WASHINGTON STATE INSTITUTE ON ADDICTIONS TREATMENT

PRESENTS

A WORKSHOP ON EFFECTIVE EVIDENCE-BASED RELAPSE PREVENTION FOR ADOLESCENTS USING THE 12 STEPS

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PRESENTER

FRED DYER, Ph.D., CADC
TRAINER/CONSULTANT

“I can’t speak for other kids, and I can’t say that AA or NA are for every kid or not, but what I can say is that attending 12-step AA meetings worked for me. I don’t look down on other kids who are recovering from alcohol and drugs who don’t attend.”

Diane
16-year-old recovering from alcohol

FACTORS THAT PREDICT SUCCESS FOR ADOLESCENTS FOLLOWING ALCOHOL AND DRUG TREATMENT

Adolescent 12-step Self-help Group Attendance

1. **Just as the determinants of relapse differ for adolescent and adults, there are also important distinctions in success strategies. For example, developmental factors (e.g., motivation, source of social supports) lead to differences in the ways adolescents respond to traditional 12-step based support groups compared with adults.**

2. **Alcoholics Anonymous (AA) is by far the most prominent of these, with over 90% of adolescent alcohol and drug treatment programs currently, including these 12-step groups as a facet of treatment (Kelly, Myers & Brown, 2002).**

3. **Evidence is mounting that AA programs lead to higher levels of commitment to abstinence and improved outcomes for adults (Morgenstern et al., 1997) and for youth (Brown, 1993) both during and after treatment.**

4. **Brown (1993), in a study of adolescents who received inpatient treatment for alcohol abuse or dependence, found that 57% reported that they attended 12-step meetings regularly in the year following treatment. Of these, 69% had positive alcohol outcomes during the first year after treatment. In contrast, only 31% of those who did not attend meetings regularly (i.e., 1-20 sessions during the year after treatment) had a positive outcome.**

5. **Hohman and LeCroy (1996) examined characteristics of adolescents who affiliated with AA following treatment versus those that did not. They found AA affiliation to be associated with prior alcohol on drug treatment, having friends who did not use drugs, less criminal involvement in treatment, and more feelings of hopelessness.**

6. **AA attendance has also been associated with enhanced motivation for abstinence for the first three months following treatment, which predicts better subsequent success (abstinence or lower use) by teens.**

7. **For adolescents, attendance at a 12-stepgroup appears to influence outcomes by enhancing factors critical for self-regulation, such as motivation for abstinence and use of abstinence-focused coping strategies, rather than immediately improving self-efficacy or coping skills for risk situations (Kelly, Myers, & Brown, 2000).**

8. **One of the greatest problems with outpatient treatment is that it can be focused too narrowly, by concentrating on one or two issues, treatment may (not intentionally) ignore the whole picture. This overly-focused approach can preclude consideration of other important factors that actively lead the adolescent to relapse (Parrish, 1994).**

9. **If outpatient treatment programs are to be successful, they must provide the entire spectrum of therapies needed to treat the substance-abusing adolescent, including but not limited to 12-step treatment, individual psychotherapy, family therapy group, drug education, educational remediation, socialization, peer selection, and judicious use of medications. In all of these settings 12-step treatment plays a central role.**

Source: ***Manual of Adolescent Substance Abuse Treatment*, Todd Wilk Estroff, M.D., 2003. American Psychiatric Publishing, Inc.**

10. **Certain personal and environmental factors contribute to success for adolescents following treatment for a SUD. Of significance, treatment length has been shown to lead to better outcomes in adolescents, independent of problem severity (Hser et al., 2001).**

11. **In the domain of family factors, greater expression in the family (communication) the adolescent's perception of family support**

and less exposure to substance-abusing family member models are associated with more positive outcomes following treatment (Brown et al., 1990).

