



# Adolescent Development Training Workbook

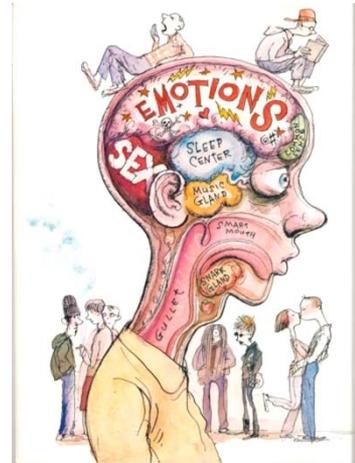
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# This workbook was designed to provide general information about the development of adolescents

- Participants will be able to have a better understanding of the adolescent development process.
  - The Adolescent Life Stage
  - Brain development During Adolescence
  - Physical Development During Adolescence
  - Emotional Development During Adolescence
  - Social Development During Adolescence
  - Working with adolescents (skills, safety guidelines)
  - Contemporary Trends & Issues in Adolescent Substance Abuse
  - Treatment Strategies, Considerations and Program Elements



# The Adolescent Life Stage





# Adolescent Lifespan

- **adolescence** [ad'əles'əns] Etymology: L, *adolescere*, to grow up  
the period in development between the onset of puberty and adulthood. It usually begins between 11 and 13 years of age with the appearance of secondary sex characteristics and spans the teenage years, terminating at 18 to 20 years of age with the completion of the development of the adult form. During this period, the individual undergoes extensive physical, psychologic, emotional, and personality changes. (*Mosby's Medical Dictionary, 8th edition. © 2009, Elsevier*)
- A large and relatively new body of research is revealing that **young adulthood** is a time of dramatic change in basic thinking structures, as well as in the brain. Consensus is emerging that an 18-year-old is not the same person she or he will be at 25, just as an 11-year-old is not the same as he or she will be at 18. They don't look the same, feel the same, think the same, or act the same. Across theories and research frameworks, a sequence of developmental shifts emerges, which can be organized into three overall categories:
  - Adolescence (generally defined as puberty through age 18)
  - Young adulthood (generally defined as...18 to 25)
  - Later adulthood (generally defined as mid-20s and older)



# Theoretical Perspectives

## Sigmund Freud Psycho-Sexual Theory of Development

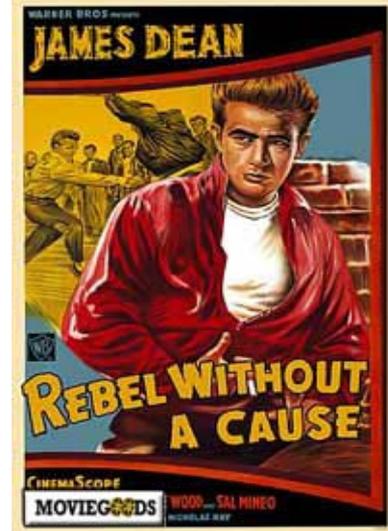
- Psychoanalytic Theorist
- 5 Stages of Psycho-Sexual Development
- Adolescence is the fifth and final stage named *The Genital Stage*
- First time exploration of sexuality “outside of the home”



# Theoretical Perspectives

## Erik Erikson Psycho-Social Theory of Development

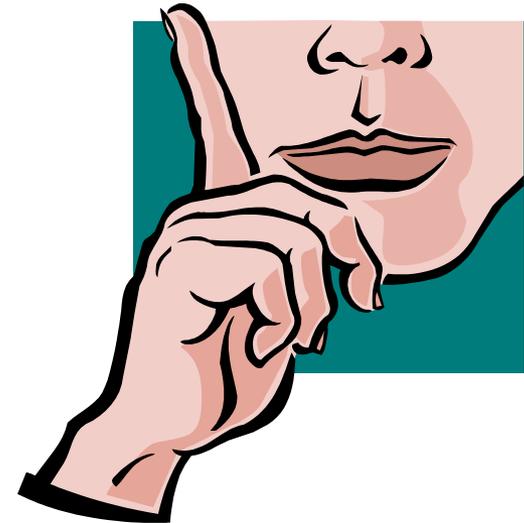
- The Stages Psycho-Social Development
- Polarized, Developmentally Appropriate Crisis to be resolved
- Fifth Stage, *Identity vs. Identity or Role Confusion*
- Significant Radius of Relationships is Peers
- Adolescence 12-18
- Older Adolescence 18-22



# Theoretical Perspectives

## Piaget Theory of Cognitive Development

- Cognitive Theorist
- Learning is Cumulative
- Learning Occurs in a Biological Frame
- Revising the Schema through Assimilation, Accommodation and Adaptation
- 4 Stages of Cognitive Development
- Formal Operations, “Cognitive Maturity”
- Developmental Delays and Arrest



# Theoretical Perspectives

## Peter Blos

- Second Separation-Individuation Process
- Process not an event!
- Separation from caregivers to become autonomous young adults



# Adolescent Development

**Development occurs in different domains concurrently, but not at the same rate.**

- Physical
- Cognitive
- Emotional
- Social
- Moral
- Spiritual
- Racial/Cultural
- Sexually



# Adolescent Development

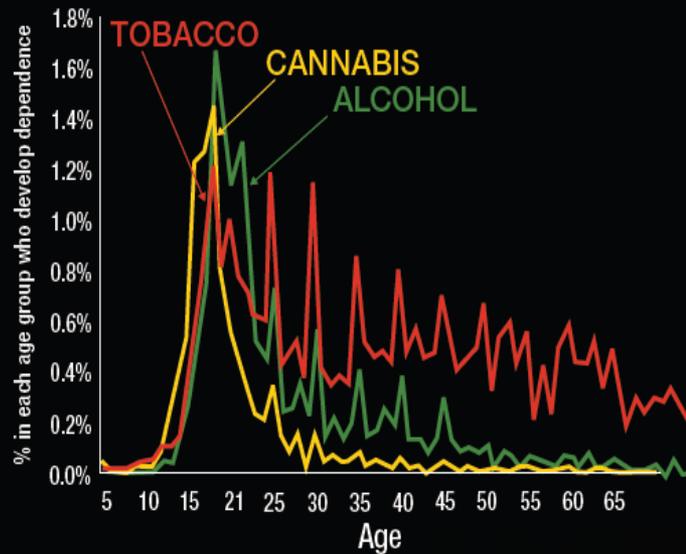
## Development is variable and ongoing:

- Adolescents demonstrate range of strengths and weaknesses
- Competencies in some areas, deficits in others
- Development is uneven – some 16-year-olds appear to be 21, while others appear to be 12
- Despite our preconceptions, adolescents are still growing and maturing (e.g., cognitive development)



# ADDICTION IS A DEVELOPMENTAL DISEASE

*that starts in adolescence and childhood*



Age at **tobacco**, **alcohol** and **cannabis** dependence per DSM IV

*National Epidemiologic Survey on Alcohol and Related Conditions, 2003.*



# Normal Adolescent Development- The Move Towards independence

- Increased independent functioning
- More cohesive sense of identity
- Examination of inner experiences
- Ability to think ideas through
- Conflict with parents begins to decrease

(ACCAP, 2005)



# Normal Adolescent Development- The Move Towards independence

- Increased ability for delayed gratification and compromise
- Increased emotional stability
- Increased concern for others
- Increased self-reliance
- Peer relationships important and take an appropriate place among other interests

(ACCAP, 2005)



# Developmental Tasks

## **Appreciate own uniqueness:**

- Identify interests, skills and talents
- Identify differences from peers by accepting personal strengths & limitations
- Challenge skill levels



## **Defining and practicing masculine and feminine roles:**

- Learn and accept comfortable adult masculine or feminine role
- Role flexibility = role ambiguity

## **Adapt to adult body functioning:**

- Adapt to body changes
- Refine balance and coordination
- Acquisition of physical strength
- Consider sexual and reproduction issues



# Developmental Tasks

## **Accepting one's physique and using the body effectively:**

- To be proud, or at least tolerant, of one's body

## **Achieving emotional independence from parents and other adults:**

- Emerge from childish dependence on parents
- Develop affection without dependence for parents
- Respect for other adults without dependence
- Accepting a degree of parental guidance

## **Achieving new and more mature relationships with peers of both sexes:**

- Integration of heterosexual interactions
- Social experimentation generally in the security of group settings
- Movement away from group companionship toward more intimate individual relationships



# Developmental Tasks

## **Determine own value system:**

- Identify options
- Establish priorities
- Translate values into behaviors
- Resist peer and cultural pressures to conform to their value system
- Find a comfortable balance between one's own and the peer/cultural standards and needs

## **Develop self-evaluation skills:**

- Develop basis for self-evaluation
- Assess approach to tasks and responsibilities
- Evaluate dynamics of interpersonal relationships



# Developmental Tasks

## **Assuming increasing responsibility for own behavior:**

- To participate as a responsible adult in the life of the community
- Take account of the values of society into one's personal behavior
- Emotional tone
- Time management
- Decision making and problem solving
- Social behaviors
- Personal habits



## **Acquire skills essential for adult living:**

- Acquire skills essential to independent living
- Develop social and emotional abilities and temperament
- Acquire employment skills; preparation and exploration for an occupation based on skills and interests



# Developmental Tasks

## Find meaning in life:

- Accept and integrate meaning of death
- Develop philosophy on life
- Begin to identify life or career goals



## Acquire a set of values and ethics that can guide behavior:

- Establish personal values, which include rejecting or modifying previously held values, bestowed by parents and/or society
- Define one's place in the physical world and in relation to other people

## Seek affiliations outside family of origin:

- Seek companionship with compatible peers
- Affiliate with organizations that support uniqueness
- Actively seek models or mentors
- Identify potential emotional support systems
- Differentiate between acquaintances and friends
- Identify ways to express one's sexuality



# Physical And Brain Development During Adolescence



# Puberty

## **Puberty:**

- The biological process that results in the physical transformation of a child into a reproductively mature adult
- Generally regarded as the physiological marker of adolescence



# Puberty And Females

- Approximately 7-9 years of age in girls
- Invisible
- Uterus size increases
- Estrogen levels begin to increase
- Growth hormone begins to increase
- Hormones leading to underarm and
- Pubic hair growth increase



# Puberty And Males

- Most boys begin puberty between the ages of 9 and 14 and they generally mature at about 15 or 16.
- In boys:
  - The testicles and the penis get bigger first.
  - Next, hair grows in the pubic area and the armpits. A small amount of breast tissue might develop at this time as well.
  - The voice becomes deeper.
  - Muscles grow.
  - Lastly, acne and facial hair show up.
- Remember: Puberty starts when a boy's body is ready; every boy grows at their own pace.

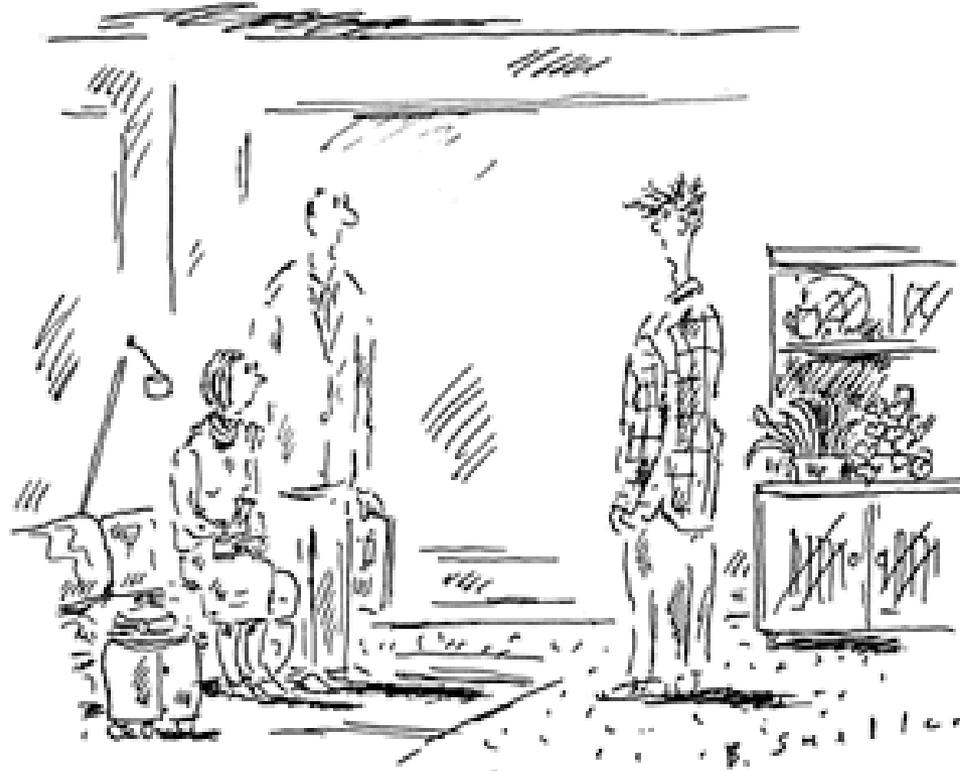


# Brain Development During Adolescence



**“Go to your room and stay there until your cerebral cortex matures.”**

© Cartoonbank.com



*“Young man, go to your room and stay there until your cerebral cortex matures.”*



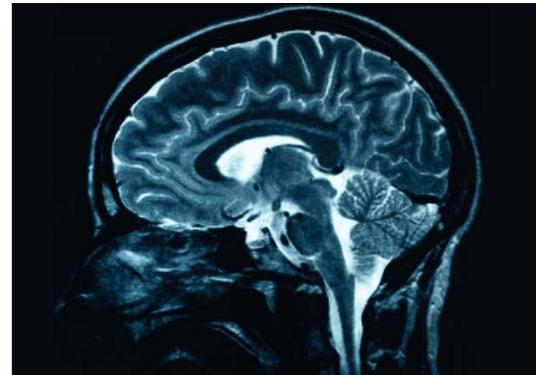
# Brain Development During Adolescence

- Although the brain only weighs approximately three pounds, it is considered the command center of the body.
- When drugs enter the brain, they can interrupt how the brain performs.
- Brain maturation continues until a later age than previously believed.



