

Family Centered Treatment for Adolescents with Substance Use Disorders



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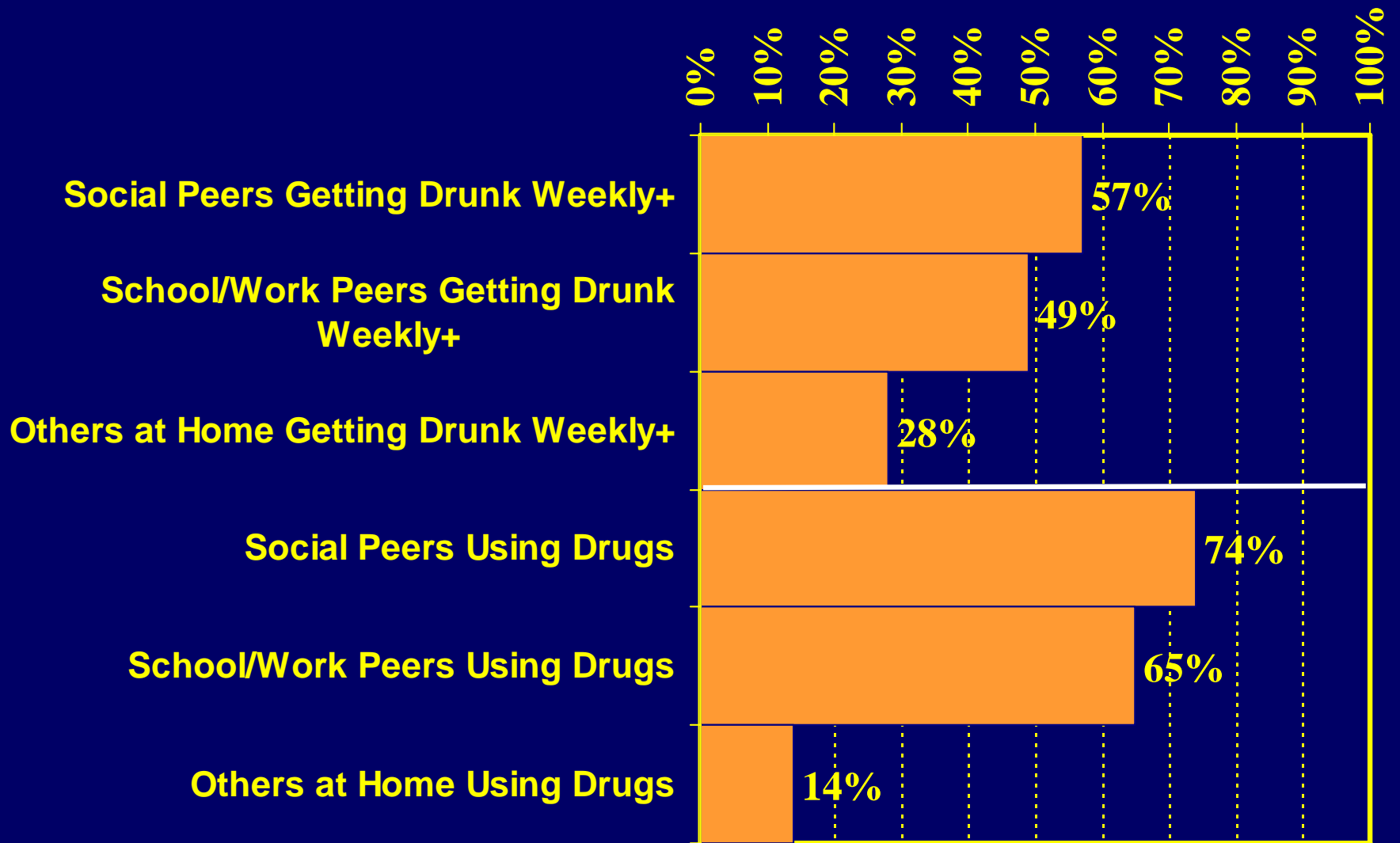
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240-276-1576



Why Involve the Family or Primary Care Givers?

Recovery Environment

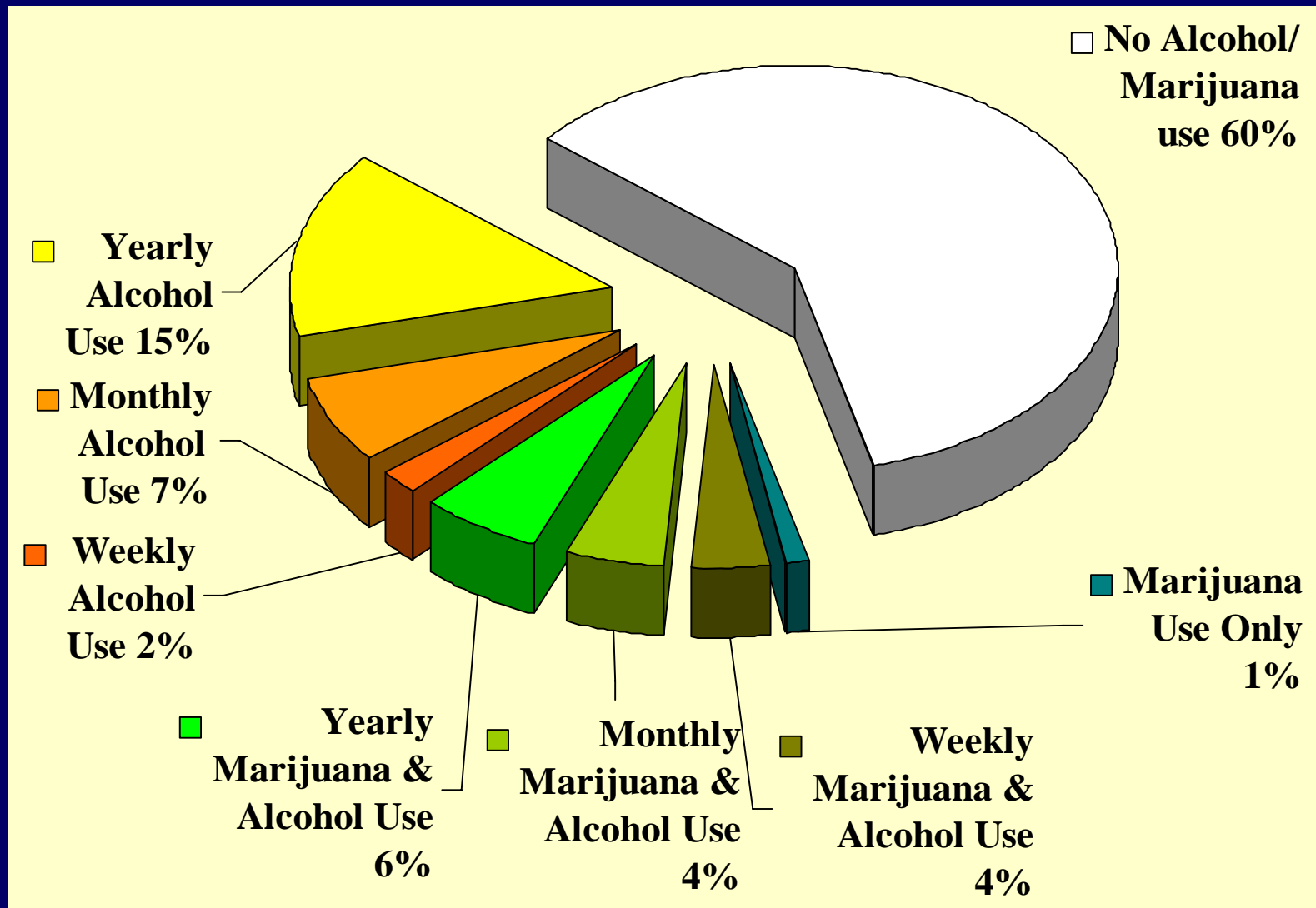


Source: CSAT AT Outcome Data Set (n=9,276 adolescents)



Prevalence and Need for Treatment

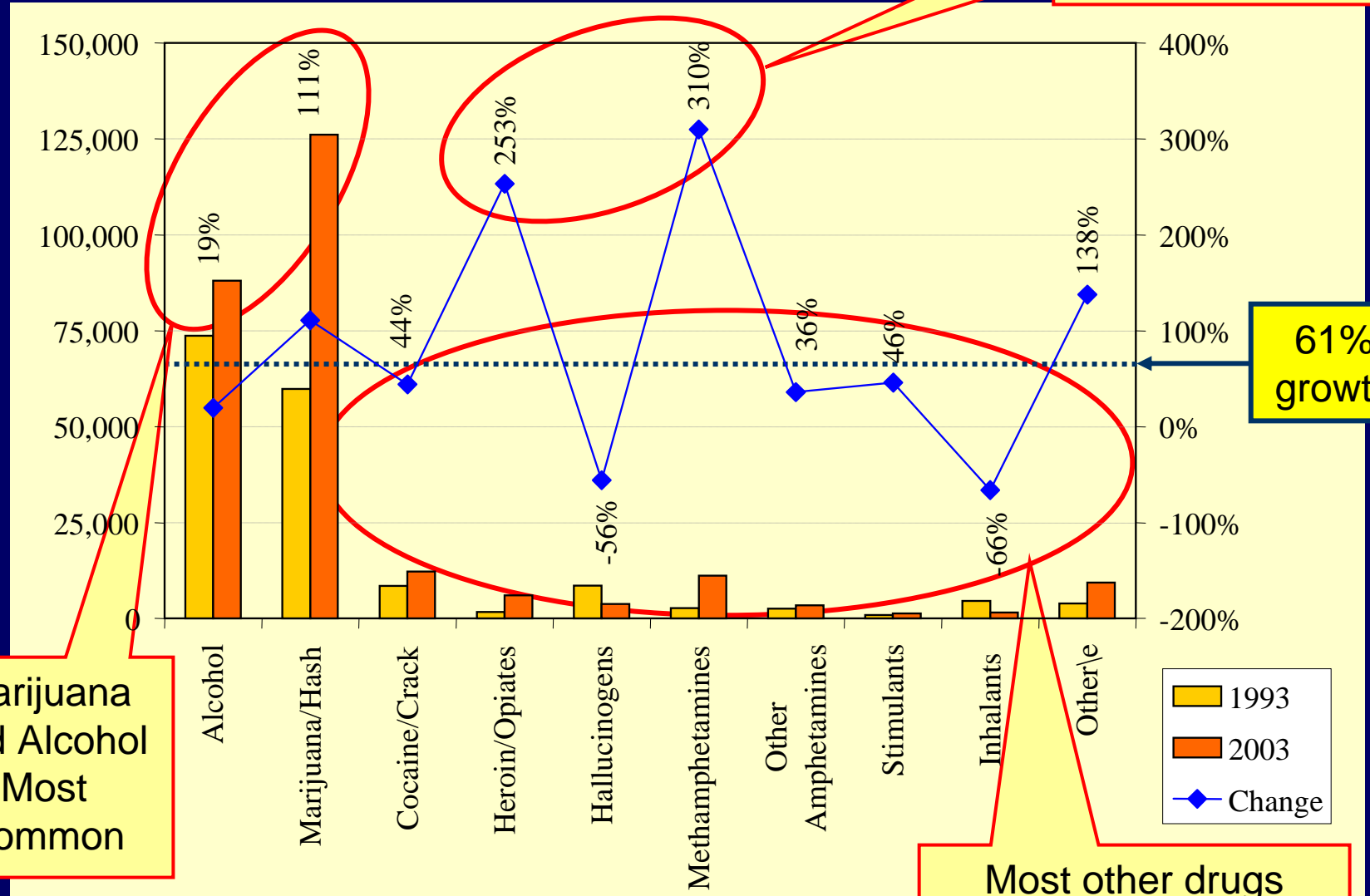
Substance Use in the Community



Source: Dennis and McGeary (1999) and 1997 NHSDA

Change in Focal Substances*: 1993-2003

Methamphetamines & Opiates Rare but Growing Fast



Marijuana and Alcohol Most Common

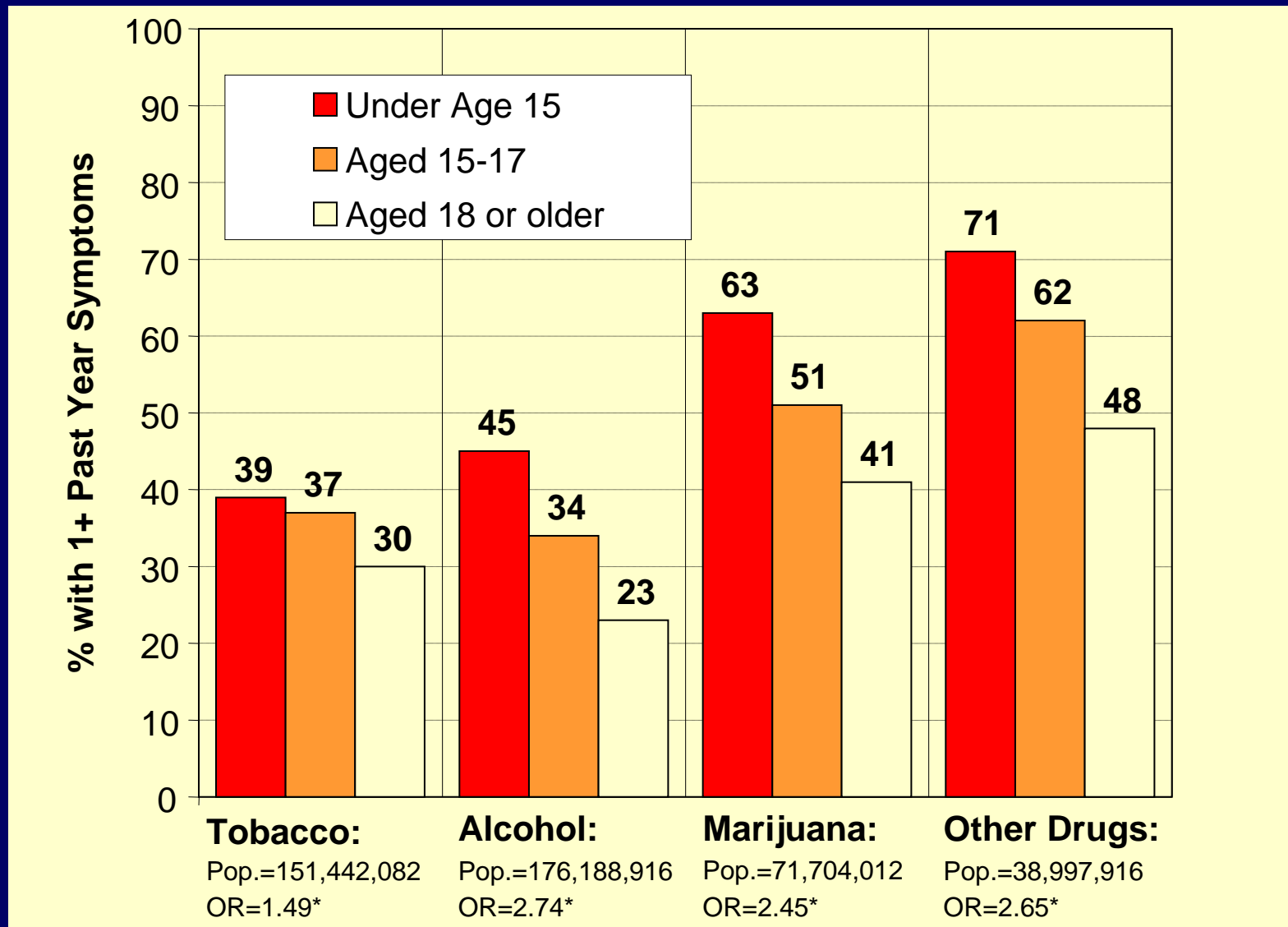
61% growth

Most other drugs admissions grew slower than expected

*TEDS Primary, Secondary or Tertiary problem

Source: Treatment Episode Data Set (TEDS) 1993-2003.

