Evidence-Based Practice for Adolescent Substance Abuse:

A Primer for Providers and Families

JULY 2008

Published by the UNCG Center for Youth, Family, and Community Partnerships in collaboration with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), US Department of Health and Human Services (grant number 6 J79 T117387-02-2). Reproduction of the text is encouraged; however, copies may not be sold. NC DHHS DMH/DD/SAS, Community Policy Management, Substance Abuse Services, 3005 Mail Service Center, Raleigh, NC 27699-3005; 919-733-4670; 919-733-4556 (fax)

Evidence-Based Practice for Adolescent Substance Abuse: Summary Sheets

Table of Contents

SAMHSA

dhhs nc department of health and human services

NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Center for youth, family, and community Partnerships

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Acknowledgements

The Center for Youth, Family, and Community Partnerships and the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services would like to thank the following people for their contributions to the development of this primer:

Gail Cormier
Executive Director, North Carolina Families United

April Jackson Gilfort, Ph.D.

Susan Harrington Godley, Rh.D.
Senior Research Scientist, Chestnut Health Systems

Olga E. Hervis, MSW, LCSW
Co-developer, Brief Strategic Family Therapy
Director, Family Therapy Training Institute of Miami

George A. Parks, Ph.D.
Associate Director, Addictive Behaviors Research Center
Department of Psychology, University of Washington

Paul Savery
Adolescent Substance Abuse Treatment Coordinator
North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Erin Triplett, B.A.
GAIN Project Coordinator, GAIN Coordinating Center
Lighthouse Institute, Chestnut Health Systems

We also would like to acknowledge the following individuals at the Center for Youth, Family, and Community Partnerships who contributed to the development of the primer:

Erin Balkind, Kim Freund, Kelly Graves, Jason Johnson, Caroline Moseley, Terri Shelton, Megan Smell, Chris Townsend, and Claretta Witherspoon

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

The Adolescent Substance Abuse Treatment Project

The Adolescent Substance Abuse Treatment Project

The Adolescent Substance Abuse Treatment Project (ASATP) began as part of a three-year grant awarded to North Carolina by Substance Abuse Mental Health Services Administration (SAMHSA) and the Center for Substance Abuse Treatment (CSAT) for statewide adolescent substance abuse treatment coordination. The University of North Carolina at Greensboro's (UNCG) Center for Youth, Family and Community Partnerships (CYFCP) assists the Division in the implementation of the state's infrastructure grant.

The goal of the grant is to strengthen the ability of North Carolina to deliver substance abuse treatment to youth and their families that is:

- *Comprehensive;*
- *Effective;*
- *Accessible;*
- *Affordable; and*
- *Integrated into the continuum of services for children and youth.*

In addition to this primer, a variety of resources have been made available through this grant, including:

Grant Website

Information about the grant, upcoming trainings, and the other resources listed below can be accessed through the grant's website which can be found at: http://www.uncg.edu/csr/asatp/index.htm. The grant contains resources targeted for both providers as well as families and youth.

Information Clearinghouses, Fact Sheets, and Resources

Several clearinghouses and fact sheets on adolescent substance abuse, person-centered thinking and planning, system of care, evidenced-based practices in screening, assessment, and treatment are available via the *"Resources"* link on the grant website.

For Families and Youth

There are resources specifically geared for families and youth. On the grant website, look on the left hand side and click on the link for either caregivers (http://www.uncg.edu/csr/asatp/helpforcaregivers.htm) or for youth (http://www.uncg.edu/csr/asatp/helpforyouth.htm). There is also a list serve, monthly updates, and quarterly newsletters for families and youth with substance abuse challenges.

For Providers

There is an active list serve for adolescent substance abuse/mental health providers. Monthly updates in addition to a quarterly newsletter provide information about the grant, updates from the field, SAMHSA, and the state as well as updates on available training opportunities. To access this information click onto the link http://www.uncg.edu/csr/asatp/helpforproviders.htm.

To sign up for either the family/youth and/or provider network, just log onto http://www.uncg.edu/csr/asatp/form1.html and complete the form.

If you are interested in more information about the project, have suggestions for training topics, or are interested in becoming part of the provider or family/youth networks, please contact the grant staff at: bestasat@uncg.edu.

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Introduction

What is the purpose of this primer?

The Adolescent Substance Abuse Treatment Project at UNCG's Center for Youth, Family, and Community Partnerships compiled this document to serve as a comprehensive introduction to several important evidence-based practices for adolescent substance abuse assessment and treatment. Inclusion in this primer does not constitute an endorsement of the approach by our agency. Our intent is to provide information to parents and providers for assistance in making informed choices about which treatment approaches to use.

What do all the acronyms mean?

There are many different acronyms used in adolescent substance abuse treatment. Many practitioners (and researchers) use these terms without completely understanding their meaning. At the back of this primer, Appendix A explains the most commonly used terms and acronyms. This section should provide much needed clarity around the various treatments and practices. Please do not practice without it!

What information does this primer contain?

This primer contains a brief overview of 11 evidence-based treatment programs (EBTs) and one evidence-based assessment commonly used in the adolescent substance abuse field. They were selected because of their inclusion in several databases of EBPs and the strength of the literature available on them. See Appendix B for a matrix that summarizes those databases and which EBPs they include. A brief description of behavior therapy and cognitive-behavioral therapy comes first because they form the foundation of several of the treatments presented. We also are including a four-page fact sheet for caregivers that provides a brief description of each approach. The primer concludes with additional resources highlighting the most current available research on each EBP (see Appendix C).

What is the difference between Evidence-Based Practice and Practice Based Evidence?

As defined by the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP), EBPs "...generally refer to approaches to prevention or treatment that are validated by some form of documented scientific evidence."[1] This simply means that several clinical research studies showed the treatment was effective. EBP promotes high quality care and better outcomes for adolescents with substance use disorders.[2]

Practice-Based Evidence (PBE) is the flip side of EBP, but is proving to be just as important. Communities, agencies and families create PBE when they attempt to adapt treatment practices to their unique needs.[3] Treatment methods based on the intuition and experience of practitioners and families often are tough to measure with traditional research methods. Practitioners of PBE merge culturally and traditionally defined methods of treating substance abuse to insure a comprehensive, or wellness, approach to treatment. PBE informs selected interventions with the history and culture of the community in which it is practiced. PBE accepts that treatment should be grounded by scientific evidence, but also recognizes that treatment is most successful when informed by community experience.[2] The involvement of an adolescent and his or her family is a strong component of PBE, with the adolescent and his or her caregivers collaborating with the provider on goals, success measures, and the best ways to achieve success.

In adolescent substance abuse treatment, EBPs range widely in their design and application, from individual forms of counseling to family therapy. The expected outcomes for EBPs often are not the same, though all seek a measurable reduction in the negative consequences of substance abuse. EBPs used without regard for a person's cultural, family, or community values will likely lower long term, positive outcomes.[3] Similarly, PBE by itself is a subjective collection of judgments about what might work. Therefore, achieving the best outcomes for adolescents requires some combination of EBP and PBE.[3]

(continued next page)

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

What is the Cannabis Youth Treatment Series (CYT)?

The Cannabis Youth Treatment Series (CYT) is not a treatment unto itself. It is a compilation of five treatments for adolescent substance abuse. The Substance Abuse Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) funded this treatment series in 1997.[4] The goals were: 1) to determine the relative effectiveness as well as the costs and benefits of five treatment programs for adolescent substance abuse, and 2) to provide evidence-based, manualized treatment models for community practice.[4] This study was the first of its kind, arising out of a need to better understand how to treat adolescent substance abuse according to unique developmental needs. Until this time, all adolescent treatment was based on adult treatments modified to fit adolescents. The CYT study paved the way for further research in adolescent-specific treatment modalities for substance abuse. This research continues contribute to viable evidence to support the premise that adolescents with substance abuse problems benefit the most from treatment programs designed specifically for them.

The five treatments included in CYT are the Adolescent Community Reinforcement Approach (A-CRA), the Family Support Network (FSN), Motivational Enhancement Therapy and Cognitive-Behavioral Therapy (MET/CBT5, MET/CBT12), and Multidimensional Family Therapy (MDFT). For a comprehensive introduction to each treatment, see Diamond et al.[5] The CYT authors chose these treatments because they were grounded in theory, appropriate for community implementation, had a draft manual, and showed some promising evidence of effectiveness. The researchers randomly assigned participants to a treatment condition and evaluated outcomes at intake, three, six, nine, and twelve months.[4] The researchers used urine tests and family reports to validate self-reports of abstinence.[4] Six hundred adolescents between the ages of 12 and 18 participated in the study at four different sites across the country for two trials.[4] Inclusion criteria were: used cannabis in the past 90 days; met American Society of Addiction Medicine (ASAM) 1996 criteria for outpatient or intensive outpatient treatment; and met one or more of the DSM-IV criteria for cannabis abuse or dependence.[4]

The two central outcomes of the study were days of abstinence from baseline to 12-months and whether the adolescent was in recovery by the end of treatment, defined as living in the community and reporting no past-month substance use or related problems at the follow-up interview.[6] Cost effectiveness (the cost per day of abstinence and cost per person in recovery) also was measured.[6] All of the treatments demonstrated increases in days abstinent and percent in recovery; however, the outcome measures did not differ significantly between treatment modalities.[6] The same was also true for percent in recovery.[6] The positive effects of each treatment modality were stable through the 12-month follow up interview.[6] Cost effectiveness differed significantly between conditions, with MET/CBT5 being more cost effective in trial one and A-CRA being more cost effective in trial two, compared to all other treatment modalities.[6]

What directories are available for Evidence-Based Practice?

Several evidence-based practice registries have been created and are publicly accessible. For the purposes of this primer, we have consulted five such databases: the State of Oregon's Addictions and Mental Health (AMH) Approved Practices; SAMHSA's National Registry of Evidence-based Programs & Practices (NREPP); Helping America's Youth (HAY) Community Guide; the University of Washington's EBP Database; and the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Model Programs Guide. We picked these five databases because they contain a comprehensive set of criteria that together present a consensus on how to best determine whether or not a treatment is evidence-based and applicable in a community setting.