# Brain Development During Adolescence

- Different systems mature at different points in time and at different rates
- Most important areas
  - prefrontal cortex
  - limbic system



# Brain Development During Adolescence

## Brain Stem

- The brain stem is in charge of all of the functions to stay alive – breathing, circulating blood, and digesting food.
- The brain stem is linked to the spinal cord, which runs down the back and is responsible for moving muscles and limbs as well as letting the brain know what is happening to the body.



# Brain Development During Adolescence

## Limbic system

- The limbic system links together brain structures that control emotional responses such as pleasure. This good feeling motivates us to repeat the behavior.
- The cerebral cortex is the outer part of the brain and makes up  $\frac{3}{4}$  of the entire brain. It is divided into four areas called lobes.



# Brain Development During Adolescence

## **Limbic system**

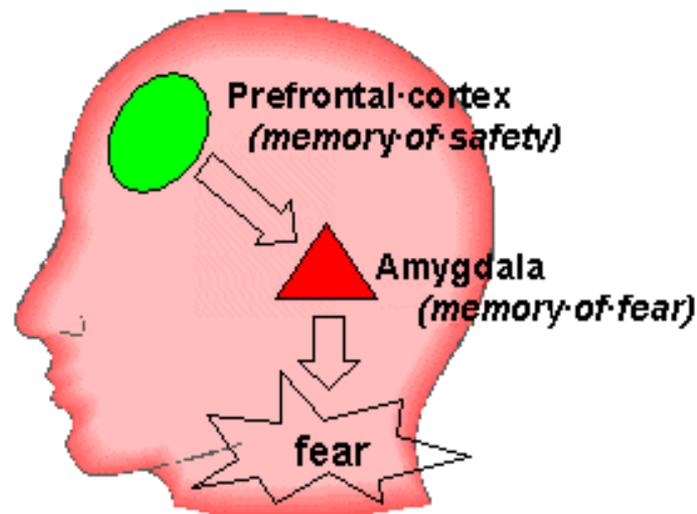
- Processing emotions
- Associating emotions with memories
- Processing social information
- Experience of reward and punishment



# Brain Development During Adolescence

## Prefrontal Cortex

- The final portion of the brain to mature is the front of the brain, largely dominated by the prefrontal cortex.
- The "area of sober second thought," is responsible for rational, executive brain functions
- Organizing thoughts
- Weighing consequences
- Assuming responsibility
- Interpreting emotions



# Cerebral Cortex Functions

- Process information from our senses
- Frontal Cortex or forebrain is the thinking center – the region of the brain involved in judgment, decision-making, and control of emotional responses. This is the last area of the brain to fully mature.



# Adolescent Brain Development Can Be Divided Into Three Processes

- **PROLIFERATION** – Rapid growth of brain matter and the formation of new connections within the brain.
- **PRUNING** – Cutting away of unused or unimportant connections
- **MYELINATION** – Insulating of brain pathways to make them faster and more stable

(Sowell et al., 1999; Soweell et al. 2001)



# Proliferation

- By age 6, the brain is about 95% of its maximum size
- It reaches maximum size at 11.5 years in girls and at 14.5 years in boys (Giedd et al, 1999).
- Boys brains are larger (on average) than girls brains.

(Lenroot & Giedd 2006)



# Proliferation

- Maximum brain size does NOT mean maximum brain maturity.
- The brain continues to mature for at least another 10 years
- Although boys brains are anatomically bigger than girls brains, size is NOT directly related to intelligence.



# Grey Matter And White Matter

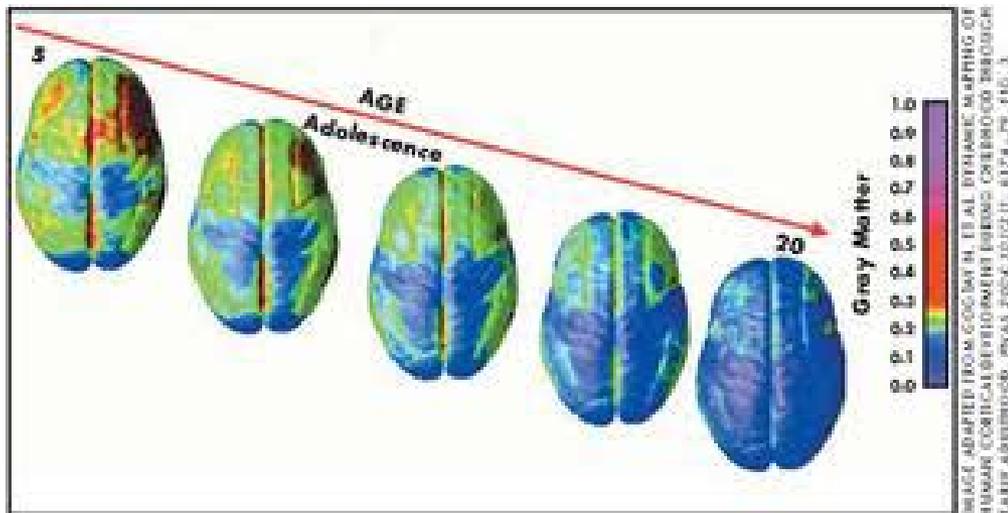
**The grey and white matter grow and mature at different rates**

Grey matter is where all of the thinking happens. This is your brain's processing center.

White Matter transport information to different parts of your brain.



# Proliferation: Grey Matter



Grey matter develops quickly during childhood, but slows during adolescence.

↓  
Grey matter volume peaks at age 11 in girls and at 13 in boys.

↓  
Then, the volume of grey Matter begins to decline



# Pruning: Grey Matter Maturation

- The maturation of grey matter is best described as a constant “**push and pull.**” New pathways grow, while others are pruned back.
- Pruning is greatly influenced by experience, so it really is a case of “**use it or lose it.**”
- This makes the adolescent brain extremely **versatile**, and able to make changes depending on the demands of the environment.



# Proliferation and Myelination: White Matter

- White matter makes up myelin, which insulates axons and speeds up communication between neurons.
- It develops continuously from birth onwards, with a slight increase at puberty.
- The increase occurs just after the peak in grey matter volume (around 11 in girls and around 13 in boys).

(Lenroot and Giedd 2006)



# The Teen Brain is in a Constant State of Development

Some areas of the brain mature faster than others.

The areas of your brain associated with reward, motivation, and impulsivity matures early.



# The Teen Brain Development- Poor Judgment and Impulsivity

Your prefrontal cortex, which thinks about things logically, weighs the pros and cons, and restrains you matures later.

This means teens can be more prone to riskier behaviors, and less likely to consider consequences than an adult would be.

**The Teen Brain is in a Constant State of Development**



# Risk and Reward



It's NOT that teens are stupid or have no control over their own brain. Studies have shown that teens know when they are engaging in risky behavior (like unprotected sex, drug or alcohol use). *However*, they are more likely to think that the benefits of those behaviors outweigh any potential harm.

(Reyna & Farley 2007)



# Risk and Reward

It is important to take a step back and realize that though not every risky choice will result in harm – some will. It's not enough to know there's risk, you need to also understand the consequences. It could impact the rest of your life in a really negative way.



**Playing Russian Roulette with only one bullet is much safer than playing it with five. But should we really play at all?**

(Reyna & Farley 2007)



# Brain Changes During Adolescence

- **Remodeling of receptors** – receptors for different neurotransmitters increase, decrease, or are redistributed
- **Synaptic pruning** – network of neural circuits becomes more efficient by elimination of unused synapses
- **Myelination** – transmission of electrical impulses becomes more efficient by “insulation” of neural pathways with myelin
- **Connectivity** – regions and systems of the brain become more interconnected



# How Does the Brain Mature After Adolescence?

- There is evidence that these changes continue well after the teenage years.
- In a study of young adults, the frontal lobes showed large changes up to age 30.
- This suggests that frontal lobe maturation is important for adult cognition.

(Sowell et al, 1999; Sowell et al., 2001)



# Dopamine Control

- **DOPAMINE** has been thought to be associated with :
  - Risky behaviors
  - Novelty seeking
- Individuals who have fewer dopamine "auto-receptors" -- which control the release of the brain chemical -- may be more prone to risk-taking, researchers say
- Individuals with a deficiency of dopamine auto-receptors experience higher levels of dopamine release during thrill-seeking activities, which reinforces and rewards risk-taking.

(The study was published in the Dec. 31, 2008 issue of the [Journal of Neuroscience](#)).



# **Risk Versus Resiliency During Adolescence**



# What do we mean by resiliency and risk?

- **Resiliency:** Focuses on healthy development despite risk exposure. Factors which contribute to some adolescents being more able to cope with exposure to potentially negative influences and avoid negative developmental trajectories.
- **Risk:** Those factors (both internal and external) which contribute to potentially negative outcomes for adolescents.

(Fergus & Zimmerman, 2005)



# Types of Risk Factors

- Family Risk
- Peer Risk
- VIP Risk
- Individual Factors
- Genetic/Biological Factors
- Social Factors

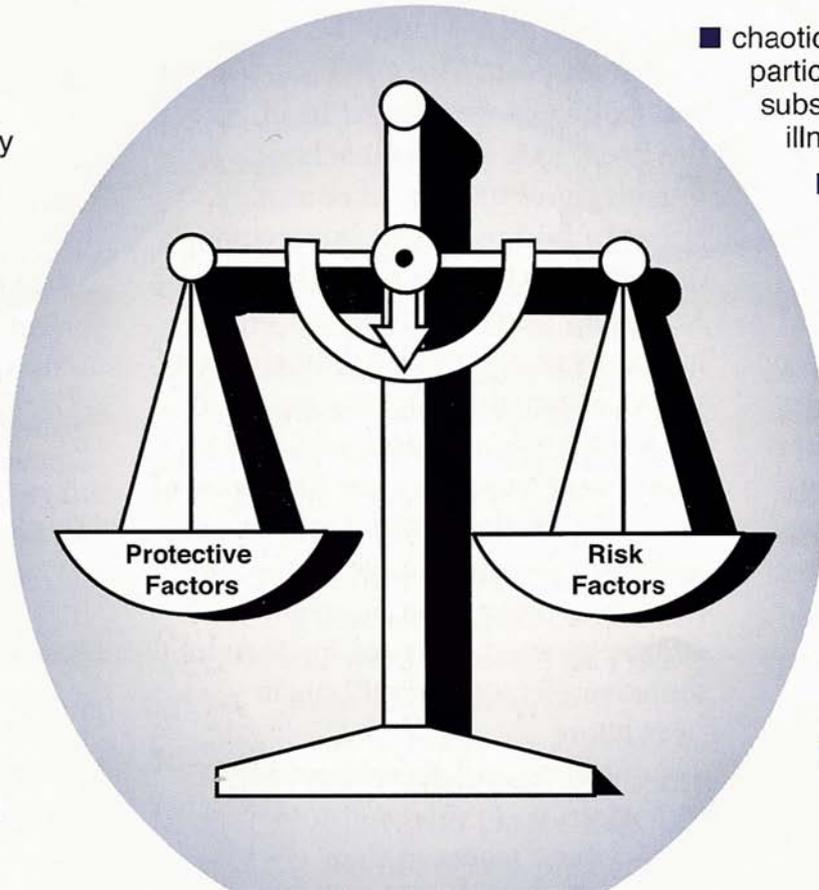
(Beam, Gil-Rivas, Greenberger & Chen, 2002)



# Risk and Protective Factors in Drug Abuse Prevention

## Protective factors:

- strong and positive family bonds;
- parental monitoring of children's activities and peers;
- clear rules of conduct that are consistently enforced within the family;
- involvement of parents in the lives of their children;
- success in school performance; strong bonds with institutions, such as school and religious organizations; and
- adoption of conventional norms about drug use.



## Risk factors:

- chaotic home environments, particularly in which parents abuse substances or suffer from mental illnesses;
- ineffective parenting, especially with children with difficult temperaments or conduct disorders;
- lack of parent-child attachments and nurturing;
- inappropriately shy or aggressive behavior in the classroom;
- failure in school performance;
- poor social coping skills;
- affiliations with peers displaying deviant behaviors; and
- perceptions of approval of drug-using behaviors in family, work, school, peer, and community environments.



# How Risk Behavior Manifests Itself During Adolescence

- Developmental Arrest and/or Regression
- Somatic manifestations; bodily concerns, aches and pains and illness
- Behavioral difficulties, acting out, delinquency, substance use, unsafe sex, etc.
- School difficulties, academic failure and/or behavioral problems
- Emotional difficulties



# Trauma Exposure is High

- Approximately **40% of youth will experience one or more** traumatic events in their lifetime

*(Steiner et al, 1997)*

- A longitudinal study of 9-16 year-old youth found:
  - 25% experienced at least one traumatic event
  - 6% within the past 3 months

*(Costello, Erkanli, Fairbank & Angold, 2002)*

- Rates much higher in juvenile justice populations (as high as 80-90% in some studies)

*(Teplin, et al, 2002)*



# Trauma And Gender

- Studies consistently find that among those who are exposed to trauma, females are more likely than males to develop mental health problems.

*(Cauffman et al., 1998; Giaconia et al., 1995)*

- Substance use/abuse
- Involvement in violent activity
- Relational impairments
- Developmental lags
- Subsequent victimization
- Aggressive behavior
- Poor academic performance
- Numbness; desensitization to threat
- Recklessness and re-enacting behavior
- Delinquency and adult offending



# Suicide Risk is High

16-17 year olds are in the highest risk category  
Rates of suicide attempts have doubled in recent years.  
Rates even higher for juvenile justice youth.