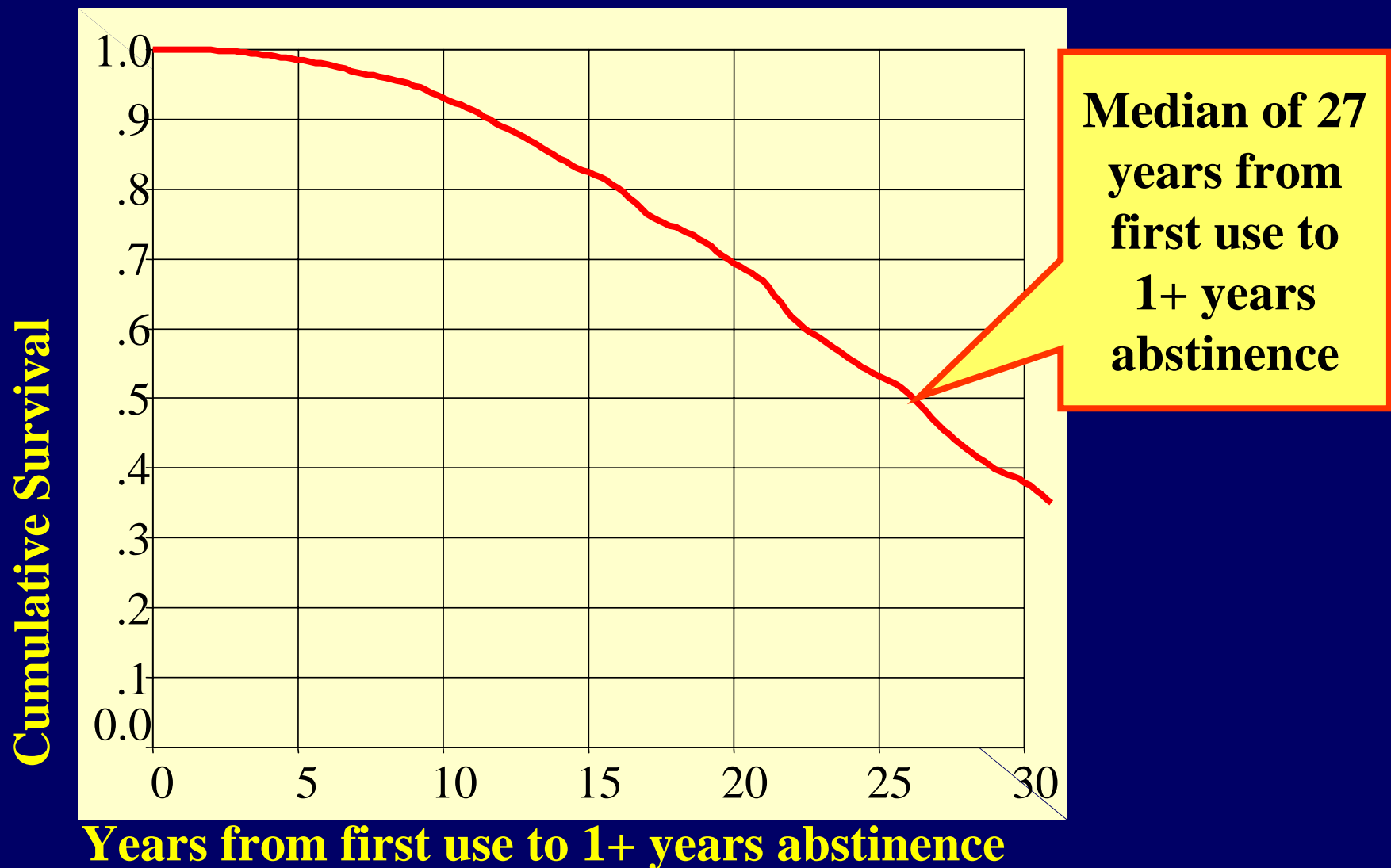
Age of First Use Predicts Dependence an Average of 22 Years Later



Source: Dennis, Babor, Roebuck & Donaldson (2002) and 1998 NHSDA

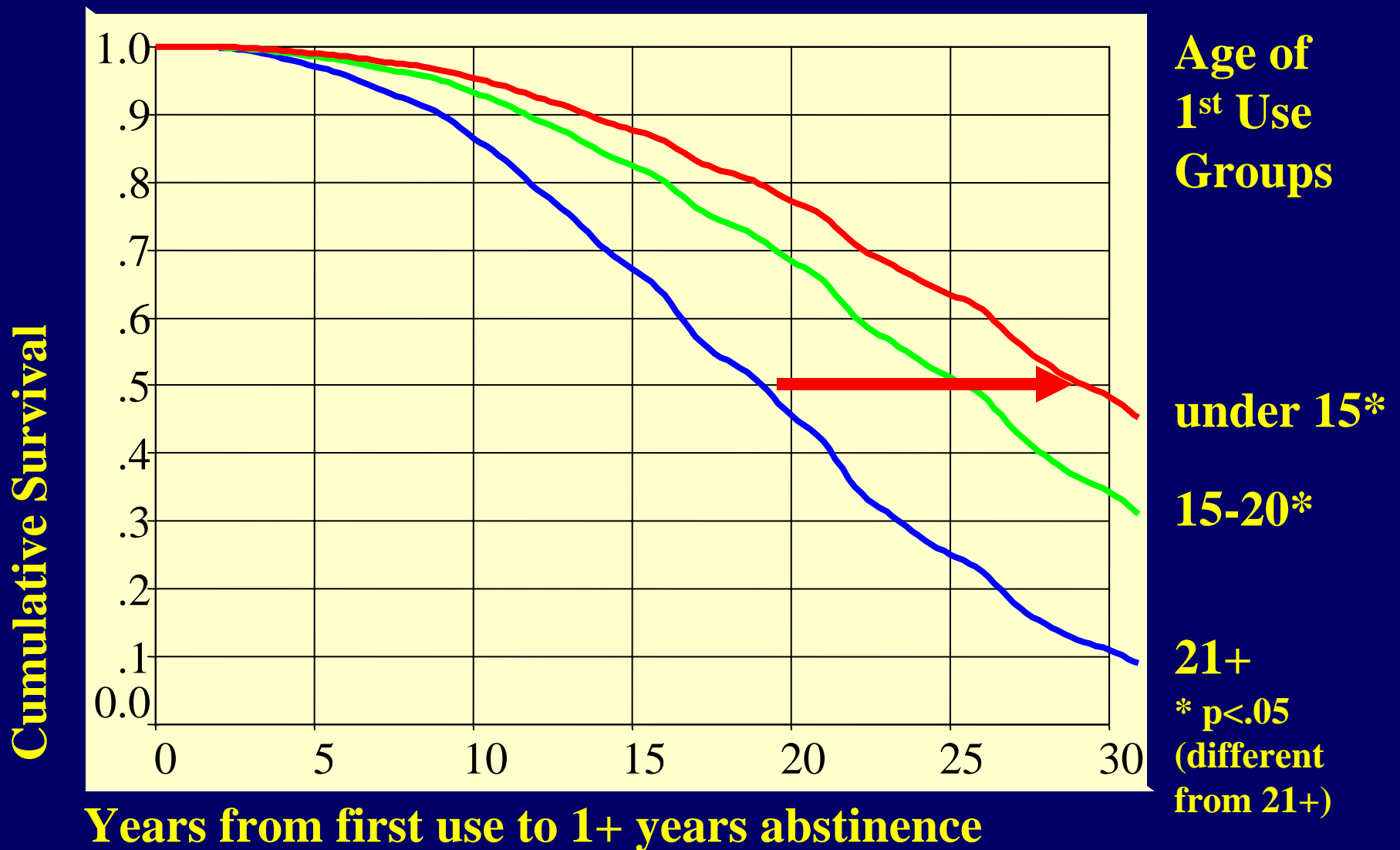
* p<.05

Substance Use Careers Last for Decades



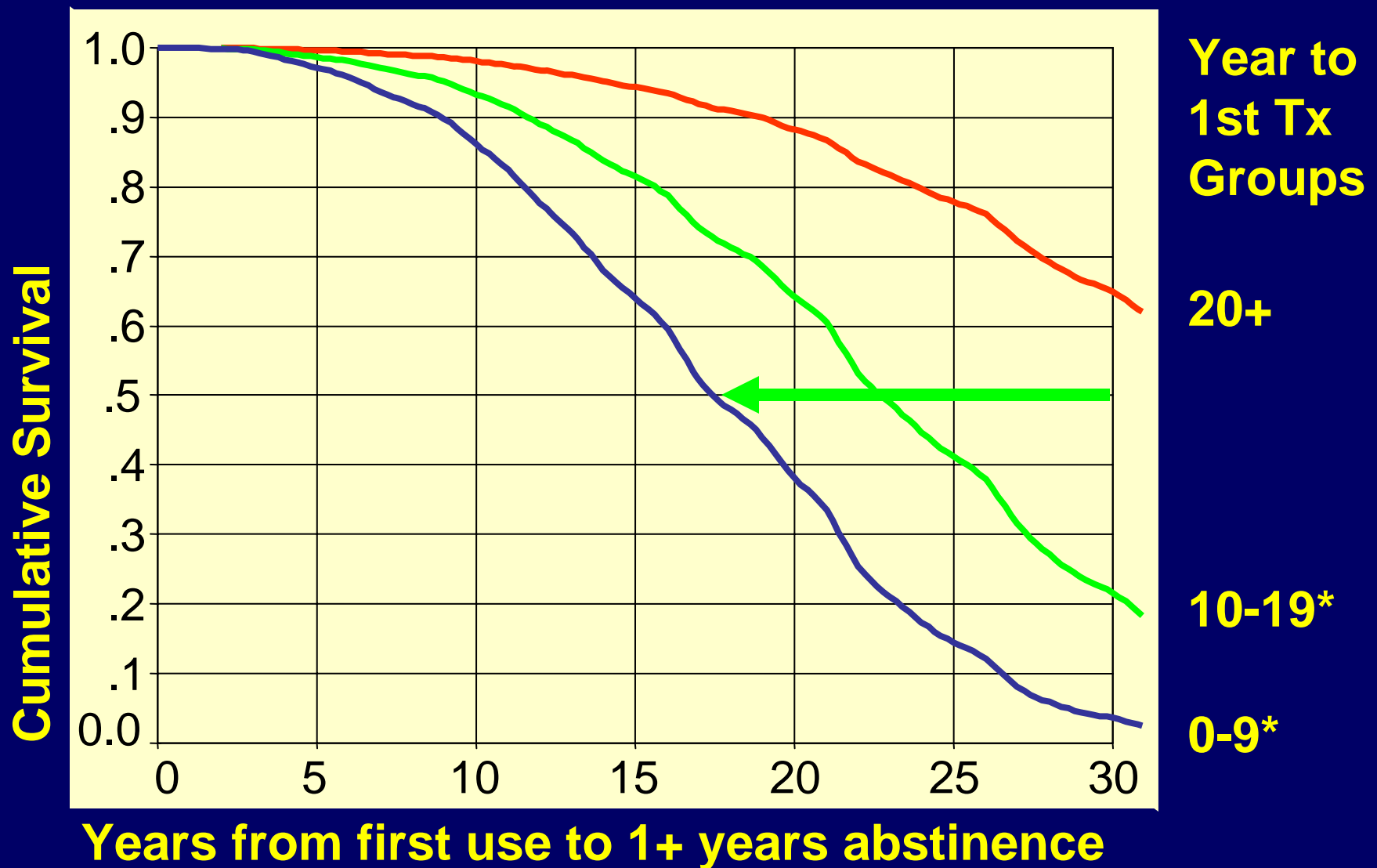
Source: Dennis et al., 2005

Substance Use Careers Are Longer the Younger the Age of First Use



Source: Dennis et al., 2005

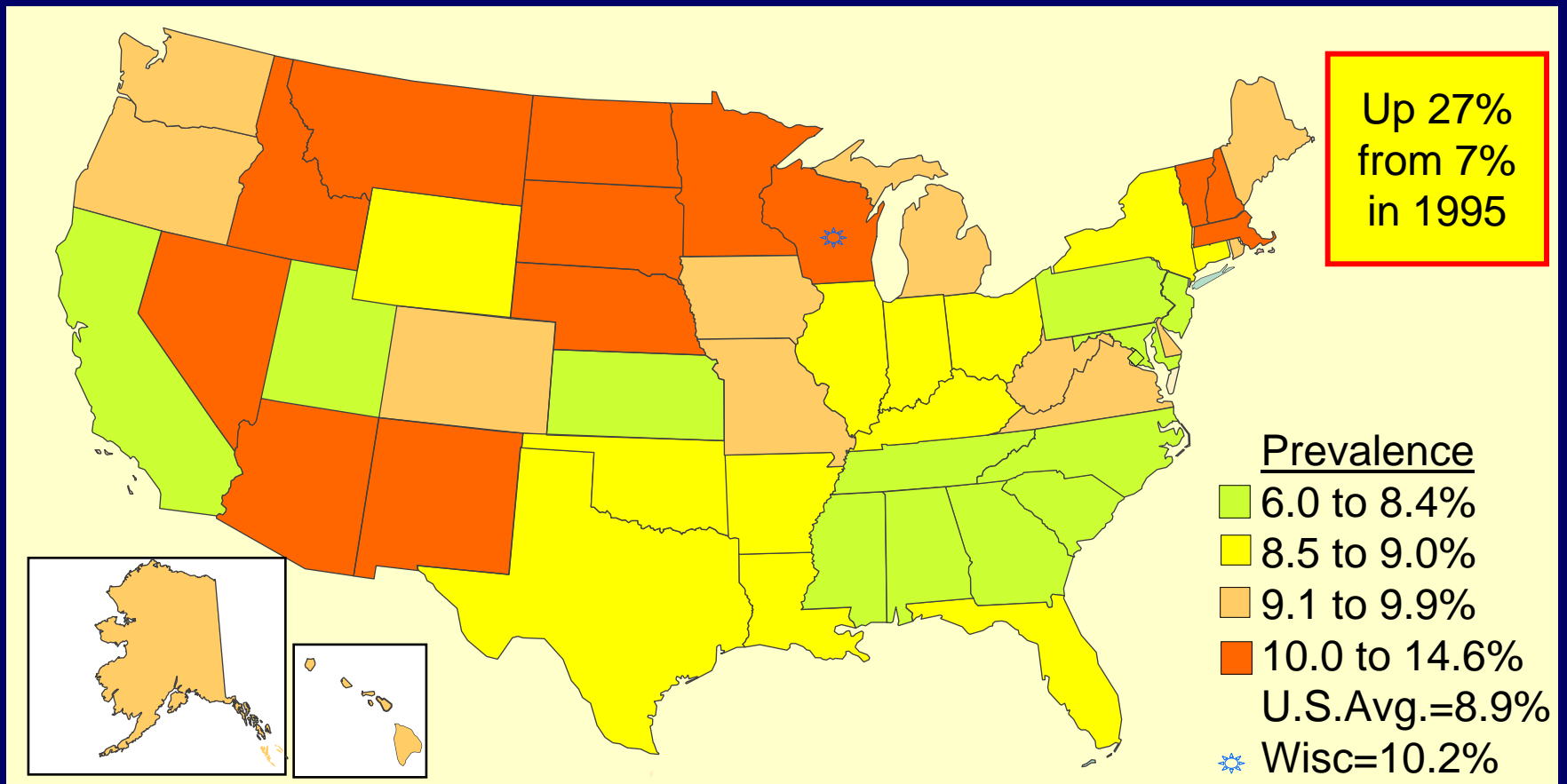
Substance Use Careers Are Shorter the Sooner People Get to Treatment