12. **Also, identification with abstaining peers and a greater proportion of non-users in the social resource network are associated with less substance use after treatment (Richter, Brown, and Mott, 1991; Vik et al., 1992), personal characteristics such as higher self-esteem and from conduct disorder-type behaviors have also been linked to more positive outcomes (Brown et al., 1996; Richter et al., 1991).**

13. **Friedman, Terras, and Ali (1998) found that predictors of successful outcomes from inpatient treatment for adolescents with SUD were younger age, greater years of education, not dropping out of high school, not being expelled from school, and not being court referred to treatment. In the outpatient sample, better outcomes were associated with being female, not having been expelled from school, and being self-referred.**

14. **It is evident that a large number of individual factors contribute to success following treatment for SUD in adolescents, including attendance at self-help group meetings as well as personal and environmental characteristics, most notably school involvement and a social network that promotes abstinence. An important matter for further investigation involves how youth succeed who are not involved with treatment-recommended abstinence-focused support groups such as AA.**

ALTERNATIVE PATHS TO SUCCESS

1. **A number of strategies have been identified for maintenance of lifestyle change after substance abuse treatment that do not include sustained treatment involvement (e.g., aftercare, 12-step groups, religious groups) (Brown et al 1990).**

2. **Research indicates some adolescents are able to establish abstinent lifestyles following alcohol and drug treatment despite little involvement with self-help groups. Research also indicates there may be another group of adolescents who exhibit marked improvement in post-treatment functioning despite minimal involvement with treatment self-help groups.**

3. **Evidence is mounting that 12-step programs are effective for a portion of youth. Involvement of fellow teenager appears to help to sustain 12-step attendance. These programs benefit youth by sustaining motivation to abstain. However, some adolescents will choose not to attend or sustain 12-step involvement and not all teems fail. In fact, there is evidence that they can use resources such as strong family ties, environmental and activity changes, and social relationships with nonusing teens to help to sustain their success after treatment.**

Source: Howard A. Liddle, E.D. & Cynthia C. Rowe (2006), *Adolescent Substance Abuse: Research and Clinical Advances.*

Fred Dyer, Ph.D., CADC **dyertrains@aol.com** **(773) 934-6350**

12 STEPS FOR ADOLESCENT SUBSTANCE ABUSERS

In programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), sobriety is mandated by carefully employing a 12-step philosophy outlined by the AA/NA principles and by sharing experiences with others who have suffered similar problems with substance abuse and dependence. During primary treatment 12-step-based programs typically focus on the first five steps, while the remaining steps are attended to during aftercare. These first five steps are presented below in a way that is tailored for young people.

Step 1: We admit we are powerless over alcohol and that our lives have become unmanageable. The primary goal of this step with adolescents is to assist them in revealing their drug use history and to have them associate it with harmful consequences.

Step 2: We come to believe that a power greater than ourselves can help restore us to a drug-free lifestyle. To convey this message, new clients are encouraged to interact with those who have been successful in treatment and who are leaving the program. The definition of a greater power can be the traditional concept of God or refer to a personalized concept of a helping force. The bottom line of this step is to emphasize to the client the importance of obtaining help to stop drug selling and using behavior.

Step 3: We will turn to others for help. This step can be simplified by saying, "Try making decisions in a different way; take others' suggestions, permit others to help you." Emphasizing the phrase "Helping Power" instead of "Higher Power" benefits some young people.

Step 4: We make a complete inventory of ourselves. Step 5, we admit to ourselves and to significant others the extent/nature of our wrongs. Steps 4 and 5 provide an opportunity to be accepted by another person

in spite of one's past behaviors and to take a personal inventory of those past behaviors.

As essential therapy component of 12-step is the use of group therapy. Group therapy can be well-suited to adolescents who tend to rely heavily on peer examples and approval. Often the more experienced clients with guidance from counselors are placed in a helping role in group sessions. While there are not systematic studies regarding the extent to which AA/NA are tailored to youth, it stands to reason that a significant barrier to youth participation in post-treatment AA/NA is the low availability of youth-friendly meetings.

