

Adolescent Substance Use and Interventions



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May 17, 2011

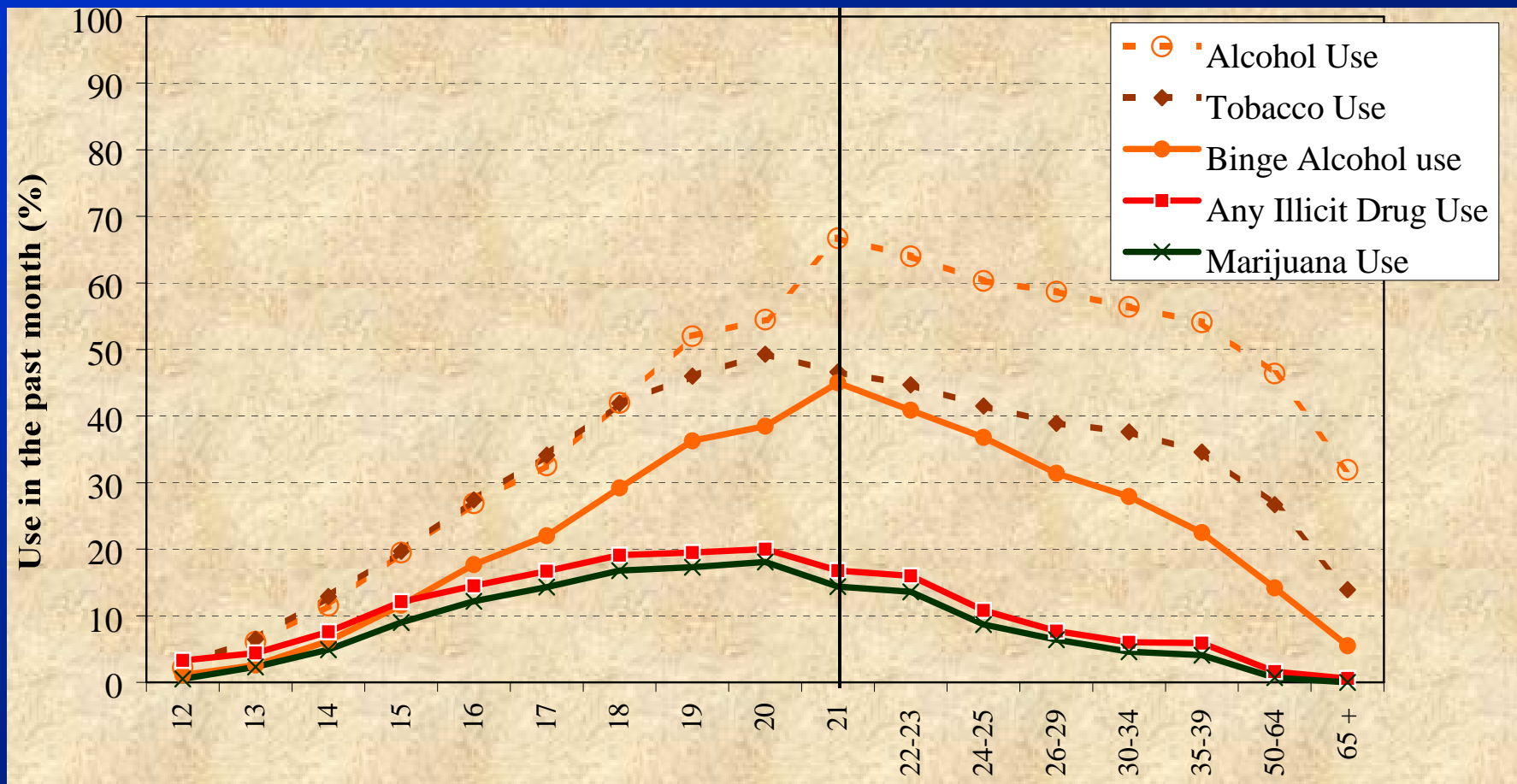
**Integrated Substance
Abuse Programs**



Agenda

- Review importance of epidemiological data – understand adolescent substance issues.
- Review standardized **screening & assessment** infrastructure to support the move to improve treatment effectiveness
- Review clinical strategies deemed EB as brief treatments/interventions

Research shows that 90% of all adults with dependence started using under the age of 18, half of which were under the age of 15.



Substance Use Disorders are **Adolescent Onset Disorders**

Where have we been?

- Past decade, adolescent substance use field has gained growing attention

- ◆ Moving away from adult paradigm

- Since 1997 research has grown tremendously

- ◆ Supported the field as an “emerging science”





Adolescent Substance Abuse Research

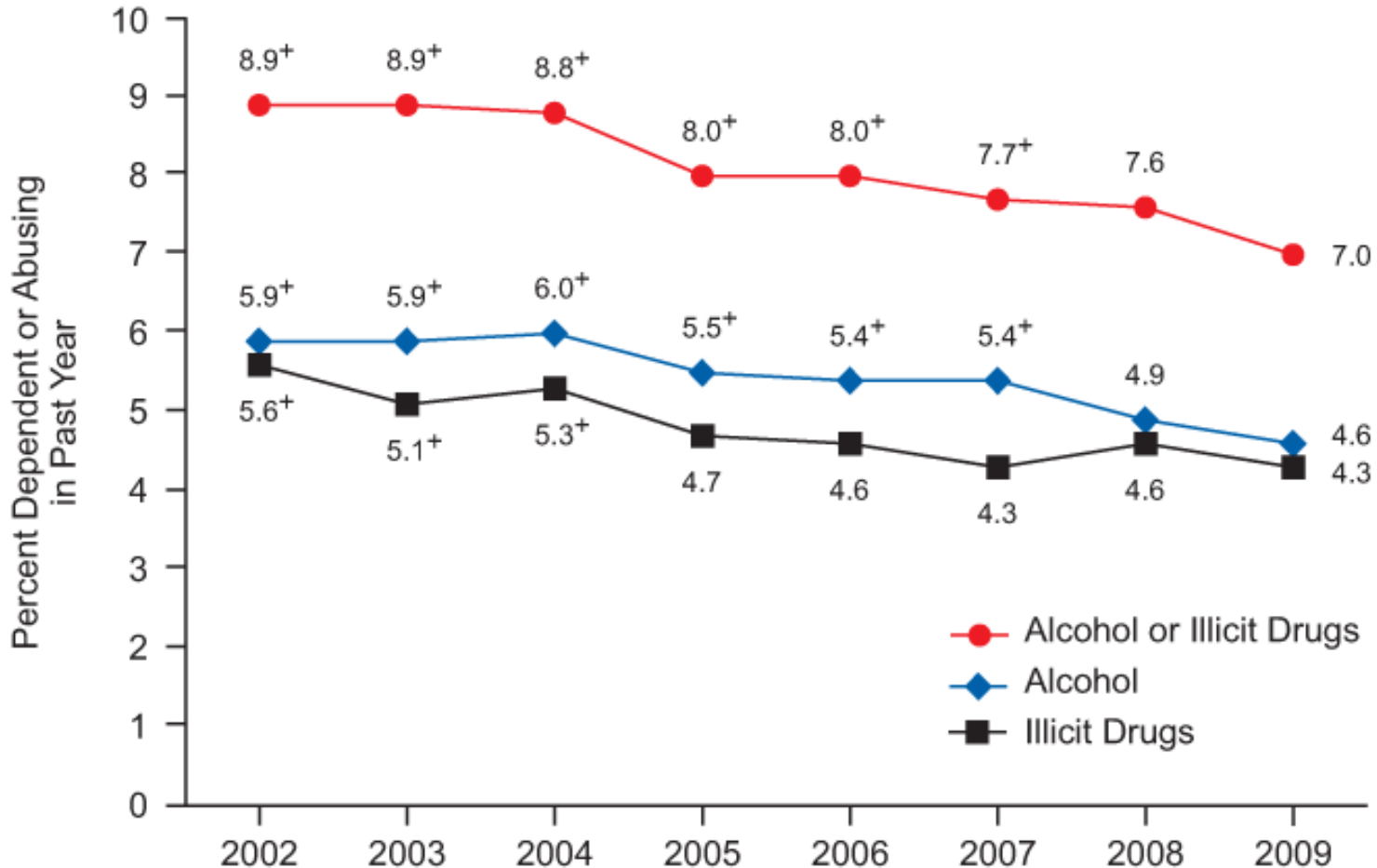
Feature	1930-1997	1997-2009
Treatment Studies	16	500+
Random/Quasi	9	48+
Tx Manuals	0	50+
QA/Adherence	Rare	Common Practice
Epidemiology Studies	Slow	Common Tracking
Evaluations	Descriptive/Simple	More Advanced
Economic	Some Cost	Cost, CEA, BCA