Source: Dennis et al., 2005

* $p < .05$ (different from 20+)

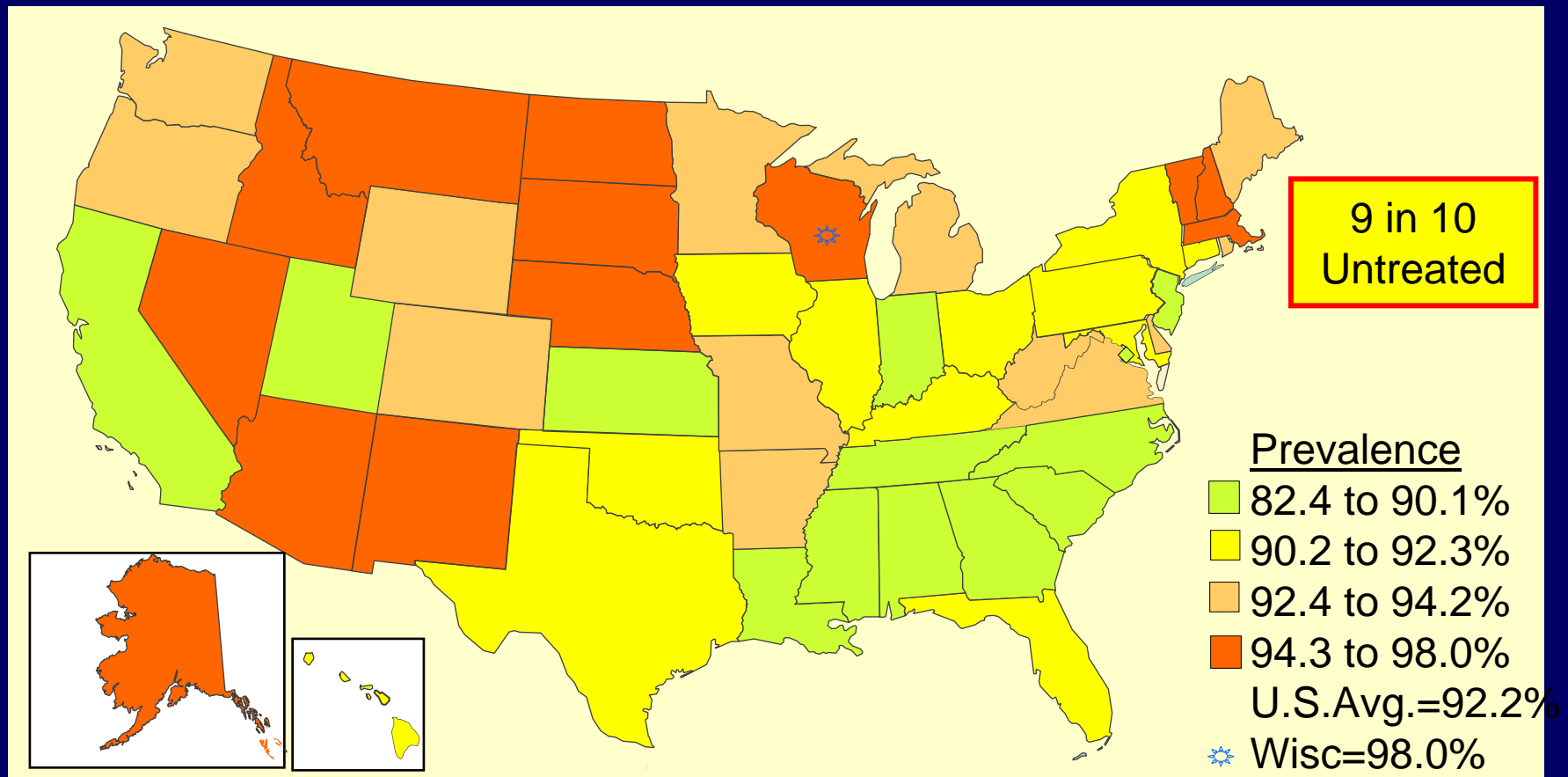
Adolescent AOD Dependence/Abuse



Source: Wright, D., & Sathe, N. (2005). State Estimates of Substance Use from the 2002–2003 National Surveys on Drug Use and Health (DHHS Publication No. SMA 05-3989, NSDUH Series H-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies (retrieved from <http://oas.samhsa.gov/2k3State/2k3SAE.pdf>) and Kilpatrick et al, 2000.

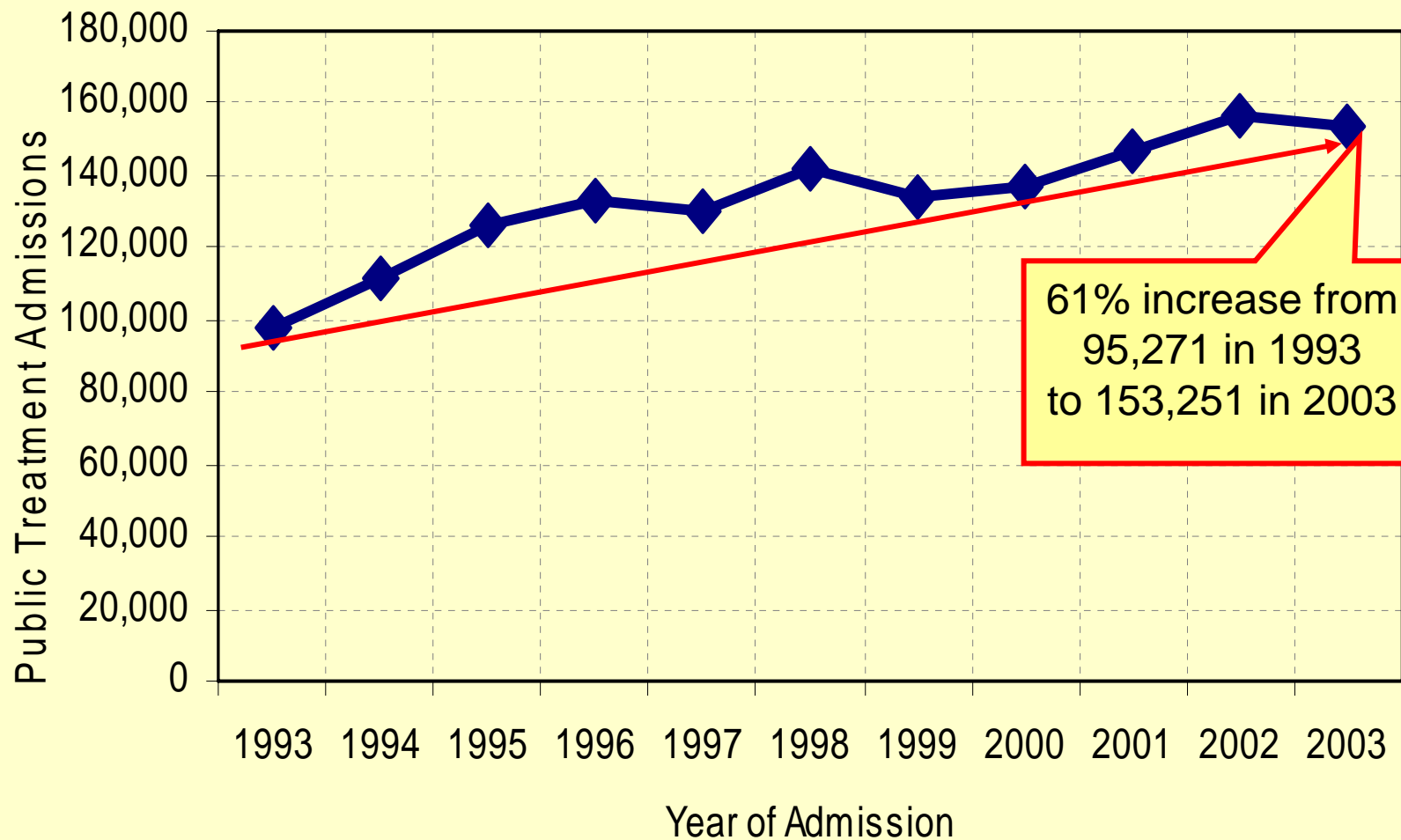
Unmet Treatment Need Adolescent

(% of AOD Dependence/Abuse without any private/public treatment)



Source: Wright, D., & Sathe, N. (2005). State Estimates of Substance Use from the 2002–2003 National Surveys on Drug Use and Health (DHHS Publication No. SMA 05-3989, NSDUH Series H-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies (retrieved from <http://oas.samhsa.gov/2k3State/2k3SAE.pdf>)

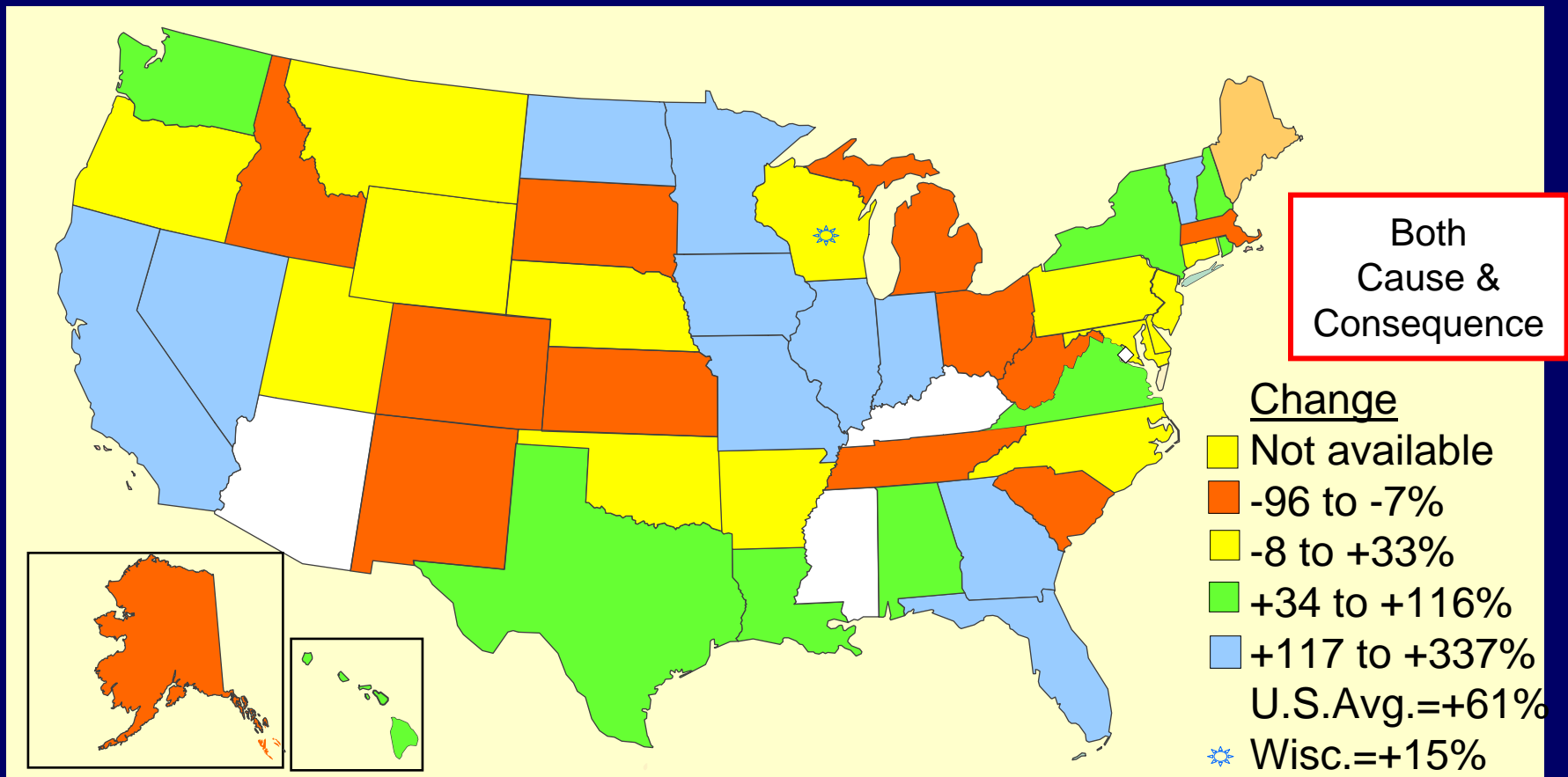
Adolescent Treatment Admissions Have Increased by 61% over the Past Decade



Source: Office of Applied Studies 1992- 2002 Treatment Episode Data Set (TEDS)
<http://www.samhsa.gov/oas/dasis.htm>