Each database uses a slightly different set of criteria to determine whether a treatment is "evidenced-based," although there are some commonalities:

- Positive outcomes - must demonstrate a reduction in problem behaviors or risk factors;
- Evaluation design - must be experimental and published in peer-reviewed journals;
- Fidelity - must demonstrate consistency between with the experimental design and the actual intervention; and
- Conceptual framework and standardization – must include a manual or materials are available to the public.

Three of the databases have their own rating system to provide an additional level of information. SAMHSA rates the quality of the research and the readiness for dissemination of each intervention on a scale from zero to four, zero being the lowest. OJJDP and HAY have the same rating system but the names for the levels are different. The type of experimental design and the strength of the positive results determine each level. The levels are as follows:

- Exemplary/Level 1 – experimental design and random assignment of subjects, evidence demonstrates prevention and/or reduction;
- Effective/Level 2 – experimental or quasi-experimental with a comparison group, evidence suggests effectiveness; and
- Promising/Level 3 – limited research methods, strong theoretical base, evidence is promising but more research is needed.

(continued next page)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Appendix B contains a matrix that lists each of the EBPs discussed in this primer and indicates which databases have included each EBP. If there is more information available on the approach through the database, there is a link in the corresponding box. The information we have provided is the most up to date and available as of July 2008. Information in the databases are subject to change because of funding, re-reviewing periods, and changes in criteria.

Databases:

- State of Oregon's AMH Approved Practices: http://www.oregon.gov/DHS/mentalhealth/ebp/main.shtml
- SAMHSA's NREPP: http://www.oregon.gov/DHS/mentalhealth/ebp/main.shtml
- HAY Community Guide: http://guide.helpingamericasyouth.gov/programtool-ap.cfm
- University of Washington's EBP Database: http://www.adai.washington.edu/ebp/
- OJJDP Model Programs Guide: http://www.dsgonline.com/mpg2.5/mpg_index.htm

Additional Sites:

- Ohio State EBP Database: http://www.alted-mh.org/ebpd/search.php
- Hawaii Dept of Health EBP Services: http://hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html

REFERENCES

1. What is Evidence-Based? (n.d.) Retrieved March 31, 2008 from http://www.nrepp.samhsa.gov/about-evidence.htm

2. Isaacs, M.R., Huang, L.N., & Echo-Hawk, H. (2005). *The road to evidence: The intersection of evidence-based practices and cultural competence in children's mental health.* Washington, DC: The National Alliance of Multi-Ethnic Behavioral Health Associations.

3. Lau, A.S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice, 13,* 295-310.

4. Dennis, M., Titus, J.C., Diamond, G., Donaldson, J., Godley, S.H., Tims, F.M., et al. (2002). The cannabis youth treatment (CYT) experiment: Rationale, study design and analysis plans. *Addiction, 97,* 16-34.

5. Diamond, G., Godley, S.H., Liddle, H.A., Sampl, S., Webb, C., Tims, F.M., et al. (2002). Five outpatient treatment models for adolescent marijuana use: A description of the cannabis youth treatment interventions. *Addiction, 97,* 70-83.

6. Dennis, M., Godley, S.H., Diamond, G., Tims, F.M., Barbor, T., Donaldson, J., et al. (2004). The cannabis youth treatment (CYT) study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment, 27,* 197-213.

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Foundations of Evidence-Based Practice

How did the field of Adolescent Substance Abuse Treatment begin?

According to the Monitoring the Future Study, adolescent drug use started increasing in the early 1990s, while perceived harm and risk from drug use declined.[1] Adolescents also were using drugs at earlier ages than in years past, causing a myriad of public health problems such as injuries, behavioral and mental disorders, and sexually transmitted diseases.[1,2] Because adolescents are fundamentally different from adults, they often do not benefit from adult treatment approaches.[2] For example, adolescents differ from adults in the developmental issues they are dealing with, the values and beliefs that they hold, and environmental considerations such as school climate and peer influences.[2] The field of adolescent substance abuse treatment began to grow when clinicians and researchers sought to reconcile the gap in services. Highlighted below are Behavior Therapy (BT), Cognitive Behavior Therapy (CBT), and Motivational Interviewing (MI); these are modalities which serve as foundations for many evidence-based practices.

Behavior Therapy - Also known as Behavior Management /Modification

Behavior Therapy's (BT) major tenant is that behavior is learned and, thus, can be unlearned.[3] Therapy reduces or extinguishes maladaptive behaviors by reinforcing desired behaviors with contingency rewards.[4] Reinforcement schedules are set up to increase positive behaviors (i.e., abstinence) and decrease negative behaviors (i.e., substance use).[4] Change occurs by only reinforcing desirable behaviors and ignoring or punishing negative behaviors. This is done with practices such as homework, self-recordings of behaviors between sessions, increasing positive activities, setting up reinforcement schedules for outside of sessions, and extensive praise for progress.[5] In this model, thoughts do not really matter; instead, behavioral contingencies ultimately drive behaviors.

BT has not been approved for adolescent substance abuse treatment as a stand-alone practice. However, Contingency Management (CM), providing rewards for meeting treatment milestones, appears to offer some promising results.[3,4] See Appendix C at the end of this primer for current research articles.

In addition, read The Center for Youth, Family, & Community Partnerships' (CYFCP) fact sheet and April 2008 newsletter devoted to this practice. You can access both at www.uncg.edu/csr/asatp.

Cognitive-Behavioral Therapy

Cognitive-Behavioral Therapy (CBT) is a psychotherapeutic approach that emphasizes the connections between how we think, feel, and behave.[6] The "cognitive" part of CBT involves examining the automatic, irrational, and maladaptive thoughts related to a particular person or problem.[6] In the case of substance use, CBT would examine thought patterns during, before, and after the use of any substance.[7] A person may have recurring automatic thoughts that cause them to seek out substances. The clinician using cognitive-behavioral therapy would help the person identify these thoughts and realize the connection they have to the resulting behaviors.[7] The person is then taught other coping behaviors to use instead of substance use.[8] The person also is taught that the automatic thoughts and beliefs are not necessarily true and are akin to hypotheses that need to be tested.[8] The "behavior" part of CBT involves examining what behaviors occur before, during, and after the use of any substance that result from the underlying irrational beliefs.[7] This examination is sometimes called a functional analysis and can help a person identify and cope with triggers.[7]

CBT strategies include skills training using role plays, behavioral modeling, practice exercises, realistic goal setting, and reward contingencies (i.e., reinforcement).[6,7,9] Another technique involves documenting automatic thoughts to become more aware of patterns of thinking.[8] In this sense, CBT views substance use as a learned behavior that can be unlearned through the development and use of new skills, more adaptive thinking processes, and a change in reinforcement patterns.[6,7,9]

(continued next page)

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Motivational Interviewing

Motivational Interviewing (MI) is a client-centered, directed method that providers can integrate into any therapeutic process.[10] Some use MI as a stand-alone approach while others incorporate it into other approaches. The goal is to enhance a person's internal motivation for change.

The basic MI principles include:[10]

1) Expressing empathy—demonstrating an understanding of the client's perspective;
2) Developing discrepancy—exploring the difference between where clients currently are and where they want to be;
3) Rolling with resistance—accepting a reluctance to change as a normal occurrence; and
4) Supporting self-efficacy—embracing client autonomy and helping them develop confidence in their ability to change.

Another important consideration in MI is The Stages of Change Model developed by Prochaska & DiClemente in 1982.[11,12] The stages are as follows:

Pre-contemplation: Adolescents in this stage typically do not recognize that they have a problem and do not see any reason to change. Adolescents seemingly are unaware of the consequences of their behavior and do not typically respond well when other people try to talk to them about the problem. Because there is no intention for change, change is not likely at this stage. Individuals at this stage are typically referred by others to treatment (rather than self-referred).

Contemplation: Ambivalence is the hallmark of this stage, with adolescents typically thinking about making changes, but not sure they are currently able to do so. These adolescents are able to see the pros and cons of their behavior, but may not be ready to move towards change as the pros tend to weigh more heavily in their decisions.

Preparation: Adolescents in this stage typically accept the need to change and plan to take action. They see the benefits of changing as outweighing the costs and begin to take small steps toward reaching their ultimate goals. Depending upon the outcomes of these small steps, the risk of relapse back into the contemplation stage is great. Thus, adolescents in this stage should be provided with additional support and encouragement.

Action: Adolescents in this stage typically use a set of identified strategies to directly change their behavior. For the greatest likelihood of relapse prevention and maintenance of positive behavioral changes, clients should be in the action phase for at least six months.

Maintenance: Adolescents in this stage continually work toward strengthening the positive outcomes of the action stage and minimizing the risk for relapse. Adolescents spend different amounts of time in this stage (depending on the presenting issue) with some remaining in this stage for life.

Adolescents can begin anywhere within these stages, and thus, clinicians are encouraged to work with them where they are.[11,12] Clients in the pre-contemplation and contemplation stages may benefit from more consciousness-raising and environmental reevaluation techniques.[11,12] Self-evaluation may be beneficial for clients in the preparation stage.[11,12] Some techniques for clients in the action and maintenance phases include self-liberation and contingency management.[11,12]

See Appendix C at the end of this primer for more current research articles on the use of MI as a brief intervention for adolescent substance abuse and the stages of change model.

REFERENCES

1. Johnston, L.D., O'Malley, P.M., & Bachman, J.G. (2001). *The Monitoring the Future national survey results on adolescent drug use: Overview of key findings, 2000* (NIH Publication No. 01-4923). Rockville, MD: National Institute on Drug Abuse.

