute so I can summarize what I have discovered so far.

Tony: Sure, go ahead.

Therapist: Tony primarily uses marijuana. As a therapist, I would say that marijuana is Tony's "drug of choice."

Tony: Yep.

Therapist: Tony's drug use is significant enough that it has caused him to get arrested and has contributed to declining grades, a school suspension, and disturbed relationships with his mother and stepfather.

Tony: Yep, screaming matches.

Therapist: Also, it seems that Tony uses alcohol from time to time and that use may also pose a threat to his well-being.

Caregiver: Right, so can we work on both alcohol and pot?

Therapist: One nice thing about the treatment I am going to provide is that we will be able to work on both things at the same time. So, while we will focus on marijuana, we will also test for alcohol and other drugs periodically. In other words, we will work together to help Tony get off both pot and alcohol. [Transitions into introducing contingency management, as outlined in Chapter 3.]

Guilford Publications
72 Spring Street
New York, NY 10012
212-431-9800
800-365-7006
www.guilford.com