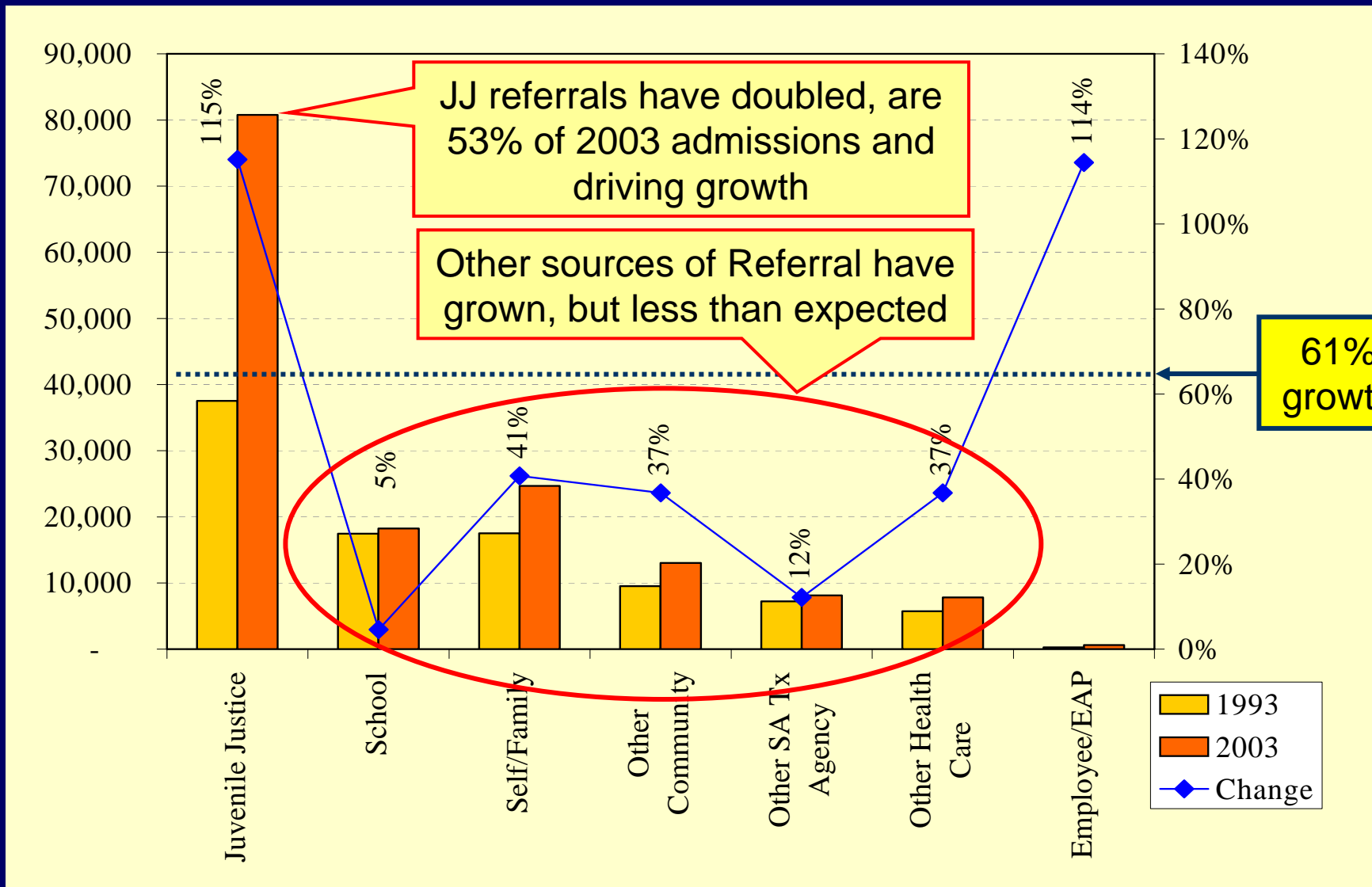
Change in Public Sector Admissions

Percent change = $(2003-1993)/1993$



Source: Wright, D., & Sathé, N. (2005). State Estimates of Substance Use from the 2002–2003 National Surveys on Drug Use and Health (DHHS Publication No. SMA 05-3989, NSDUH Series H-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies (retrieved from <http://oas.samhsa.gov/2k3State/2k3SAE.pdf>)

Change in Referral Sources: 1993-2003



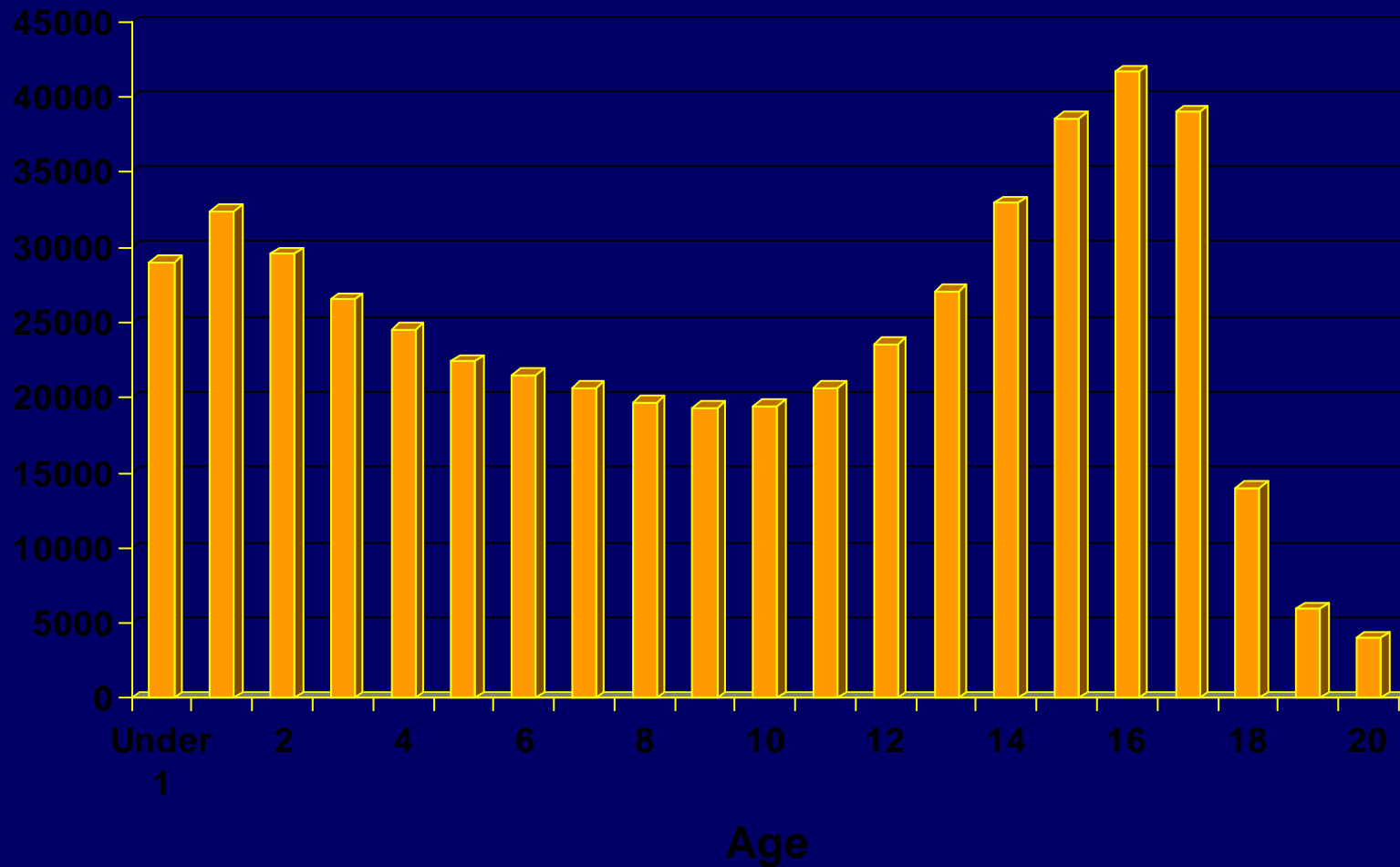
Source: Treatment Episode Data Set (TEDS) 1993-2003.

Substance Abuse Treatment and Foster Care Status

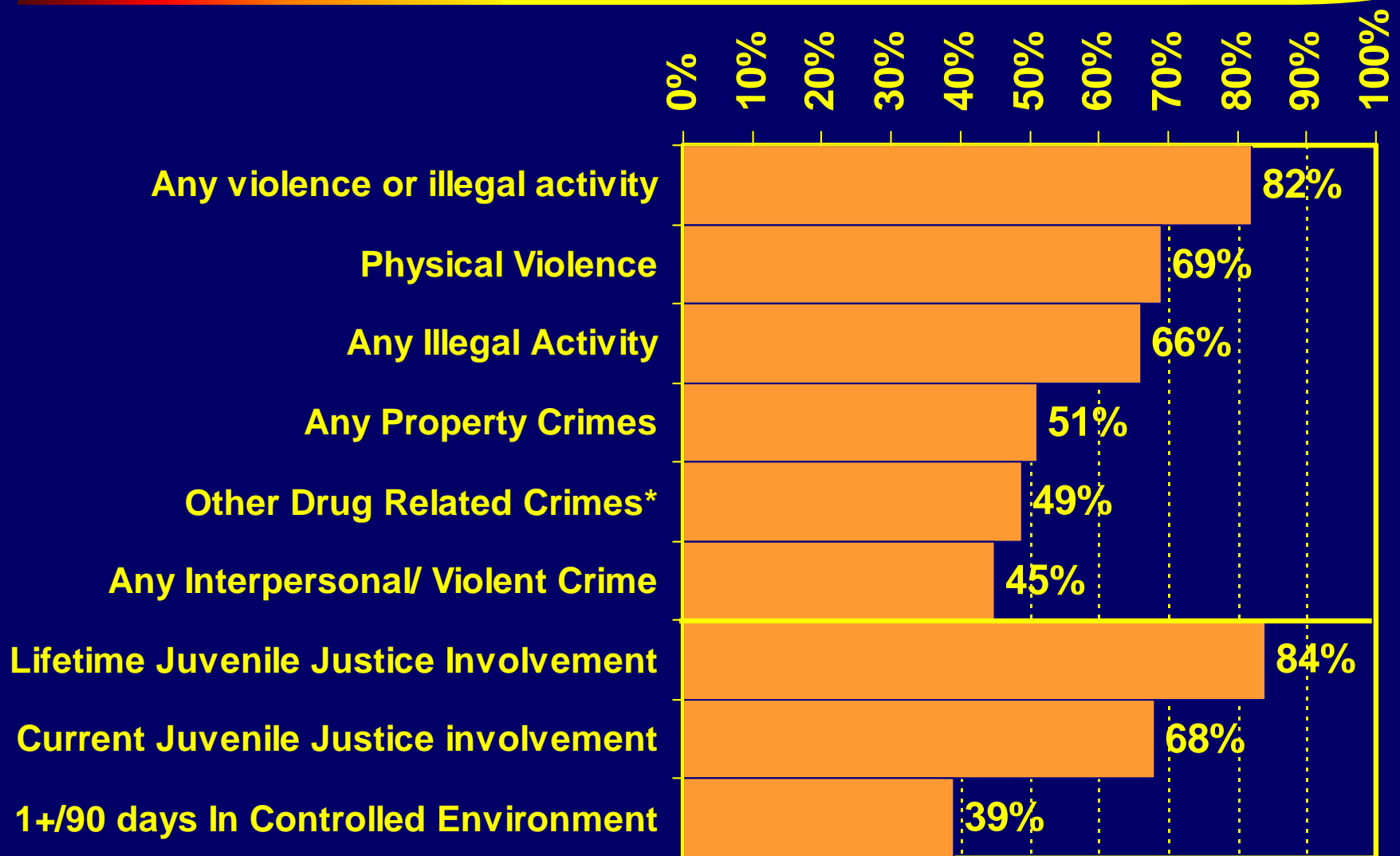


- **CSAT data set – 8.3% in treatment currently in foster care**
- **NSDUH (2005) – 0.6% of youth 12 – 17 ever in foster care**
- **Odds ratio of 15:1 (but an underestimate)**

Age of Children in Foster Care as of September 30, 2005



Past Year Violence and Crime



*Dealing, manufacturing, prostitution, gambling (does not include simple possession or use)
Source: CSAT AT Outcome Data Set (n=9,276 adolescents)



Screening and Assessment

GAIN Short Screen (GAIN-SS)



- Administration Time: 5 minutes
- Training Requirements: Minimal
- Mode: Self or staff administered

GAIN Short Screen (GAIN-SS)



Purpose: Designed for use in general populations or where there is less control, to identify who has a disorder warranting further assessment or behavioral intervention, measuring change in the same, and comparing programs

GAIN Short Screen (GAIN-SS)



Scales: Can be used to generate symptom counts for

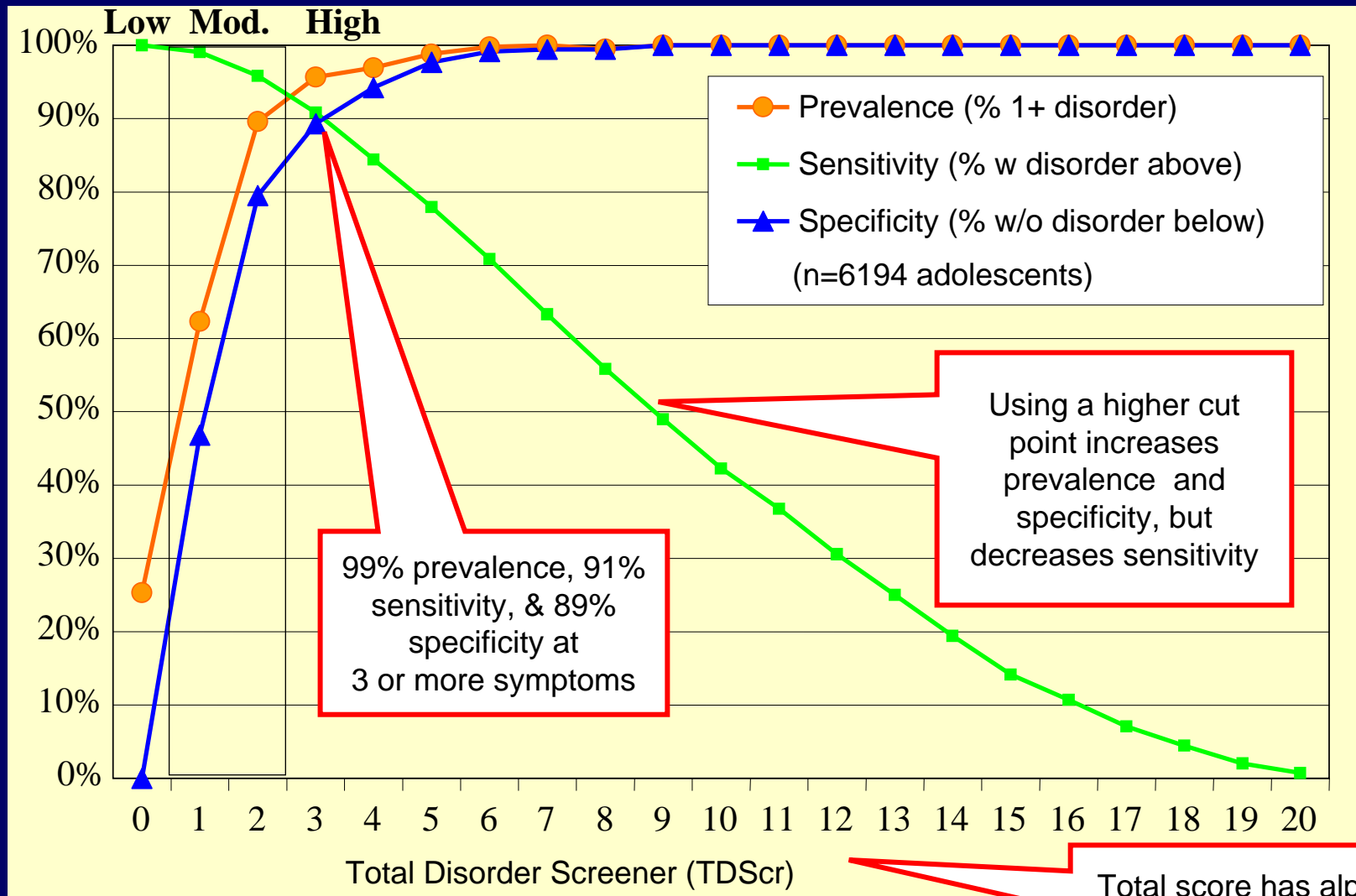
- Past month to measure change
- Past year to identify current disorders
- Lifetime to serve as covariates/validity checks

Total scale – 20 symptoms

Four subscales – 5 symptoms each

- Internal disorders: somatic, depression, suicide, anxiety, trauma
- Behavioral disorders: ADHD, CD
- Substance use disorders: abuse, dependence
- Crime/violence: interpersonal violence, property crime, drug related crime

GAIN Short Screen (GAIN-SS)