2. Winters, K.C. (1999). *Treatment of adolescents with substance use disorders: Treatment Improvement Protocol (TIP) series 32* (DHHS. Publication No. (SMA) 99-3283). Rockville, MD: Substance Abuse and Mental Health Services Administration (SAMHSA).

3. Higgins, S., & Petry, N. (1999). Contingency management: incentives for sobriety. *Alcohol Research & Health, 23*(2), 122-127.

4. Petry, N. (2000). A comprehensive guide to the application of contingency management procedures in clinical settings. *Drug and Alcohol Dependence, 58*, 9-25.

5. Onken, L.S., Blaine, J.D., & Boren, J.J. (1993). *Behavioral treatments for drug abuse and dependence.* Rockville, MD: National Institute on Drug Abuse. http://www.nida.nih.gov/pdf/monographs/137.pdf

(continued next page)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

6. Waldron, H.B., & Kaminer, Y. (2004). On the learning curve: The emerging evidence supportive cognitive-behavioral therapies for adolescent substance abuse. *Addiction, 99*, 93-105.

7. Carroll, K.M. (1998). *Therapy manuals for drug addiction. A cognitive-behavioral approach: Treating cocaine addiction*. (NIH Publication Number 98-4308). Rockville, MD: National Institute on Drug Abuse (NIDA). http://www.drugabuse.gov/pdf/CBT.pdf

8. Warman, D.M., & Beck. (2003). *About treatments & supports: Cognitive-behavioral therapy*. Retrieved July 21, 2008 from http://www.nami.org/Template.cfm?Section=About_Treatments_and_Supports&template=/ContentManagement/ContentDisplay.cfm&ContentID=7952

9. Kadden, R., Carroll, K., Donovan, D., Cooney, N., Monti, P., Abrams, D., et al. (1995). *Cognitive behavioral coping skills therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence.* (NIH Publication No. 94-3724). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism (NIAA). http://pubs.niaaa.nih.gov/publications/MATCHSeries3/Project%20MATCH%20Vol_3.pdf

10. Rollnick, S., & Miller, W.R. (n.d.). *What is MI?* Retrieved July 20, 2008 from http://www.motivationalinterview.org/clinical/whatismi.html.

11. Prochaska, J.O. & DiClemente, C.C. (1982). Transtheorical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research, & Practice, 19*, 276-288.

12. Prochaska, J.O., & Prochaska, J.M. (1999). Why don't continents move? Why don't people change? *Journal of Psychotherapy Integration, 9*, 83-102.

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Global Appraisal of Individual Needs (GAIN)

The Global Appraisal of Individual Needs (GAIN) is an assessment instrument used for diagnosis, placement, and treatment planning. GAIN is used in a variety of settings, including outpatient, intensive outpatient, partial hospitalization, methadone, short-term residential, long-term residential, therapeutic community, and correctional programs. The GAIN is used for individuals 12 years of age and older.

Content
The GAIN has eight core sections:

- Background
- Substance Use
- Physical Health
- Risk Behaviors & Disease Prevention
- Mental & Emotional Health
- Environment & Living Situation
- Legal
- Vocational

Each section contains questions on the recency of problems, extent of symptoms, and recent prevalence. The assessment also looks at service utilization including lifetime use, recency of use, and frequency. There are over 100 scales and subscales included in the GAIN.

Assessments:
GAIN-Short Screener (GAIN-SS) = 2-page (5 minute) screening form for use with the general population to quickly identify those with internalizing or externalizing disorders, issues with crime/violence, and/or substance use.
GAIN-Quick (GAIN-Q) = 11-15 page (20-30 minute) form for basic assessment of a targeted population to determine eligibility and need for referral. It can also be used to support motivational interviewing related to substance use.
GAIN-Initial (GAIN-I) = 61-100 page (120 minute) standardized assessment for use in substance abuse diagnosis, placement, treatment planning, outcome monitoring, economic analysis, and/or program planning. This assessment can also be used to support motivational interviewing.

Materials and Administration
The GAIN is available in both paper and electronic forms. It can be administered with a computer or with paper and pencil. The assessment should be completed by a certified GAIN administrator to maintain validity and reliability.

Norms
Norms have been established for both adults and adolescents across levels of care. Additional norms are currently being established by gender and race.

Reliability and Validity
Studies have shown good test/retest reliability (r = .7 to .8) as well as diagnostic consistency (kappa of .5 to .7) with both adults and adolescents.

Licensure, Training, and Support
Chestnut Health Systems holds the copyright of the GAIN. GAIN trainings are held throughout the year and continuing education credits (CEU) are available. GAIN software, which includes data entry as well as the ability to create clinical reports, is available for purchase. There is a licensing fee of $100 per agency for five years of access to the family of GAIN assessments.

References:
The official website for the assessment: http://www.chestnut.org/li/gain

Contact GAINInfo@chestnut.org for information on training, licensing, or software purchase.

Dennis, M.L., Chan, Y.F., & Funk, R. (2006). Development and validation of the GAIN Short Screener (GSS) for psychopathology and crime/violence among adolescents and adults. *American Journal on Addictions, 15*, 80-91.

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

MET/CBT 5 and 12

Part of the Cannabis Youth Treatment (CYT) Series

Description:

MET/CBT is a specific treatment protocol that involves the integration of sessions of Motivational Enhancement Therapy (MET) and Cognitive-Behavioral Therapy (CBT). It is an adaptation of adult treatment for adolescents. This sheet focuses on how these elements are combined for adolescent cannabis users. The treatment protocol is available in two versions: 5 sessions or 12 sessions. *See the info sheet on MET (page 16) or the Foundations section for information on CBT (page 7) for more info on the individual elements.*

MET/CBT should not be used with adolescents who:

- Require more than outpatient treatment
- Have severe conduct disorder
- Have poly-substance dependence problems
- Cannot participate in group due to social anxiety
- Have an acute psychological disorder that would affect their participation

MET involves a functional analysis, which is a collaboration between the therapist and adolescent to examine the antecedents, behaviors, and consequences (ABCs) of substance use behaviors. Efforts are made to try to alter maladaptive patterns at each stage so that negative thoughts and behaviors are extinguished and positive thoughts and behaviors are reinforced.

CBT involves role playing, reviewing progress, real life practice exercises, and teaching relaxation techniques and coping skills. Refer to the treatment manual for specific timelines, procedural steps, handouts, and material lists for each session. In many cases, urinalysis is conducted at the beginning of specific treatment sessions.

Treatment Logistics:

Appropriate Age Range: 12-18
Participants: Adolescent
# of Sessions: 5 or 12 - The first two are 60 min., individual, MET sessions. The rest are 75 min., group, CBT sessions. Therapy is preceded by an initial assessment session.

Session 1: Motivation– Building
Session 2: Goal-Setting
Session 3: Marijuana Refusal Skills
Session 4: Enhancing Social Support & Increasing Pleasant Activities
Session 5: Planning for Emergencies & Coping with Relapse
Session 6: Problem Solving
Session 7: Anger Awareness
Session 8: Anger Management
Session 9: Effective Communication
Session 10: Coping with Cravings and Urges to Use Marijuana
Session 11: Depression Management
Session 12: Managing Thoughts

Evidence-Base:

Refer to Appendix B for a matrix that lists the organizations that have approved MET/CBT as an EBP or go to http://www.uncg.edu/csr/asatp/ebp/ebpmatrix.pdf to view it online. When compared with a longer relapse prevention treatment (18 sessions), there were no post-treatment differences regarding abstinence, days of use, severity of problems, or dependence symptoms, suggesting that brief treatment is just as effective as a longer-term approach. Brief treatments also are more cost effective than longer programs.

MET is applicable to adolescents because of its less directive, non-confrontational approach in teaching clients coping skills. Group therapy seems to work well with teens based on the power of peer influence in adolescence. Previous research has found contagion effects in adolescent group therapy; however, research through the CYT study found no such effects.

Reference to Treatment Manual:

Sampl, S., & Kadden, R. (2001). *MET and CBT for adolescent cannabis users: 5 sessions, CYT series, volume 1.* (BKD384). Rockville, MD: CSAT, SAMHSA. http://kap.samhsa.gov/products/manuals/cyt/

Webb, C., Scudder, M., Kaminer, Y., & Kadden, R. (2001). *MET and CBT supplement: 7 sessions of CBT for adolescent cannabis users, CYT series, volume 2.* (BKD385). Rockville, MD: CSAT, SAMHSA.

Additional References:

There are three additional volumes of the CYT Series. *(see ARCA, FSN, and MDFT info sheets)*

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Family Support Network (FSN)

Part of the Cannabis Youth Treatment (CYT) Series

Description:

The Family Support Network (FSN) for Adolescent Substance Abuse is based on the belief that adolescents who do not have sufficient family support and structure will have a harder time during recovery. Dimensions of authority, roles, rules, boundaries, communication, and routines are all important.

The goals of FSN are to:

- Include the family in the process of recovery
- Use communication and relationship building to increase family functioning
- Improve parental effectiveness in responding to substance abuse and accompanying behaviors
- Assess the family's commitment to recovery and suggest changes in the family's problem solving approaches

FSN consists of case management, parent education, and in-home family therapy. Specifics of each component include:

Parent Education

- Create healthy families by building competence
- Discuss methods for coping with parenting pressure
- Encourage appropriate authority, roles, rules, boundaries, communication, and routines

In-Home Therapy

- Assess family environment
- Individualize the treatment process
- Increase family commitment to recovery
- Create an alliance between adolescent, family, & program

Case Management

- Assist families in overcoming barriers to participation
- Identify service and treatment needs
- Monitor progress & attendance - act to prevent drop-out
- Provide motivational enhancement
- Make referrals & connect families with services
- Engage participants in a community support group

Treatment Logistics:

Appropriate Age Range: 12 and up
Participants: Parents primarily, adolescent should be present during home visits
# of Sessions:

- 6 90-minute parent education sessions, scheduled concurrently with adolescent Cognitive-Behavioral Therapy sessions
- 3-4 90-minute home visits
- Case management as needed

FSN is designed for use in combination with any evidence-based adolescent treatment; however, the recommendation is that it be used in conjunction with MET/CBT because this is the combination that was used in the Cannabis Youth Treatment clinical trials. It was manualized in 2001 as part of the Cannabis Youth Treatment Series (CYT).

