Wisconsin Bureau of Substance Abuse Services

EMERGING EFFECTIVE TREATMENTS FOR *ADOLESCENT* SUBSTANCE DEPENDENCY 2002

This document gives the reader an overview of emerging adolescent treatment approaches for alcohol and other drug use disorders. Six approaches backed by solid research are highlighted in this report. Adolescent treatment professionals are advised to develop skills in these techniques in order to improve the quality of treatment.

Introduction

The disease of addiction progresses more rapidly in children and teens than it does in adults. While physical withdrawal symptoms are somewhat rare in adolescents, a normal, loving, well-behaved son or daughter can seem to change to a self-destructive stranger sometimes in a matter of months. The abuse of alcohol or other drugs among youth interferes with physical, psychological, social, and intellectual development. The young person abusing alcohol or drugs becomes more prone to immediate dangers and costly consequences such as traffic and other accidents, violence, dropping out of school, and risky sexual behavior, to name a few.

The rate of substance abuse among youth is very close to that of adults. In *Checking the Alcohol and Other Drug Health of Wisconsin Residents*, the researchers found that 8.3 percent of youth age 12 to 17 could be classified as having a substance use disorder requiring treatment. In comparison, the adult rate was only slightly higher at 9.8 percent.

Other studies have shown that the age when youth first begin experimenting with alcohol and drugs is getting younger. The Youth Risk Behavior Survey (YRBS), conducted every two years by the Wisconsin Division of Public Health, and treatment data bear this out. In 1988, 18 percent of Wisconsin youth reported using alcohol by grade 5 (about age 10) and 2 percent used marijuana by grade 5. In the 1999 YRBS survey, 21 percent had used alcohol and 3 percent had used marijuana by grade 5. Wisconsin treatment data show a similar trend with marijuana use among girls. In 1993, the average age of first use of marijuana among girls treated for marijuana abuse was 16. In 1999 it was 15. These trends are significant because the earlier youth start using alcohol or drugs the higher their risk of developing substance abuse problems later on.

General Characteristics of Effective Programs

It is becoming increasingly important for addiction treatment centers to utilize best practices that have been proven to show results. Since adolescents are not a single, homogeneous group, no one form of treatment is the most effective for every youth. The principles and approaches described in this report have demonstrated reductions in delinquency, crime, out-of-home placements, institutionalization, teen pregnancy, and emergency room incidents as well as improved school attendance, and cost savings.

Much of the research on effective adolescent treatment approaches has its origins in child welfare, mental health, and juvenile justice. And so this research and some of the approaches have only recently been applied and practiced in addictions treatment programs with similar success.

Principles of effective adolescent care can be applied in outpatient, in-the-home, residential, inpatient, therapeutic community, and even faith-based settings.

Adolescent treatment programs need to be community-based, structured, intensive and of a sufficient duration to adequately address the multiple problems (school, trauma, mental illness, delinquency, family break-up, etc.) that adolescents and their families face. Programs should identify and address co-morbidity (conduct, attention deficit hyperactivity, depression, and post traumatic stress disorders). Effective programs also take into account adolescent developmental issues.

A focus on changing specific behaviors such as interpersonal/social skills, self control, anger management, or peer resistance to using substances provides clear direction to all involved in the treatment regimen. Programs should not just have group-oriented

approaches. Individual counseling sessions are an important adjunct with adolescents as well as adults.

Principles of Effective Adolescent Treatment

Community-based
Structured
Sufficient intensity and duration
Includes individual sessions
Addresses multiple problems
Focuses on changing specific behaviors
Takes into account developmental issues
Family-centered
Puts in place natural supports
Intentional outreach

Families have a wealth of information about and a significant influence over a youth's needs and behavior. Programs that are family-based or family-centered and seek to put in place natural family and community supports show better results.

Young people with substance use problems are less likely than adults to come to treatment voluntarily or even through a family member. Intentional outreach components through underage drinking violation programs, Student Assistance Programs, child welfare agencies, runaway programs, health clinics and hospitals are essential. Techniques such as "Strategic Structural Systems Engagement" are effective for reducing family and adolescent resistance and it begins by simply having multiple phone contacts with parents.

Consequently, approaches that stress "punishment," incarceration, surveillance, electronic monitoring, home confinement, unstructured counseling, frequent drug testing, "scared straight" experiences, wilderness/survival activities, and "boot camps," while they may be popular, these do not work in the long run.

Aside from what the scientific literature has demonstrated, let's remember that one of the single most important factors in effective adolescent treatment is the quality of the relationship between the counselor or therapist and the adolescent/family. A positive, caring, empathic, and sensitive counselor with good listening skills who seeks to facilitate the family's journey from relationships that enable addiction to relationships that support recovery will do much to ensure treatment effectiveness.