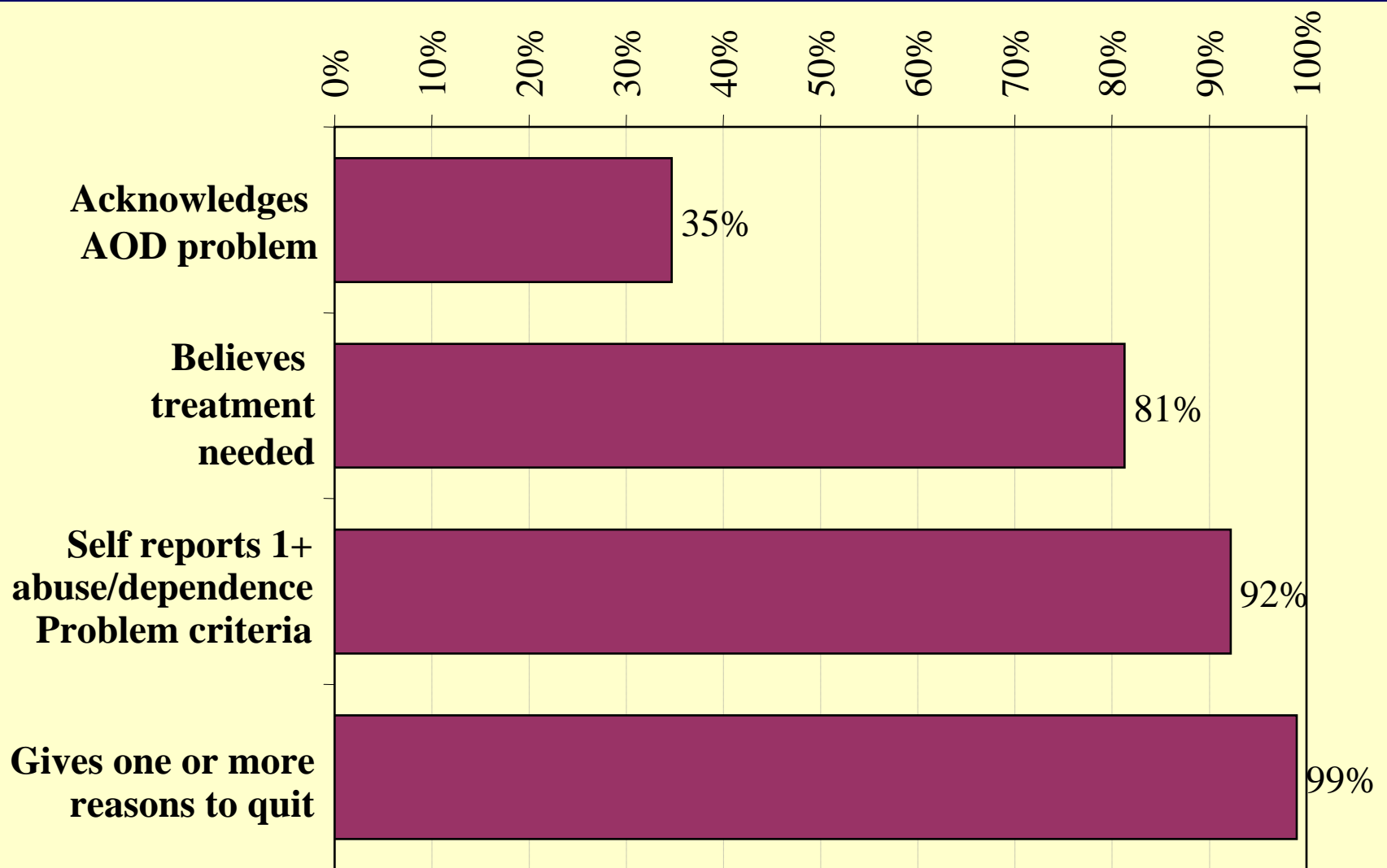
Source: Dennis et al 2005 GSS manual



Global Appraisal of Individual Needs Short Screener (GAIN-SS)

**Available at www.chestnut.org
(and it's free!)**

Mixed Problem Recognition



Source: CSAT AT Common GAIN Data set

Other Assessment and Treatment Resources

- **Assessment Instruments**

- **GAIN Coordinating Center** at www.chestnut.org/li/gain
- **CSAT TIP 3** at http://www.athealth.com/practitioner/ceduc/health_tip31k.html
- **NIAAA Assessment Handbook** at <http://www.niaaa.nih.gov/publications/instable.htm>

- **Treatment Programs**

- **CSAT CYT, ATM, ACC and other treatment manuals** at www.chestnut.org/li/apss/csat/protocols and on CDs provided
- **SAMHSA Knowledge Application Program (KAP)** at <http://kap.samhsa.gov/products/manuals>
- **NCADI** at www.health.org
- **National Registry of Effective Prevention Programs Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services** : <http://www.modelprograms.samhsa.gov>

Other Resources (continued)

- **Implementing Evidenced Based Practice**
 - **Central East ATTC Evidence Based Practice Resource Page**
http://www.ceattc.org/nidacsat_bpr.asp?id=LGBT
 - **Northwest Frontier ATTC Best Practices in Addiction Treatment: A Workshop Facilitator's Guide**
<http://www.nattc.org/resPubs/bpat/index.html>
 - **Turning Knowledge into Practice: A Manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practices**
<http://www.tacinc.org/index/viewPage.cfm?pagelid=114>
 - **Evidence-Based Practices: An Implementation Guide for Community-Based Substance Abuse Treatment Agencies**
<http://www.uiowa.edu/~iowapic/files/EBP%20Guide%20-%20Revised%205-03.pdf>
 - **National Center for Mental Health and Juvenile Justice Evidence Based Practice resource list at**
<http://www.ncmhjj.com/EBP/default.asp>

Other Resources (continued)



- **Society for Adolescent Substance Abuse Treatment Effectiveness (SASATE)**
www.chestnut.org/li/apss/sasate
- **2006 Joint Meeting on Adolescent Substance Abuse Treatment Effectiveness**
<http://www.mayatech.com/cti/jmate/>
 - next meeting March 27-29, 2006, Baltimore, MD



Treatment

The Current Renaissance of Adolescent Treatment Research

Feature	1930-1997	1997-2005
Tx Studies*	16	Over 200
Random/Quasi	9	44
Tx Manuals*	0	30+
QA/Adherence	Rare	Common
Std Assessment*	Rare	Common
Participation Rates	Under 50%	Over 80%
Follow-up Rates	40-50%	85-95%
Methods	Descriptive/Simple	More Advanced
Economic	Some Cost	Cost, CEA, BCA

* Published and publicly available

Adolescent Treatment Research Currently Being Published

- 1994-2000 NIDA's Drug Abuse Treatment Outcome Study of Adol. (DATOS-A)
- ★ 1995-1997 Drug Abuse Treatment Outcome Study (DOMS)
- ★ 1997-2000 CSAT's Cannabis Youth Treatment (CYT) experiments
- 1998-2003 NIAAA/CSAT's 15 individual research grants
- ★ 1998-2003 CSAT's 10 Adolescent Treatment Models (ATM)
- ★ 2000-2003 CSAT's Persistent Effects of Treatment Study (PETS-A)
- ★ 2002-2007 CSAT's 12 Strengthening Communities for Youth (SCY)
- 2002-2007 RWJF's 10 Reclaiming Futures (RF) diversion projects
- ★ 2002-2007 CSAT's 12+ Targeted Capacity Expansion TCE/HIV
- ★ 2003-2009 NIDA's 14 individual research grants and CTN studies
- ★ 2003-2006 CSAT's 17 Adolescent Residential Treatment (ART)
- 2003-2008 NIDA's Criminal Justice Drug Abuse Treatment Study (CJ-DATS)
- ★ 2003-2007 CSAT's 38 Effective Adolescent Treatment (EAT)
- ★ 2004-2007 NIAAA/CSAT's study of diffusion of innovation
- ★ 2004-2009 CSAT 22 Young Offender Re-entry Programs (YORP)
- ★ 2005-2008 CSAT 20 Juvenile Drug Court (JDC)
- ★ 2005-2008 CSAT 16 State Adolescent Coordinator (SAC) grants

Full (★) or Partial (●) use of the Global Appraisal of Individual Needs (GAIN)

Adolescent and Adult Treatment Program GAIN Clinical Collaborators



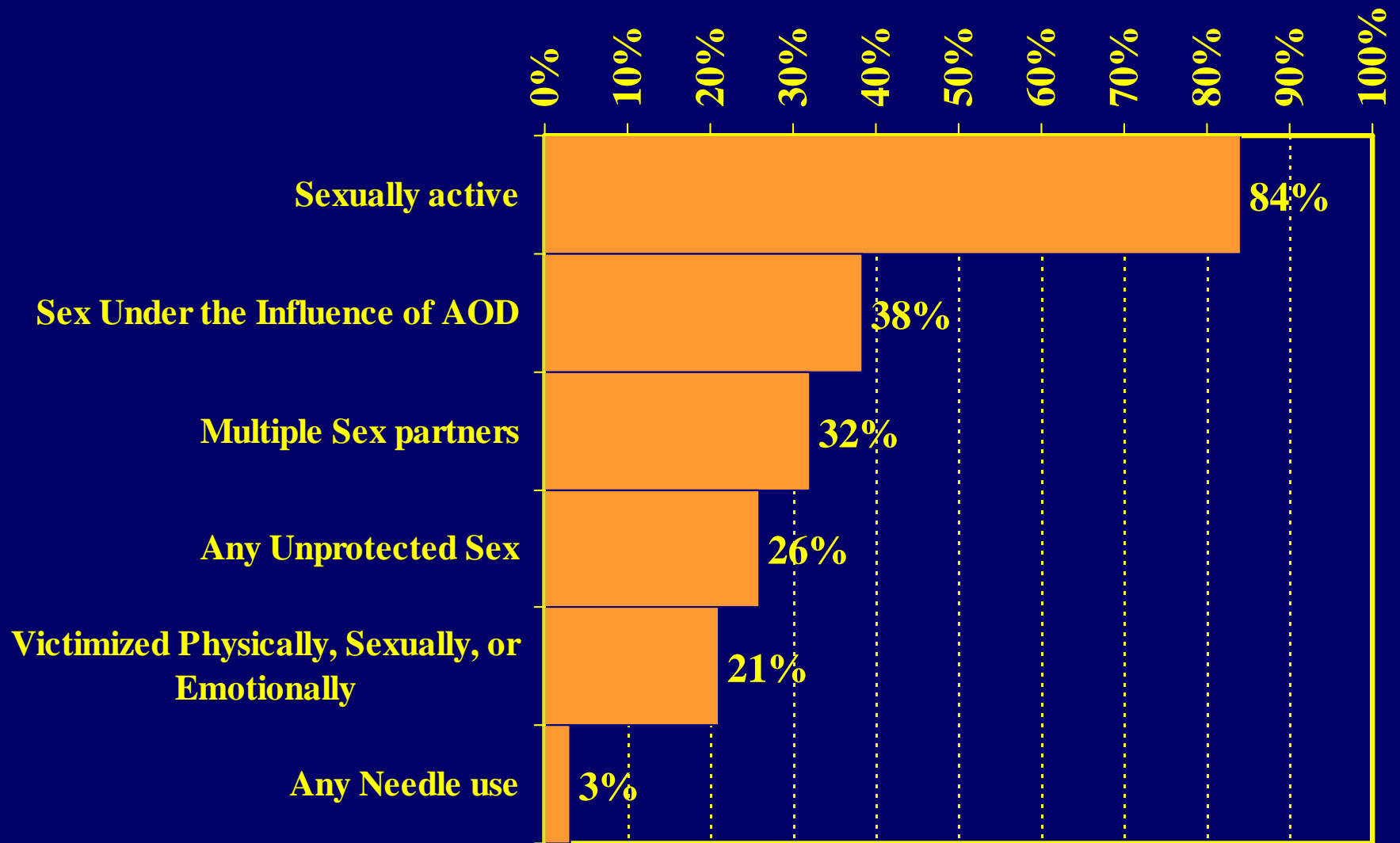
07/05

- ★ One or more state or county wide systems uses the GAIN
- ★ One or more state or county wide systems considering using the GAIN

CSAT Adolescent Treatment (AT) Outcome Data Set

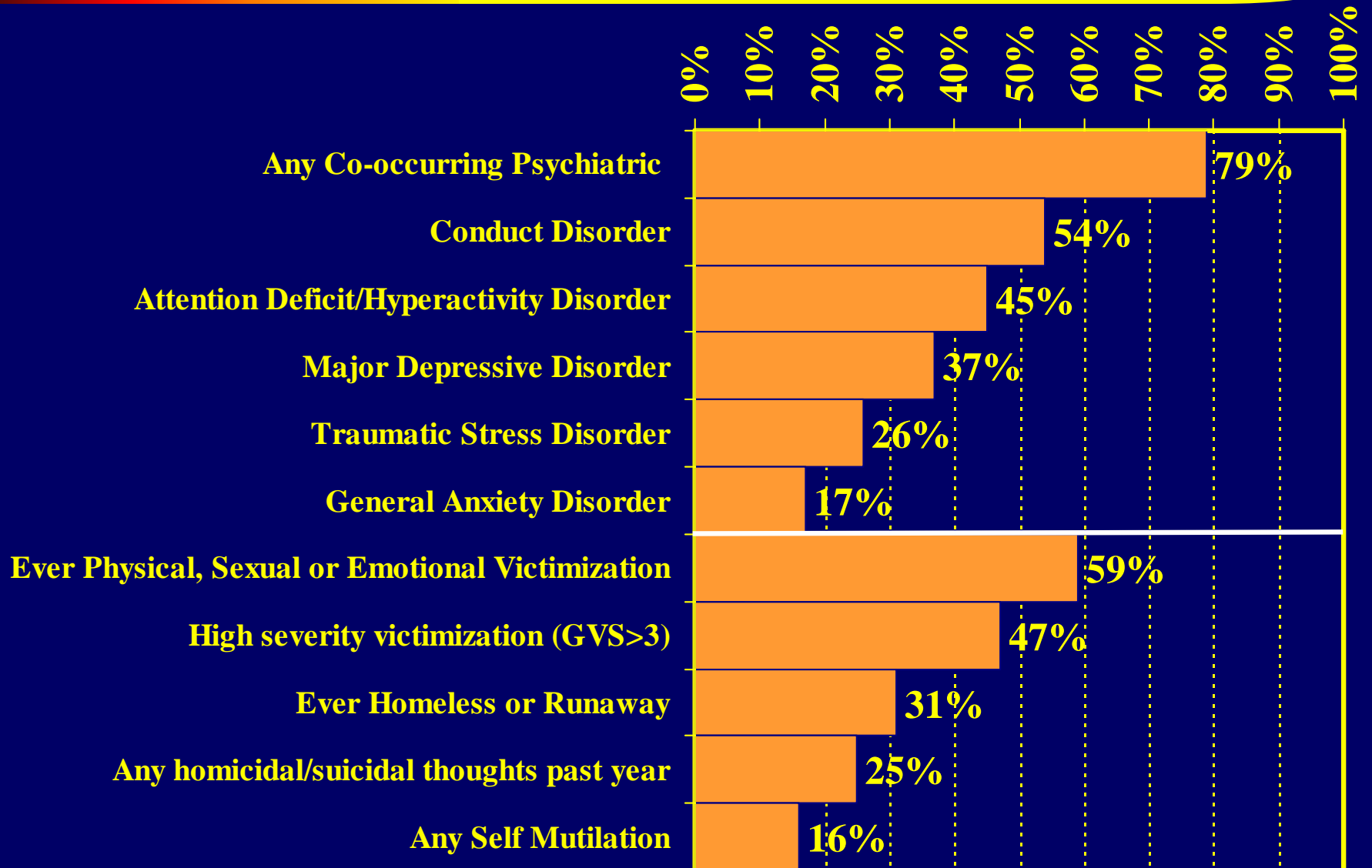
- Recruitment:** 1998-2005 (updated annually)
- Sample:** The 2005 CSAT adolescent treatment data set included data with 1 to 4 follow-ups on 9,276 unique adolescents from 72 local evaluations
- Levels of Care:** Early Intervention, Outpatient, Intensive Outpatient, Short, Moderate & Long term Residential, Corrections Based and Post Residential Outpatient Continuing Care
- Instrument:** Global Appraisal of Individual Needs (GAIN) (see www.chestnut.org/li/gain)
- Follow-up:** Over 80% follow-up 3, 6, 9 & 12 months post intake
- Funding:** CSAT contract 270-2003-00006 and 72 individual grants