Home visits and parent education sessions were designed to be conducted in a specific order which is detailed in the manual. Parent education topics include an introduction, drugs and adolescents, relapse signs and recovery, family dimensions, conflict resolution, and the family context.

Evidence-Base:

Refer to Appendix B for a matrix that lists the organizations that have approved FSN as an EBP or go to http://www.uncg.edu/csr/asatp/ebpmatrix.pdf to view it online. Research supports the utility of family therapy for the treatment of substance abuse. Studies have shown that treatment retention increases when families are involved.

Reference to Treatment Manual:

Hamilton, N.L., Brantley, L.B., Times, F.M., Angelovich, N., & McDougall, B. (2001). *Family support network for adolescent cannabis users, CYT series, volume 3.* (BKD386). Rockville, MD: CSAT, SAMHSA. http://kap.samhsa.gov/products/manuals/cyt/index.htm

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Adolescent Community Reinforcement Approach (A-CRA)

Part of the Cannabis Youth Treatment (CYT) Series

Description:

The Adolescent Community Reinforcement Approach (A-CRA) is based on the assumption that environmental factors have an effect on the encouragement or discouragement of drug use. A-CRA is a behavioral intervention that a clinician uses to help the adolescent learn to replace environmental contingencies that have supported alcohol or drug use with prosocial activities and behaviors that support recovery.

Therapists choose from 15 A-CRA procedures that address the adolescent's needs and self-assessment of happiness in multiple areas of functioning. Some of these procedures include problem-solving skills to cope with day-to-day stressors, communication skills, and active participation in prosocial activities with the goal of improving life satisfaction and eliminating alcohol and substance use. Role-playing/behavioral rehearsal is a critical component of the skills training used in A-CRA, particularly for the acquisition of better communication and relapse prevention skills. Homework between sessions consists of practicing skills learned during sessions and participating in prosocial leisure activities.

The A-CRA manual provides guidelines for adolescent sessions, individual caregiver sessions, and combined adolescent and caregiver sessions. The goals of each section of the treatment are as follows:

Adolescent Sessions

- Promote abstinence
- Promote positive social activities
- Promote positive peer relationships
- Promote improved familial relationships

Caregiver Sessions

- Encourage participation in the recovery process
- Promote the adolescent's abstinence
- Provide information on effective parenting

Treatment Logistics:

Appropriate Age Range: 12-18

Participants: Adolescent, Caregivers

# of Sessions: The minimum recommended contact would be 14 60 minute sessions over a 3 month period, 10 individual sessions with the adolescent, 2 individual sessions with the caregiver, and 2 joint sessions. Community contact is added on a case by case basis.

There are 12 standard procedures and 3 optional ones. The delivery of the intervention is flexible based on individual adolescent needs, although the manual provides some general guidelines regarding the general order of procedures. Optional procedures are Dealing with Failure to Attend, Job-Seeking Skills, and Anger Management. Standard procedures include:

1: Functional Analysis of Substance Use
2: Analysis of Prosocial Behavior
3: Happiness Scale & Goals
4: Increasing Prosocial Recreation
5: Relapse Prevention Skills
6: Communication Skills
7: Problem-Solving Skills
8: Urine Testing
9: Caregiver Overview, Rapport Building, and Motivation
10: Caregiver Communication Skills
11: Caregiver-Adolescent Relationship
12: Treatment Closure

A-CRA was manualized in 2001 as part of the Cannabis Youth Treatment Series (CYT) and was tested in that study (Dennis et al., 2004) and more recently, with homeless youth (Slesnick, et al., 2007). It was also adapted for use with another manual for Assertive Continuing Care following residential treatment (Godley et al., 2001).

Evidence-Base:

Refer to Appendix B for a matrix that lists the organizations that have approved A-CRA as an EBP or go to http://www.uncg.edu/csr/asatp/ebpmatrix.pdf to view it online.

Reference to Treatment Manual:

Godley, S.H., Meyers, R.J., Smith, J.E., Karvinen, T., Titus, J.C., Godley, M.D., et al. (2001). *The adolescent community reinforcement approach for adolescent cannabis users: CYT series, volume 4.* (BKD387). Rockville, MD: CSAT, SAMHSA. http://kap.samhsa.gov/products/manuals/cyt/

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Multidimensional Family Therapy (MDFT)

Part of the Cannabis Youth Treatment (CYT) Series

Description:

Multidimensional Family Therapy (MDFT) encompasses treatment within four areas: including the individual adolescent, the adolescent's family members as individuals, the family unit, and how the family unit interacts with the social environment. It is solution-focused and strives to provide immediate/practical outcomes that apply to all aspects of the adolescent's life.

MDFT is a community and home-based therapy that works within the youth's everyday environment in several domains. Key points for interventions in each domain are as follows:

Individual

- Youth's current difficulties
- Motivation is enhanced
- Skills are introduced and practiced

Peer

- Peers are accessed through youth
- Discuss the maladaptive nature of drug-using and delinquent peers

Family

- Everyday events in family
- Improvement of family relations
- Important past events are explored

School

- Mediating and advocating on behalf of youth
- Creating new opportunities in school

Community

- Help families become more vigilant about negative influences
- Accessing resources available

Critical components of the program include community service, community collaboration, parent training, school collaboration, skill development, substance abuse/prevention education, and therapy. If youth are involved with the court, the court system may be involved as well.

Treatment Logistics:

Appropriate Age Range: 12-17
Participants: Treatment is for child and family primarily, with possible involvement of school and community personnel.
# of Sessions: 3-6 months of treatment, sessions vary according to needs and can be 1-2 hours in length.

MDFT has been adapted and manualized as part of the Cannabis Youth Treatment Series (CYT). They suggest the following progression for therapy (see manual for more specific info about each stage):

Stage 1: Build the Foundation (3 weeks) - Use distress to motivate/focus, create expectations, visit school/neighborhood.
Stage 2: Prompt Action & Change by Working the Themes (5 weeks) - Mobilize, make small steps toward progress, think in stages, use mistakes as opportunities.
Stage 3: Seal the Changes & Exit (4 weeks) - Appraise current status honestly, except imperfect outcomes, emphasize all changes made, assess future needs and next steps.

Evidence-Base:

Refer to Appendix B for a matrix that lists the organizations that have approved MDFT as an EBP or go to http://www.uncg.edu/csr/asatp/ebpmatrix.pdf to view it online. Studies have shown the following:

- 41% to 66% reduction in substance abuse intake to completion. Gains were maintained up to 1-year post-treatment.
- 93% of youth receiving treatment reported no substance-related problems at 1-year post-intake.
- It has been shown to reduce negative attitudes/behaviors and improve school functioning.
- MDFT parents increased their involvement in their teen's life, improved their parenting skills, and decreased their stress.

Reference to Treatment Manual:

Liddle, H.A. (2002). *Multidimensional family therapy treatment (MDFT) for adolescent cannabis users: CYT series, volume 5*. (BKD388) Rockville, MD: CSAT, SAMHSA. http://www.kap.samhsa.gov/products/manuals/cyt/

Additional References:

SAMHSA. "Multidimensional Family Therapy." http://www.modelprograms.samhsa.gov/pdfs/model/multi.pdf

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

Description:

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) is designed to help children and adolescents who experience symptoms of post-traumatic stress disorder (PTSD). This psychotherapeutic approach utilizes CBT (*see Foundations section on page 7*) techniques to help traumatized children and adolescents cope with the negative consequences of experiencing trauma while increasing positive skills that can foster resiliency. This therapy is not intended to specifically treat substance abuse, but given that untreated trauma symptoms increase the likelihood of substance abuse, this approach is important to consider when working with youth who have trauma histories.

Key Components can be summarized by the acronym, **PPRACTICE**:

Psycho-education
Parenting skills
Relaxation
Affective modulation
Cognitive coping and processing
Trauma narrative
***I**n vivo* mastery of trauma reminders
Conjoint child-parent sessions
Enhancing future safety and development

Treatment Logistics

Participants: Child/Adolescent and their non-abusing caregiver
Number of Sessions: Usually 12-18 sessions of 60 to 90 minutes, including several joint sessions with the child and caregiver as appropriate.

Evidence-Base

Studies have shown that TF-CBT is effective in decreasing symptoms of PTSD in both children and caregivers. When compared to traumatized children who received supportive therapy, children treated with TF-CBT:

- Had significantly less acting-out behavior;
- Had significantly reduced PTSD symptoms;
- Had significantly greater improvement in depressive symptoms;
- Had significantly greater improvement in social competence; and
- Maintained these improvements a year after treatment ended.

Refer to Appendix B for a matrix that lists the organizations that have approved TF-CBT as an EBP or go to http://www.uncg.edu/csr/asatp/ebpmatrix.pdf to view it online.

Reference to Treatment Manual

Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York: The Guilford Press.

Additional References:

A web-based learning course from the Medical University of South Carolina, Alleghany General Hospital, and The National Child Traumatic Stress Network: http://tfcbt.musc.edu/

National Child Traumatic Stress Network: www.nctsn.org

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Motivational Enhancement Therapy (MET)

Description:

Motivational Enhancement Therapy (MET) initially was developed for use with problem drinkers, but it has been adapted for use with those who abuse any type of drug. It works well with adolescents who attend therapy infrequently or only for a few sessions. MET mobilizes change by motivating the adolescent as opposed to the therapist driving the change from the outside. Motivational Interviewing (MI) is the basis for the treatment protocol. (*see Foundations section on page 7)*

There are two phases of treatment. Phase One involves building motivation for change through the following:

- Eliciting self-motivational statements
- Listening with empathy
- Questioning
- Presenting feedback
- Affirming the client
- Reframing
- Summarizing

Phase Two consists of strengthening commitment to change by:

- Recognizing readiness to change
- Discussing a plan
- Communicating free choice
- Discussing consequences of action and inaction
- Providing info and advice in response to client questions
- Emphasizing abstinence
- Recapitulating (offering a broad summary)
- Asking for commitment

Treatment Logistics:

Appropriate Age Range: 12 and up
Participants: Adolescent and family or supportive person for first 2 sessions
# of Sessions: 4 sessions split across 90 days. However, in practice it is possible to conduct the sessions on a more flexible schedule in a shorter period of time.