Source: Winters, K.C. (1999) Treating Adolescents with SUD: An Overview of Practice Issues and Treatment Outcomes. *Substance Abuse, Vol. 20*, No. 4.

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CHALLENGE TO ATTENDING 12-STEP MEETINGS FOR ADOLESCENTS

1. **Locations**
2. **Lack of or poor family support/encouragement**
3. **Continual and constant exposure to drug using peers and environment not conducive to recovery**
4. **Lack of prosocial adjuncts outside of home**
5. **12-step meetings not designed to address adolescents with comorbid disorders**
6. **Age of attendees**
7. **Medication challenges**
8. **Poverty**
9. **Family in crisis**
10. **Continual exposure to sibling alcohol and drug use**
11. **Feelings of disconnectness**

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ADOLESCENT COMORBIDITY OF SUBSTANCE ABUSE AND PSYCHIATRIC DISORDERS

Points to Ponder

1. **Disruptive behavior disorders or undercontrolled or externalizing disorders include various acting out, disruptive, delinquent, hyperactive, and aggressive behaviors.**

   The second broad dimension of childhood psychopathology has been labeled as overcontrolled or internalizing and include such behaviors as social withdrawal, anxiety, and depression.

Source: Achenbach, 1995; Achenbach & Edelbrock, 1978; Quaz, 1986).

2. **The most common comorbid disorders associated with adolescent SUD are the disruptive behavior disorders (i.e., oppositional defiant disorder, conduct disorder, ADHD), with conduct disorder being the most common 60-80%. Once conduct disorder develops, it becomes one of the most robust predictors of progression from "experimentation" with drugs and alcohol to the development of a SUD (Crowley & Riggs, 1995).**

3. **Most children and adolescents who meet diagnostic criteria for conduct disorder previously met diagnostic criteria for oppositional defiant disorders when they were younger. However, only about 50% of children with oppositional defiant disorder progress to conduct disorder, and the former often does not share the same severe correlates and outcomes (Biederman et al., 1996).**

4. **Evidence-based treatment interventions have been shown to improve family functioning and reduce the risk of progression to more severe behavior problems and development of adolescent SUD. Such treatments include parent and family, management training, generally with individual skills training for the child (Kazdin, Siegel, &Bass, 1992); family behavior therapy (Donohue & Azrin, 2001); motivational enhancement therapy/cognitive-**

behavior therapy (Muck et al., 2001); school-and community-based interventions (Wagner et al., 1999), and multidimensional approaches (Henggeler et al., 1999; Liddle & Hogue, 2001). Because of the high rates of co-occurrence of conduct disorder with SUD in adolescents, most substance treatment programs have developed programming that address both disorders.

5. **The onset of ADHD is prior to age 7; consequently it also precedes the development of SUD (American Psychiatric Association, 1994). Most studies indicate that ADHD alone does not impact a significant increase in the risk for developing SUD in adolescence unless associated with conduct disorder (Barkley et al, 1990; Mannuzza et al., 1993). However, if both ADHD and conduct disorder co-occur, the risk of developing SUD in adolescence rises dramatically. As many as 30-50% of adolescents with SUD have both ADHD and conduct disorder, which not only increases the risk of adolescent SUD but is also associated with greater impulsivity, neuropsychological deficits, more severe substance abuse and behavior problems, worse treatment outcomes, and worse prognosis compared with either disorders alone (Crowley & Riggs, 1995); Forehand et al., 1991; Gittelman et al., 1985; Mannueza, et al., 1993).**

<u>Internalizing Disorders</u>

1. **Depressive disorders (major depression, dysthymia) occur in approximately 5-10% of school age children and adolescents without SUD with prevalence rates rising to 15-30% in adolescents with SUD. These disorders may impact the severity and pattern of their substance involvement (Barkley et al, 1990; Chiles, Miller, & Cox, 1980; Gittelman, et al., 1985).**