Past 90 day HIV Risk Behaviors



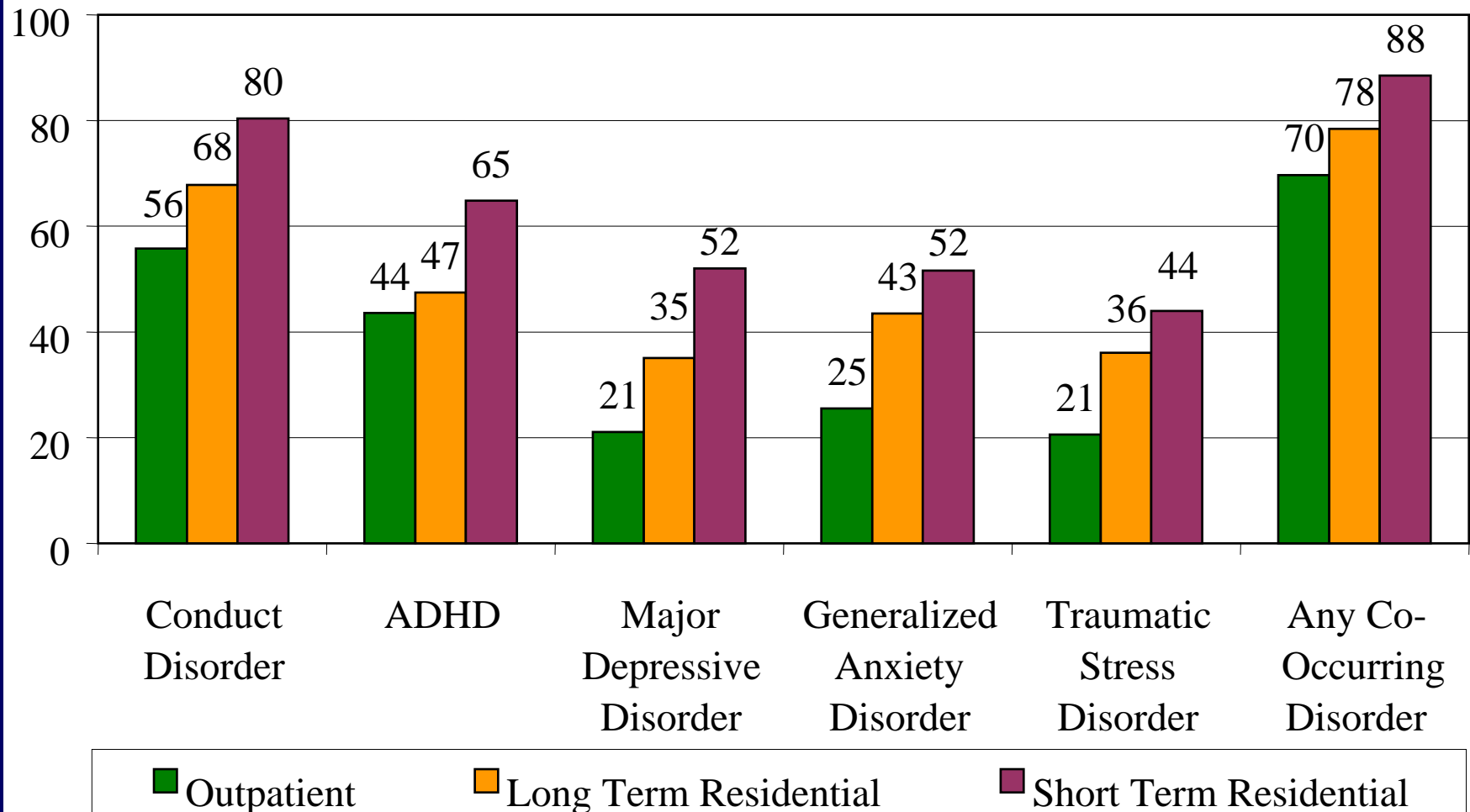
Source: CSAT AT Outcome Data Set (n=9,276 adolescents)

Co-Occurring Psychiatric Problems



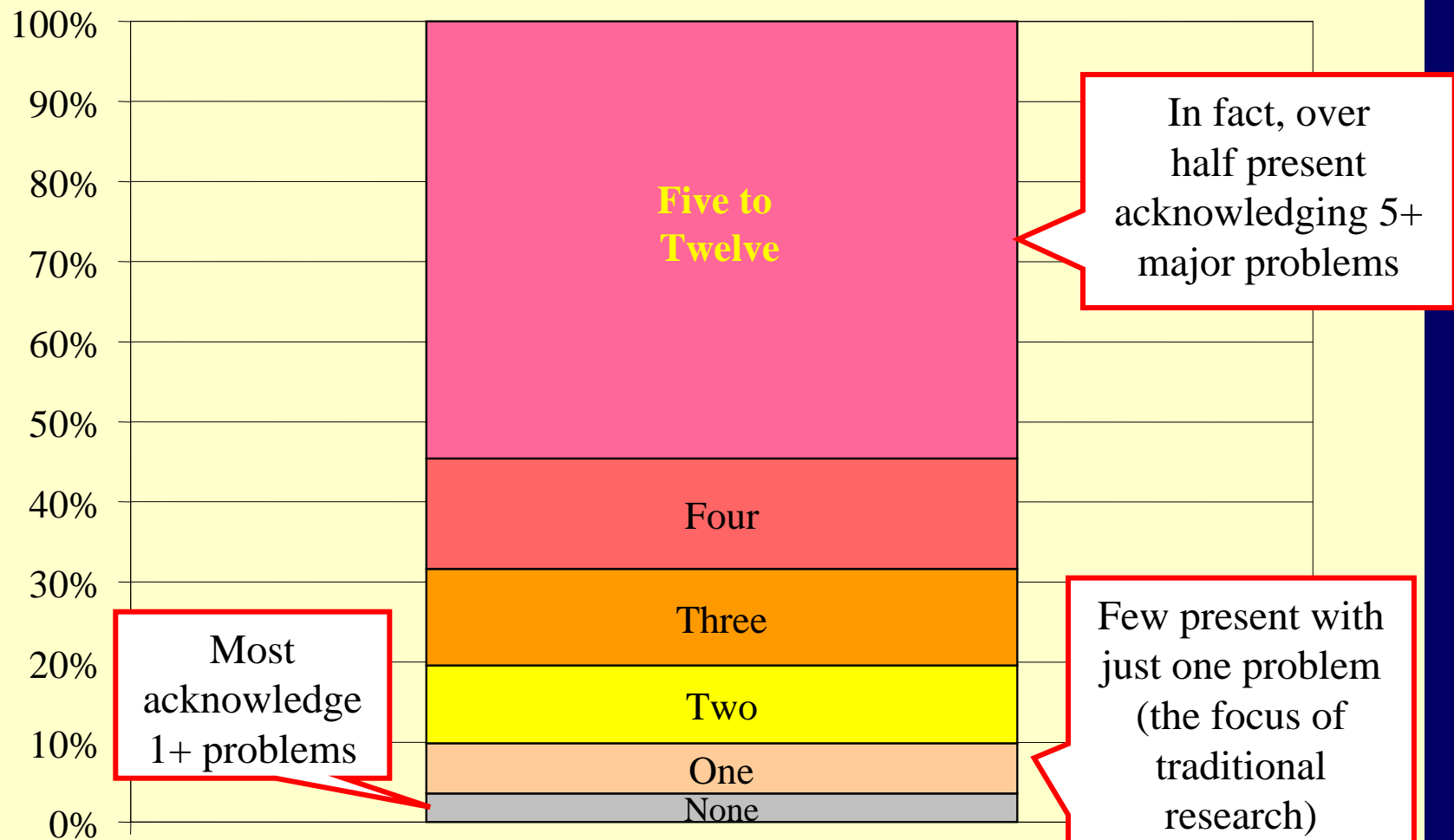
Source: CSAT AT Outcome Data Set (n=9,276 adolescents)

Multiple Co-occurring Problems Were the Norm and Increased with Level of Care



Source: CSAT's Cannabis Youth Treatment (CYT) and Adolescent Treatment Model (ATM),

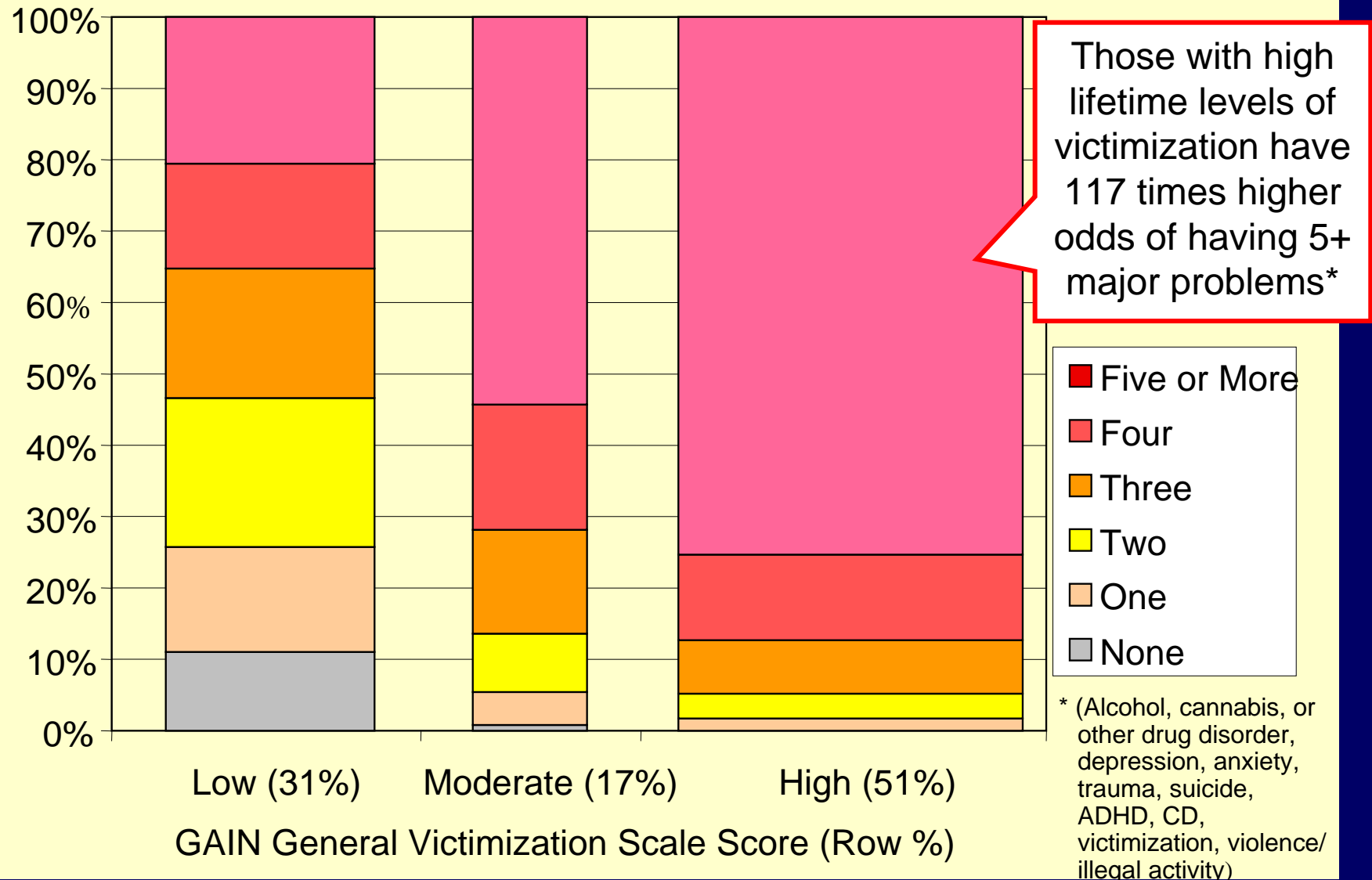
Multiple Problems* Are the Norm



* (Alcohol, cannabis, or other drug disorder, depression, anxiety, trauma, suicide, ADHD, CD, victimization, violence/ illegal activity)

Source: CSAT AT Common GAIN Data set

Number of Problems* by Severity of Victimization



Source: CSAT AT Common GAIN Data set (odds for High over odds for Low)



- **National Child Traumatic Stress Network**

http://www.nctsnet.org/nccts/nav.do?pid=hom_main

- **Promising Approaches for Behavioral Health Services to Children and Adolescents and Their Families**

http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/promising_approaches/default.cfm

Response/Resources



- **Co-occurring Center of Excellence (COCE)**
<http://coce.samhsa.gov/>
- **Integrated Co-occurring Treatment (ICT)**
Patrick Canary – pjkanary@sbcglobal.net
- **Co-occurring Substance Abuse and Mental Health Disorders in Adolescents**
<http://www.neattc.org/>

Response/Resources



- **VOICES – Stephanie Covington**

<http://www.stephaniecovington.com/>

- **7 Challenges**


Robert Schwebel

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Treatment Effectiveness

Presenting the findings from several recent treatment outcome studies on substance abuse treatment research, trauma and violence/crime



Meta Analysis of the Effectiveness of Programs for Juvenile Offenders

Offender Sample	N of Studies
Preadjudication (prevention)	178
Probation	216
Institutionalized	90
Aftercare	25
Total	509

Source: Adapted from Lipsey, 1997, 2005

Most Programs Are Actually a Mix of Components

**Average of 5.6 components distinguishable in
program descriptions from research reports**

Intensive supervision
Prison visit
Restitution
Community service
Wilderness/Boot camp
Tutoring
Individual counseling
Group counseling
Family counseling
Parent counseling
Recreation/sports
Interpersonal skills

Anger management
Mentoring
Cognitive behavioral
Behavior modification
Employment training
Vocational counseling
Life skills
Provider training
Casework
Drug/alcohol therapy
Multimodal/individual
Mediation

Most Programs Have Small Effects But Those Effects Are Not Negligible

- The median effect size (.09) represents a reduction of the recidivism rate from .50 to .46
- Above that median, most of the programs reduce recidivism by 10% or more
- One-fourth of the studies show recidivism reductions of 30% or more, that is, a recidivism rate of .35 or less for the treatment group compared to .50 for the control group
- The “nothing works” claim that rehabilitative programs for juvenile offenders are ineffective is false

Major Predictors of Bigger Effects



- 1. Chose a strong intervention protocol based on prior evidence**
- 2. Used quality assurance to ensure protocol adherence and project implementation**
- 3. Used proactive case supervision of individual**
- 4. Used triage to focus on the highest severity subgroup**

Impact of the Numbers of Favorable Features on Recidivism (509 JJ studies)