In Connecticut:

- 16 % of youth seriously considered
- 13.5% of youth made a plan
- 10% actually attempted
- 3 % required medical attention



# Risk Factors For Substance Abuse

- Family and Community
- Exposure to Substance
- Abuse
- Genetic/Family History
- Stressful/Negative Life Events
- Trauma Exposure
- Negative Influence of
- Peers/Peer Pressure
- Depressed Mood
- Low Self-Esteem
- Delinquent Behavior
- Disrupted Family Environments
- Lack of Coping Resources



# Protective Factors To Ameliorate Substance Abuse

- Positive Self-Esteem
- Family Connectedness
- Internal Locus of Control
- Positive Mood
- Religious Involvement
- Academic Achievement
- Future Orientation
- Participation in Extracurricular Activities and Athletics



# Risk Factors For Problem Behaviors and Depressed Mood

- Family Structure
- Parent Education
- Disrupted Families
- Poverty
- Stressful Life Events
- Gender
- Exposure to Violence or Conflict
- Peer Difficulties
- Exposure to Trauma or Loss
- Depressed Parents or Family Members



# Protective Factors To Ameliorate Problem Behaviors and Depressed Mood

- Supportive Caregivers & Adults
- Supportive, Pro-social Peers
- Loving, Warm Environment
- Moderate Levels of Stress
- Distance from Family
- Adaptive Coping Skills
- Involvement in athletics & extracurricular activities
- Pro-social Community Involvement
- Religious Involvement



# Sexually Risky Practices

- Adolescents are at higher risk than adults for acquiring STDs. They are more likely to have multiple sexual partners and to engage in unprotected sex.
- They are also more likely to select partners who are at higher risk for STDs.
- Among females, those 15 to 19 years old have the highest rates of gonorrhea.
- 20 to 24 year olds have the highest rate of primary secondary syphilis.

(CDC, 1996)



# Sexual Behavior

**Risk Factors:** Substance Use  
Peer Pressure  
Lack of Education & Awareness  
Low School Achievement  
Poverty  
Low Self-esteem  
Mental Health Concerns

**Protective Factors:** Positive Self-Esteem  
Participation in Extracurricular Activities  
School Achievement  
STD Knowledge & Awareness  
Positive Attitudes Toward Condom Use  
Religiosity  
Peer Norms  
Parental Support



# Risk Behavior

## A Public Health Concern

- Major contributors to morbidity and mortality in adolescence are behavioral
- Compared to adults, adolescents
  - Have more fatal car crashes
  - Commit more crimes
  - Engage in more binge drinking
  - Are less likely to practice safe sex
- Reckless behavior during adolescence often occurs with peers



# Myths About Adolescent Risk-Taking

- Adolescents are illogical
- Adolescents underestimate risk
- Adolescents believe they are invulnerable
- Adolescents engage deficient cognitive processes when making decisions
- Adolescents are unaware of the dangers associated with risky behavior



# Educational Interventions to Prevent Adolescent Risk Taking Are of Limited Success

- Most interventions designed to reduce adolescent risk-taking attempt to change adolescents' knowledge or attitudes
- Taxpayers spend hundreds of millions of dollars annually on unproven or ineffective educational programs to reduce risk-taking
- Perhaps the problem is not deficient knowledge or problematic attitudes



# Risk Behavior From A Developmental Paradigm An Alternative View

- Risk taking in adolescence is normative
- Risk taking in adolescence is evolutionarily adaptive
- Heightened risk taking in adolescence is due primarily to socio-emotional, not cognitive, factors
- Recent research on adolescent brain development provides a useful framework



# Adolescent Risk-Taking Usually Occurs in Groups

- Most **experimentation with alcohol and illicit** drugs occurs with peers.
- Risk of a serious **automobile accident** significantly increases with presence of same-aged passengers
- Adolescents are relatively more likely than adults to **commit crimes** in groups than by themselves

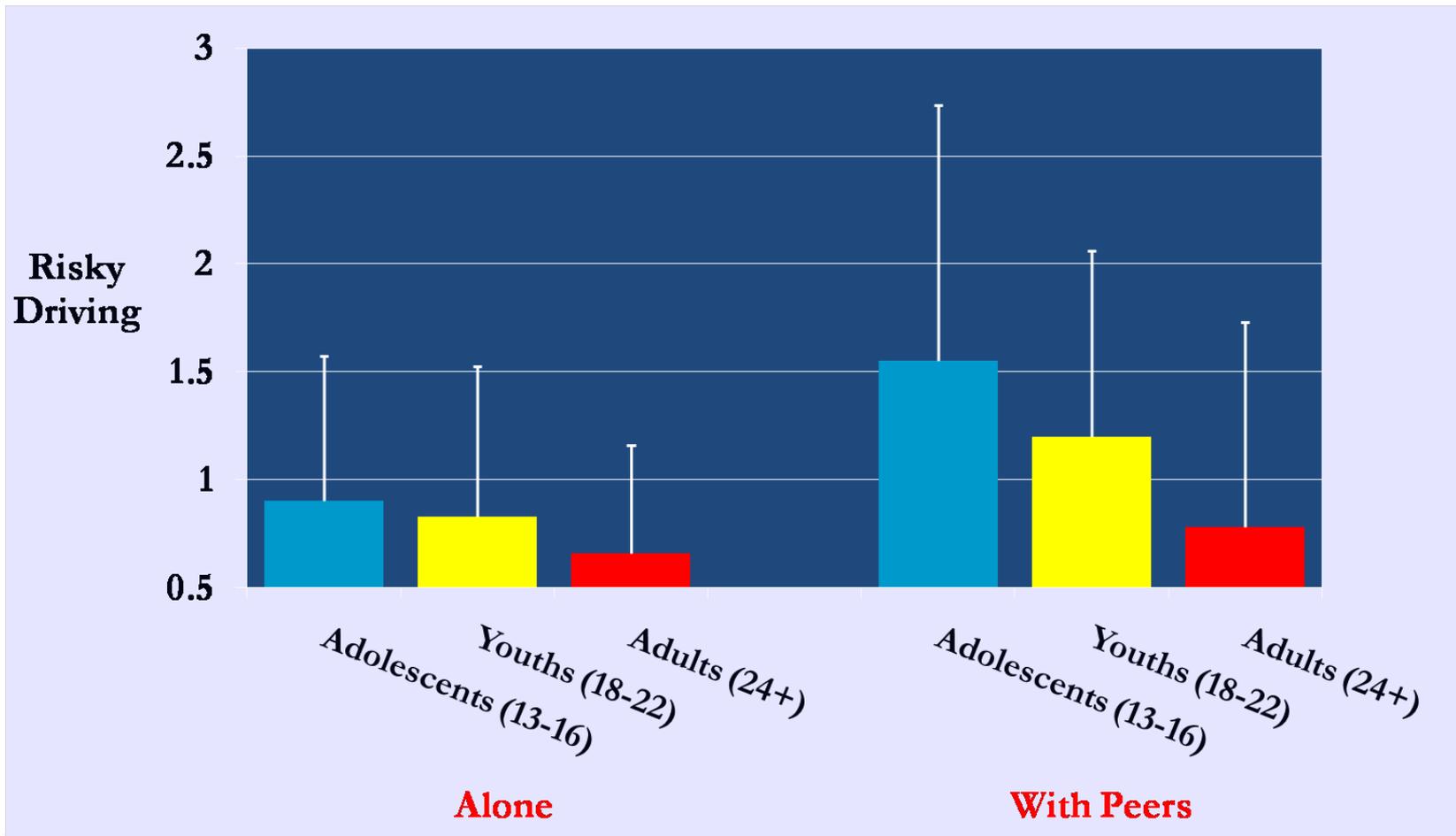


# Peer Influences on Risk-Taking

- Have participants come to the lab with two same-aged, same-sex friends
- Randomly assigned to take test battery alone or with friends watching
  - Initial studies had friends in same room
  - Current research has friends in adjacent room
- Have used this paradigm with
  - Risk-taking tasks
  - Delay discounting
  - Response inhibition



# Risky Driving-Impact of the Presence of Peers

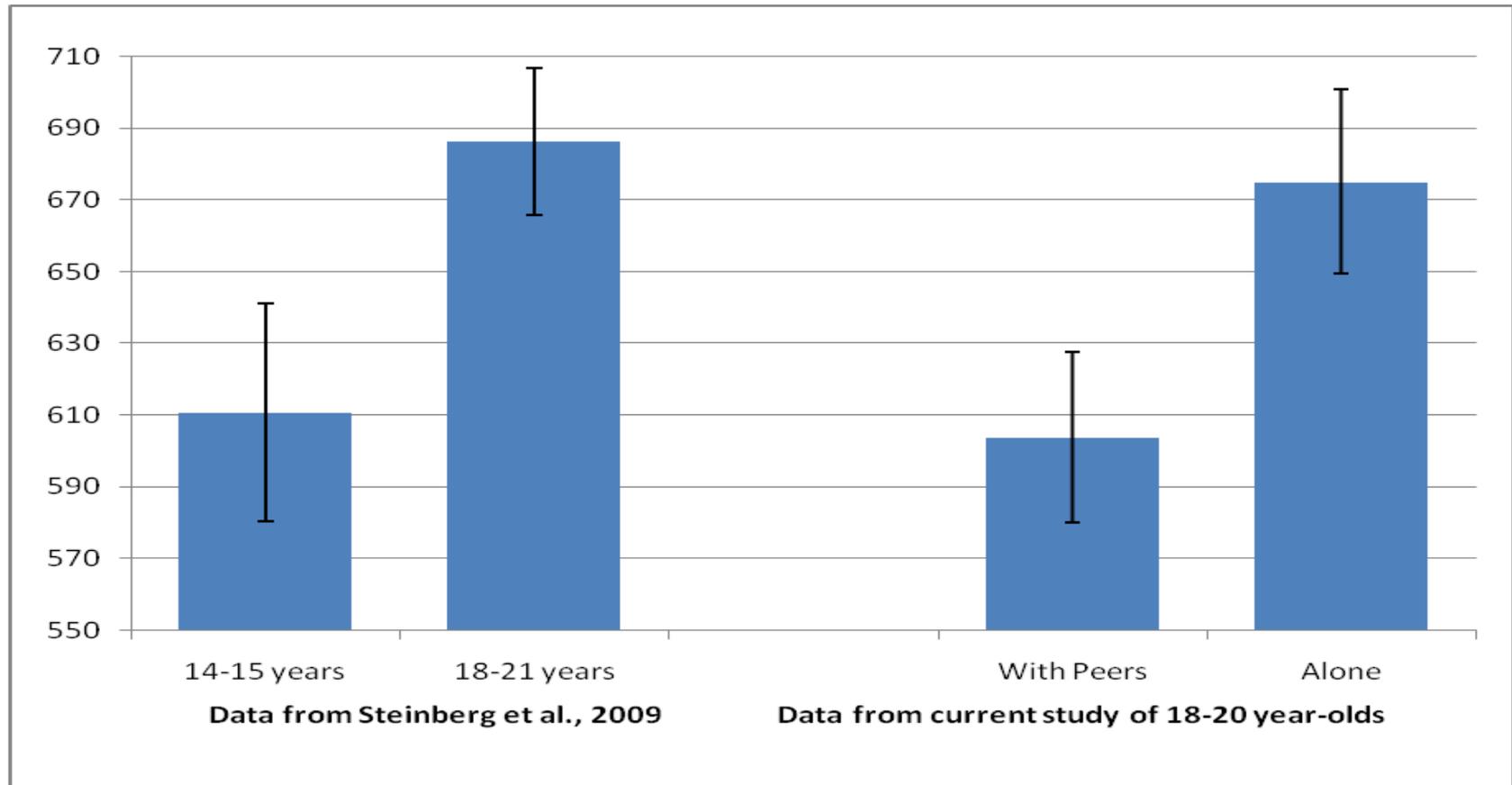


# Hypotheses About Peers and Risk Taking

- Presence of peers activates reward circuitry, increasing reward salience
- Presence of peers deactivates avoidance circuitry, decreasing cost salience
- Presence of peers deactivates cognitive control regions, disrupting process of cost-benefit calculation (e.g., through diminished response inhibition)



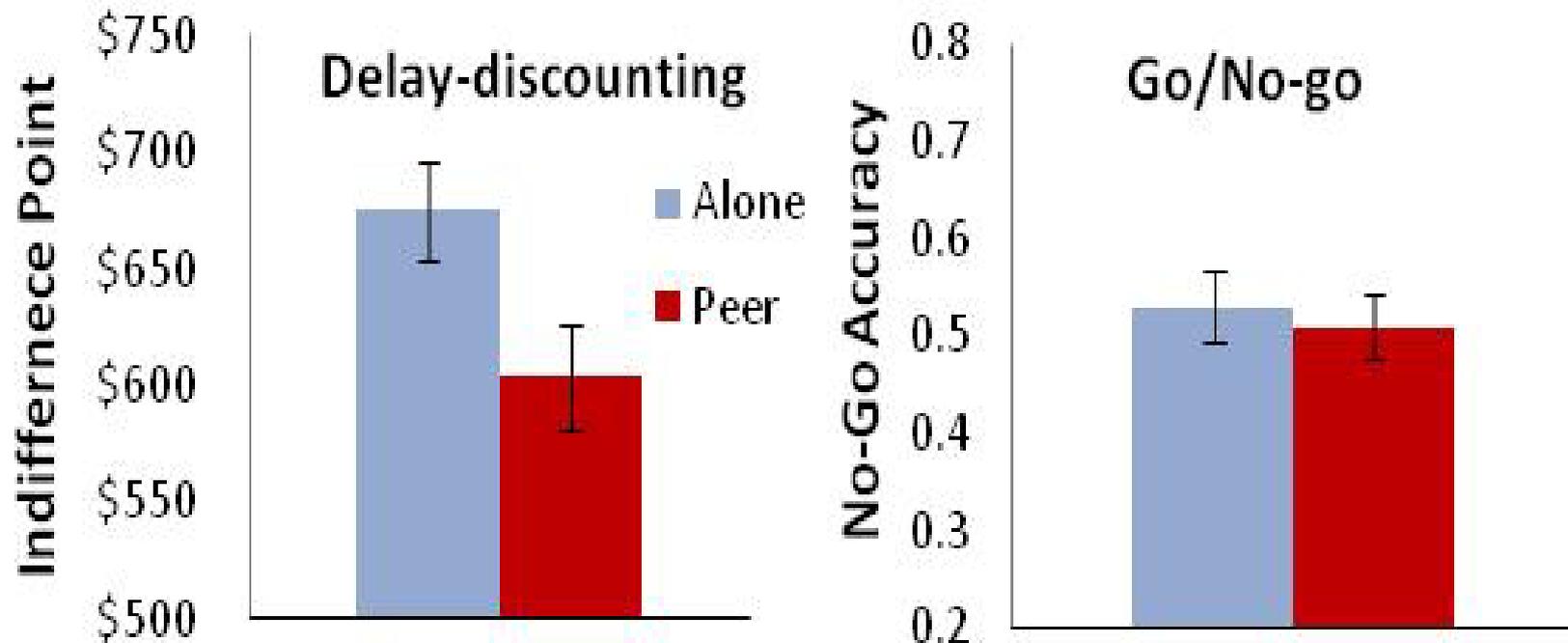
# In Presence of Peers, 19-year-olds Discount Comparably to 14-year-olds