As originally developed for the Project MATCH Monograph Series (supported by the NIAAA) the sessions go as follows:
Session 1 (Week 1): Structured feedback about the initial assessment battery, including problems associated with drinking, level of consumption, symptoms, decisional considerations, future plans, and building client motivation for change
Session 2 (Week 2): Consolidating commitment to change
Session 3 (Week 6) and Session 4 (Week 12): Monitoring and encouraging progress

Evidence-Base:

Refer to Appendix B for a matrix that lists the organizations that have approved MET as an EBP or go to http://www.uncg.edu/csr/asatp/ebpmatrix.pdf to view it online. Studies using MET have shown decreased marijuana use in adolescents, decreased heavy drinking in adults, and decreased binge drinking in college students. Both group and individual approaches have been tested with favorable results. However, the research is inconsistent as to whether MET is more effective than other brief interventions.

Reference to Treatment Manual:

Miller, W.R., Zweben, A., DiClemente, C.C., & Rychtarik, R.G. (1995). *Motivational enhancement therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence.* Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Additional References:

Additional treatment manual: http://motivationalinterview.org/clinical/METDrugAbuse.PDF
More resources online: http://motivationalinterview.org/
NIDA Overview: http://www.nida.nih.gov/ADAC/ADAC9.html

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

The Seven Challenges® Program

Description:
The Seven Challenges® Program focuses on trust and relationship building as primary motivators for change. Cognitive and emotional aspects of decision making are used to help adolescents think through their decisions about alcohol and drugs. Young people also are encouraged to use a Health-Decision Model, which involves evaluating their choices with regard to health consequences.

The Seven Challenges are as follows:

1. We decided to open up and talk honestly about ourselves and about alcohol and other drugs.
2. We looked at what we liked about alcohol and other drugs, and why we were using them.
3. We looked at our use of alcohol or other drugs to see if it has caused harm or could cause harm.
4. We looked at our responsibility and the responsibility of others for our problems.
5. We thought about where we seemed to be headed, where we wanted to go, and what we wanted to accomplish.
6. We made thoughtful decisions about our lives and about our use of alcohol and other drugs.
7. We followed through on our decisions about our lives and drug use. If we saw problems, we went back to earlier challenges and mastered them.

Treatment Logistics:
Appropriate Age Range: 12-24
Participants: Adolescent and possibly family
# of Sessions: Variable, no set schedule or agenda
Strategies for sessions and individual work include:
- Reading and journaling
- Educational/counseling sessions in one-to-one and/or group settings - these deal directly with the seven challenges; and
- Family or multi-family sessions, when feasible and appropriate.

Evidence-Base:
Refer to Appendix B for a matrix that lists the organizations that have approved Seven Challenges as an EBP or go to http://www.uncg.edu/csr/asatp/ebpmatrix.pdf to view it online. Seven Challenges has been implemented and evaluated in many different treatment settings. It has been shown to decrease substance use and also work well with co-occurring disorders and adolescents who have experienced trauma.

Participants also show the following:
- Reductions in aggressive behavior;
- Improvements in mental health;
- Decreases in criminal behavior;
- Increases in HIV/AIDS knowledge;
- Improved relationships and communication with family and adults; and
- Higher levels of honesty.

Reference to Treatment Manual: (Only agencies who have been authorized to use the Program can get these materials)
Schwebel, R. (2004). *The Seven Challenges® Manual.* Tucson, AZ: Viva Press.

A book of readings for the program and accompanying journals for each challenge also are available.

Additional References:
http://www.sevenchallenges.com/ - The website for the program, with information on trainings, materials, etc.

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Brief Strategic Family Therapy (BSFT)

Description:

Brief Strategic Family Therapy (BSFT) is a short term, problem-focused therapeutic treatment intervention designed for children and adolescents aged 6-17 years old and their families.

BSFT focuses on problem behavior by eliminating or reducing illicit drug use. Family involvement is a key piece of this treatment. It includes establishing a viable and effective therapeutic system that is inclusive of the whole family. The therapist works with the family to identify interactional patterns that give rise to and/or maintain problematic youth behavior. After these patterns are identified, the therapist helps the family change these patterns to encourage positive family interactions.

BSFT addresses family behavior, affect, and cognitions that work to restructure interactions and change systems. BSFT strategies and treatment plans are designed specifically for each family and are based on a structured diagnostic schema. Strategies include:

- Reframing
- Shifting alliances
- Building conflict resolution skills
- Parental empowerment
- Reversals
- Giving and micromanaging behavioral tasks

Treatment Logistics:

Appropriate Age Range: 6-17
Participants: Children/adolescents and their families
# of Sessions: 12-16 weekly sessions; 60-90 minutes.
Location: Clinic or Home-based

Evidence-Base:

Refer to Appendix B for a matrix that lists the organizations that have approved BSFT as an EBP or go to http://www.uncg.edu/csr/asatp/ebpmatrix.pdf to view it online. Children and adolescents treated with BSFT show:

- Decreases in substance abuse
- Reductions in negative attitudes/behaviors
- Improvements in positive attitudes/behaviors
- Reduction in association with anti-social peers
- Improvements in family functioning

Other outcomes include:

- Retained over 75% of families in the program
- Increased family participation in therapy (92% of referred/non-mandated families)
- Improved youth self-concept and self-control
- Improved family communication, conflict resolution, and problem-solving skills
- Increased parental involvement and develops more positive effective parenting
- More effective parental management of child's behavior
- Improved family cohesiveness, collaboration, and child bonding to the family

Reference to Treatment Manual:

Szapocznik, J., Hervis, O., Schwartz, S. (2003). *Therapy manuals for drug addiction. Brief strategic family therapy for adolescent drug use.* (NIH Publication No. 03-4751). Washington DC: U.S. Department of Health and Human Services. http://www.nida.nih.gov/pdf/Manual5.pdf

Additional References:

SAMHSA. "Brief Strategic Family Therapy." http://www.modelprograms.samhsa.gov/pdfs/model/Bsft.pdf
Family Therapy Training Institute of Miami: http://www.brief-strategic-family-therapy.com/bsft
Helping America's Youth: http://guide.helpingamericasyouth.gov/programdetail.cfm?id=305

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Multisystemic Therapy (MST)

Description:

Multisystemic Therapy (MST) is an intensive family and home-based treatment. It was originally developed to address the limitations of existing mental health services for juvenile offenders, but there has been a recent trend to use it with non-offending adolescents who have substance abuse or conduct-related problems.

The program focuses on substance use and abuse and services are provided in the home and the community. The family collaborates with the therapist on how to best improve the youth's behavior. The primary goals of the program are to help parents develop the skills they need to deal with behavioral concerns that may occur after the therapist has left the home environment. MST also helps parents identify their strengths, develop a natural support system, and remove barriers. At the same time, the therapist aims to give the adolescent coping skills to use with problems they may encounter in their environment. There are three different types of interventions:

Individual
- Institutional placement and/or
- Individual counseling
- Life/social skills training

Family
- Family therapy
- Parent education
- Parenting skills training

Peer
- Peer-resistance education

MST therapists typically have small caseloads to ensure that they are available 24 hours a day, 7 days a week in order to provide services at times that are convenient for the family.

Once the parents have become engaged, they collaborate with the therapist to develop strategies to:

- Set and enforce curfew and rules
- Decrease the youth's involvement with deviant peers
- Promote friendships with pro-social peers
- Improve the youth's academic/vocational performance
- Cope with any criminal subculture that may exist in the neighborhood

Treatment Logistics:

Appropriate Age Range: 12-17
Participants: Adolescent, family
Hours of contact: Average of 60 hours during a 4-month period (ideal treatment cycles are 3-5 months)

To provide MST services, clinicians must become extensively trained in the method. Consistent monitoring of adherence to the model takes place through the use of MST fidelity instruments.

Evidence-Base:

MST has been found to decrease substance use, psychiatric symptoms, associations with negative peers, and antisocial/criminal activities. It also improves family relations/functioning and increases school attendance. Youth who have participated in this treatment have fewer arrests, spend less time in out-of-home placements, and show less aggression towards peers. MST has also been shown to decrease depressive symptoms. Refer to Appendix B for a matrix that lists the organizations that have approved MST as an EBP or go to http://www.uncg.edu/csr/asatp/ebpmatrix.pdf to view it online.

Reference to Treatment Manual:

Henggeler, S.W., Schoenwald, S.K., Liao, J.G., Letourneau, E.J., & Edwards, D.L. (2002). *Multisystemic treatment of antisocial behavior in children and adolescents.* New York: Guilford Press.

Agencies must be extensively trained to receive materials and use MST. Info is available at http://www.mstservices.com/

Additional Resources:

SAMHSA. "Multisystemic Therapy." http://www.modelprograms.samhsa.gov/pdfs/model/Bsft.pdf

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Relapse Prevention Therapy (RPT)

Description:

Relapse Prevention Therapy (RPT) is a method of teaching clients to anticipate and cope effectively with high-risk scenarios where relapse is most likely. There are several approaches to relapse prevention. Those with the most research support are based on Cognitive-Behavioral Therapy (*See Foundations Section*). This fact sheet focuses on Marlatt's model of RPT.