Growth has helped shape service improvement agendas

What does Epidemiology Research Tell Us about Adolescent Substance Use Problems?



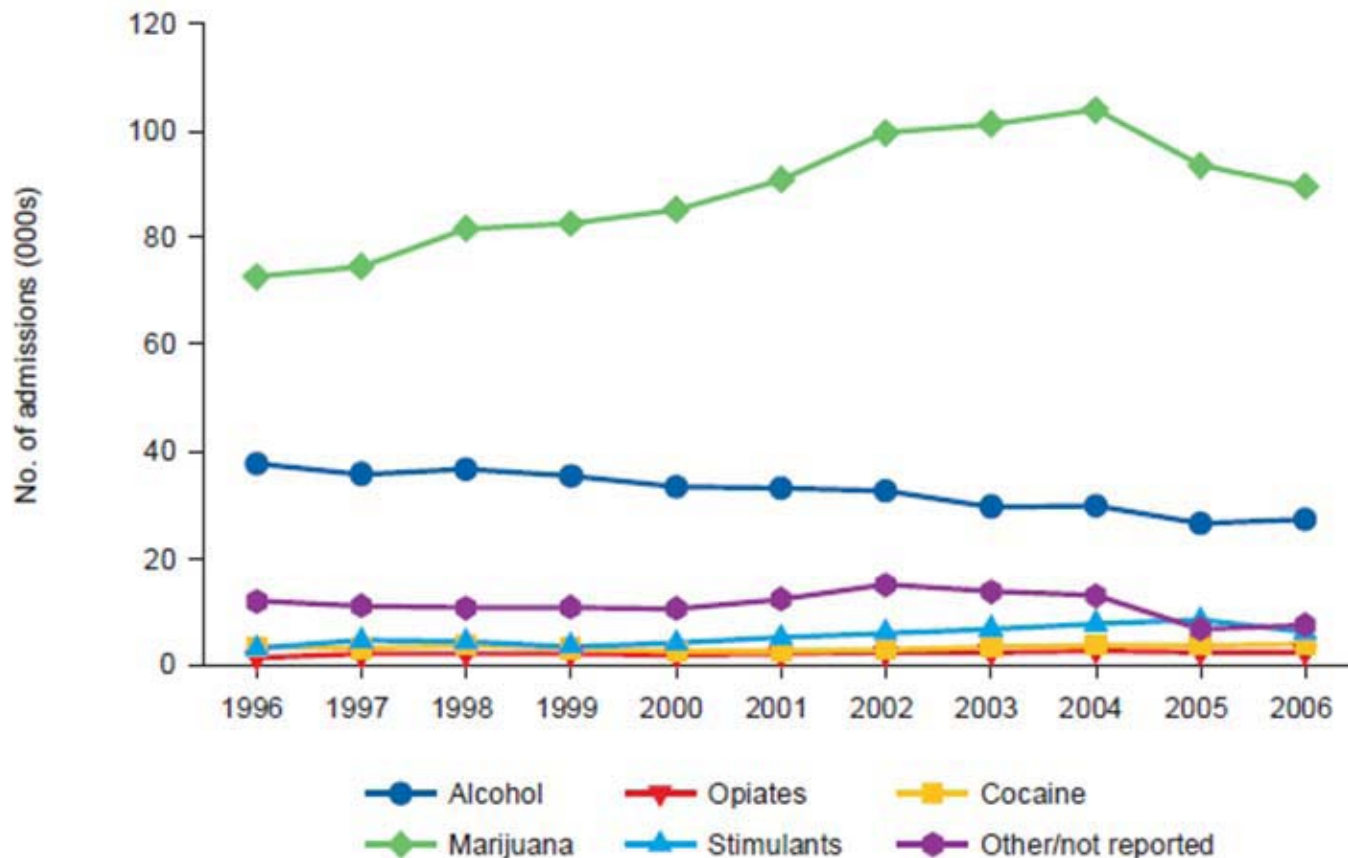
National Survey Data: Substance Abuse/Dependence among Youth (12-17)



Clinical Concern: Whose Presenting for Treatment?



National Treatment Data: Adolescent Admissions by Primary Substance of Abuse/Dependence



Common Use Trends...