Six Effective Approaches

1. Cognitive-Behavioral Therapy (CBT). Based upon learning theory, cognitive-behavioral styles of therapy seek to help clients recognize and understand the causes of their problems and teach them the skills to overcome them. CBT involves teaching youth about the thought-emotion-behavior link and working with them to modify their thinking patterns in a way that will allow them to cope more effectively in challenging situations.

Beginning CBT with motivational enhancement therapy makes it even more effective with adolescents. Specific areas that are addressed in adolescent CBT include coping skills, refusal skills, problem solving, anger awareness and control, responding to criticism, coping with cravings, relapse prevention, communication skills, improving family cohesion, parenting skills, and job finding.

The treatment team seeks to establish a social network (Adolescent Community Reinforcement Approach) supportive of recovery, incorporate role playing, include real-life practice, and develop a drug-free activity plan. Individual sessions should be added for victimized or traumatized adolescents.

The family is involved in a variety of ways. There can be home visits for family therapy, parent education meetings, referral to parental support groups, and wraparound care coordination.

CBT approaches are particularly effective with youth in the juvenile justice system as well as for children with anger, conduct, or depression disorders.

2. Multi-Systemic Therapy (MST). In MST, the therapist collaborates with the family and other systems to determine the factors in the youth's life that are contributing to problems. The therapist then can design ways to address them. MST is based upon the philosophy that the adolescent's problems stem from poor discipline in the family, parental drug use, peers who use drugs, problems at school, and neighborhood

culture. The objective is to empower the family to cope with the challenges of raising children and to empower the adolescent to cope with problems effectively, decrease affiliation with antisocial and drug-using peers, and establish new positive relationships.

MST is particularly effective with adolescents that are involved in other public systems (mental health, juvenile justice, child welfare, or special education) and have serious antisocial behavior. These children are best served when agencies coordinate and integrate care and "wrap" services around them in an individualized way. Care or treatment plans are developed using a "strengths-based" perspective. The collaborating systems seek to remove barriers to effective parenting, communication, and closeness among family members. In-the-home visits and 24-hour crisis intervention are also hallmarks of this approach.

3. Behavioral Therapy. The underpinnings of behavioral therapy lie in the belief that "unwanted" behavior can be changed by clear demonstration of the desired behavior in small, incremental steps with consistent rewards given as the desired behaviors are practiced.

Behavioral therapy seeks to give the adolescent three types of control:

a) *Stimulus control* to avoid situations associated with drug use and spend more time in drug-free activities.
b) *Urge control* to recognize and change thoughts, feelings, and plans that lead to drug use.
c) *Social control* to come under the influence of positive family members, mentors, and peers.

Therapeutic activities include "homework" assignments, rehearsing or role-playing desired behaviors, recording and reviewing progress, and praise and privileges given for achieving satisfactory progress on assignments. Urine samples are collected regularly but are only used to monitor drug use, not to "punish" drug use. The family is closely involved in all aspects of behavioral therapy.

4. Multidimensional Family Therapy (MDFT). This is typically an outpatient, family-based treatment for teenagers which holds to the view that a network of influences (family, peers, and community) can help contribute to or reduce unwanted behavior. Treatment includes individual and family sessions at the office or in the home. During individual sessions, the therapist and adolescent work on developmental tasks such as decision making, negotiating, problem solving, communication skills, coping with life stressors, and vocational skills. Parallel sessions with parents deal with parenting skills and style, parental influence versus control, and how to have a developmentally appropriate influence on the child. MDFT is particularly effective with adolescents in foster care with or without natural parents.

5. Functional Family Therapy (FFT). Originally designed as a delinquency prevention and intervention program, it has since been used in the treatment of conduct, oppositional defiant, disruptive behavior, and substance use disorders for adolescents who are also delinquent and/or violent. As a clinical model, FFT has been conducted in varied clinical settings and as a home-based model by one- and two-person teams. It has been proven to significantly reduce recidivism and both National Institutes on Alcohol Abuse and Alcoholism and Drug Abuse are checking its efficacy in substance abuse. It's based on the following premises:

1. Targeting risk (e.g. parenting practices; trouble at school; alienation) and protective (e.g. positive parent-child communication; presence of caring, supportive relationships; critical thinking skills) factors that can be changed;
2. Engaging and motivating the families and youth so they participate more in the change process;
3. Entering each counseling session and phase of intervention with a clear plan;
4. Constantly monitoring process and outcome;
5. Taking a positive "can do" approach.