Six key questions are addressed in RPT:

1. What are the specific high-risk scenarios (HRS) that pose the greatest risk for relapse?
2. How are the processes occurring before first use or a lapse different from a full-blown relapse?
3. How does a client react after a lapse? How does this effect the chances of a full-blown relapse occurring?
4. How do some clients set-up a relapse by covertly entering a high-risk scenario where it is virtually impossible to resist temptation?
5. Where in the process can a client intervene to prevent or manage a relapse episode?
6. How can clients be taught to anticipate exposure to HRS for relapse and learn more effective coping strategies?

In RPT, Relapse "Prevention" involves helping a client recognize and deal effectively with their unique profiles of high-risk scenarios to avoid the initial use of substances. In contrast, Relapse "Management" involves intervening after the initial substance lapse to prevent a full-blown relapse.

Treatment Logistics:

Appropriate Age Range: 12 and up
Participants: Adolescent, family members, peers, and others as appropriate
# of Sessions: variable numbers of individual, family, or group meetings

RPT uses five categories of intervention strategies:

- Assessment - history, motivation, recent use, risk factors/ history, coping skills, self-efficacy
- Insight/Awareness Raising - understanding the process of relapse, learning principles of self-efficacy, self-monitoring of exposure to high-risk scenarios and urges/ cravings
- Coping Skills Training - problem-solving, relapse rehearsal, stress management
- Cognitive Strategies - appraisal, coping imagery, cognitive restructuring
- Lifestyle Modification - relaxation and meditation for stress reduction, social support, balancing wants/shoulds

Evidence-Base:

Refer to Appendix B for a matrix that lists the organizations that have approved RPT as an EBP or go to http://www.uncg.edu/csr/asatp/ebpmatrix.pdf to view it online. RPT is equally effective in preventing relapse when compared to other substance abuse treatments; however, it is more effective in reducing the frequency, intensity, and duration of lapses when they do occur. RPT is also more effective in maintaining treatment effects over long-term follow up periods. RPT has been evaluated using several different treatment modalities including individual, group, and couples therapy.

Reference to Treatment Manual:

Marlatt, G.A, Parks, G.A., Witkiewitz, K. (2002). *Clinical guidelines for implementing relapse prevention therapy.* Peoria, IL: The Behavioral Health Recovery Management Project.

Larimer, M.E., Palmer, R.S., & Marlatt, G.M. (1999). Relapse prevention: An overview of Marlatt's cognitive-behavioral model. *Alcohol Research & Health, 23*, 151-160.

Additional References:

Delay, D.C. & Sproule, C.R. (2004). *Adolescent relapse prevention workbook: A guide to staying off alcohol and drugs.* Holmes Beach, FL: Learning Publications, Inc.

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Seeking Safety (SS)

Description:

Seeking Safety (SS) is a manual-guided, cognitive-behavioral approach designed for individuals with co-occurring substance abuse and post-traumatic stress symptoms. It is a present-focused therapy that focuses on building current coping skills rather than focusing on past traumatic events.

The central tenets of the treatment are:

1) Safety is the first priority of treatment.
2) PTSD and substance abuse are treated concurrently and in an integrated fashion.
3) Promoting recovery thinking (ideals).
4) Four content areas: cognitive, behavioral, interpersonal, and case management.
5) The therapist processes are important.

The treatment uses educational research strategies for skill building to focus on building potential rather than current problems.

Treatment Logistics:

Appropriate Age Range: 12 and up
Participants: Adolescent - may be individual or group format
# of Sessions: 25 sessions

The treatment tends to be relatively structured within each session; however, the topics can be presented in any order, in a variety of formats, and across a variety of populations. It was designed to be integrated with other approaches.

Topics include:

- Intro to treatment
- Safety
- PTSD: Taking back your power
- Detaching from emotional pain (grounding)
- When substances control you
- Asking for help
- Taking good care of yourself
- Compassion
- Red and green flags
- Honesty
- Recovery thinking
- Integrating the split self
- Commitment
- Creating meaning
- Community resources
- Setting boundaries in relationships
- Discovery
- Getting others to support your recovery
- Coping with triggers
- Respecting your time
- Healthy relationships
- Self-nurturing
- Healing from anger
- The life choices game (review)
- Termination

Each session contains the following parts:

1) **Check-in** - five questions are used to find out how patients are doing.
2) **Quotation** - to emotionally engage clients in the session.
3) **Relating the material to clients' lives** - to connect the topic to clients' experiences in a meaningful way.
4) **Check-out** - to reinforce progress and give feedback.

Each session integrates discussion, role plays, practicing, and other techniques. Several handouts are included in the treatment manual along with details on how to prepare the therapist for delivering them.

Evidence-Base:

Results showed significant improvement in substance abuse, trauma-related symptoms, suicide risk, suicidal thoughts, social adjustment, family functioning, problem solving, depression, and cognitions about substance abuse, when compared with treatment-as-usual. The program has been evaluated with a variety of populations and has been validated in outpatient, inpatient, residential, individual, and group formats. Refer to Appendix C for a matrix that lists the organizations that have approved Seeking Safety as an EBP or go to http://www.uncg.edu/csr/asatp/ebpmatrix.pdf to view it online.

Reference to Treatment Manual:

Najavits, L.M. (2001). *Seeking safety: A treatment manual for PTSD and substance abuse.* New York, NY: Guilford Press.

Treatment website: http://www.seekingsafety.org/ (research, training, etc.)

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

What are some treatments used with adolescents?

This sheet serves as an introduction to different treatment options that are used with adolescents. The treatments offered will differ depending on your community. If you would like more information, we have created a more detailed fact sheet for each treatment.

Adolescent Community Reinforcement Approach (A-CRA)

Adolescent Community Reinforcement Approach is based on the thought that the home and community environment have a great influence on the encouragement or discouragement of drug use. A-CRA seeks to involve youth in activities that discourage drug use and utilize the strengths of the home and community. A-CRA includes individual adolescent sessions, individual caregiver sessions and community work that address peer relationships, youth motivation, and problem solving skill building.

Behavior Therapy (BT)

Behavior Therapy is also called Behavioral Management/Modification. This model looks at several principles that might trigger substance abuse including:
-Substance abusers begin to use after watching peers (and sometimes family members) use drugs.
-Substance use seems enjoyable at times so they continue to use.
-Substance use gets tied to other things like earning money or hanging out with what seems like "popular" people, etc.
Over time, being in the mist of earning money and hanging out with "popular" people, becomes enough to make youth want to continue to use.

Behavior Therapy uses therapist modeling (showing client the way they are expected to act), behavioral reversal (replacing one behavior with another- stop doing this and start doing that), homework (practicing what was discussed during the session), self-recording between sessions (writing down what is happening in your life between sessions), and extensive praise for progress to encourage change in behaviors.

Sometimes urine tests are used and rewards are given for clean results. Punishment may consist of loss of privileges when the test is not clean, but that varies by the treatment provider.

Brief Strategic Family Therapy (BSFT)

Brief Strategic Family Therapy uses reduction or elimination of illegal drug use as the way to address problem behaviors. Family involvement is a key part of the therapy, which includes establishing a healthy relationship with both the client and the family. The therapist works with the family to identify times in the family's life when youth has the most acting out behaviors. After these patterns are identified, the therapist helps the family change these patterns and encourages more positive family time. Specific strategies are used to assist the family with making the changes necessary such as:

-Reframing (Finding and stating something positive about a negative statement)
-Changing alliances (Two in the family ganging up on another about their thinking)
-Building conflict resolution skills (Learning better ways to solve problems)
-Parental empowerment (Parents learning to take some control in the lives of their children)

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

Cognitive-Behavioral Therapy (CBT)

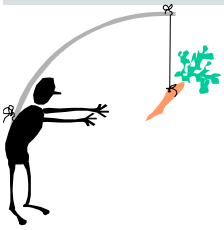
Cognitive-Behavioral Therapy is a combination of cognitive therapy and behavior therapy. It works with the thoughts of youth (what are they thinking about just before they start to use drugs, while they are using and after they finish using) and how those thoughts influence their behaviors. Several areas are reviewed during therapy:

-Start to figure out why youth use and help them to deal with the "trigger" thoughts that make them want to use;
-Talk about what makes it hard to stop using and why;
-Talk about the skills needed to stop using, practicing the skills with the therapist, and using the skills learned between sessions while in the community (e.g., what to do when your thoughts are telling you to use but you don't want to);
-Talk about problems the youth faces and how to address them;
-Learn what to do when "just say no" is not enough (e.g., distraction methods); and
-Plan for emergencies like when the youth uses drugs after being clean for a while (e.g., crisis planning).

Family Support Network (FSN)

Family Support Network involves the family in treatment in order to help adolescents during recovery. The therapist works with the family to talk about authority, roles, rules, boundaries, communication, and routines in the family. Caregivers are supported as the ones in charge of the family and the responsibility that comes with that position. Caregivers will get help in setting rules and consequences in the home and add some new ways to problem solve. Caregivers will learn how to respond to the youth that is using drugs and the behaviors that come when they are using. Caregivers are taught how to participate in the drug treatment of the youth.

Motivational Enhancement Therapy (MET)



Motivational Enhancement Therapy works well with youth that cannot attend therapy on a regular basis or for only a few sessions. The youth uses self motivating statements and are encouraged to pull on the strengths available (both within the youth and in the youth's environment) to resist drug use. This therapy is usually used in combination with Motivational Interviewing.

Motivational Interviewing (MI)

Motivational Interviewing is used to help the youth understand that motivation to change their drug using behavior comes from within the youth themselves. The youth must discuss any resistance they have to stopping their drug use. They also are helped to develop confidence in their ability to change. The relationship between the therapist and the adolescent is one of genuine partnership and collaboration. This therapy uses open-ended questions, affirmations (positive up lifting statements), reflective listening (repeating what was said in different words), and summaries (going over the high points of everything discussed during the session).