Mainstay Substances

- Tobacco
- Alcohol
- Marijuana

Hot Issues at the National front

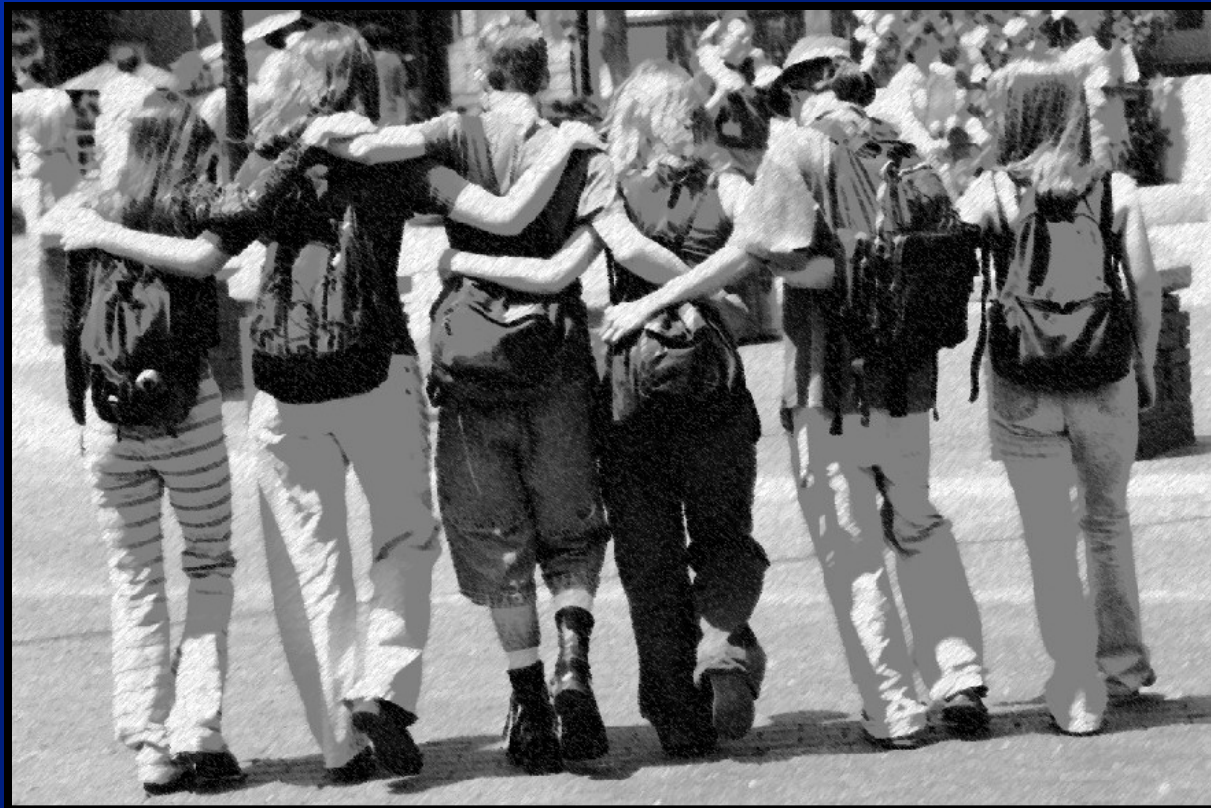
- Prescription & over-counter medications
- Inhalants
- Club Drugs (MDMA – “x”)

Where are adolescents at with harder drugs?

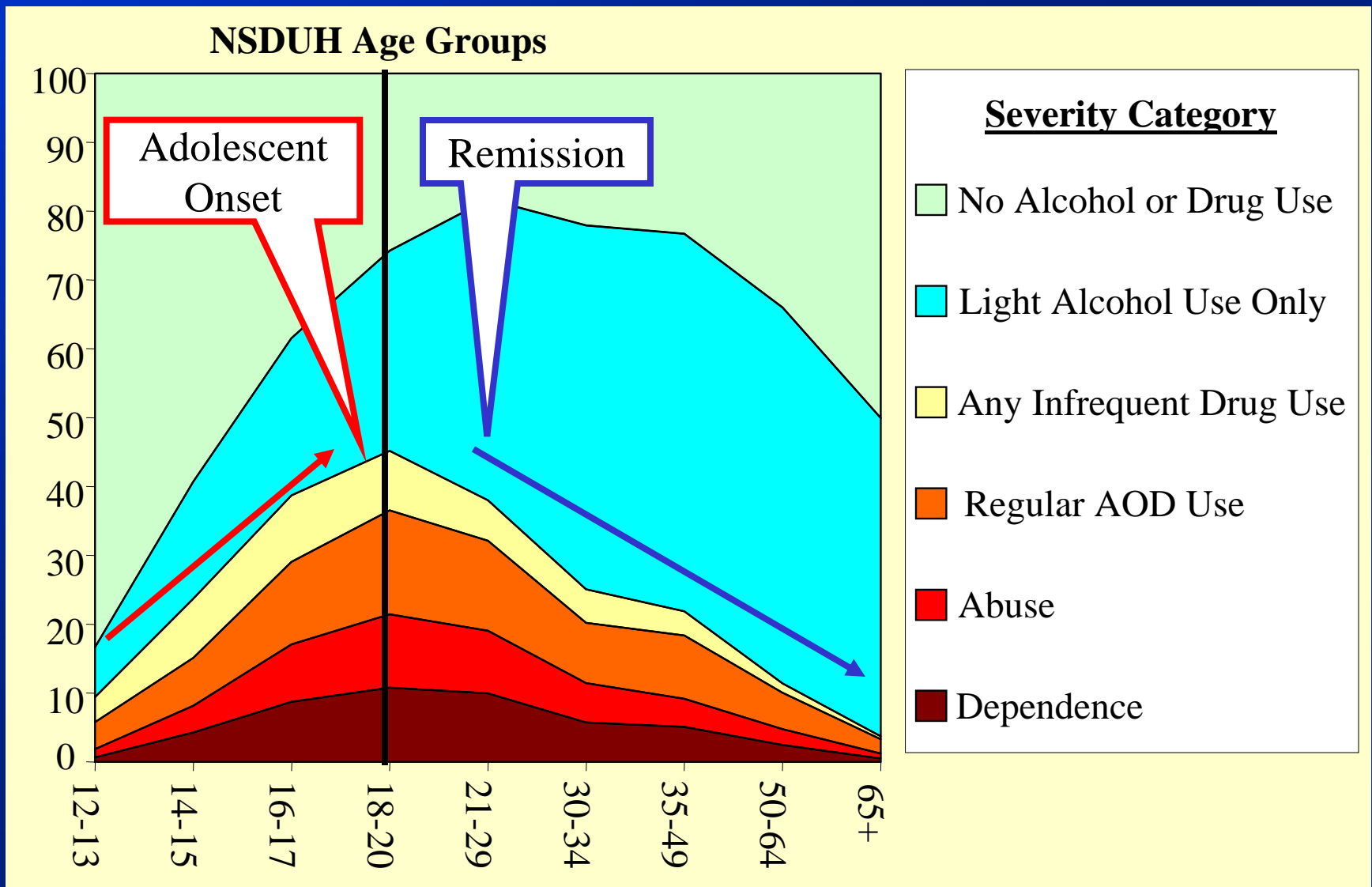
- Harder Drugs – meth, cocaine, heroin

**Access &
Availability**

Every Generation of Teens Looks for New Ways to Get “High”