(O'Brien et al., in press)



# Peers Affect Reward Processing But Not Response Inhibition



# fMRI Study of Risk-Taking

- **Neural Underpinnings of Susceptibility to Peer Influence**
- **Peer Context (within-subjects)**

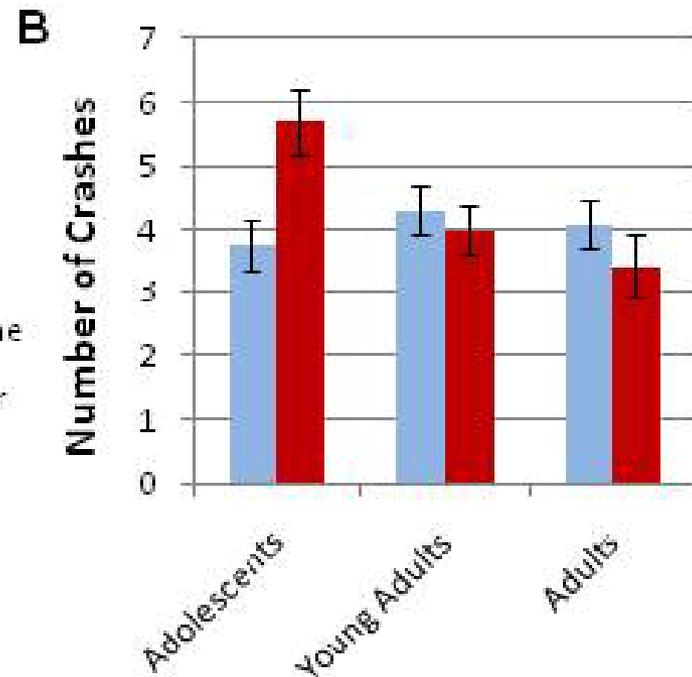
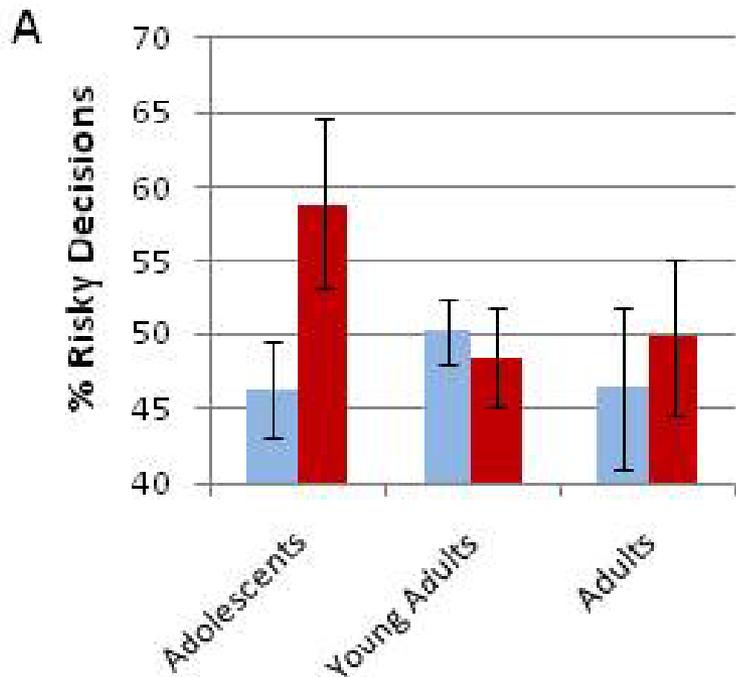
**ALONE** Subject completes tasks with no one watching

**Audience** Two peers predict and observe behavior from a neighboring room

- **Age (between-subjects)** (Reyna & Farley 2007)
  - Adolescents: Age 14 – 18 (N = 16, mean age = 16)
  - Young Adults: Age 19– 23 (N = 16, mean age = 21)
  - Adults: Age 24 – 30 (N = 16, mean age = 26)



# Impact of Peer Presence on Risky Driving in fMRI Context



(Chein et al., in press)



# **Working with adolescents with SUD-Considerations and Safety Guidelines**

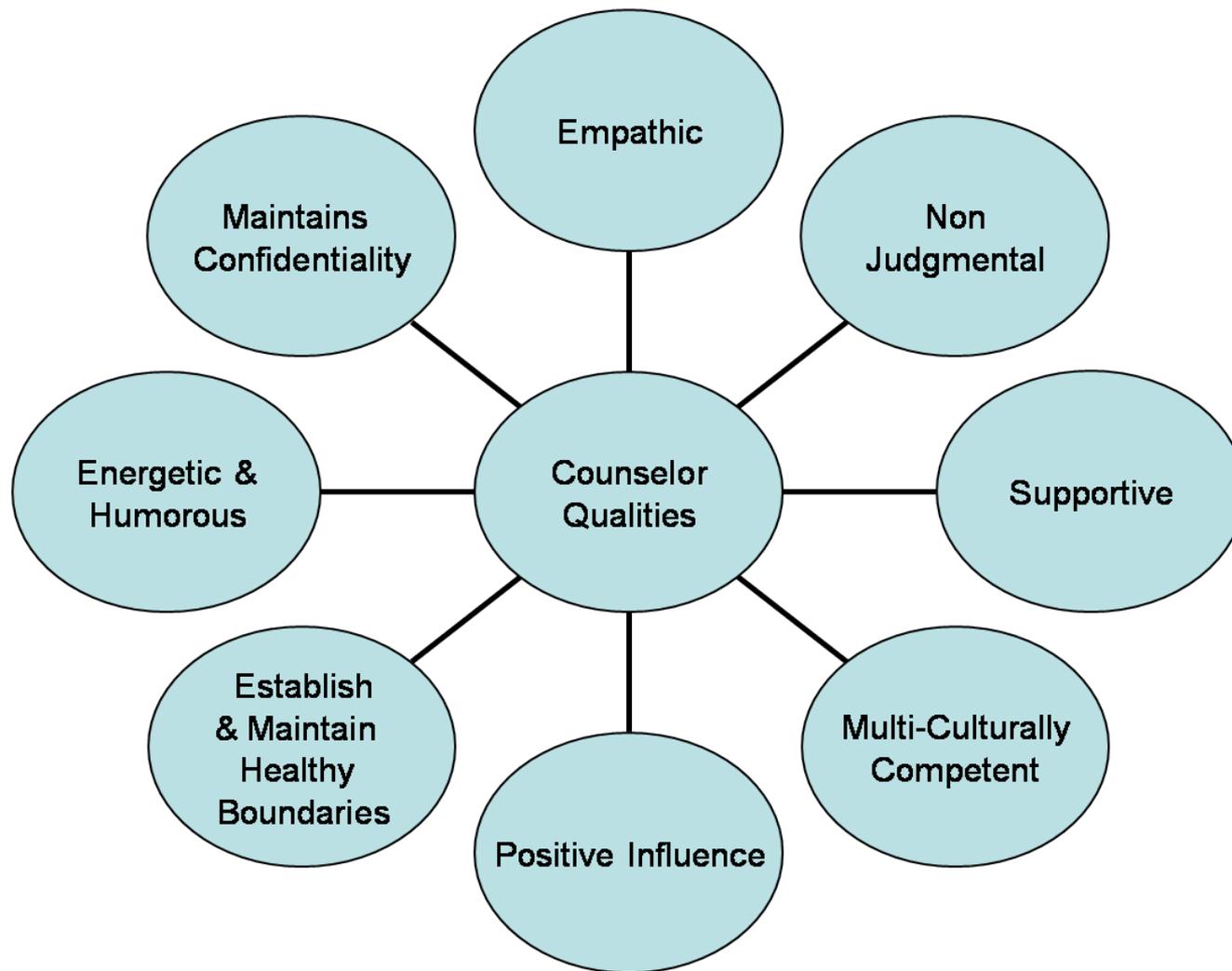


# 10 Points To Consider If You Want To Work With Adolescents

1. Are you aware of and adhere to the CASAC Code of Ethics?
2. Are you knowledgeable in the field of addiction and of the multitude of supportive measures to those needing such services?
3. What characteristics within yourself determine that you are “good” at working with adolescents?
4. Are you approachable, personable and have the ability to provide: advice, guidance, & direction?
5. Are you knowledgeable about the mental health needs of clients within this population?
6. Are you aware of the impact of family dynamics on Adolescents with SUD’s?
7. Are you aware of the social, behavioral, emotion, & psychological needs of a developing adolescent with SUD’s?
8. Are you aware of the impact of social media promoting/influencing the normalization of substance use for adolescents?
9. Does one recognize the pressure that adolescents face in their social environment?
10. What community based resources are available for an adolescent with SUD’s?



# Successful Counselor Qualities



# Barriers to Treatment

- Low Motivation
- Anger & Aggressiveness
- Impulsivity
- Poor Mood Regulation
- Lack of Communication Skills
- Abandonment Issues
- Transference
- Lack of Parental Involvement
- Family History of SUDs
- LD - Learning Disabilities
- ADHD – Attention-Deficit/Hyperactivity Disorder
- ODD – Oppositional Defiant Disorder
- Co-Occurring Disorders (i.e. Anxiety, Depression, PTSD)
- Low S.E.S. (socioeconomic status)
- Lack of Community Resources



# Consider an Eclectic Approach

**Is the counselor familiar with different Evidence Based Practices, and are they open to incorporating different interventions into Treatment?**

- Motivational Enhancement Therapy (MET) or Motivational Interviewing (MI)
- Strength Based Approaches
- Cognitive–Behavioral Therapy (CBT)
- Dialectical Behavioral Therapy (DBT)
- Family–Based Interventions (PMT, MST, MDFT)
- Community Reinforcement Therapy
- Pharmacotherapy
- Relapse Prevention



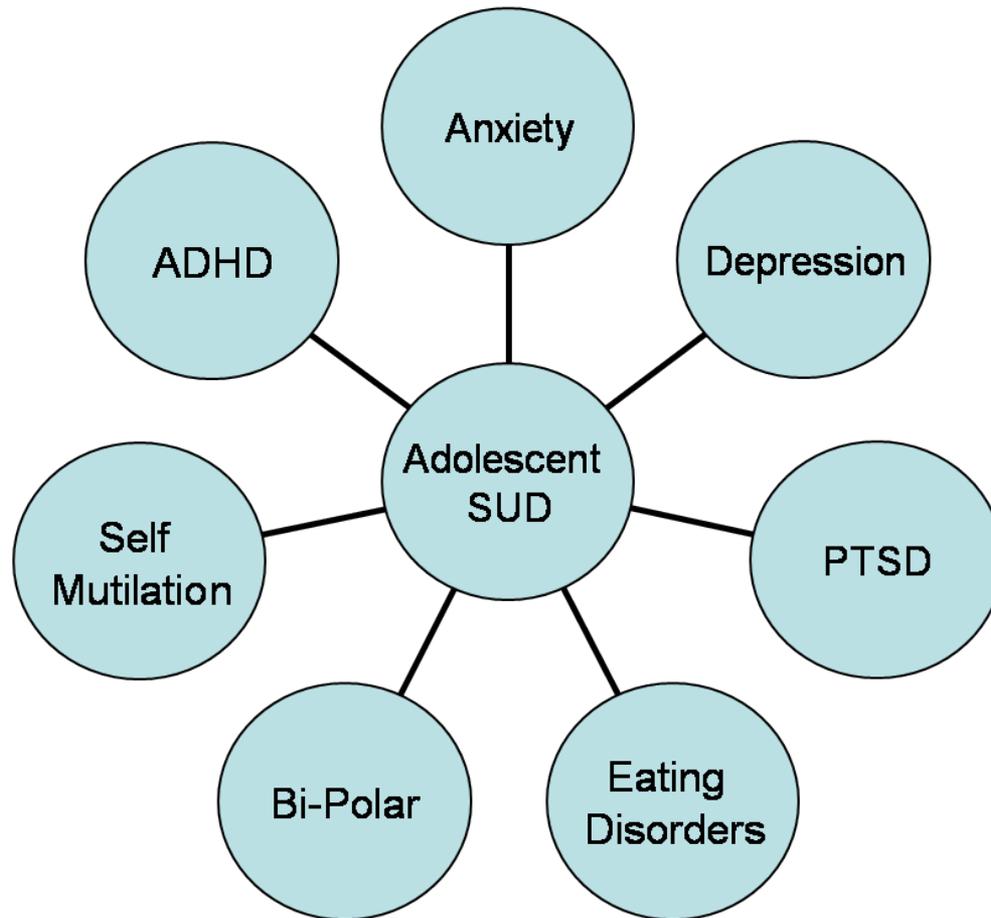
# Incorporating Family in Treatment

**Dysfunctional Family Dynamics contribute to Adolescent SUD and other related problems. Counselors should be familiar with and consider:**

- Facilitating Open Communication between Family Members
- Identifying Problematic Behaviors & Develop Interventions to Combat these Behaviors
- Identifying Relationship Patterns & Develop Interventions to Restructure these Relationships
- Assisting the family in Develop a Home Environment that is Conducive to the Adolescent's Recovery



# Recognizing Co-Occurring Disorders & Mental Health Issues



# Consider Medication Supported Treatment

Will the adolescent benefit from medications to treat their SUD?