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Motivational Enhancement Therapy with Cognitive-Behavioral Therapy (MET/CBT)

MET/CBT is a therapy used with adolescents that are using and abusing marijuana. It includes conversations about the positive and negative results of using marijuana, about what triggers a person to use marijuana, and the feelings, thoughts, and behaviors of the person using the drug.

This therapy IS NOT for an adolescent that has severe behavior problems, or for an adolescent using different or multiple drugs. It also isn't appropriate for an adolescent who does not work well in groups, or if the adolescent has a mental health challenge that would prevent him/her from participating in this kind of therapy.

Multidimensional Family Therapy (MDFT)

Multidimensional Family Therapy works with the youth, family, the family as a unit, and the family as it interacts in the community. The therapy works in the youth's everyday environment. Some of the areas addressed include: the youth's current difficulties, skills needed (these are taught and practiced), and how to access their peers and discuss some problem behaviors of their peers. Everyday events of the family are reviewed to see areas in family relations that may need to be improved and important past events in the youth's life are explored. School and community are important partners in this therapy. This is part of Cannabis Youth Treatment (CYT).

Multisystemic Therapy (MST)

Multisystemic Therapy is an intensive family therapy that gives strong focus to substance use and abuse. Services are provided in the home or in the community. Parents collaborate with the therapist on how to best improve the youth's behavior. Therapists are available 24 hours a day 7 days a week in order to provide services at times that are convenient for the family. A major focus is empowering the family and helping them to develop their own supports. The family learns skills on how to set and enforce curfews and rules, how to cope with illegal behaviors that maybe in the neighborhood, and how to help the youth separate from peers with problem behaviors.

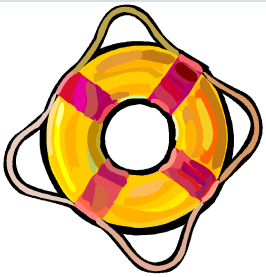
Relapse Prevention Therapy (RPT)

Relapse Prevention Therapy teaches youth to recognize and respond to their relapse warning signs. This model is used with youth that have not been successful at keeping clean after treatment. Areas addressed in this therapy include:

1. Self regulation of your thinking, feeling, memory and behavior
2. Integration – understanding and accepting events that have led to past relapses
3. Understanding what causes relapse
4. Self-knowledge – recognizing your personal relapse warning signs
5. Coping skills – managing your relapse signs
6. Change – the program changes to meet the needs of the youth
7. Awareness – check yourself daily for relapse warning signs
8. Significant others become involved in recovery planning
9. Maintenance – regularly update your recovery plan

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Seeking Safety (SS)



Seeking Safety model can be used with youth struggling with both substance abuse and Post Traumatic Stress Disorder (PTSD). Safety of the youth is the first priority of this therapy model. Treating the effects of the past trauma and the substance abuse happens at the same time. Some of the process used in this therapy includes: going deep into the issues of the youth, giving the youth praise and expecting accountability for behaviors, teaching the youth to "take back their power", validating the criticisms of previous treatment, and focusing on good use of their time to create a positive future.

Seven Challenges® Program

Seven Challenges® meets the youth where they are in their substance use. It assumes that adolescents cannot change until they are personally ready to change. Trust and relationship building are keys to the youth making the change. Youth are taught to think through their decisions about alcohol and drugs and how they may affect their health.

The Seven Challenges are:
1. We decide to open up and talk honestly about ourselves and about alcohol and other drugs.
2. We look at what we like about alcohol and other drugs, and why we were using them.
3. We look at our use of alcohol or other drugs to see if it has caused harm or could cause harm.
4. We look at our responsibility and the responsibility of others for our problems.
5. We think about where we seem to be headed, where we want to go, and what we want to accomplish.
6. We make thoughtful decisions about our lives and about our use of alcohol and other drugs.
7. We follow through on our decisions about our lives and drug use. If we see problems, we go back to earlier challenges and master them.

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

Trauma-Focused Cognitive-Behavioral Therapy meets the needs of adolescents who are suffering from Post-Traumatic Stress Disorder (PTSD). This is a reaction to trauma that can include flashbacks, nightmares, physical complaints, and other symptoms. The therapist uses Cognitive Behavioral Therapy (CBT) and other techniques that are sensitive to the adolescent's experiences to help them cope with negative consequences and increase coping skills.

These skills may include managing distressing thoughts, feelings, and behaviors; enhancing the family's safety, parenting skills, and family communication. This therapy does not specifically treat substance abuse; however, adolescents who are using drugs may be trying to deal with past traumatic experiences. Helping the adolescent to work through the traumatic experience and learn more positive coping skills should help them decrease their substance use.

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Appendix A: Acronyms and Definitions

ASA: Adolescent substance abuse

A-CRA: Adolescent Community Reinforcement Approach: Based on the assumption that environmental factors have an effect on the encouragement or discouragement of drug use

AMH: The State of Oregon's Addictions and Mental Health Approved Practices

Abstinence: Refraining from a specific activity. For this primer, the activity is substance abuse

BT: Behavior Therapy, which focuses on working therapeutically with people to change maladaptive behaviors

Behavioral rehearsal: Practice of new behaviors both in and out of therapy in order to bring about behavior change

Behavioral contingencies: Specific goals set in a treatment plan designed to modify or change behaviors

BSFT: Brief Strategic Family Therapy, which is a short term, problem-focused therapeutic treatment intervention designed for children and adolescents aged six to seventeen years old and their families

CBT: Cognitive-Behavioral Therapy, which is a psychotherapeutic approach that emphasizes the connections between how we think, feel, and behave

CYFCP: Center for Youth, Family, and Community Partnerships

CYT: Cannabis Youth Treatment, which is the first clinical trial for best practice treatment of adolescent substance abuse

CM: Contingency Management, which is the practice of providing rewards for reaching treatment milestones

Caregiver: The primary person responsible for the well-being of youth

Evidence-Based Practice: An approach to prevention or treatment that is validated by some form of documented scientific evidence

FSN: Family Support Network, which is a treatment that stresses the importance of authority, roles, rules, boundaries, communication, and routine in a family support structure

Fact Sheets: Provide information to parents and providers for assistance in making informed choices about which treatment approaches to use

GAIN: Global Appraisal of Individual Needs, which is an evidence-based assessment instrument used for diagnosis, placement, and treatment planning

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

HAY: Helping America's Youth Community Guide

MI: Motivational Interviewing, which is an interpersonal style integrated into the therapeutic approach

MET: Motivational Enhancement Therapy, which aims to mobilize change within clients

MDFT: Multidimensional Family Therapy, which encompasses treatment at several levels, including individual family members, the family unit, and how the family unit interacts with the social environment

MST: Multisystemic Therapy, which is an intensive family and community-based treatment

NREEP: National Registry of Evidence-Based Programs and Practices

NC DMH/DD/SAS: North Carolina Division of Mental Health Developmental Disabilities and Substance Abuse Services

NCASATP: North Carolina Adolescent Substance Abuse Treatment Project

OJJDP: Office of Juvenile Justice and Delinquency Prevention

PTSD: Post-Traumatic Stress Disorder, which is an anxiety disorder that can develop after exposure to either psychological, emotional, or physical trauma

Practice Based Evidence: The adapting of scientifically proven treatments with the needs and experience of the therapists and communities being served to come up with a unique and individualized treatment plan

Reinforcement Schedule: A schedule used to either reinforce or withhold reinforcement based on behaviors

RPT: Relapse Prevention Therapy, which is a method for teaching clients to recognize and manage relapse warning signs

Role Play: Practicing roles of people who may have different personalities, motivations, and backgrounds from one's own for educational purposes in a therapeutic setting

SAMHSA: Substance Abuse Mental Health Services Administration

SS: Seeking Safety, which is a skill-building therapy based on CBT principles used for those suffering from co-occurring substance abuse and PTSD

Seven Challenges®: Focuses on trust and relationship building as primary motivators for change

Stages of Change Model: Developed by Prochaska & DiClemente and includes pre-contemplation, contemplation, preparation, action, and maintenance as five stages of change

Substance Abuse Provider: The therapist or mental health individual or facility that provides treatment for substance abuse

TF-CBT: Trauma-Focused Cognitive-Behavioral Therapy, which utilizes CBT principles specific to situations in which individuals have experienced trauma

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Appendix B: EBP Matrix

Go to http://www.uncg.edu/csr/asatp/ebpmatrix.pdf for the complete matrix with links to more information.

			Organization					
Practice	EBP for MH	EBP for SA	Oregon Addictions and Mental Health Approved Practices	SAMHSA National Registry of Evidence-based Programs & Practices	Helping America's Youth Community Guide	University of Washington EBP Database	The Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide	Therapy Manual Online
Adolescent Community Reinforcement Approach (A-CRA)		Promising	Pending Review	X				SAMHSA
Behavior Therapy for Adolescents	X	X	X			X		
Brief Strategic Family Therapy		X	X	Model Program	Level 2	X	Effective	NIDA
Cognitive Behavioral Therapy	X	X	Depression	Legacy Program		X		
CBT - Trauma Focused	X	X	X	Model Program	Level 1		Exemplary	
Family Support Network (FSN) for Adolescent Cannabis Users		X	Pending Review			X		SAMHSA
Global Appraisal of Individual Needs	____	____	X					
MET/CBT		X	X			X		SAMHSA - Vol. 1
								SAMHSA - Vol. 2
Motivational Enhancement Therapy (MET)	X	X	X	X				
Motivational Interviewing	X	X	X	X				
Multidimensional Family Therapy		X	X	Model Program	Level 2	X	Effective	SAMHSA
Multisystemic Therapy		X	X	X	Level 1	X	Exemplary	
Relapse Prevention Therapy		X	X			X		
Seeking Safety: A Psychotherapy for PTSD and SA	X	X	X	X		X		
Seven Challenges® Program		Promising						

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Appendix C: Additional Resources

Adolescent Community Reinforcement Approach (A-CRA)

Godley, M. D., Godley, S. H., Dennis, M. L., Funk, R. R., & Passetti, L. L. (2007). The effect of assertive continuing care on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders. *Addiction, 102*, 81-93.