Substance Use Disorders Onset in Adolescents

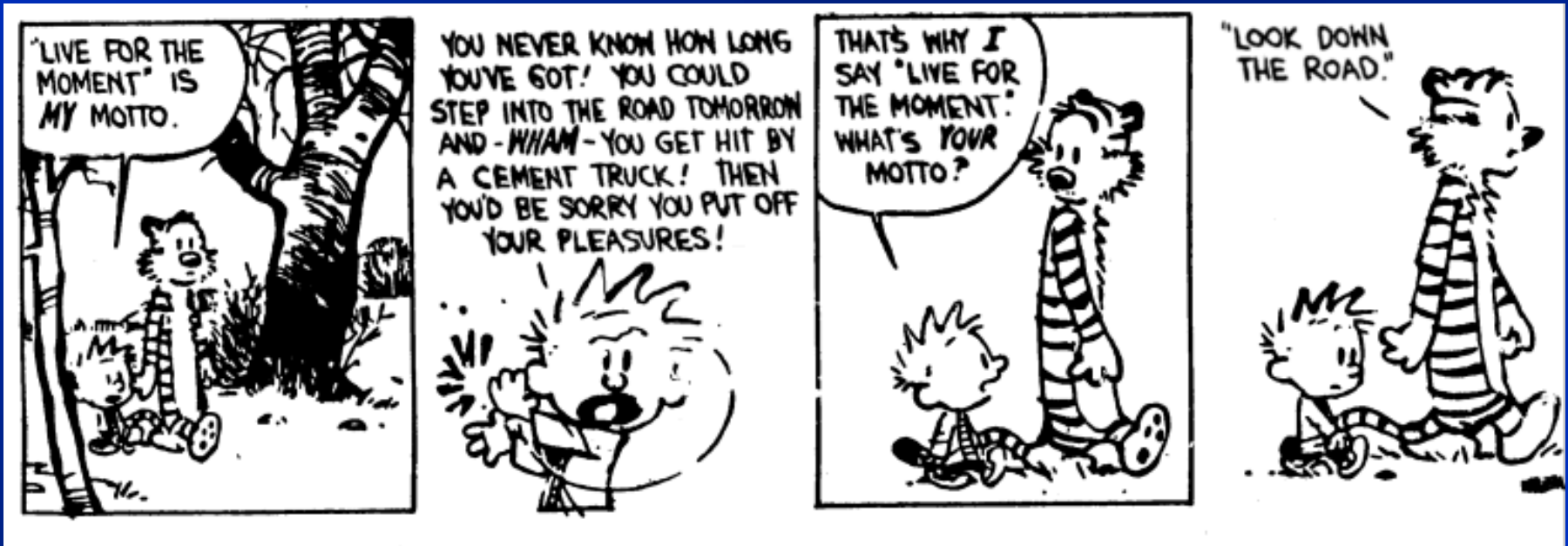


Clinical Situation is Complicated

**Problem
Severity**

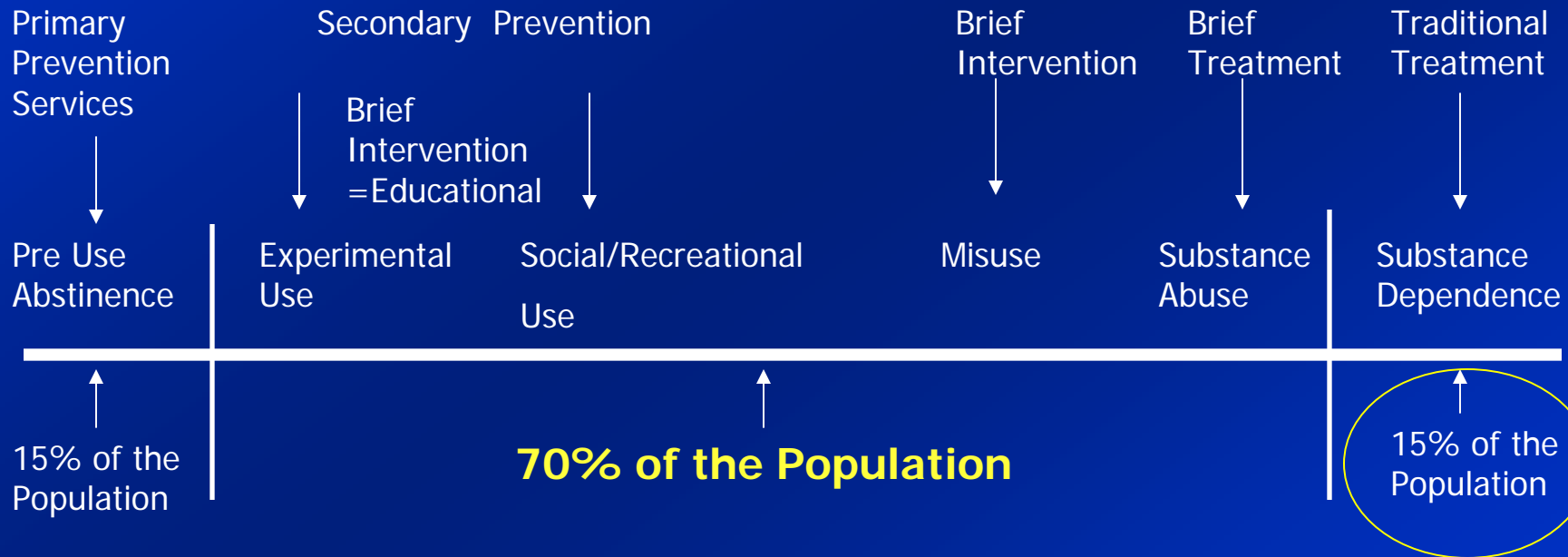


Clinical Risk Differs



Clinical Risk & System Response

Clinical Trajectory



Source: SBIRT Project 2007, Stephen O'Neil

Understanding Problem Severity

■ Screening is essential

✦ To determine RISK - the actual problem severity— where are they along the clinical **risk** continuum of use?

✦ Standardized Screeners – **handout**

▀ CRAFFT: Eng/Span



Client Screening Activity



CRAFFT

1. Have you ever ridden in a **Car** driven by someone (including yourself) who was high or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to **Relax**, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs when you are by yourself **Alone**?
4. Do you ever **Forget** things you did while using alcohol or drugs?
5. Do your **Family** or **Friends** ever tell you that you should cut down on your drinking or drug use?
6. Have you ever gotten into **Trouble** while you were using alcohol or drugs?

Responsibility element

Coping element – use moves beyond pleasure

Isolation/Social Withdraw element

Impairment element

Problem Use recognized by others

Consequences of use*

Scoring: 2 or more positive items indicate the need for further assessment.