FFT is a short-term intervention with, on average, 8 to 30 one-hour sessions of direct service. In most programs sessions are spread over a three-month period of time. Families progress through these phases:

Phase 1: *Engagement, Motivation, and Assessment*. During these initial phases, FFT applies reattribution (e.g., reframing) and related techniques to impact maladaptive perceptions, beliefs, and emotions.

Phase 2: *Behavior Change*. This phase applies individualized and developmentally appropriate techniques such as communication training, specific

tasks and technical aids, basic parenting skills, and contracting and response-cost techniques.

Phase 3: *Generalization.* In this phase, Family Case Management is guided by individualized family functional needs, their interaction with environmental constraints and resources, and the alliance with the therapist.

6. AA/NA 12-Step Facilitation Therapy. Adolescent 12-step approaches provide an orientation to AA, facilitation through the steps of AA, AA reading assignments, and attendance at AA meetings. This approach consists of individual and group counseling along with lectures on a variety of substance abuse-related topics. Occupational and recreational therapy as well as academic classes are also provided on the premises if in a residential setting. Structured family education meetings and sessions are also scheduled.

Implications

With these six approaches in mind, we must ask ourselves, "How many of these techniques is my agency incorporating into the adolescent treatment we provide?" As alluded to earlier, no single approach is effective for all adolescents and the more approaches practiced, the better will be the treatment outcomes. It was our intent here to give adolescent treatment professionals in Wisconsin a brief overview of what has been proven to work in the treatment of adolescent substance dependency. We encourage counselors and supervisors to seek books and manuals, professionals who have these skills, and training so that your agency's repertoire of adolescent approaches is such that it improves the quality of care provided to the families we serve.

References

Alexander, J., et.al. (1998). *Blueprints for Violence Prevention, Book Three: Functional Family Therapy*. Boulder, CO: Center for the Study of Prevention and Violence.

Alford, G.S. et. al. (1991). Alcoholics Anonymous Narcotics Anonymous model for the inpatient treatment of chemically dependent adolescents: A two-year outcome study. *Journal of Studies on Alcohol*, 52, 118-126.

Aos, P. (1999). The comparative costs and benefits of programs to reduce crime: A review of national research findings with implicatons for Washington state. Washington State Institute for Public Policy.

Azrin, N.H. et. al. (1994). Behavioral therapy for drug abuse: a controlled treatment outcomes study. *Behavioral Research & Therapy*, 32(8), 857-866.

Desmond, D. et. al. (1981). Religious programs and careers of chronic heroin users. *American Journal of Drug and Alcohol Abuse*, 8(1), pp. 71-83.

Dold, Lyric, et.al. (1999). *Checking the Alcohol and Other Drug Health of Wisconsin Residents: The Final Report of a Statewide Household Survey, 1997*. Published by the Wisconsin Department of Health and Family Services.

Gendreau, P. & Goggin (1996). Principles of effective correctional programming. *Forum on Correctional Research*, 3, 1-6.

Godley, Susan, et. al. The Cannabis Youth Treatment Study. In collaboration with the federal Center for Substance Abuse Treatment, Chestnut Health Systems (Illinois), and the Alcohol Research Center (Connecticut).

Greenwood, P. (1994). What works with juvenile offenders: A synthesis of the literature and experience. *Federal Probation*, 58(4), 63-67.

Henggeler, S.W. et. al. (1996). Eliminating treatment dropout of substance abusing delinquents through home-based multisystemic therapy. *American Journal of Psychiatry*, 153, 427-428.

Kaminer, Y. et. al. (1998). Psychotherapies for adolescent substance abusers: A pilot study. *Journal of Nervous and Mental Disorders*, 186(11), pp. 684-690.

Lipsey, M. (1992). Juvenile delinquency treatment: A meta-analytic inquiry into the variability of effects. In Thomas Cook, et. al. *Meta-Analysis for Explanation: A Casebook*. Russell Sage Foundations: New York.

National Institute on Drug Abuse (1977). *An Evaluation of the Teen Challenge Treatment Program*. Services Research Report.

Schmidt, S.E. et. al. (1996). Effects of multidimensional family therapy: Relationship of changes in parenting

practices to symptom reduction in adolescent substance abuse. *Journal of Family Psychology*, 10(1), 1-16.

Sherman, L., et. al. (1997). *Preventing Crime: What Works, What Doesn't, What's Promising?* Office of Justice Programs: Washington DC.

Simpson, D., et.al. (2000). Treatment Process Model. Institute of Behavioral Research, Texas Christian University.

Titus, Janet et. al. (1999). *What Research Tells Us About the Treatment of Adolescent Substance Use Disorders.* Chestnut Health Systems, Bloomington, Illinois.

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