- Methadone
- Buprenorphine
- Nalrexone
- Antabuse
- Suboxone
- NRT's (Nicotine Replacement Therapies)



# Being Multi-Culturally Competent

- How does an adolescent's environment (i.e. family and social network) affect their outlook on their recovery?
- How are substance use disorders & issues similar and different in the adolescent LGBTQ population vs. the "normal" adolescent population?
- When helping adolescents with SUD's, how does one's age, maturity level, & gender play into the development of their treatment process?
- How can one's SES (socio-economic status), be a potential barrier to their treatment? How does one, as a counselor, incorporate an adolescent's cultural background/environment into their recovery process?
- Why do some adolescents feel that the gang lifestyle is better way of life, than one of recovery and abstinence?



# Special Populations



# What is LGBTQ???

- **LGBTQ** - Commonly known as "the alphabet soup," this acronym refers to people who's gender identity, gender expression, or sexual orientation differ from heterosexual norms.



# Let's break it down...

- **L-Lesbian** - a female who is attracted to other females.
- **G-Gay** - a male who is attracted to other males  
However, the word "gay" is sometimes used as an overarching term to describe a variety of people who fall under the LGBTQ umbrella.
- **B-Bisexual** - a person who is attracted to both sexes.



# Let's break it down...

- **T-Trans** - “Trans,” is used here, as some people refer to themselves as transsexual, others as transgender. It refers to a person whose gender identity does not match up with their biological gender. For example, a person may have a penis and testicles (assigned gender-male) but may feel strongly that they are female (gender identity) and may choose to go by a female name and female pronouns, or present as a female in appearance, or may not.



# Let's break it down...

- **Q-Queer/Questioning** - Questioning refers to a person who is still determining where they fit in the gender and sexuality spectrum.  
Queer is the word that traditionally has been used as a slur, but is now being reclaimed by some members of the LGBTQIA community as a positive word. However, is still considered extremely offensive by most people, so be safe and avoid using it.



# Let's break it down...

- **A-Ally** - Anyone of any gender or sexual orientation, who supports and accepts the LGBTQI community.



# Why the Focus?

- Youth are coming out as lesbian, gay, bisexual and transgender (LGBTQ) at younger ages than ever before.
- Education can lead to acceptance. To put an end to the hate and discrimination, people must be educated.
- LGBTQ Youth are at high risks for depression, anxiety, homelessness, and suicide.



# Did You Know...

- There is an increase of homelessness among LGBTQ youth.
- Children of LGBTQ parents are harmed by restrictions on parenting, foster parenting, and adoption.
- LGBTQ students are subjected to widespread harassment and alienation in schools.
- 33% of all teen suicides are from the LGBT community.



# Homelessness Among LGBTQ Youth

- Of the estimated 1.6 million homeless American youth, between **20 and 40 percent** identify as lesbian, gay, bisexual or transgender. In comparison, the general youth population is only 10% LGBT.
- In one study, **26 percent** of gay teens who came out to their parents/guardians were told they must leave home.
- Homeless LGBT youth are more likely to: use drugs, participate in sex work, and attempt suicide.
- LGBT youth report they are threatened, belittled and abused at shelters by staff as well as other residents.



# LGBTQ Youth in Foster Care

- At a minimum **12,000 - 24,000** LGBTQ youth are in out-of-home care
- Research on gay adolescent males found that **50%** reported negative reactions from their parents when they disclosed their sexual identity. **26%** were forced to leave home as a result.



# LGBTQ Youth in Foster Care

- Unless assured that they will be accepted and protected, many LGBTQ youth in the foster care system will continue to hide this aspect of their identity from the agencies that should provide them support.
- LGBTQ Youth suffer disapproval by caseworkers, rejection by foster families, harassment and violence at the hands of foster care peers, and prejudice and neglect by group home staff.



# LGBTQ Youth & Bullying

- LGBT youth hear anti-gay slurs about **26 times per day**. Faculty intervention only takes place in approximately **3%** of these cases.
- Teenage students (gay AND straight) say the worst harassment in school is being called 'gay'.
- LGBT youth are **3 times** more likely to be bullied and/or harassed at school than their peers.
- Approximately **28%** of gay and lesbian youth drop out of high school because of discomfort (due to verbal and physical abuse) in the school environment.



# LGBTQ Youth & Bullying

- GLBT students, who report much higher rates of school violence and harassment than heterosexual students, are more than twice as likely as their peers to skip school because they don't feel safe.
- Nearly **58%** of LGBT students have had property stolen or deliberately damaged at school.
- **64%** of students who were harassed or assaulted in school *never* reported it to school staff, and **56%** *never* told a family member about the incident. Among students who did report incidents to school authorities, only **28%** said that reporting resulted in effective intervention.



# Cyber-Bullying

- "**Cyber-Bullying**" is when a child, preteen or teen is tormented, threatened, harassed, humiliated, embarrassed or otherwise targeted by another child, preteen or teen using the Internet, interactive and digital technologies or mobile phones.



# Cyber-Bullying

- A survey by Iowa State of 444 junior high, high school and college students between the ages of 11 and 22 (including 350 self-identified non-heterosexual people) found that **54%** of LGBT youth had been victims of cyber-bullying within the past 30 days.
- This bullying causes emotional distress, and was frequently associated with depression (45%), embarrassment (38%), anxiety (28%), and in **26%** of the victims, thoughts of suicide.



# Suicide and LGBTQ Youth

Suicide is becoming a leading cause of death among LGBT youth for multiple reasons including:

- Harassment/Bullying
- Limited or no social support
- Increase in LGBT youth homelessness

(Information provided by SPRC.com)



# Suicide and LGBTQ Youth

- **28.1%** of gay or bisexual males in grades 7 through 12 had attempted suicide at least once during their lives, while only **4.2%** of heterosexual males in those grades had attempted suicide.

(Remafedi et al., 1998))

- **58%** of LGB people who had attempted suicide reported that they had really hoped to die. In contrast, **only 33%** of heterosexuals who had attempted suicide reported that they had really hoped to die.

(Safren & Heimberg,1999)



# The Trevor Project



- <http://www.thetrevorproject.org/>
- <http://www.youtube.com/watch?v=0RsTNzRVfdo>



# The Counselor's Role: SUPPORT

- LGBTQ youth may wonder whether to come out to parents, friends, teachers, care managers, etc. Coming out is a very personal decision. While it can strengthen and deepen relationships and improve self-esteem, it can be a very scary thing. In some situations, it can even be risky. Only they can decide if and when to come out, to whom, and how to do it.



# It Gets Better!

In September 2010, syndicated columnist and author Dan Savage created a YouTube video with his partner Terry to inspire hope for young people facing harassment. In response to a number of students taking their own lives after being bullied in school, they wanted to create a personal way for supporters everywhere to tell LGBT youth that, yes, it does indeed get better.

<http://www.youtube.com/watch?v=7skPnJOZYdA>



# It Gets Better!

Two months later, the It Gets Better Project (TM) has turned into a worldwide movement, inspiring over 10,000 user-created videos viewed over 35 million times. To date, the project has received submissions from celebrities, organizations, activists, politicians and media personalities. The website [www.itgetsbetter.org](http://www.itgetsbetter.org) is a place where young people who are lesbian, gay, bi, or trans can see how love and happiness can be a reality in their future. It's a place where our straight allies can visit and support their friends and family members. It's a place where people can share their stories, take the It Gets Better Project pledge, watch videos of love and support, and seek help through the Trevor Project and GLSEN.



# LGBT Youth Resources

- Local Gay-Straight Alliances in schools
- [GLSEN \(Gay, Lesbian, Straight Education Network\)](#)
- [PFLAG](#)
- [The Trevor Project](#)
- [It Gets Better Campaign](#)



# Adolescents, Crime & Delinquency



# Why Joining A Gang Appeals To An Adolescent

- Protection – from being bullied, from rival gangs
- Power - a sense seniority/rank
- Power - a feeling of control; being territorial
- Respect – recognition of stature in one’s environment
- Sense of “family” or “loyalty”
- Generational links to the gang life (i.e. “blood drop”)
- Cultural Bias
- Peer Acceptance/Image or Identity
- Ambition to obtain money
- Feels an affliction for violence
- Feels an affliction for drugs
- Opposed to healthy boundaries, rules, and structure
- For the gangs specific: beliefs, values, colors & symbol



# Juvenile Delinquency and Substance Abuse

- The link between adolescent substance use and juvenile delinquency is complex.
- There is a strong and consistent association between conduct disorder and substance use among teenagers.
- Many young people entering the juvenile justice system have a host of problems ranging from impaired emotional, psychological, and educational functioning to physical abuse, sexual victimization, and substance use disorders.

(Crowley and Riggs, 1995, Dembo, 1996, Jainchill, 1997)



# Safety Considerations



# Requirements for Programs Treating Adolescents

Programs are required to take reasonable efforts to ensure that the staff, volunteers, and other individuals who have regular contact with children/adolescents do not pose substantial risks.



# Staffing

- It is the responsibility of the agency to ensure that there is sufficient staffing to monitor the activities of the children/adolescents.
- This includes providing adequate coverage to evening and night shifts for residential programs.
- Staffing plans and procedures should also include plans for dealing with emergencies (medical, behavioral, physical plant, etc.)
- Agencies may incorporate technology such as video equipment, door alarms, etc. as appropriate to assist in supervision.



# Child Abuse and Maltreatment Screening Guidelines

- The New York State Child Protective Services Act of 1973 [i](#) created a comprehensive program of child protective services, including the establishment of criteria for reporting and investigation of allegations of child abuse and maltreatment and a State Central Register of Child Abuse and Maltreatment (“SCR”). [ii](#) A key purpose of the SCR is to maintain a central record of reports of child abuse and maltreatment that are determined, following investigation, to be “indicated.” An “indicated” report is a report for which there is determined to be some credible evidence that child abuse or maltreatment occurred and is attributed to the conduct of, by an individual or individuals named as subject(s) of the report. **Any alleged sexual activity between staff, volunteers, consultants, adult clients and children/adolescents is reportable to the SCR.**
- Chapter 480 of the Laws of 1980 amended the Child Protective Services Act to add Section 424-a of the Social Services Law. The purpose of this provision was to improve the prevention of child abuse and maltreatment by requiring authorized agencies to inquire whether persons actively considered for employment in child-caring positions were subjects of an indicated report of child abuse or maltreatment. Section 424-a of the Social Services Law(s) was subsequently amended in 1983, 1984, and 1985 [iii](#) to improve “the assessment and evaluation of persons who will have the potential for regular and substantial contact with children being cared for by child-caring agencies, programs, or facilities, through increased access to screening persons with the State Central Register of Child Abuse and Maltreatment”.



# Screening Staff through the Statewide Central Register (SCR)

In 1997, Section 424-a of the Social Services Law was amended to include programs and facilities certified by the Office of Alcoholism and Substance Abuse Services (OASAS) and requires or allows them to access information contained in the Statewide Central Register of Child Abuse and Maltreatment.



# Screening Staff through the Statewide Central Register (SCR)

- A.** Under Social Services Law Section 424-a it is the responsibility of programs and facilities certified by the Office of Alcoholism and Substance Abuse Services to ensure that Form LDSS-3370 (Statewide Central Register Form) is completed and submitted to the SCR for:
- any person who is being actively considered for employment and who will have the potential for regular and substantial contact with children; and
  - any prospective individual contractors providing goods or services who will have the potential for regular and substantial contact with children. (NOTE: this refers only to those contractors who perform their service on-site at the agency. It does not apply to services such as (clinics, hospitals, private practices) provided off site. If, however, the agency does frequent business with a particular provider, a Business Agreement that attests to the compliance with all regulations may be appropriate.



# Screening Staff through the Statewide Central Register (SCR)

- B.** Programs and facilities certified by the Office of Alcoholism and Substance Abuse Services should *require* that form LDSS-3370 be completed and submitted by:
- current and new employees who have the potential for regular and substantial contact with children;
  - current and prospective consultants and volunteers who have the potential for regular and substantial contact with children; and
  - current individual contractors providing goods and services who will have the potential for regular and substantial contact with children.



# Screening Staff through the Statewide Central Register (SCR)

- In order for programs to screen/utilize the State Central Registry they need to have registered with the Office of Children and Family Services, this will allow them to receive a Resource Identification Number (RID), which will identify them as a program needing to screen staff through the SCR.



# Screening Staff through the Statewide Central Register (SCR)

- To obtain a RID, programs must send an electronic e-mail request to the Office of Children and Family Services at [ocfs.sm.conn\\_app@ocfs.ny.gov](mailto:ocfs.sm.conn_app@ocfs.ny.gov)
- Include the following information so they can determine if issuance of a RID is appropriate:
  - The name, address and telephone number of your organization
  - Contact person within your organization;
  - a statement of which of the categories listed above your organization falls under;
  - the name and telephone number of a contact person in your licensing agency who can verify the status of your organization; and
  - a copy of your license, certification or other official documentation of approval by the relevant State or local agency.



# Screening Staff through the Statewide Central Register (SCR)

If someone is working, and the results of the inquiry have not yet been received, the agency must make reasonable efforts to ensure the individual **does not** have unsupervised contact with youth under the age of 18.



# Mandated Reporting of Suspected Child Abuse and Treatment

- Per the requirements of the New York State Social Services law, as amended by Chapter 323 of the Laws of 2008, OASAS considers all State and community agency staff and volunteers to be mandated reporters who are required to adhere to the reporting requirements. If a mandated reporter has reasonable concern that child abuse or maltreatment (even and especially at their own institution) may have occurred, that person is mandated to report the allegation to the Statewide Central Register Hotline.