The CRAFFT is intended specifically for adolescents. It draws upon adult screening instruments, covers alcohol and other drugs, and calls upon situations that are suited to adolescents

Assessing beyond Problem Severity

■ Assessment & Diagnosis

- ◆ This process helps determine the **specific issues** of the individual - **beyond substance use** (& to guide tx planning/placement)

- ▬ Global Appraisal of Individual Needs (GAIN)
- ▬ Addiction Severity Index 4 Teens (T-ASI)
- ▬ Adolescent Problem Severity Index (APSI)



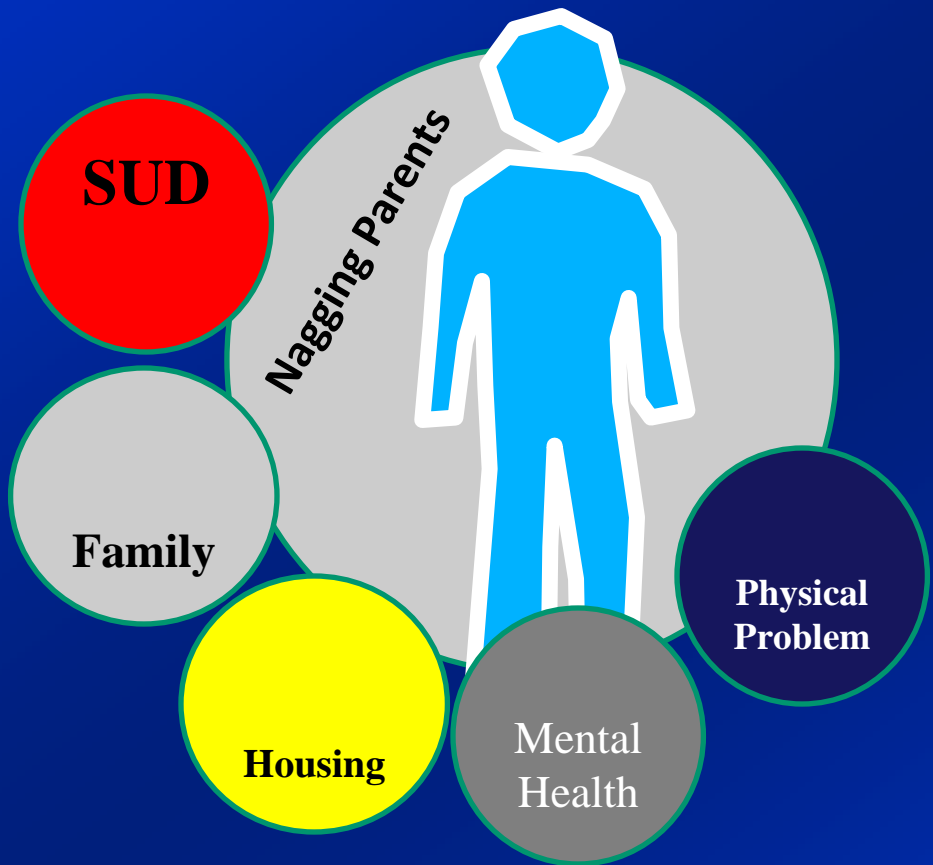
MET Brainstorming: Review reasons for quitting...ask which they think is most important

- What is typically the client's main problem (reasons for quitting) from **their perspective**?
- From **your perspective** is this the case? What is typically your clinical impression of the client's main problem?
 - ✦ What are some **characteristics of your most difficult clients**?

Complexities for Clinical Tx



- Majority of adolescents presenting for tx with more than just substance use problems...
 - ◆ **Psychological co-occurring** (trauma, depression, anxiety, etc.) histories
 - ◆ **Delinquent/legal** court/probation issues
 - ◆ **School** drop-out/academic failure issues
 - ◆ **Family** dysfunction



SUD



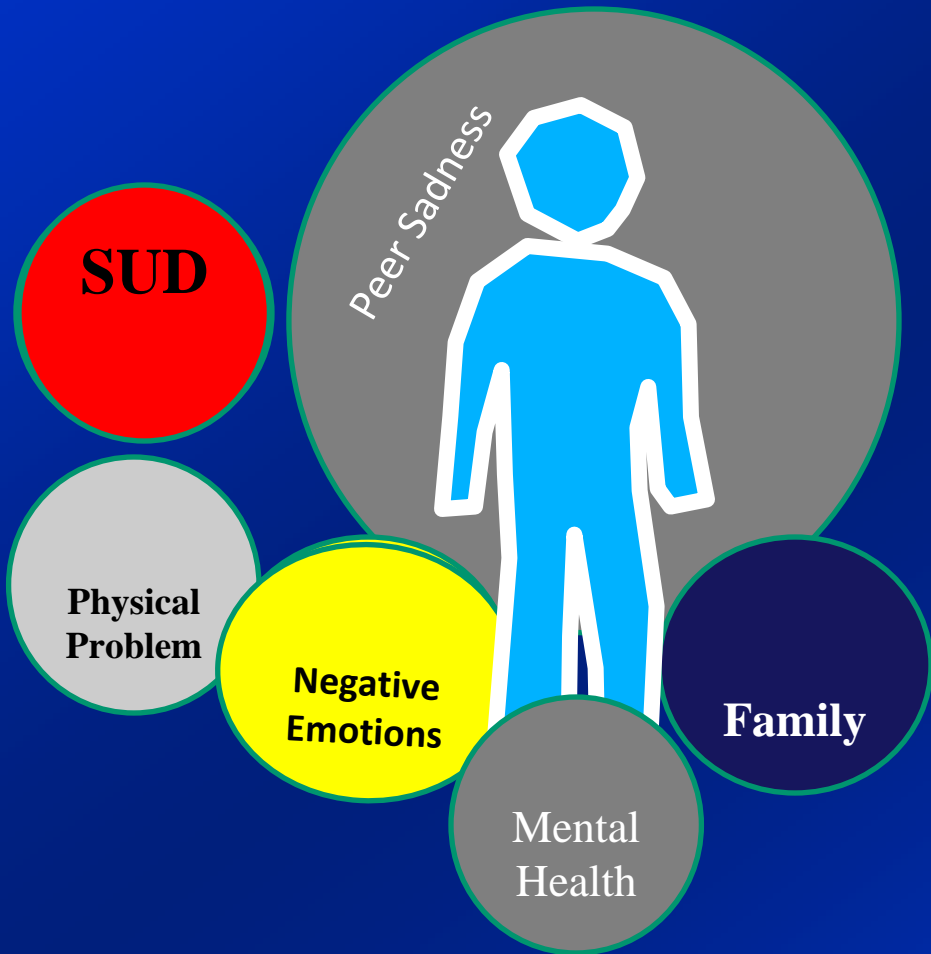
Turn Our Attention to: **Treatment Effectiveness Studies**

- Tell us about the effectiveness of different treatment models for adolescents with substance use disorders
- Includes studies with programs deemed “evidence-based”
 - ✦ Proven to be successful through research methodology and have produced a consistent pattern of positive results.

EBP Treatment Series

- 1. Motivational Enhance Treatment/Cognitive Behavior Therapy (MET/CBT5)**
- 2. Cognitive Behavior Therapy 7 (CBT7)**
- 3. Family Support Network (FSN)**
- 4. Adolescent Community Reinforcement Approach (ACRA)**
- 5. Multidimensional Family Therapy (MDFT)**





Difficult Clients are Categorized as...