2. **In both epidemiological samples and clinically referred samples, approximately half report that depression started prior to SUD and about half reported that depression had onset either concurrently or after onset of SUD (Lewinsohn, et al., 2002: Riggs et al., 1995; Swendsen & Merikangas, 2000).**

3. **Although there is some evidence that depression that arises in childhood increases the risk of developing adolescent SUD somewhat, it is not yet known whether treatment of depression in childhood and adolescence reduces the risk of later developing SUD. Standard clinical management of pediatric depression without SUD generally calls for combined psychotherapy and pharmacotherapy. The efficacy of interpersonal psychotherapy (Mufson et al., 1999) and cognitive-behavioral therapy for depression have been demonstrated in both children and adolescents without SUD (Brent, et al., 1997).**

4. **Although less is known about the prevalence of bipolar disorder among adolescents with SUD, it is most likely greater than the 1% prevalence found in the general population, with prevalence estimated ranging from 3 to 15% among adolescents with SUD (Wilen, et al, 1999; Wise, et al., 2001). There is some evidence that bipolar disorders in childhood may increase the risk of developing adolescent SUD, and that treatment may reduce this risk (Wilens et al., 1999). Adolescent-onset bipolar disorder, however, dramatically increases the risk of developing a SUD (greater than eight times the risk compared with childhood onset) (Wilen et al., 1999). Treatment of mania or hypomania with lithium in adolescents with bipolar disorder and SUD has been shown to be relatively safe and effective in stabilizing mood even without abstinence, but it was not effective in treating substance abuse in the absence of specific treatment for SUD (Geller et al, 1998).**

5. **Anxiety disorders also have a higher prevalence in adolescents with SUD than found in the general population, and they may increase the risk of developing SUD (e.g., generalized anxiety disorder, social anxiety disorder, posttraumatic stress disorder. (Breslar, et al., 1997; Davies et al., 2002: Lewinsohn. et al 2002; Rohde, et al, 1996).**

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ADOLESCENT SUBSTANCE ABUSE TREATMENT IN A SCHOOL SETTING

While there is empirical support for the effectiveness of several adolescent AOD abuse treatment, many studies document the high level of unmet needs among substance abusers. Recent estimates suggest that only one out of eighteen adolescents with a substance use problem receives treatment (Clark et al., 2002; Dennis, et al., 2003).

Part of the reason why so few adolescents in need of treatment actually receive it is a reliance on "the traditional service-delivery model" (Wagner, Swenson, and Henggeler, 2000). The traditional service-delivery model involves trained professionals treating teenagers with AOD problems and their families in clinics located in hospitals, universities, or other institutional settings. In the traditional service-delivery model, clients first must present to the clinic to receive service. Since substance-abusing adolescents rarely recognize the need for treatment, parents and other influential adults bear the responsibility for pursuing treatment. For some adults and for many reasons (e.g., time conflicts, lack of knowledge, estrangement from the adolescent, personal substance use problem, reluctance to accept the label "substance abuser" for their children).

WHY USE SCHOOLS FOR DELIVERY OF SUBSTANCE ABUSE TREATMENT

1. **School-based treatment can take place at one or multiple levels, including individuals, classroom, existing social groups (e.g., the football team, the marching band), purposely assembled social groups (e.g., students with substance use problems, children of alcoholics, and/or the entire school).**

2. **Emory Cowen (1977), a pioneer in school-based mental health service delivery, has discussed the school-based treatment approach as the practice of community mental health with the school being the community.**

3. **An important strength of the school-based treatment approach is that it goes where most adolescents spend most of their mornings and early afternoons most of their weekday mornings most of the time.**

4. **School-based treatments provide a unique opportunity to assess and influence directly the proximal determinants and consequences of substance abuse in one of the more important environments in which such problems occur.**

5. **Services are provided in a very high-impact social environment for influencing the psycho-social growth and adaptation of youth (Cowen. 1977).**