# Mandated Reporting of Suspected Child Abuse and Treatment

- Since October 1, 2007, those mandated reporters who work in an OASAS setting, and who have direct knowledge of any allegation(s) of suspected child abuse or maltreatment, must personally make a report to the Statewide Central Register and then notify the person in charge of the institution or his/her designated agent that a report has been made. The person in charge, or the designated agent of such person, is then responsible for all subsequent internal administration necessitated by the report. This may include providing follow-up information (e.g., relevant information contained in the child's educational record) to the body investigating the allegation.



# Mandated Reporting of Suspected Child Abuse and Treatment

- The Statewide Central Registry Hotline telephone number is: (800) 342-3720
- For further information and clarification please see LSB 2007-08 *Mandated Reporting of Suspected Child Abuse or Maltreatment* at the following link:
- <http://www.oasas.ny.gov/mis/bulletins/lrb2007-08.cfm>
- Free on-line Mandated Reporter Training is available at: <http://nysmandatedreporter.org/>



# Institutional Abuse and Neglect

Chapter 323 of the Laws of 2008 took effect on January 17, 2009. This law amends the definitions of abuse and neglect pertaining to children and youth in a residential setting and expanded the definition of residential setting to include OASAS residential programs serving youth under the age of 18.



# Abused Child in Residential Care

**One who is subjected to the following acts by a custodian, regardless of whether the child is injured:**

- 1) being thrown, shoved, kicked, pinched, punched, shaken, choked, smothered, bitten, burned, cut, or stricken
- 2) the display of a weapon or other object that could reasonably be perceived as being meant to inflict pain or injury, in a threatening manner;
- 3) the use of corporal punishment;
- 4) the withholding of nutrition or hydration as punishment; or
- 5) the unlawful administration of any controlled substance or alcoholic beverage.

For all of the above actions, the statute presumes that such actions create risk of injury and classifies these actions as abuse **unless the action is accidental or is done as an emergency physical intervention to protect the safety of the child or another person.**



# Abused Child in Residential Care

- one who, by other than accidental means, has had inflicted upon the child and/or subjected to a reasonably foreseeable injury that causes death or creates a **substantial risk of**:
  - 1) death;
  - 2) serious or protracted disfigurement;
  - 3) serious or protracted impairment of the child's physical, mental or emotional condition; or
  - 4) serious or protracted loss or impairment of the function of any organ.



# SEXUAL ABUSE

Includes:

- sex offenses
- use of a child for purposes of prostitution
- use of a child for a sexual performance and incest

**No injury is needed for an allegation of sex abuse**



# NEGLECT

- A **"neglected child in residential care"** is a child who is impaired physically, mentally or emotionally or is at substantial risk of impairment because of failure to receive:
  - adequate food, clothing, shelter, medical, dental, optometric or surgical care consistent with the applicable rules and regulations of the licensing or operating State agency, provided that the facility has reasonable access to the provision of such services and that necessary consents for health care have been sought and obtained;
  - access to educational instruction in accordance with the compulsory education provisions in the Education Law;
  - proper supervision or guardianship, consistent with the applicable rules and regulations of the licensing or operating State agency.



# A Neglected Child in Residential Care

- a child who is inflicted with a physical, mental or emotional injury, excluding a minor injury, by other than accidental means, or is subjected to the risk of a physical, mental or emotional injury, excluding a minor injury, by other than accidental means, where such injury or risk of injury was reasonably foreseeable.



# A Neglected Child in Residential Care

- A child who is inflicted with a physical, mental or emotional injury, excluding a minor injury, by other than accidental means, or is subjected to the substantial risk of a physical, mental or emotional injury, excluding a minor injury, by other than accidental means, as a result of a failure to implement an agreed upon plan of prevention and remediation.
- A child who is subjected to the intentional administration of any prescription or non-prescription drug other than in substantial compliance with a prescription or order issued for the child by a licensed, qualified health care practitioner.



# Reporting Guidelines

- Allegations of child abuse or neglect occurring in mental hygiene residential facilities must be reported to the Child Abuse Hotline: 1-800-342-3720 (voice only); 1-800-638-5163 (TTY/TDD)
- Investigations will be commenced within 24 hours of the reporting of the allegation to initially seek to ensure the child's safety.



# Reporting Guidelines

- Do You Suspect Abuse or Maltreatment?
- Call the Statewide Toll Free Telephone Number:  
**1-800-342-3720**  
TDD/TTY: 1-800-638-5163
- If you believe that a child is in **immediate danger**, call **911** or your local police department.
- For more information visit: <http://www.ocfs.state.ny.us/main/cps/>



# Mandated Reporting of Suspected Child Abuse and Maltreatment

Per the requirements of the New York State Social Services law, as amended by Chapter 323 of the Laws of 2008, OASAS considers all State and community agency staff and volunteers to be mandated reporters who are required to adhere to the reporting requirements. If a mandated reporter has reasonable concern that child abuse or maltreatment (even and especially at their own institution) may have occurred, that person is mandated to report the allegation to the Statewide Central Register Hotline.

**1-800-342-3720 TDD/TTY: 1-800-638-5163**



# Mandated Reporting of Suspected Child Abuse and Maltreatment

Since October 1, 2007, those mandated reporters who work in an OASAS setting, and who have direct knowledge of any allegation(s) of suspected child abuse or maltreatment, must personally make a report to the Statewide Central Register and then notify the person in charge of the institution or his/her designated agent that a report has been made.



# Mandated Reporting of Suspected Child Abuse and Maltreatment

- The person in charge, or the designated agent of such person, is then responsible for all subsequent internal administration necessitated by the report. This may include providing follow-up information (e.g., relevant information contained in the child's educational record) to the body investigating the allegation.
- Free on-line Mandated Reporter Training is available at: <http://nysmandatedreporter.org>



# Reporting Potential Crimes to Law Enforcement

- When an allegation involves the potential of the commission of a crime, agencies are required to report the allegation to law enforcement as well as to the state hotline. Actions that would be considered crimes would include (but are not limited to):
  - any sexual contact between an adult staff member, volunteer, contractor, consultant, etc. and a child/adolescent
  - sexual activity involving a youth aged 16 years or under and a youth older than 16; Individuals aged 16 or younger are, by law, considered unable to give their consent.
  - Sexual activity involving two (or more) youths aged 16 years or under that involves force or coercion; and
  - assaults on youth by adults or other youths.
  - If the agency is not sure, it should consult with SCR and/or local law enforcement. It is always better to be careful and report, rather than to risk problems with not reporting.



# Prohibition of Restraint, Seclusion and Corporal Punishment

- Federal Regulations [42 CFR §482.13 (e) (2006)] establish strict rules for the use of restraint and seclusion.
- All patients have the right to be free from physical or mental abuse, and corporal punishment.
- All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.



# Restraint Is Defined As Follows

- Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely;
- A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition; or
- A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).



# Seclusion

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.



# Prohibition of Restraint, Seclusion and Corporal Punishment

- OASAS strongly supports the prohibitions against restraint and seclusion. Programs are required to adhere to these rules. While not strictly restraint or seclusion, some programs have incorporated behavioral interventions that restrict and/or isolate individuals from the rest of the treatment milieu. While these practices may have some therapeutic value, it is critical that their use be carefully defined and not be initiated as punishment. Appropriate use of such an intervention should be defined in procedure manuals



# Contemporary Trends In Adolescent Substance Abuse



# Trends in Adolescent Substance Abuse

- Adolescent drug abuse is a significant problem in the United States and throughout the world. The scope of the problem can only be estimated.
- The “Monitoring the Future” study funded by the National Institute on Drug Abuse found that the self-reported prevalence of drug abuse (all drugs combined) among 12th graders in 2005 was 48 %. Although rates of illicit drug abuse in adolescents have been declining, rates of prescription drug abuse are on the rise.



# Trends in Adolescent Substance Abuse

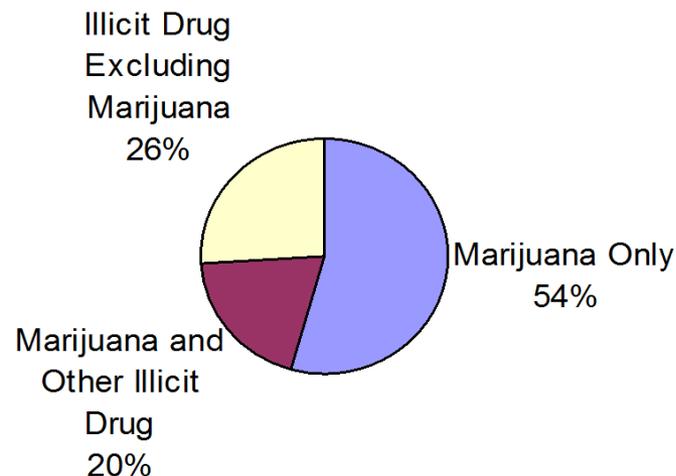
## The National Survey on Drug Use and Health (NSDUH)

- In 2005, an estimated 19.7 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 8.1 % of the population aged 12 years old or older.
- Marijuana was the most commonly used illicit drug (14.6 million past month users). In 2005, it was used by 74.2 % of current illicit drug users. Among current illicit drug users, 54.5 % used only marijuana, 19.6 % used marijuana and another illicit drug, and the remaining 25.8 % used only an illicit drug other than marijuana in the past month.



# Trends in Adolescent Substance Abuse

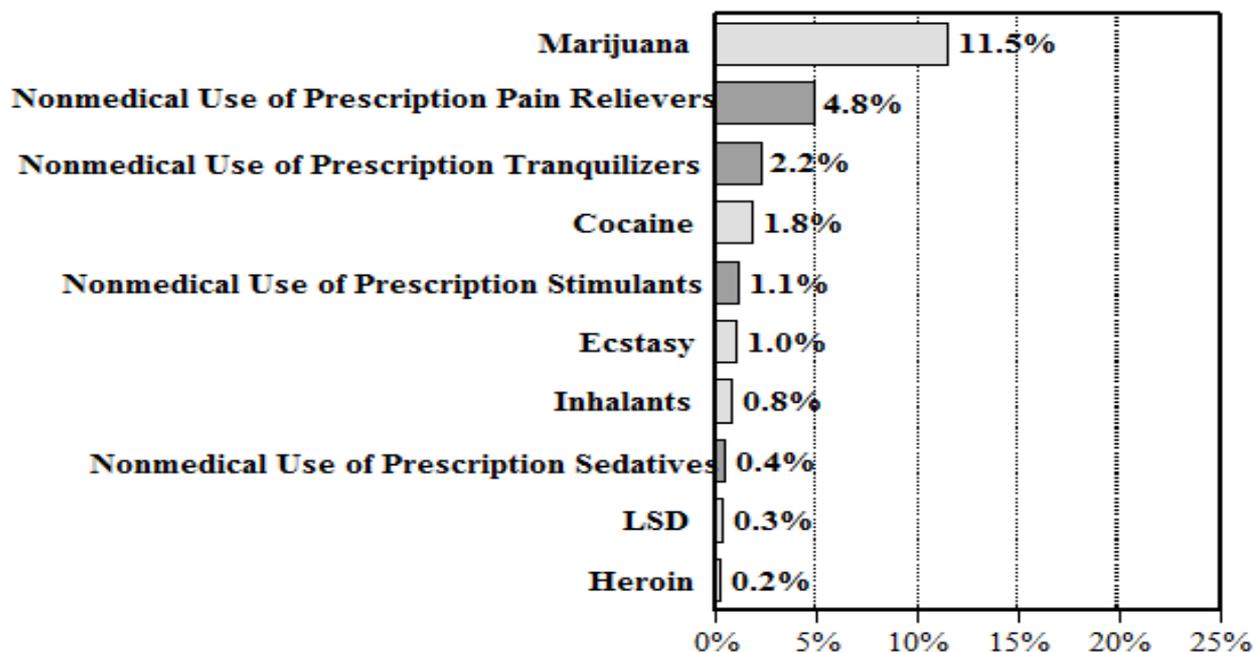
**Types of Drugs Used by Past Month Illicit Drug Users Aged 12 or Older: 2005**



**The National Survey on Drug Use and Health (NSDUH)**



# Percentage of U.S. Residents (Age 12 or Older) Reporting Past Year Substance Use, 2010



SOURCE: Adapted by CESAR from Substance Abuse and Mental Health Services Administration (SAMHSA), *Results from the 2010 National Household Survey on Drug Use and Health: Detailed Tables*, 2011. Available online at <http://oas.samhsa.gov/NSDUH/2k10NSDUH/tabs/Cover.pdf>.

# Trends in Adolescent Substance Abuse

- The U.S. government spent \$1.6 billion on drug abuse prevention in 2007. In spite of this, new drugs and novel methods of use continue to be quickly circulated using current technologies.
- In one small study, 100 % of adolescent drug users had modified their drug use based on information obtained from the Internet. Instant messaging, email, and cell phones are used to disseminate drug information. Because many drug abusers end up in the emergency department, clinicians need to be aware of current trends and new drugs of abuse.



# Alcohol: Trends In Use

- Among 12th graders, binge drinking peaked at about the same time as overall illicit drug use, in 1979. It held steady for a few years before declining substantially from 41% in 1983 to a low of 28% in 1992 .
- This was a drop of almost one third in binge drinking. Although illicit drug use rose by considerable proportions in the 1990's, binge drinking rose by only a small fraction, followed by some decline in binge drinking at all three grades.
- By 2010, proportional declines since the recent peaks reached in the 1990's are 46%, 32%, and 26% for grades 8, 10, and 12, respectively.