- Main problem: **AOD/SUD**
- The client perception of the issue: **XXX**
- **B/C Disconnect & Mismatch**



5 Manualized Tx Protocols

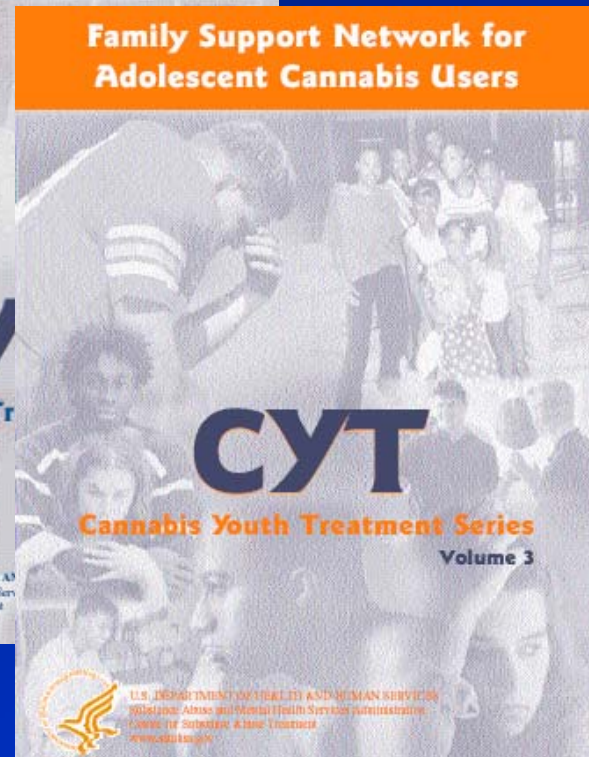
**Motivational Enhancement Therapy
and Cognitive Behavioral Therapy for
Adolescent Cannabis Users: 5 Sessions**

**The Motivational Enhancement Therapy and
Cognitive Behavioral Therapy Supplement:
7 Sessions of Cognitive Behavioral Therapy for
Adolescent Cannabis Users**

**The Adolescent Community
Reinforcement Approach for
Adolescent Cannabis Users**

**Multidimensional Family Therapy
For Adolescent Cannabis Users**

**Family Support Network for
Adolescent Cannabis Users**



Treatment manuals available from National Clearinghouse for Alcohol and Drug Information (NCADI) or www.chestnut.org/li

CYT

Cannabis Youth Treatment
Trials

Treatment
Series
Volume 1

Motivational Enhanced Treatment/ Cognitive Behavior Therapy 5 (MET/CBT5)

Sampl, S., & Kadden, R. (2001)
University of Connecticut Health Center
Farmington, CT USA



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Individual MET Sessions 1 & 2

(50-75 min)

1. Assessment Feedback (Review PFR), Rapport-Building, Orientation to Treatment
 - ◆ Peer reference norming
 - ◆ Tell me about...(endorsed symptoms of abuse and dependence)
 - ◆ Review reasons for quitting...ask which they think is most important
2. Review of Progress, Functional Analysis, **Personalized Goal Setting**, and Orientation to the Group Sessions

Group CBT Sessions 1-3

(50-75 Min)

2. Increasing Social Support and Pleasant Activities
3. Coping with Emergencies and Relapse
 1. Drug/ETOH Refusal Skills

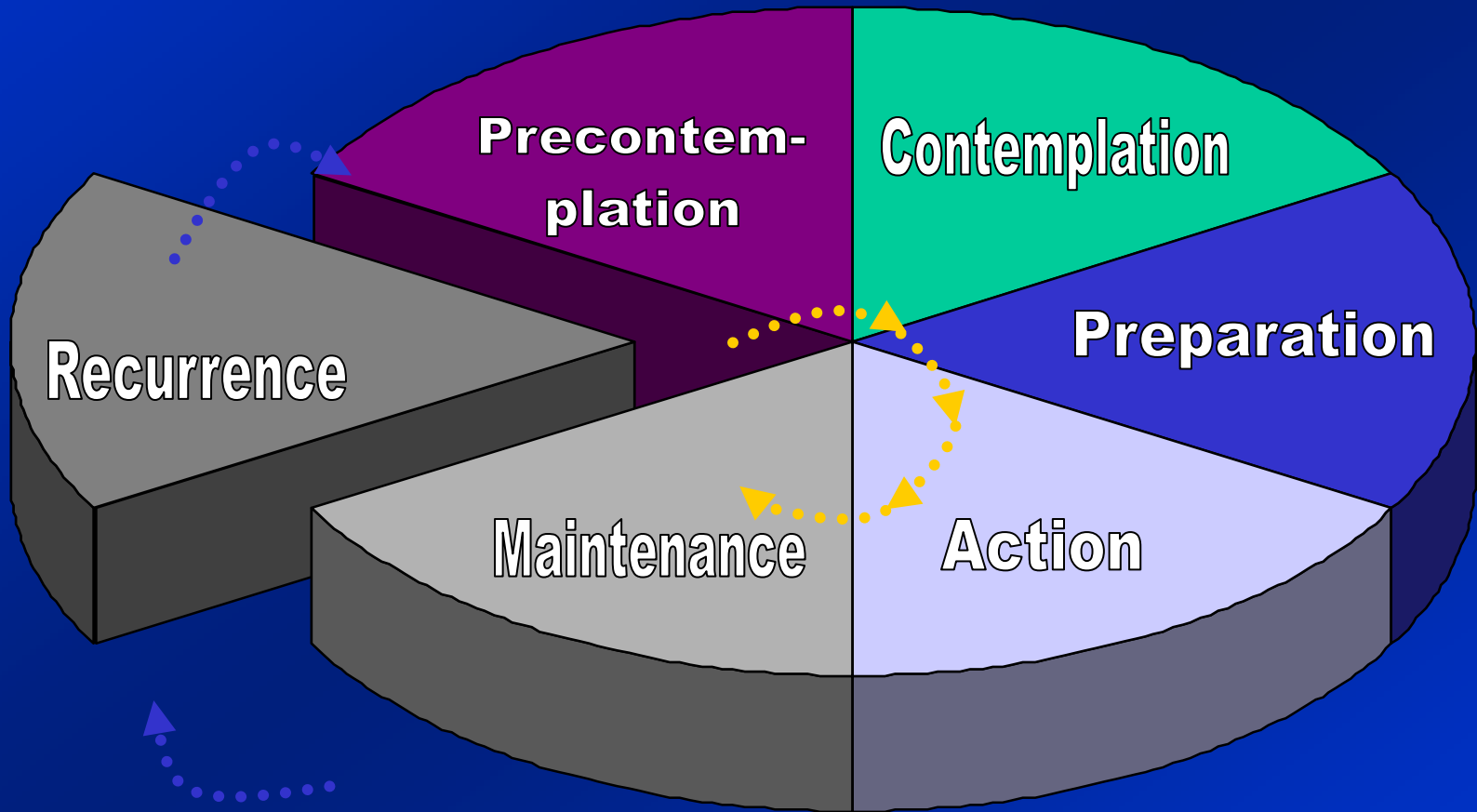
Client Preparedness



Plus 2 Random Urines over
six weeks

Stages of Change

Prochaska & DiClemente



How you talk to the adolescent matters

You are singing off key if you find yourself...