Number of favorable features	Distribution of programs	Percentage reduction in recidivism
0	7%	+12
1	50%	-2
2	27%	-10
3	15%	-20
4	2%	-24

Usual Practice has little or no effect

Some Programs Have Negative or No Effects on Recidivism

- “Scared Straight” and similar shock incarceration program
- Boot camps mixed – had bad to no effect
- Routine practice – had no or little ($d=.07$ or 6% reduction in recidivism)
- Similar effects for minority and white (not enough data to comment on males vs. females)
- The common belief that treating anti-social juveniles in groups would lead to more “iatrogenic” effects appears to be false on average (i.e., relapse, violence, recidivism for groups is no worse than individual or family therapy)

Program Types with Average or Better Effects on Recidivism

AVERAGE OR BETTER

Preadjudication

Drug/alcohol therapy
Parent training
Tutoring

Probation

Drug/alcohol therapy
Family counseling
Mentoring

Institutionalized

Family counseling
Cognitive-behavioral therapy
Employment/job training

BETTER/BEST

Interpersonal skills training
Employment/job training
Group counseling

Cognitive-behavioral therapy
Interpersonal skills training
Parent training
Tutoring

Behavior management
Group counseling
Individual counseling
Interpersonal skills training

Source: Adapted from Lipsey, 1997, 2005

Cognitive Behavioral Therapy (CBT) Interventions that Typically Do Better than Practice in Reducing Recidivism (29% vs. 40%)

- Aggression Replacement Training
- Reasoning & Rehabilitation
- Moral Reconciliation Therapy
- Thinking for a Change
- Interpersonal Social Problem Solving
- Multisystemic Therapy
- Functional Family Therapy
- Multidimensional Family Therapy
- Adolescent Community Reinforcement Approach
- MET/CBT combinations and Other manualized CBT

NOTE: There is generally little or no differences in mean effect size between these brand names

Implementation Is Essential

(Reduction in Recidivism from .50 Control Group Rate)

Program Implementation:
Amount of Service, Quality of Delivery

Program Type Grouped by Rank	Low	Medium	High
Group 1 (best)	24%	34%	46%
Group 2	16%	30%	40%
Group 3	6%	20%	32%
Group 4 (poorest)	0%	12%	24%

The best is to have a strong program implemented well

Thus one should optimally pick the strongest intervention that one can implement well

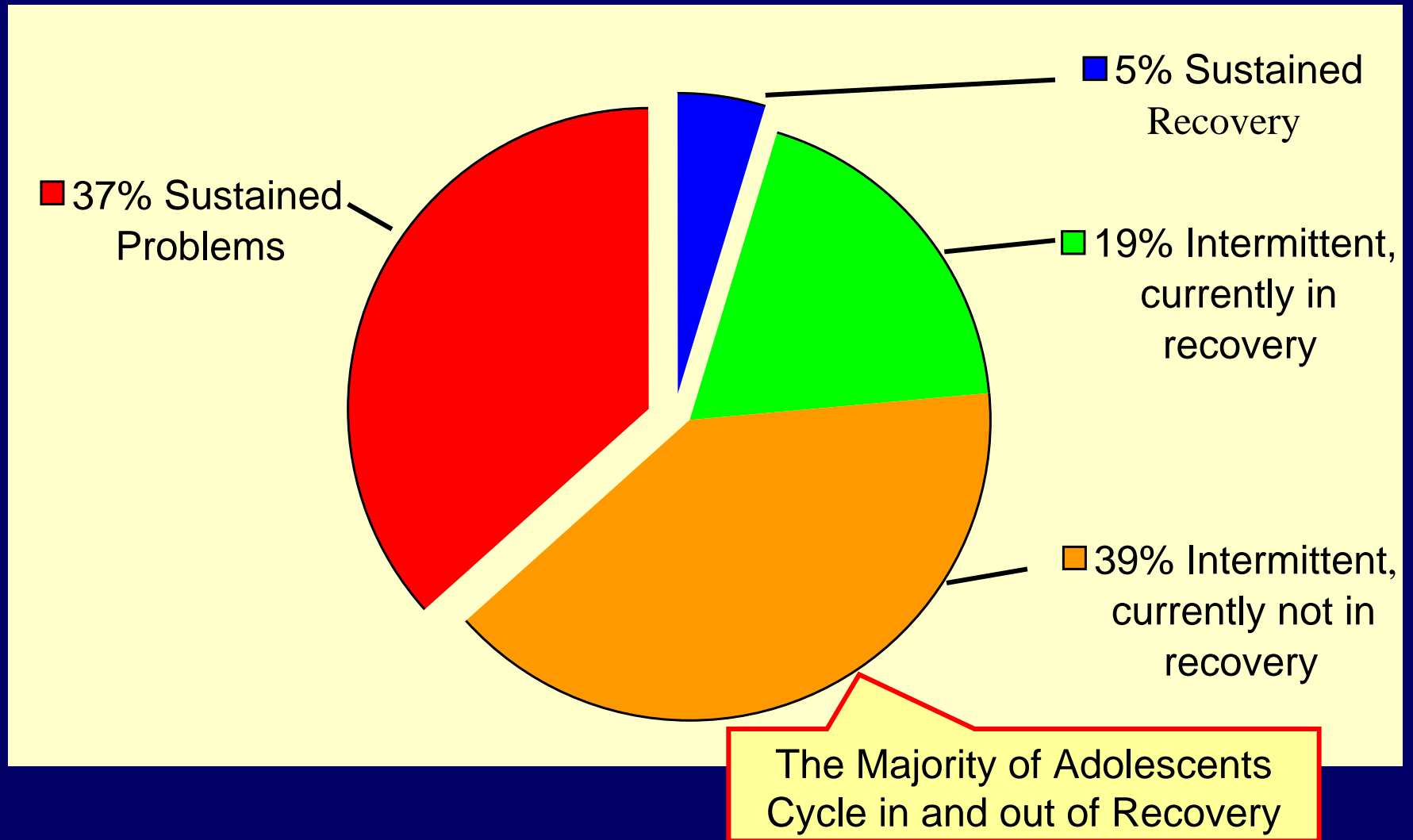
The effect of a well implemented weak program is as big as a strong program implemented poorly

Assertive Adolescent and Family Treatment



- **15 Sites Funded**
- **Adolescent Community Reinforcement Approach (A-CRA) followed by Assertive Continuing Care (ACC)**

Cumulative Recovery Pattern at 30 Months

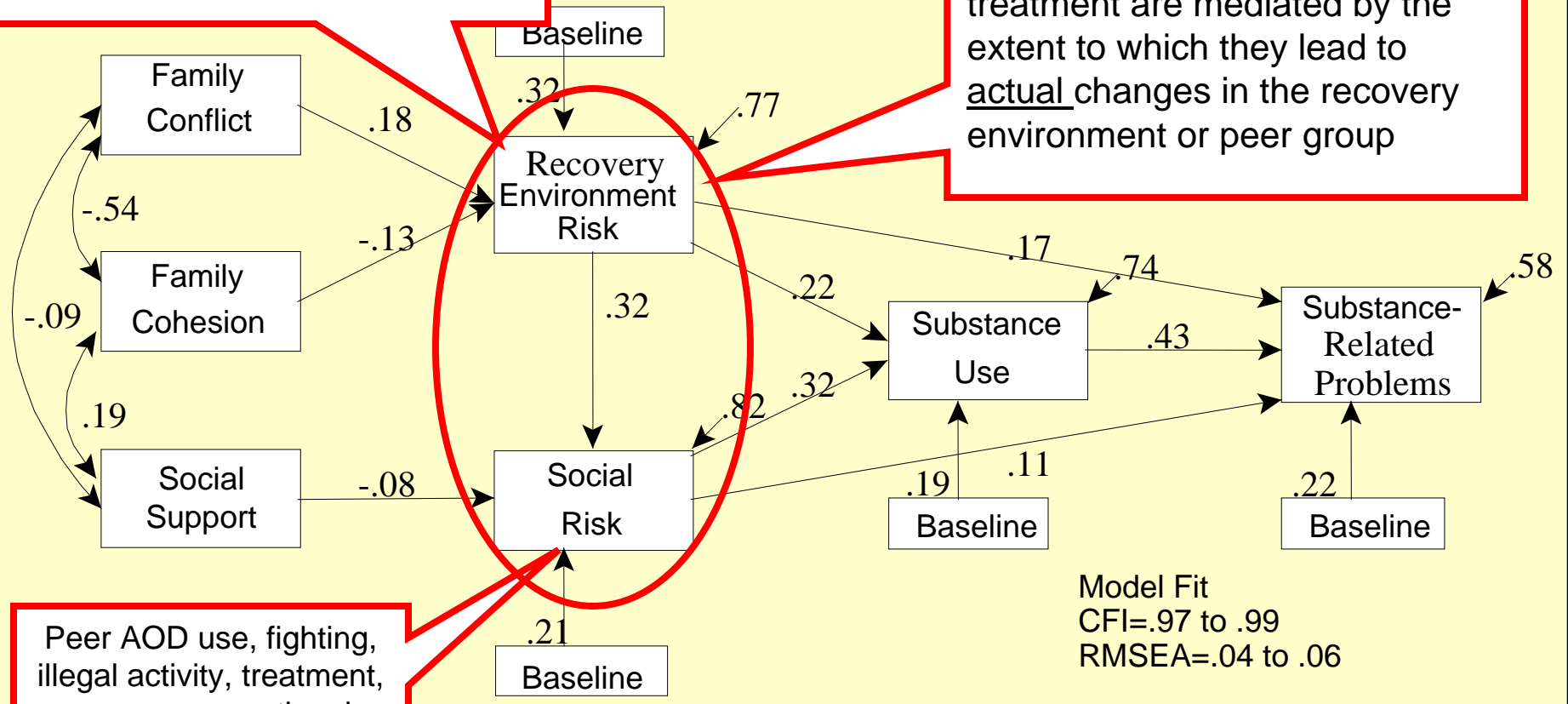


Source: Dennis et al, forthcoming

Environmental Factors Are Also the Major Predictors of Relapse

AOD use in the home, family problems, homelessness, fighting, victimization, self help group participation, structure activities

The effects of adolescent treatment are mediated by the extent to which they lead to actual changes in the recovery environment or peer group



Peer AOD use, fighting, illegal activity, treatment, recovery, vocational activity

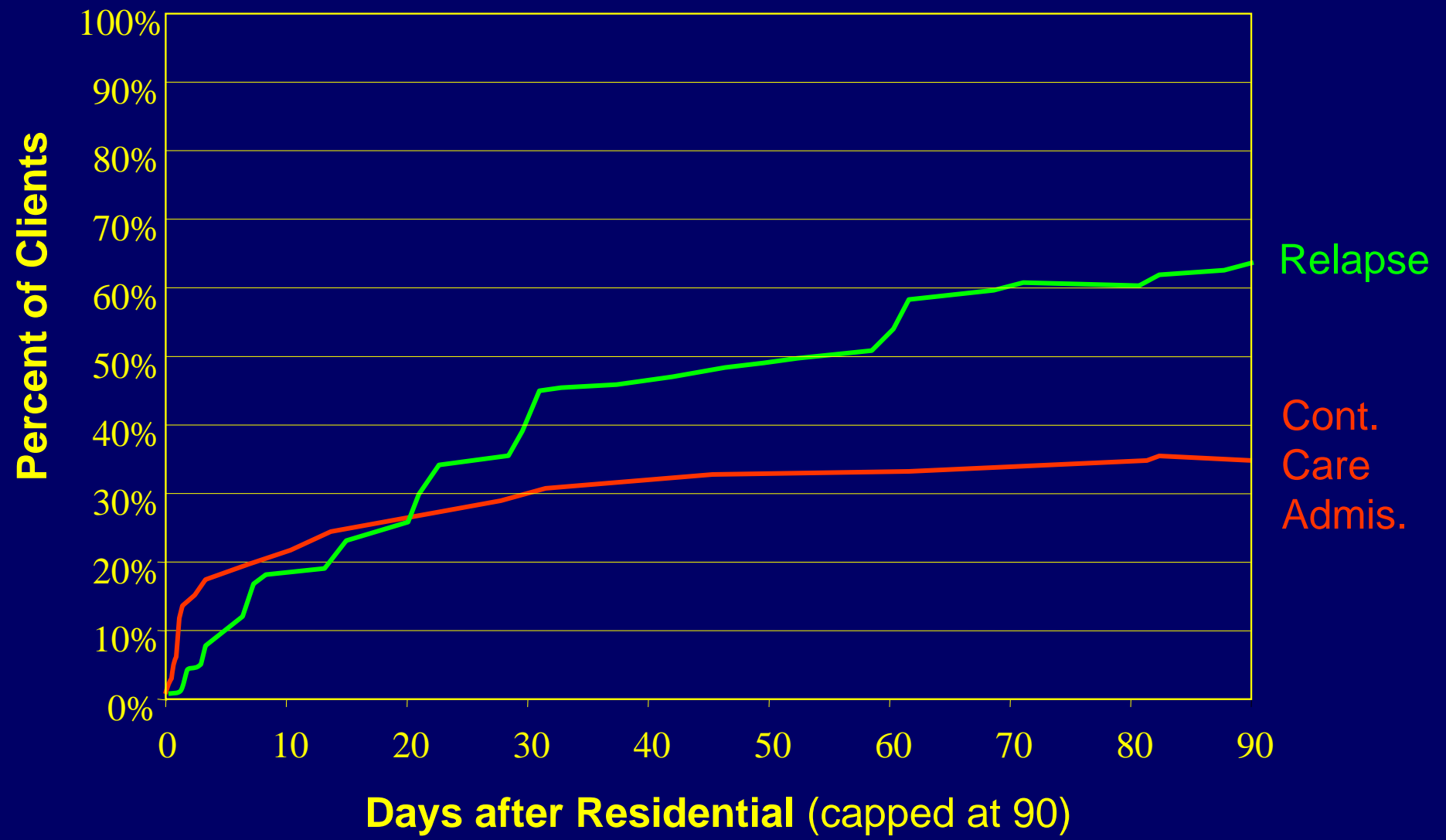
Source: Godley et al (2005)

Findings from the Assertive Continuing Care (ACC) Experiment



- 183 adolescents admitted to residential substance abuse treatment
- Treated for 30-90 days inpatient, then discharged to outpatient treatment
- Random assignment to usual continuing care (UCC) or “assertive continuing care” (ACC)
- Over 90% follow-up 3, 6, & 9 months post discharge

Time to Enter Continuing Care and Relapse after Residential Treatment (Age 12-17)