Schaeffer, C.M., Saldana, L., Rowland, M.D., Henggeler, S.W., & Swenson, C.C. (2008). New initiatives in improving youth and family outcomes by importing evidence-based practices. *Journal of Child & Adolescent Substance Abuse, 17*, 27-45.

Slesnick, N., Prestopnik, J. L., Meyers, R. J., & Glassman, M. (2007). Treatment outcome for street living, homeless youth. *Addictive Behaviors, 32*, 1237-1251.

Behavior Therapy (BT)

Kamon, J., Budney, A., & Stanger, C. (2005). A contingency management intervention for adolescent marijuana abuse and conduct problems. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*, 513-521.

Tevyaw, T.O., Gwaltney, C., Tidey, J.W., Colby, S.M., Kahler, C.W., Miranda, R., et al. (2007). Contingency management for adolescent smokers: An exploratory study. *Journal of Child & Adolescent Substance Abuse, 16*, 23-44.

Brief Strategic Family Therapy (BSFT)

Distelberg, B.J. (2008). History of evidence-based practices: An interview with Jose Szapocznik. *The Family Journal, 16*, 173-179.

Robbins, M.S., Bachrach, K., & Szapocznik, J. (2002). Bridging the research-practice gap in adolescent substance abuse treatment: The case of brief strategic family therapy. *Journal of Substance Abuse Treatment, 23*, 123-132.

Santisteban, D.A., Suarez-Morales, L., Robbins, M.S., & Szapocznik, J. (2006). Brief strategic family therapy: Lessons learned in efficacy research and challenges to blending research and practice. *Family Process, 45*, 259-271.

Szapocznik, J., & Williams, R.A. (2000). Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. *Clinical Child and Family Psychology Review, 3*, 117-134.

Cognitive-Behavioral Therapy (CBT)

Curry, J.F., Wells, K.C., Lochman, J.E., Craighead, W.E., & Nagy, P.D. (2003). Cognitive-behavioral intervention for depressed, substance-abusing adolescents: Development and pilot testing. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 656-665.

Waldron, H.B., & Turner, C.W. (2008). Evidence-based psychosocial treatments for adolescent substance abuse. *Journal of Clinical Child & Adolescent Psychology, 37*, 238-261.

Motivational Enhancement Therapy (MET)

D'Amico, E.J., Anderson, K.G., Metrik, J., Frissell, K.C., Ellingstad, T., & Brown, S. (2006). Adolescent self-selection of service formats: Implications for secondary interventions targeting alcohol use. *American Journal on Addictions, 15*, 58-66.

Helstrom, A., Hutchison, K., & Bryan, A. (2007). Motivational enhancement therapy for high-risk adolescent smokers. *Addictive Behaviors, 32*, 2404-2410.

Walker, D., Roffman, R.A., & Stephens, R.S. (2006). Motivational enhancement therapy for adolescent marijuana users: A preliminary randomized controlled trial. *Journal of Consulting and Clinical Psychology, 74*, 628-632.

(continued next page)

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services
3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Global Appraisal of Individual Needs (GAIN)

Dennis, M.L., Funk, R. Godley, S.H., Godley, M.D., & Waldron, H. (2004). Cross-validation of the alcohol and cannabis use measures in the Global Appraisal of Individual Needs (GAIN) and Timeline Followback (TLFB; Form 90) among adolescents in substance about treatment. *Addiction, 99*, 120-128.

Lennox, R., Dennis, M.L., Ives, M., & White, M.K. (2006). The construct and predictive validity of different approaches to combining urine and self-reported drug use measures among older adolescents after substance abuse treatment. *American Journal on Addictions, 15*, 92-101.

MET/CBT

Burleson, J.A., Kaminer, Y., & Dennis, M.L. (2006). Absence of iatrogenic or contagion effects in adolescent group therapy: Findings from the cannabis youth treatment (CYT) study. *American Journal on Addictions, 15*, 4-15.

Riley, K.J., Rieckmann, T., & McCarty, D. (2008). Implementation of MET/CBT 5 for adolescents. *Journal of Behavioral Health Services & Research, 35*, 304-314.

Motivational Interviewing (MI)

Baer, J.S., Garrett, S.B., & Beadnell, B. (2006). Brief motivational intervention with homeless adolescents: Evaluating effects on substance use and service utilization. *Psychology of Addictive Behaviors, 21*, 582-586.

Grenard, J.L., Ames, S.L., Wiers, R.W., Thush, C., Stacy, A.W., & Sussman, S. (2007). Brief intervention for substance use among at-risk adolescents: A pilot study. *Journal of Adolescent Health, 40*, 188-191.

Knight, J., Sherritt, L., Van Hook, S., Gates, E., Levy, S., & Chang, G. (2005). Motivational interviewing for adolescent substance use: A pilot study. *Journal of Adolescent Health, 37*, 167-169.

Multidimensional Family Therapy (MDFT)

Shelef, K., Diamond, G.M., Diamond, G.S., & Liddle, H.A. (2005). Adolescent and parent alliance and treatment outcome in Multidimensional Family Therapy. *Journal of Consulting & Clinical Psychology, 73*, 689-698.

Liddle, H.A., Dakof, G.A., Parker, K., Diamond, G.S., Barrett, K., & Tejeda, M. (2001). Multidimensional Family Therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Drug & Alcohol Abuse, 27*, 651-688.

Liddle, H.A., Rowe, C.L., Gonzalez, A., Henderson, C.E., Dakof, G.A., & Greenbaum, P.E. (2006). Changing provider practices, program environment, and improving outcomes by transporting Multidimensional Family Therapy to an adolescent drug treatment setting. *American Journal on Addictions, 15*, 102-112.

Multisystemic Therapy (MST)

Henggeler, S.W., Clingempeel, W.G., Brondino, M.J., & Pickrel, S.G. (2002). Four-year follow-up of multisystemic therapy with substance-abusing and substance-dependent juvenile offenders. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 868-874.

Henggeler, S.W., Halliday-Boykins, C.A., Cunningham, P.B., Randall, J., Shapiro, S.B., & Chapman, J.E. (2006). Juvenile drug court: Enhancing outcomes by integrating evidence-based treatments. *Journal of Consulting & Clinical Psychology, 74*, 42-54.

Schoenwald, S.K. (2008). Toward evidence-based transport of evidence-based treatments: MST as an example. *Journal of Child & Adolescent Substance Abuse, 17*, 69-91.

Stambaugh, L.F., Mustillo, S.A., Burns, B.J., Stephens, R.L., Baxter, B., Edwards, D., et al. (2007). Outcomes from wraparound and Multisystemic Therapy in a center for mental health services system-of-care demonstration site. *Journal of Emotional & Behavioral Disorders, 15*, 143-155.

Timmons-Mitchell, J., Bender, M.B., Kishna, M.A., & Mitchell, C.C. (2006). An independent effectiveness trial of Multisystemic Therapy with juvenile justice youth. *Journal of Clinical Child and Adolescent Psychopathology, 35*, 227-236.

(continued next page)

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).

Relapse Prevention Therapy (RPT)

Anderson, K.G., Frissell, K.C., & Brown, S.A. (2007). Relapse contexts for substance abusing adolescents with comorbid psychopathology. *Journal of Child & Adolescent Substance Abuse, 17*, 65-82.

Bell, T. (1990). *Preventing adolescent relapse: A guide for parents, teachers, and counselors*. Independence, MO: Herald House/Independent Press.

Catalano, R.F., Hawkings, J.D., Wells, E.A., Miller, J., & Brewer, D. (1991). Evaluation of the effectiveness of adolescent drug abuse treatment, assessment for risk for relapse, and promising approaches for relapse prevention. *International Journal of Addictions, 25*, 1085-1140.

Mishra, S.P., & Ressler, R.A. (2000). Preventing adolescent relapse: Concepts, theories and techniques. In A. Sales (Ed.), *Substance Abuse and Counseling* (pp. 273-302). Greensboro, NC: ERIC Counseling and Student Services Clearinghouse.

Seeking Safety (SS)

Najavits, L.M., Gallop, R.J., & Weiss, R.D. (2006). Seeking Safety therapy for adolescent girls with PTSD and substance use disorder: A randomized controlled trial. *Journal of Behavioral Health Services & Research, 33*, 453-463.

Seven Challenges® Program

Smith, D.C., Hall, J.A., Williams, J.K., An, H., & Gotman, N. (2006). Comparative efficacy of family and group treatment for adolescent substance abuse. *American Journal on Addictions, 15*, 131-136.

Stevens, S.J., Schwebel, R., & Ruiz, B. (2007). The Seven Challenges®: An effective treatment for adolescents with co-occurring substance abuse and mental health problems. *Journal of Social Work Practice in the Addictions, 7*, 29-49.

Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

Deters, P.B., Novins, D.K., Fickenscher, A., & Beals, J. (2006). Trauma and posttraumatic stress disorder symptomatology: Patterns among American Indian adolescents in substance abuse treatment. *American Journal of Orthopsychiatry, 76*, 335-345.

Evans, A.S., Spirito, A., Celio, M., Dyl, J., & Hunt, J. (2007). The relation of substance use to trauma and conduct disorder in adolescent psychiatric population. *Journal of Child & Adolescent Substance Abuse, 17*, 29-49.

Shane, P., Diamond, G.S., Mensinger, J.L., Shera, D., & Wintersteen, M.B. (2006). Impact of victimization on substance abuse treatment outcomes for adolescents in outpatient and residential substance abuse treatment. *American Journal on Addictions, 15*, 34-42.

This publication was produced by UNCG Center for Youth, Family, and Community Partnerships in collaboration with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (grant number 6 J79 T117387-02-2).