- Challenging
 - Warning
- Finger-wagging
 - Moralizing
- Giving unwanted advice
- Shaming
 - Labeling
- Confronting
- Being Sarcastic
- Playing expert

Five Strategies of MET

1. Express Empathy
2. Develop Discrepancy
3. Avoid Argumentation
4. Roll with Resistance
5. Support Self-Efficacy





**How can you
Express Empathy?**



Reflective Listening

- Open Ended questions...
 - ◆ “Tell me about the problem you mentioned with xxx...?”

- Demonstrate understanding of what the client is communicating
 - ◆ *“It sounds like you . . .”*
 - ◆ *“So you . . .”*
 - ◆ *“It seems to you that . . .”*
 - ◆ *“It sounds like you’re feeling . . .”*

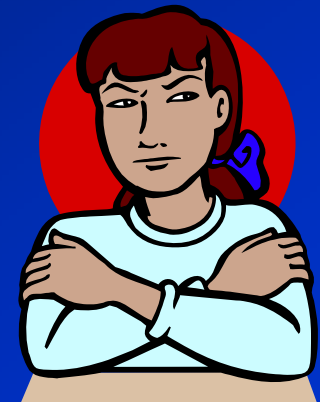
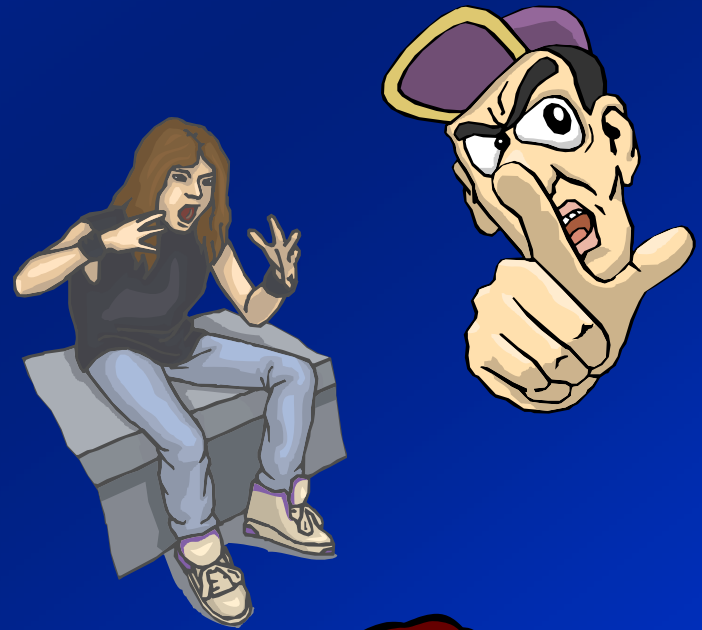
- Avoid interjecting clinical AOD perception
 - ◆ Adolescents view it as: lecturing, preaching, warning, arguing

Facilitating the Risk/Reward Analysis

- What to focus on: Decisional balance scale
 - ◆ Elicit pros and cons of use and change
 - ◆ **Emphasize client choice and responsibility**
- Elicit self-motivational statements, and **summarize them** (they are hearing what they just said)

How do you avoid argumentation with a teenager?

- **Resistance** should be a CUE to modify your approach
- Treat ambivalence (mixed feelings) **as normal**
- Bring the focus back on their concerns:
 - ✦ Elicit the client's perceptions of the problem and providing feedback



Video Demo:

Goal Setting (MET)

&

**Increasing Social
Support/Pleasant
Activities (CBT)**



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Cannabis Youth Treatment
Trials

Treatment
Series
Volume 2

Cognitive Behavior Therapy 7 Supplement (CBT-7)

**Webb, C., Scudder, M.,
Kaminer, Y., Kadden, R., &
Tawfik, Z. (2002)**

University of Connecticut Health Center
Farmington, CT USA



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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www.samhsa.gov

7 Supplemental CBT Sessions:

6. Problem-Solving Skills
7. Anger Awareness
8. Anger Management
9. Communication Skills: Assertiveness and Criticism
10. Coping with Cravings
11. Managing Negative Moods
12. Managing Thoughts about Using

CYT

**Cannabis Youth Treatment
Trials**

Treatment
Series
Volume 3

Family Support Network (FSN)

**Hamilton, N., Brantley, L.,
Tims, F., Angelovich, N., &
McDougall, B. (2001).
Operation PAR
St. Petersburg, FL USA**



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www.samhsa.gov

Importance of the Family!

	Substance Use Correlations				Intraclass Correlations w 95% C.I.
	3-month	6-month	9-month	12- month	
Family conflict	.56	.48	.47	.43	.58 (.53, .62)
Family cohesion	.56	.50	.46	.50	.54 (.50, .59)
Social support	.42	.38	.45	.44	.50 (.45, .54)
Recovery environment risk	.42	.42	.37	.24	.43 (.39, .48)
Social risk	.28	.34	.24	.21	.37 (.32, .42)
Substance use	.36	.30	.19	.27	.50 (.45, .54)
Substance-related problems	.43	.35	.31	.31	.46 (.42, .51)

A Closer Look at the Family Issue...

- **Family Support:** less family conflict and greater family cohesion corresponded to reduced risk for poor treatment outcomes
- Although families play a pivotal role, they vary in their ability and willingness to help...

How do you facilitate Parental Attendance?



Adolescent Community Reinforcement Approach (ACRA)

**Godley, S. H., Meyers*, R. J.,
Smith*, J. E., Godley, M. D., Titus, J.
M., Karvinen, T., Dent, G., Passetti,
L., & Kelberg, P. (2001).**
Chestnut Health Systems
Bloomington, IL USA, and
*University of New Mexico
Albuquerque, NM USA



CYT

Cannabis Youth Treatment
Trials

Treatment
Series
Volume 5

Multidimensional Family Therapy (MDFT)

Liddle, H. A. (2002).
University of Miami
Miami, FL USA



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Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

2010 Meta-Analysis

- Study of studies conducted to identify treatment effectiveness of various EBP treatment approaches that maximize treatment outcomes (JMATE presentation)
 - ✦ **48 studies** that included **79** treatment approaches for adolescents

Treatment Approaches

- Family therapy (k = 25, n = 88)
- Individual counseling
- Generic GROUP counseling programs
- Cognitive behavioral therapy (CBT)
- Motivational interviewing/enhancement therapy (MET)
- MET + CBT (MET/CBT)
 - ◆ MET/CBT-5
 - ◆ MET/CBT-12 (this includes the 7 additional components)

Treatment Approaches, Cont.