# Definition Of A Drink

U.S. STANDARD DRINK CONTAINS ABOUT 14 GRAMS (0.6 FLUID OZ.) PURE ALCOHOL

- 12 OZ OF BEER OR WINE COOLER
- 8-9 OZ OF MALT LIQUOR
- 5 OZ OF TABLE WINE
- 3-4 OZ OF FORTIFIED OR DESSERT WINE
- 2-3 OZ OF CORDIAL, LIQUEUR OR APERITIF
- 1.5 OZ OF SPIRITS(A SINGLE JIGGER OF GIN, VODKA, WHISKEY, ETC.)



# Blood Alcohol Concentration (BAC)

- 20 - 99 mg%:** LOSS OF MUSCULAR COORDINATION
- 100 - 199 mg%:** NEUROLOGIC IMPAIRMENT, ATAXIA, PROLONGED REACTION, MENTAL IMPAIRMENT, INCOORDINATION
- 200 - 299 mg%:** NAUSEA, VOMITING, ATAXIA
- 300 - 399 mg%:** HYPOTHERMIA, DYSARTHRIA, AMNESIA, STUPOR
- 400 - > mg%:** COMA
- \* BAC GREATER THAN 150** IF NOT SHOWING SIGNS OF INTOXICATION OR ANY TIME BAC IS > 300 EQUALS A DIAGNOSIS OF **ALCOHOL DEPENDENCE**



# Blood Alcohol Concentration (BAC)

(1) BEER = BAC OF .015

(3) BEERS = BAC OF .05

21<sup>ST</sup> BIRTHDAY – 21 SHOTS = ~0.350



# Binge Drinking

DEFINED AS 5 OR MORE DRINKS  
IN A SHORT PERIOD OF TIME



# Binge Drinking

University of Michigan Study to be published in the Journal of Consulting and Clinical Psychology

- Interviews with college students found that 34 % of male drinkers and 24 % of females said they had celebrated their 21st birthday by consuming 21 or more drinks according to a University of Michigan study.



# Binge Drinking

- The University of Michigan study, involving 2,518 college students, looked into the “21 at 21” drinking ritual, which often involves drinking shots of liquor. The tradition has been linked to a number of alcohol-overdose deaths among birthday celebrants.



# Many Students Binge to Celebrate Turning 21 – A Dangerous Practice

- The researchers estimated that half of the men and more than one-third of the women in the study had a blood-alcohol level of 0.26% or higher when celebrating their 21st birthday, more than three times the legal limit and a level that placed them at high risk for injury or death.



# Prescription Drug Abuse

- Prescription drug misuse occurs when a person takes a prescription medication that is not prescribed for him/her, or takes it for reasons or in dosages other than as prescribed.
- The non-medical use of prescription medications has increased in the past decade and has surpassed all illicit drugs except marijuana in the United States. Misuse of prescription drugs can produce serious health effects, including addiction.



# Prescription Drug Abuse

- Rates of prescription drug abuse have risen sharply in the United States. The incidence doubled from 7.8 million users in 1992 to 15 million users in 2003. Cannabis (marijuana) is the only illicit drug abused by more Americans than prescription drugs.
- Two in five teens surveyed said that prescription medications were safer than illicit drugs, and 30% of teens said these drugs were not addictive.



# Reasons adolescents state for their use of prescription drugs:

- To enhance pleasure
- To have fun
- To vary their conscious experience
- To self medicate
- As a way to cope with trauma
- To relieve anxiety, depression, insomnia
- To relieve pain
- To promote and enhance social interaction
- To stimulate artistic creativity and performance
- To rebel
- To improve physical/mental performance
- To fend off withdrawal
- To lose weight



# Classification of Commonly Abused Prescription Medications

- Opioids (indicated for pain)
- Opioids include
  - hydrocodone (Vicodin ®)
  - Oxycodone (OxyContin ®)
  - propoxyphene (Darvon ®)
  - hydromorphone (Dilaudid ®)
  - meperidine (Demerol ®)
  - diphenoxylate (Lomotil ®)



# Classification of Commonly Abused Prescription Medications

- Central nervous system depressants (sedative-hypnotics indicated for anxiety and sleep disorders)
  - Barbiturates:
    - pentobarbital sodium (Nembutal®)
  - Benzodiazepines
    - diazepam (Valium®)
    - alprazolam (Xanax®).
- Stimulants (indicated for ADHD and narcolepsy) include:
  - dextroamphetamine (Dexedrine®)
  - methylphenidate (Ritalin® and Concerta®)
  - amphetamines (Adderall®)



# Opiates

- Opioids can produce drowsiness, constipation and, depending on amount taken, can depress breathing.
- Central nervous system depressants slow down brain function; if combined with other medications that cause drowsiness or with alcohol, heart rate and respiration can slow down dangerously.
- Taken repeatedly or in high doses, stimulants can cause anxiety, paranoia, dangerously high body temperatures, irregular heartbeat, or seizures.



# Opiates

- In the Partnership Tracking Study (2009), fifteen percent of U.S. high school students had reported abuse of a prescription pain reliever in the past year; this was exceeded only by the 38 percent of respondents who reported use of marijuana in the past year.
- Among adolescents, prescription and over-the-counter medications account for 8 of the 14 most frequently abused drugs by high school seniors (excluding tobacco and alcohol).



# Opiates

- Yearly 1 in 10 high school seniors reported non-medical use of Vicodin; 1 in 20 reported abuse of OxyContin.
- When asked how prescription narcotics were obtained for non-medical use, 54% of 12<sup>th</sup> graders said they were given or bought them from a friend or relative. The number obtaining them over the internet was negligible.



# Opiates

- For the first time in history, teens report that it is easier to get prescription drugs than beer

(National Center on Addiction and Substance Abuse at Columbia University).

- An OASAS 2008 survey confirmed that the abuse of prescription painkillers by teens in New York State is higher than the national average.



# Opiates

- Opioids (specifically, opioid analgesics) are among the most commonly abused prescription drugs.
- Emergency department visits related to opioids increased 24% and visits related to methadone increased 29% between 2004 and 2005.
- According to data from the “Monitoring the Future study”, oxycodone (OxyContin) abuse increased by almost 40% between 2002 and 2005, to an annual prevalence of 5.5% among 12th grade students.
- Hydrocodone/acetaminophen (Vicodin) is also widely abused - 7.4% of college students aged 18 to 22 reported abusing it in 2005.



# Trends in Adolescent Drug Abuse

- According to the NSDUH survey, 47% of teens obtained free prescription drugs for non-medical use from relatives or friends.
- Additionally, 6% reported obtaining the drugs without asking, and 20% said they bought them from a friend or relative.



# Why This-Why Now?

- Misperceptions about their safety.

Because these medications are prescribed by doctors/dentists, many assume that they are safe to take under any circumstances. This is not the case: prescription drugs act directly or indirectly on the same brain systems affected by illicit drugs; thus their abuse carries substantial addiction liability and can lead to a variety of other adverse health effects.



# Why This-Why Now?

- Increasing environmental availability.

Between 1991 and 2009, prescriptions for stimulants increased from 5 million to nearly 40 million, an 8-fold increase, and opioid analgesics increased from about 45 million to nearly 180 million, a 4-fold increase.

(NIDA – a research update Sept 2010)



# Why This-Why Now?

- Varied motivations for their abuse.

Underlying reasons include: to get high; to counter anxiety, pain, or sleep problems; or to enhance cognition (although they may, in fact, impair certain types of cognitive performance). Whatever the motivation, prescription drug abuse comes with serious risks.

(NIDA – a research update Sept 2010)



# Games, Fads and Variations...

- “**Pharming**” is the new Slang term for grabbing a handful of prescription drugs and ingesting some or all of them.
- Teens bring prescription drugs from their home medicine cabinets and mix them all together in a grab bag. This can be an activity at adolescent parties and the medications are commonly mixed with alcohol



# Games, Fads and Variations...

- **Cheese** is a combinations of heroin with cough and cold preparations containing ingredients such as diphenhydramine, an antihistamine that can cause euphoria and hallucinations in overdose. Cheese gained national attention in 2005 when it was linked to the deaths of several teenagers in Dallas, Texas.



# Games, Fads and Variations...

- The heroin concentration in **cheese** is typically 2% to 8%, compared to 30% found in black tar heroin (produced in Mexico and prevalent in the western United States). Cheese is called “starter heroin” and is thought to be targeted at young adolescents. It is snorted, not injected, and is packaged in small, inexpensive quantities usually costing \$2 and \$10.



# Games, Fads and Variations...

- **Dextromethorphan (DXM)** abuse among adolescents has been increasing. The drug is variously known as DXM, dex, skittles, triple C, and robo (after commonly abused preparations such as Coricidin Cough and Cold and Robitussin).
- A review of exposures reported to U.S. Poison Control Centers found a sevenfold increase in calls from 1999 to 2004. One survey found that 4% of 8th graders and 7% of 12th graders had used medications containing dextromethorphan to get high in the past year.



# Dextromethorphan

- **Dextromethorphan** can be taken in pill or liquid form. The therapeutic dose is up to 30 mg at a time, but abusers take hundreds or even a thousand milligrams at a time.
- “Agent Lemon” is a home extraction technique used to produce purified “crystal” dextromethorphan that can be freebased.



# Evolving Abuse Patterns

The Internet allows teenagers rapid access to information about using new drugs of abuse, so adolescent patterns of drug misuse and abuse are continually evolving.



# Marijuana: Trends in Use

- According to the long-term data from 12th graders Annual marijuana prevalence peaked among 12th graders in 1979 at 51%, following a rise that began during the 1960's.
- Then use declined fairly steadily for 13 years, bottoming at 22% in 1992 a decline of more than half.
- The 1990's, however, saw a resurgence of use. After a considerable increase (one that actually began among 8th graders a year earlier than among 10th and 12th graders), annual prevalence rates peaked in 1996 at 8th grade and in 1997 at 10th and 12th grades.



# Marijuana: Trends in Use

- After these peak years, use declined among all three grades through 2006, 2007, or 2008; since then there has been an upturn in use in all three grades, indicating another possible resurgence in use.
- In 2010 there was a significant increase in daily use in all three grades, reaching 1.2%, 3.3%, and 6.1% in grades 8, 10, and 12, respectively.



# Inhalants: Trends In Use

- According to the long-term data from 12th graders, inhalant use (excluding the use of nitrite inhalants) rose gradually from 1976 to 1987, which was somewhat unusual as most other forms of illicit drug use were in decline during the 1980's.
- Use rose among 8th and 10th graders from 1991, when data were first gathered on them, through 1995.



# Inhalants: Trends In Use

- All grades then exhibited a fairly steady and substantial decline in use through 2001 or 2002.
- Since 2001 the grades have diverged somewhat in their trends; 8th graders showed a significant increase in use for two years, followed by a decline from 2004 to 2007; 10th graders showed an increase after 2002 but some decline since 2007; and 12th graders showed some increase from 2003 to 2005, but a decline since then.



# Inhalants: Trends In Use

- Inhalants are breathable chemical vapors and gases that produce psychoactive effects when misused. Commonly referred to in the past as “glue sniffing,” inhalants actually include a wide range of **volatile solvents, aerosols, gases and nitrites**.
- Examples of **volatile solvents** include paint thinners, dry-cleaning fluids, gasoline, blues and some felt-tip markers. **Aerosols** can contain propellants and solvents in for example, spray paints, deodorants, vegetable oil sprays and fabric protector sprays. **Gases** can be found in medical anesthetics, such as chloroform and nitrous oxide (laughing gas).



# Cocaine: Trends In Use

- There have been some important changes in the levels of overall cocaine use over the life of MTF. Use among 12th graders originally burgeoned in the late 1970's and remained fairly stable through the first half of the 1980's before starting a precipitous decline after 1986.
- Annual prevalence among 12th graders dropped by about three quarters between 1986 and 1992.



# Cocaine: Trends In Use

- Between 1992 and 1999, use reversed course again and doubled before declining by 2000; 12th-grade use stands at just 2.9% in 2010.
- Use also rose among 8th and 10th graders after 1992 before reaching recent peak levels in 1998 and 1999, respectively.
- Over the last decade, use declined in all three grades—most recently in 12th grade.



# Crack: Trends In Use

- Crack use rose rapidly in the early 1980's
- After 1986 there was a precipitous drop in crack use among 12th graders-a drop that continued through 1991.
- Public awareness contributed to this drop-off



# Crack: Trends In Use

- After 1991 for 8th and 10th graders (when data were first available) and after 1993 for 12th graders, all three grades showed a slow, steady increase in use through 1998.
- Since then, annual prevalence dropped by roughly half in all three grades. As with many drugs, the decline at 12th grade has lagged behind those in the lower grades due to a cohort effect.



# Amphetamines: Trends In Use

- The use of amphetamines rose in the last half of the 1970's, reaching a peak in 1981-two years after marijuana use peaked.
- After 1981 a long and steady decline in 12th graders' use of amphetamines began, which did not end until 1992.



# Heroin: Trends In Use

- The annual prevalence of heroin use among 12th graders fell by half between 1975 and 1979, from 1.0% to 0.5%.
- The rate then held amazingly steady until 1993.
- Use rose in the mid- and late 1990's, along with the use of most drugs; it reached peak levels in 1996 among 8th graders (1.6%)
- In 1997 among 10th graders (1.4%), and in 2000 among 12th graders (1.5%). Since those peak levels, use has declined, with annual prevalence in all three grades fluctuating between 0.7% and 0.9% from 2005 through 2009.



# RX Pain Killers: Trends In Use

- 12th graders' use of narcotics other than heroin generally trended down from about 1977 through 1992, dropping considerably.
- After 1992 use rose rather steeply, with annual prevalence nearly tripling from 3.3% in 1992 to 9.5% in 2004, before leveling.
- Vicodin, OxyContin, and Percocet were examples given, which clearly had the effect of increasing reported prevalence.



# The New “Designer Drugs”

A new group of “designer drugs”, different from that of the early 1990s has hit the US market in an attempt to bypass laws for the sales or possession of illicit drugs.

- Synthetic Cannabinoids (“spice”)
- Misleading package information usually states it is of plant origin
- The plant material really acts as a diluent for the synthetic compounds.
- The material is smoked, drank as a “tea” infusion or taken orally.
- Street names include: Spice, Aroma, Chill Out, Chill Zone, Fusion, K2 or Zen, among other names specific to the locale.