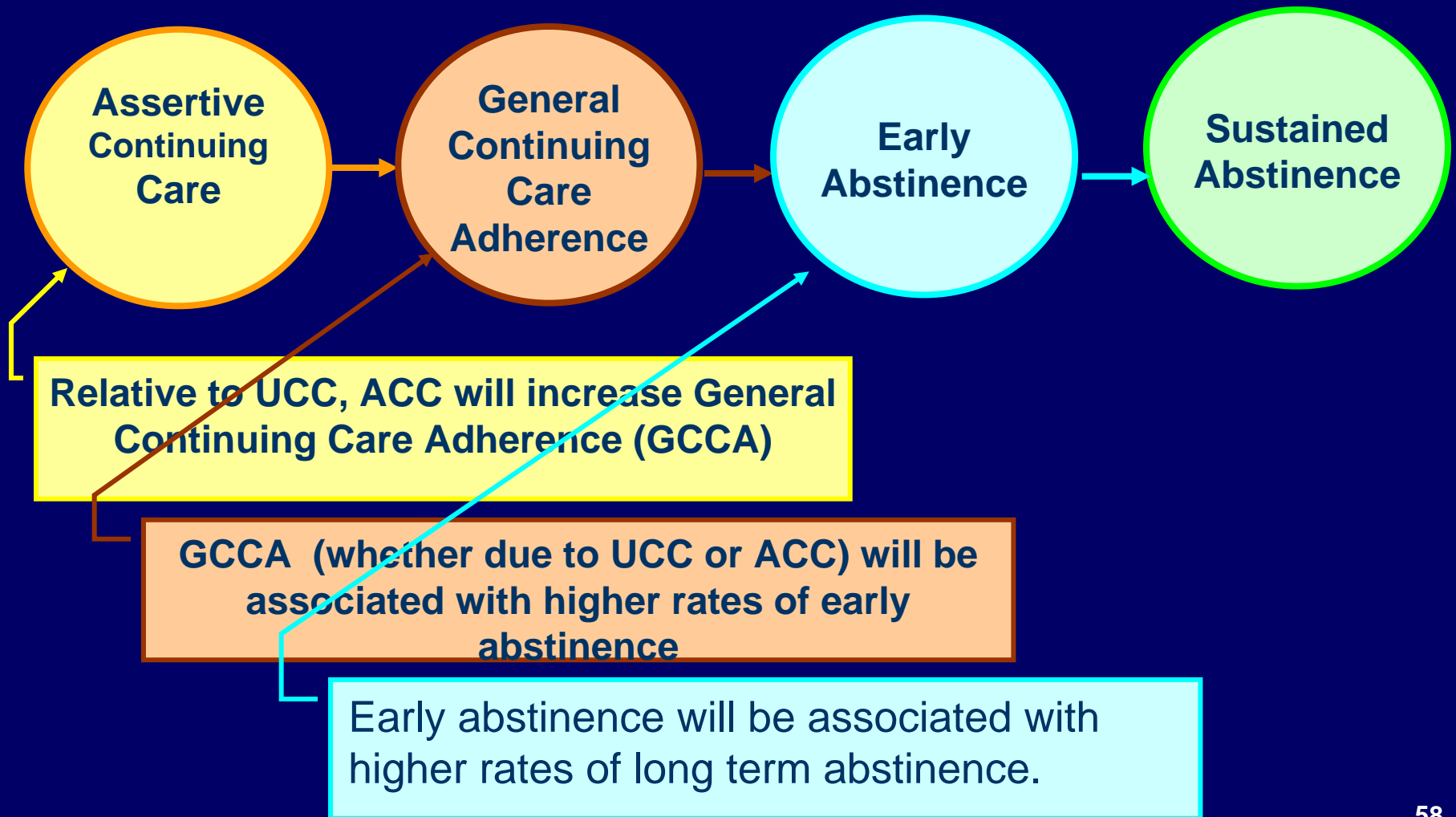
Source: Godley et al., 2004 for relapse and 2000 Statewide Illinois DARTS data for CC admissions

ACC Enhancements

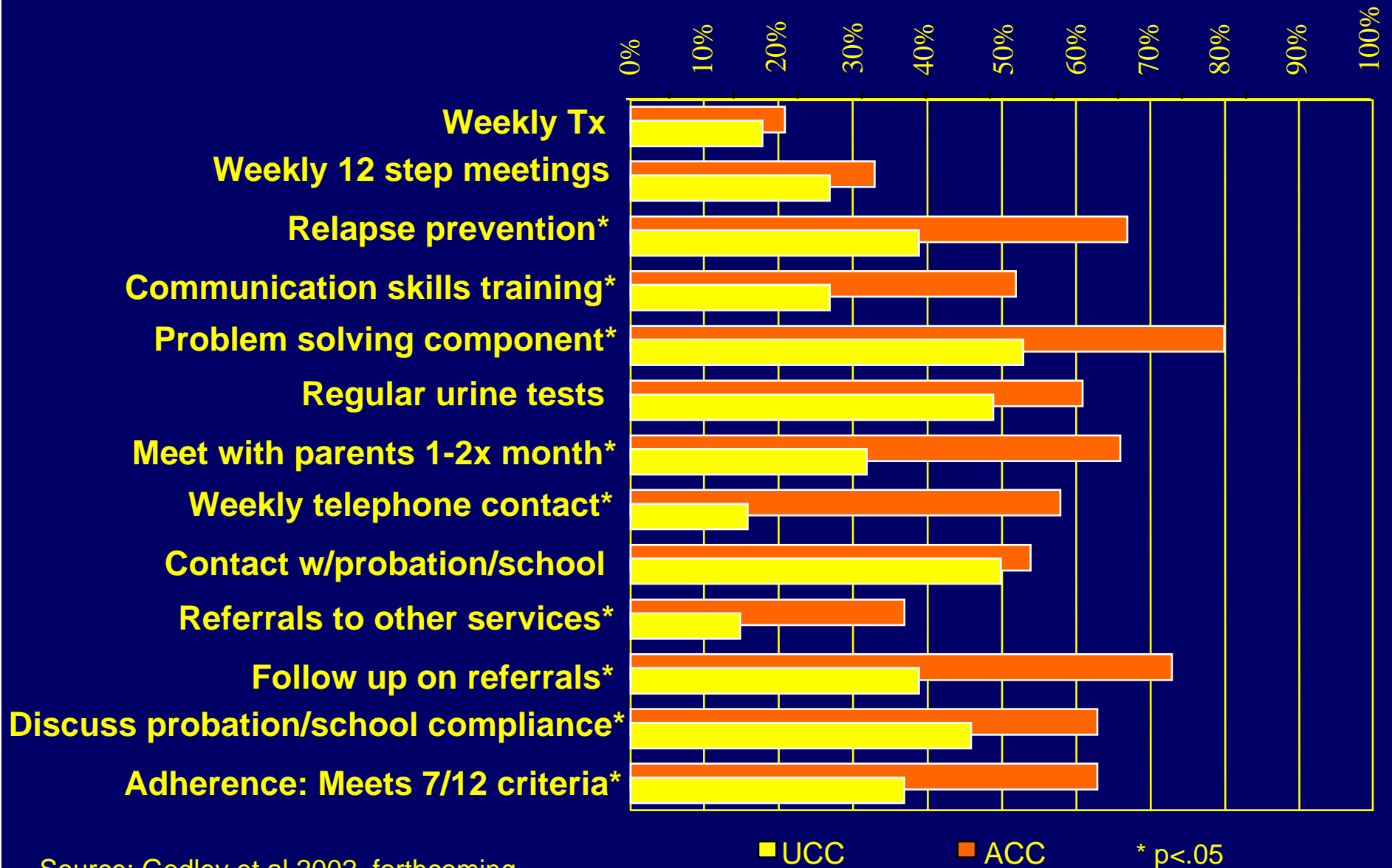


- **Continue to participate in UCC**
- **Home visits**
- **Sessions for adolescent, parents, and together**
- **Sessions based on ACRA manual (Godley, Meyers et al., 2001)**
- **Case management based on ACC manual to assist with other issues (e.g., job finding, medication evaluation)**

Assertive Continuing Care (ACC) Hypotheses

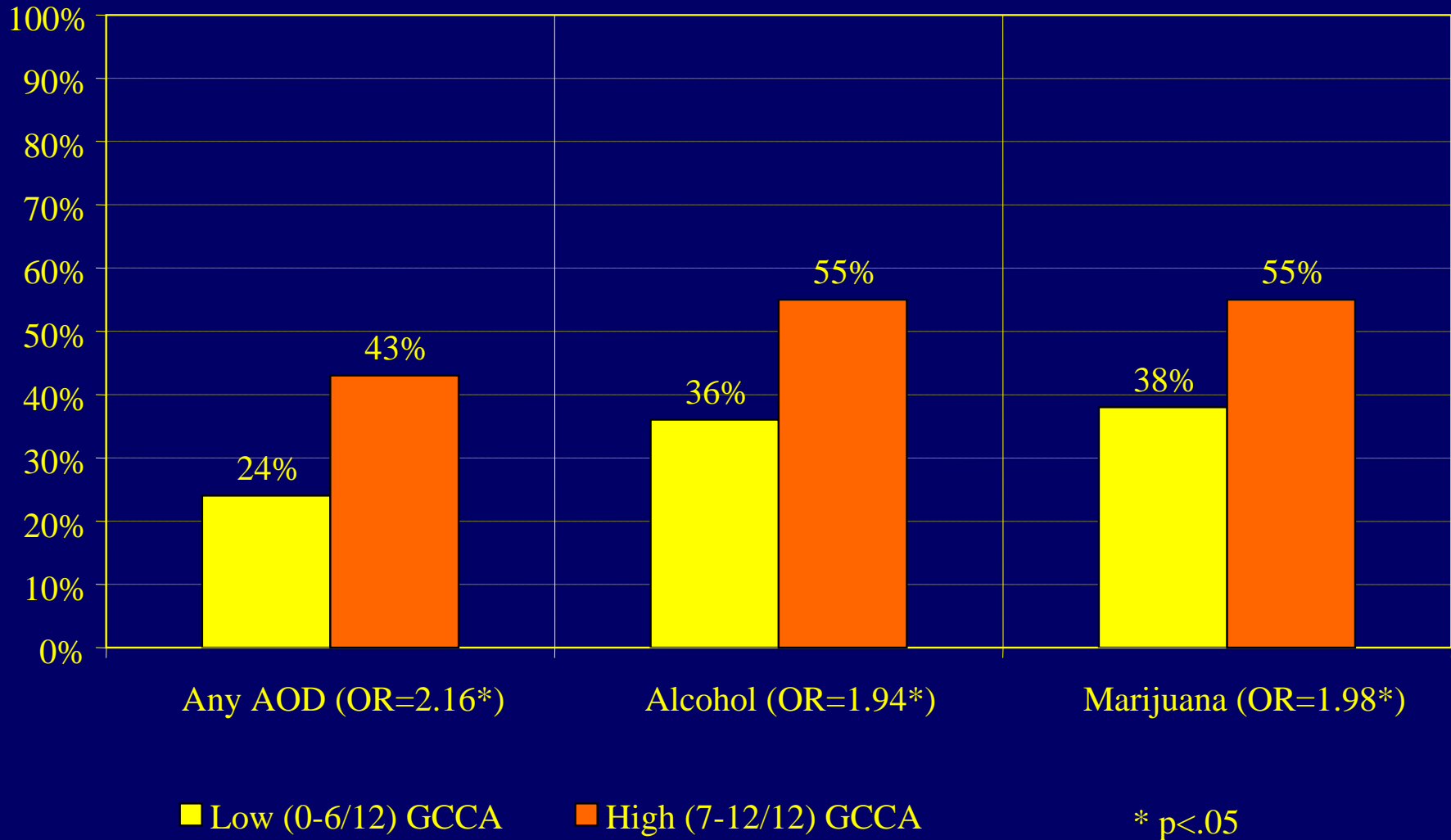


ACC Improved Adherence

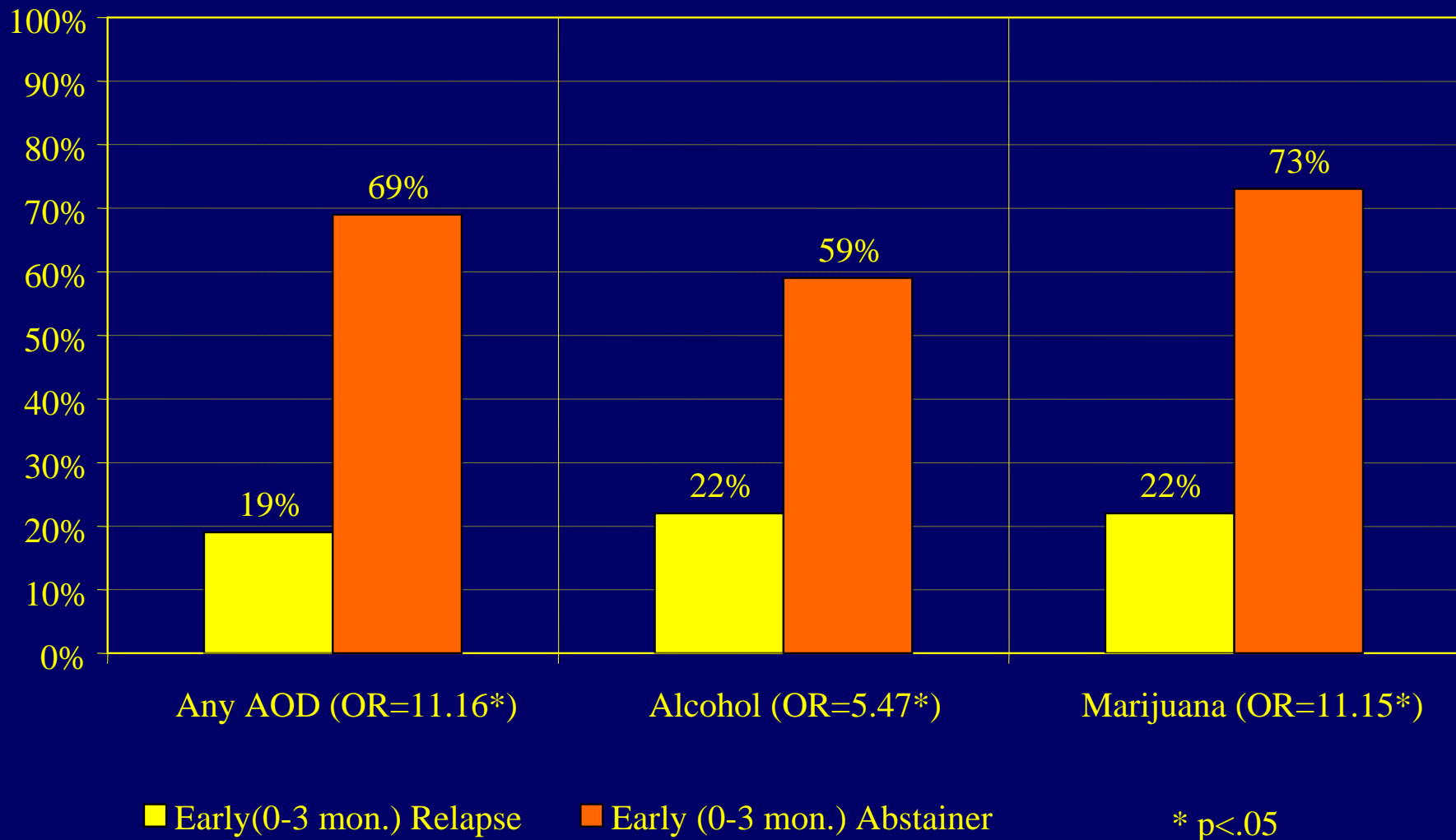


Source: Godley et al 2002, forthcoming

GCCA Improved Early (0-3 month) Abstinence



Early (0-3 month) Abstinence Improved Sustained (4-9 month) Abstinence



Source: Godley et al 2002, forthcoming

Post Script on ACC

- The ACC preliminary and main findings have been published
- Several CSAT grantees are replicated ACC as part of the Adolescent Residential Treatment (ART) program
- A second ACC experiment is currently under way to evaluate whether providing contingency management will further improve outcomes
- The ACC manual is being distributed via the website and the CD you have been provided