- Psychoeducational therapy (PET)
 - ✦ Generic psychoeducational curriculum
- Other treatments
 - ✦ contingency management; vocational counseling; Pharmacological; drug court
- No treatment (No Tx)
 - ✦ No treatment, assessment only, and delayed treatment control groups

Results

■ Effect sizes were close and not statistically meaningful to make definitive statements about superiority...BUT

- ✦ **Family therapy & CBT/MET combo** had stronger effects (on abstinence outcomes) than all compared treatment conditions
- ✦ Individual counseling was less effective than all other treatment conditions with which it was compared



Clinical Adherence to EBPs?

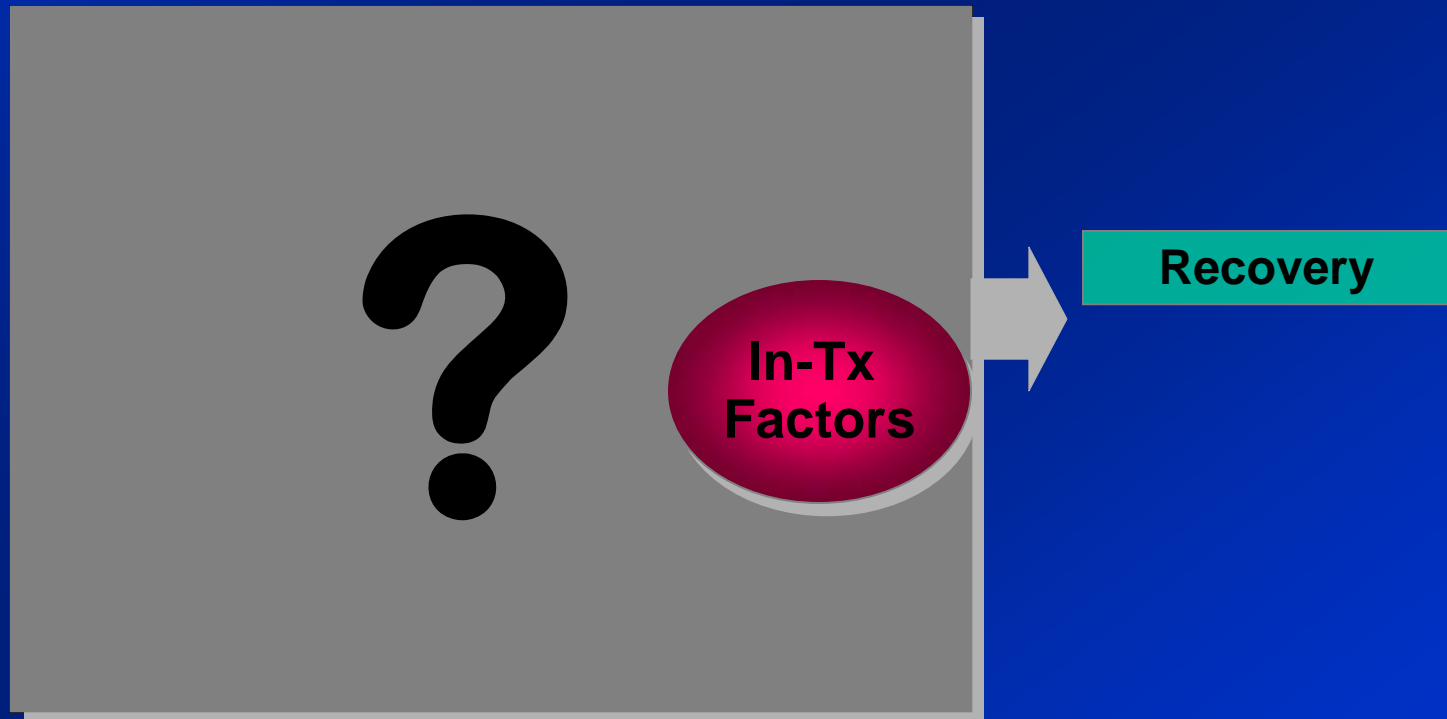


What do Counselor's Say?

- Like the structure and consistency
 - Easy to use
 - They help focus a session
-

- Can be restrictive
- Need to incorporate personal style and creativity
- Need to provide flexibility

The Post-Treatment Period



Treatment Effectiveness Studies

- Important to note: studies have NOT established a superior treatment approach
 - ◆ They all have equally effective results in terms of producing positive outcomes...
 - ▶ Reducing use
 - ▶ Improving mental health/wellbeing, and
 - ▶ Repairing social relations
- Happy Ending?

Treatment Outcome Studies

■ Although treatment is working...

- ✦ Less than half of adolescents leave treatment with a positive discharge (still using)
- ✦ **Relapse continues to be fairly common:** ~65% relapse during first three months after tx completion (Brown et al., 1989) and longer-term (12 mos; Dennis et al., 2000)



The Case for Continuity of Care

- Lack of continuity of care: less than 10% participate in aftercare after formal tx

Been called many things...

McKay (2008)

- Aftercare
- Continuing care
- Stepped-down care
- Extended interventions
- Disease management





Continuing Care Service Barriers

- Limited funding for services in the addiction field
 - Limited availability of services
 - Hence, not a standard “clinical” practice
- Why pay when we have – 12 step model?
 - Been referred to as “the perfect aftercare” (White, 2007)

Empirical Support for CC

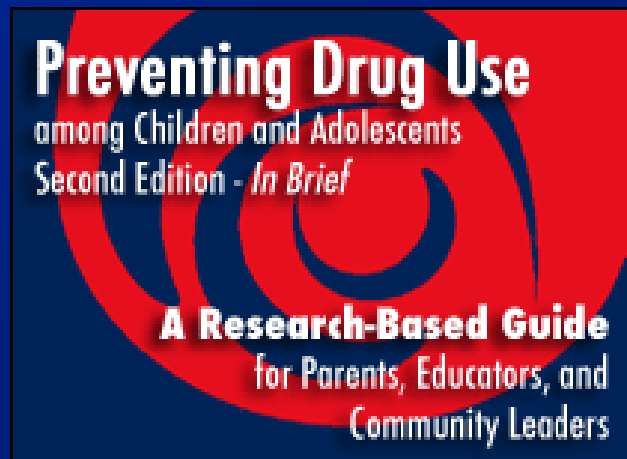
- Evidence suggests clients who get continuing care have better outcomes than clients who do not receive CC services (McKay, 2009).
- Evidence mainly established for adults; **less clear for adolescents**
 - Very few continuing care studies of adolescents in the scientific literature
 - Godley et al. 2002 – home visits with youth after residential tx (Assertive Continuing Care)

NIDA and SAMHSA Resources

TIP 31: Screening & Assessing Adolescents for Substance Use Disorders

TIP 32: Treatment of Adolescents With Substance Use Disorders

For parents offer:



“NIDA Red Book”



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