# The New “Designer Drugs”

- The synthetic compounds found in these products include:
  - Naphthoyindoles (JWH-015, JWH-018, JWH-019, JWH-073, JWH-122, JWH-200, JWH-210, JWH387, JWH-398)
- JWH-073 has been detected in 70% of the products on the market
- JWH-018 has been detected in 60% of the products on the market
  - Phenylacetylindoles
  - Cyclohexylphenols
  - Benzoylindoles
  - Classic cannabinoid compounds



# The New “Designer Drugs”

- Flavors, organic compounds of fatty acids and preservatives have also been found in these products.
- The synthetic cannabinoids:
- Mimic delta-9-THC (the primary psychoactive ingredient in marijuana)
- Are lipid soluble (can pass through cell membranes)



# The Old “Designer Drugs”/ “Club Drugs”

**The most common of these club drugs are:**

- MDMA (Ecstasy)
- GHB (G, Liquid Ecstasy)
- GBL (Blue Nitro)
- Ketamin (Special K)
- Rohypnol (Rophies)
- Methamphetamine (Speed, Ice, Crystal)
- LSD (Acid).



# Ecstasy (MDMA): Trends in Use

- Ecstasy (3,4 methylenedioxymethamphetamine or MDMA) is used more for its mildly hallucinogenic properties than for its stimulant properties.
- Annual prevalence of ecstasy use in 10th and 12th grades in 1996 was 4.6%-considerably higher than among college students and young adults at that time-but it fell in both grades over the next two years.
- Use then rose sharply in both grades from 1999 to 2001, bringing annual prevalence up to 6.2% among 10th graders and 9.2% among 12th graders. From 2000 to 2001, use also began to rise among 8th graders, to 3.5%



# Ecstasy (MDMA): Trends in Use

- In 2002, use decreased sharply-by about one fifth-in all three grades, followed by an even sharper decline in the drops continued in 2004, but decelerated considerably.
- By 2005 the decline had halted among 8th and 10th graders, but it continued for another year among 12th graders.



# Ecstasy (MDMA): Trends in Use

- For two or three years there was some rebound in use among 10th and 12th graders, raising the concern that a new epidemic of ecstasy use may be developing however, after 2007 the trend lines leveled off in all grades
- Annual prevalence increased significantly in the lower grades between 2009 and 2010 (from 1.3% to 2.4% in 8th grade and from 3.7% to 4.7% in 10th grade).



# Ecstasy (MDMA): Trends in Use

- **MDMA** – chemical methylenedioxy methamphetamine, was first developed as an appetite suppressant, but was found to have stimulant and hallucinogenic properties.
- When ingested, the pill or capsule can cause an increase in heart rate and blood pressure, confusion, depression, anxiety and paranoia.
- The immediate effects can last up to six hours; psychological effects can last for weeks. MDMA is very dangerous in high doses and can cause heart attacks, strokes, convulsions and permanent brain damage.



# “Club Drugs”

- **Ketamine** - developed as an animal anesthetic, originally gained popularity as a hallucinogen, not unlike PCP. Ketamine can cause impaired learning and memory, high blood pressure, delirium, depression and even fatal respiratory impairment.
- **Rohypnol** - a member of the benzodiazepine class of drugs, similar to Valium and Xanax. Rohypnol dissolves easily in carbonated drinks and can cause impairment, specifically the inability to remember events that occurred under the drug's influence for up to 12 hours and is one of the first drugs reported as facilitating date rape.



# “Club Drugs”

- **Methamphetamine** - a stimulant, similar to cocaine, but with a longer period of effect on the user. Like cocaine, it can cause serious health problems, such as heart and neurological damage. Agitation, violent and psychotic behaviors, and memory loss can be seen with abuse of this drug.
- **LSD** - one of the many hallucinogens that are taken to distort a person’s perception of his/her surroundings. Users can develop numbness, tremors, nausea, as well as elevated heart rates, body temperature and blood pressure. Two long-term complications, a persistent psychotic state and flashbacks, have been reported.



# **Risk Associated With Adolescent Substance Use**



# Risk Associated With Adolescent Substance Use

- Motor vehicle accidents
- Suicides
- Violence
- Homicides
- Delinquency,
- Psychiatric disorders,
- High risk sexual behaviors

(Dembo et al., 1991, Janchill et al., in press)



# Risk Associated With Adolescent Substance Use

- Impulsivity, alienation, and psychological distress.
- Delinquency and criminal behavior
- Irresponsible sexual activity that increases susceptibility to HIV infection, and
- Psychiatric or neurological impairments associated with drug use, especially inhalants, and other medical complications

(Hansell and White, 1991; Shedler and Block, 1990  
National Institute of Justice, 1994  
DiClemente, 1990  
SAMHSA, 1996)



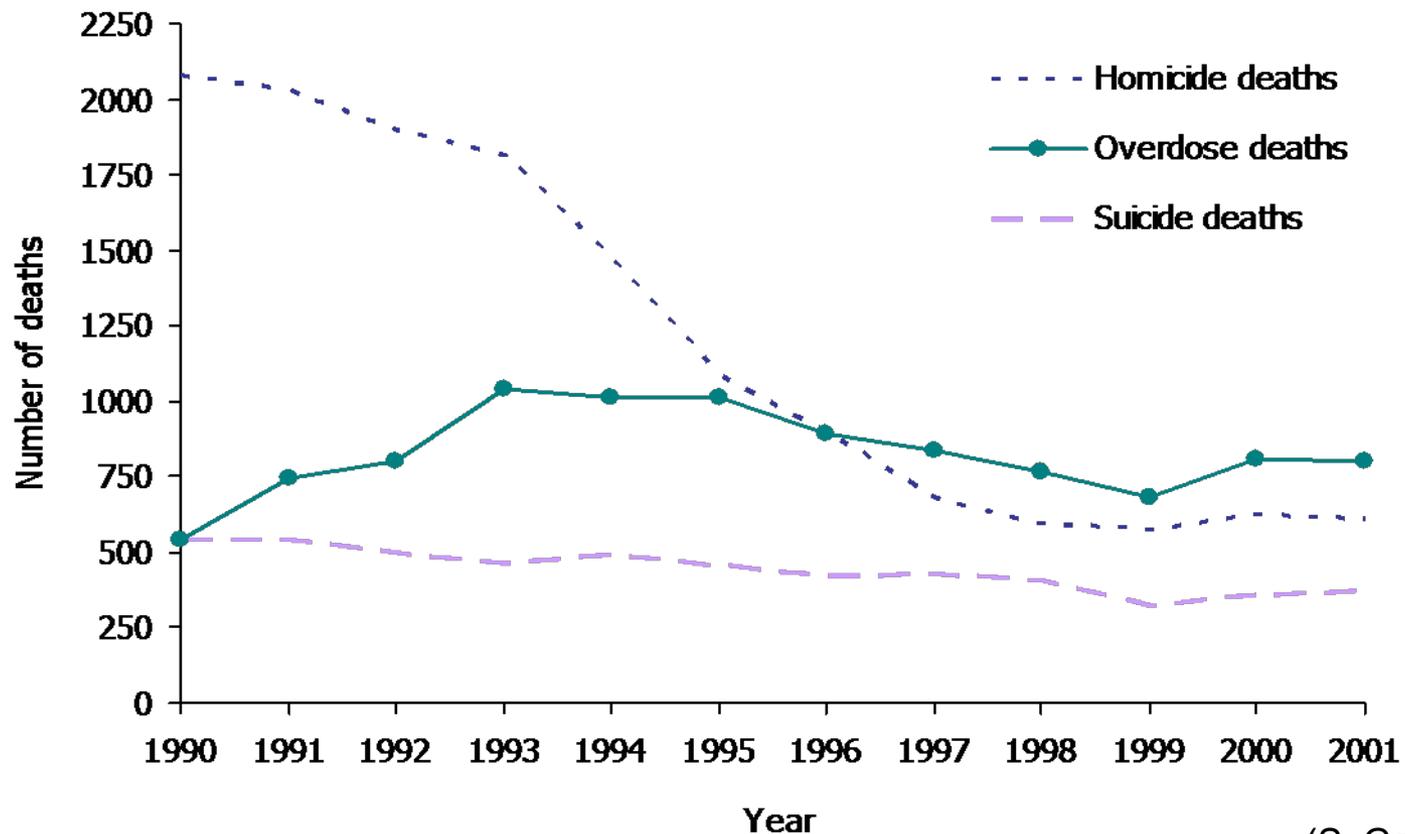
# Mortality Rates

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

(CDC, 1998)



# Accidental overdose, homicide, and suicide deaths, New York City, 1990-2001



(S. Galea)



# Many opioid overdoses are preventable

## Get the SKOOP!



# Naloxone (Narcan)

- Opioid antagonist which reverses opioid overdoses
- Displace most other opioids from the receptors, then sits on the receptor preventing it from being activated for 30-90 minutes
- Injected, works in 3-5 minutes



# The training: 10-20 minutes

- Prevention understanding the role of:
  - mixing drugs
  - reduced tolerance
  - using alone
- Overdose recognition
- Action
  - Call 911
  - Rescue breathing- using dummy
  - Naloxone administration



# Naloxone in action

- Reverses sedation and respiratory depression for 30-90 minutes
- Causes sudden withdrawal in the opioid dependent person
- No psychoactive effects
- Over the counter in Italy
- Routinely used by EMS



# Narcan & The Law

- “the purchase, acquisition, possession or use of an opioid antagonist pursuant to this section shall not constitute the unlawful practice of a profession Use of an opioid antagonist pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability”



# Narcan

## Benefit vs. Risk

- Sinking back into overdose when it wears off
- Study of 998 OD patients who were administered naloxone by EMS and refused to go to the hospital- none died in the next 12 hours
- Using more heroin - naloxone as safety net
- Risks unpleasant abrupt withdrawal

(Vilke 2003)



# Narcan

## Benefit vs. Risk

- Common side effects from Narcan: Confusion, headache, nausea and vomiting, aggressiveness
- Uncommon or rare: Seizures, pulmonary edema-possibly from the lack of oxygen not the reversal of overdose
- 32 trainees reported witnessing 36 overdoses over 6 months
- 25 trainees used naloxone in 28 cases
  - 25 lived
  - 3 unknown

(Buajordet 2004)



# Adolescent Program Considerations



# Programs that support positive youth development?

(From meta-analysis published in 2005)

- Comprehensive, time-intensive
- Earliest possible intervention
- Timing is important
- High structure is better
- Fidelity to model is key to effectiveness
- Need adult involvement
- Active, skills-oriented programs are more effective
- Programs that target multiple systems are most effective
- Programs that are sensitive to the individual's community and culture are best
- Programs based on strong theoretical constructs and proven effective by evidence are best



# Nine Key Elements of Effective Adolescent Treatment

## 1. Assessment and Treatment Matching

Screening and assessment to explore the many interrelated factors that affected the teen's life.

## 2. A Comprehensive & Integrated Treatment Approach

More than half of all adolescents in treatment have co-occurring mental disorders.

## 3. Family Involvement in Treatment

Engaging parents-family increases the likelihood that a teen will remain in treatment and that treatment gains will be sustained after treatment has ended.



# Nine Key Elements of Effective Adolescent Treatment

## 4. **Developmentally Appropriate Program**

Adolescent programs can't just be adult programs "massaged" for kids.

## 5. **Effective Strategies to Engage and Retain Teens in Treatment**

Most teens that begin treatment do not complete the process, 3 of 4 in outpatient and 2 of 5 in residential do not complete 90 days of treatment.

## 6. **Qualified Staff**

Professional staff who recognize psychiatric problems, understand adolescent development and are able to effectively work with families are critically important to treatment success.



# Nine Key Elements of Effective Adolescent Treatment

## 7. Gender and Cultural Competence

Gender and cultural competence is essential in developing a successful therapeutic alliance between the teen and the counselor.

## 8. Continuing Care

Three in four adolescents relapse in the first three months following treatment.

## 9. Treatment Outcomes

At present, very few programs conduct evaluations of any kind  
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# RESOURCES

- Al-Anon and Alateen - [www.al-anon.alateen.org](http://www.al-anon.alateen.org)
- Faces and Voices of Recovery - [www.facesandvoicesofrecovery.org](http://www.facesandvoicesofrecovery.org)
- Federation of Families for Children's Mental Health - [www.ffcmh.org](http://www.ffcmh.org)
- Join Together - [www.jointogether.org](http://www.jointogether.org)
- National Association for Children of Alcoholics (NACoA) - [www.nacoa.org](http://www.nacoa.org)
- National Center on Substance Abuse and Child Welfare (NCSACW) - [www.ncsacw.samhsa.gov](http://www.ncsacw.samhsa.gov)



# Evidenced Based Practices You Can Use NOW

- General approaches to adolescent substance abuse treatment at <http://www.chestnut.org/li/apss> or <http://www.nrepp.samhsa.gov/>
- Guidance for ambulatory/outpatient detoxification at <http://www.aafp.org/afp/2005/0201/p495.html>
- Trauma informed therapy and suicide prevention at <http://www.nctsn.org/nccts> and <http://www.sprc.org/>
- Externalizing disorders medication & practices <http://systemsofcare.samhsa.gov/ResourceGuide/ebp.html>
- Tobacco cessation protocols for youth [http://www.cdc.gov/tobacco/quit\\_smoking/cessation/youth\\_tobacco\\_cessation/index.htm](http://www.cdc.gov/tobacco/quit_smoking/cessation/youth_tobacco_cessation/index.htm)
- HIV prevention with more focus on sexual risk and interpersonal victimization at <http://www.who.int/gender/violence/en/> or <http://www.effectiveinterventions.org/en/home.aspx>
- For individual level strengths see <http://www.chestnut.org/li/apss/CSAT/protocols/index.html>
- For improving customer services <http://www.niatx.net>

