Co-Occurring Disorders and Adolescents

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What are we talking about?

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HEY MOM, COME LOOK AT THE KITTENS !

History & Issues In Co-Occurring Disorder
Module 1

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An oversimplified picture of the behavioral healthcare service systems in the US

Mental Health Services
- Leadership-psychiatrists
- Staffing-psychologists, social workers, nurses, MFTs
- Role of medications-Substantial
- Impact of behavioral therapies research-Substantial
- Knowledge of substance use disorders and their treatment Minimal
- Education on SA minimal
- Role of self-help-Minimal

Substance Abuse Services
- Leadership-A mixture of recovering people, business people, professionals
- Staffing-paraprofessionals, with increasing role of professionals
- Role of medications and behavior therapies-Informal
- Knowledge of psychiatric disorders-informal
- Role of self-help-Substantial

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Current Trends 2010

- Mental Health
- Utilizing Peer and Self Help Groups
- Addiction
- Utilizing medications to control symptoms understanding of meds significant
- Education formalized

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Why are substance use disorders treated in separate systems from other psychiatric disorders?

How has the split occurred between substance use disorders and other psychiatric disorders?

- Before 1970 in the US, research and treatment for alcoholism and drug abuse were administered out of the National Institute of Mental Health.
- A number of factors prompted the separation of alcoholism/drug abuse into their own specialty areas, distinct and separate from general psychiatry.

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Why are substance use disorders treated in separate systems from other psychiatric disorders?

- A pervasive perception existed among the public and policymakers that the professional fields of psychiatry and medicine were extraordinarily unsuccessful in providing treatment to addicts and alcoholics; and, that there was a tendency within psychiatry (and psychology) to avoid alcoholics and addicts as inherently untreatable individuals, incapable of insight.

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Why are substance use disorders treated in separate systems from other psychiatric disorders?

- The result was:
  - National Institute of Mental Health (NIMH) responsible for research on and treatment of psychiatric disorders.
  - National Institute on Alcoholism and Alcohol Abuse (NIAAA) responsible for research on and treatment for alcoholism and related issues.
  - National Institute on Drug Abuse (NIDA) responsible for research on and treatment of illicit drug problems (and later nicotine).
  - Each institute had its own experts, treatment systems, funding streams and each viewed the other as parochial, misinformed and naïve.
  - Cooperation was uncommon.

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New Day in 2010

- Federal and state agencies are attempting to work together to manage funding cuts and try to maintain service delivery.

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Issues In a Complex System

- Professionals talking in different languages
- Mental Health, Substance Use disorder staff and other professionals have different terminology
- Systems have not adapted to moving clients thru different systems, ie legal issues, confidentiality requirements

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CLINICAL NOTES

CHRIS IS A 17 YEAR OLD MALE PRESENTING AT THE REQUEST OF DFCS DUE TO RECENT FOSTER HOME PLACEMENT AND RECENT REMOVAL FROM ANOTHER FOSTER HOME. RECENT BEHAVIORAL PROBLEMS RESULTING FROM ANGER AND OUTBURST PROBLEMS WITH ADJUSTMENTS DUE TO NUMEROUS FOSTER PLACEMENTS. CHRIS REPORTS THAT HIS MOTHER IS IN PRISON ON DRUG RELATED CHARGES AND FATHER IS UNKNOWN. HE REPORTS SIGNIFICANT ABUSE FROM HIS CHILDHOOD IN WHICH HE WAS OFTEN LOCKED IN A CLOSET FOR DAYS AT A TIME FOR "MISBEHAVIOR". HE REPORTS USE OF CANNABIS ON A DAILY BASIS, USE OF ALCOHOL BINGE DRINKING ON WEEKENDS AND ECTASY SEVERAL TIMES PER MONTH. HE ALSO REPORTS VERY COMPULSIVE BEHAVIOR AND HAS TO MAKE SURE THAT EVERYTHING IS BALANCED AND OFTEN COUNTS AND CANNOT STOP UNTIL HE REACHES 20. HE WAS DIAGNOSED BY HIS MEDICAL DOCTOR WITH ADHD AND IS CURRENTLY ON CONCERTA.

PLEASE GIVE AXIS IMPRESSIONS

AXIS I PRIMARY SECONDARY

AXIS II

AXIS III

AXIS IV

AXIS V

Terminology

MICA - Mentally ill chemical abuser
MISA - Mentally ill substance abuser
MISU - Mentally ill substance using
CAMI - Chemically abusing mentally ill
SAMI - Substance abusing mentally ill
MICD – Mentally ill chemically dependent
Dually Diagnosed
Dually Disordered
Co-Morbid disordered
ICOPSD – individuals with co-occurring psychiatric and SA disorders
Co-Occurring Disordered

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Principals in Treating Adolescents with Co-Occurring Disorders

- Employ a recovery perspective
- Adopt a multi-modality viewpoint
- Develop a phased approach to treatment
- Address specific real life problems
- Plan for the client's cognitive impairments
- Use support systems to maintain effectiveness

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How the times have changed
Public school teachers rate the top disciplinary problems

1940

- Talking out of turn
- Chewing gum
- Making Noise
- Running in the halls
- Cutting in line
- Dress-code violations
- Littering

2009

- Drug Abuse
- Alcohol Abuse
- Pregnancy
- Suicide
- Rape
- Robbery
- Assault

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Vision for Integrated Treatment

- Client participates in 1 program that provides treatment for both disorders
- Staff are trained in assessment and treatment for both
- Staff offer Substance use treatment for clients who have Mental Health disorders
- Focus on preventing anxiety rather than breaking denial
- Emphasis is placed on trust, understanding and learning
- Treatment is more slow paced
- Use of evidence based models
- Self help groups for both
- Medications are used as needed

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Competency & Training in Co-Occurring Disorders and Introduction to Screening & Assessment Module 2

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Competency

Basic Competency – Every program should have staff with basic skills

Intermediate Competency – Skills in engaging SA clients, screening, mental health assessment data, supporting meds, running basic SA groups

Advanced Competency –Demonstrates skills to run an integrated program and how COD interact with a client. Staff credentialed in COD

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Clinician Competency

- Desire to work with Co-Occurring clients
- Appreciation of complexity with those with co-occurring disorders
- Open to learning new information
- Awareness of personal reactions
- Recognition of limitation and expertise
- Patience and therapeutic optimism
- Flexability in approach
- Cultural competence
- Belief that clients do recover

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CrossTraining

Substance abuse staff need to have knowledge in:
Increased knowledge of mental health disorders
Relationship between different MH symptoms, drug of choice, and treatment history
Modifying approaches to meet the needs of clients treatment goals

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Cross Training

- Mental health staff need to understand:
- Characteristics of a person with Co-Occurring issues and specifically addiction
- Nature of addiction
- Conduct of staff roles in treatment
- Interactive effects of both conditions
- Understand recovery communities and Self Help
- Understanding of Pharmacology & Neurobiology
- Resolve prejudice in working with Substance Use Disorders

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Examples of Advanced Competencies

- Use DSM-IV to assess substance related disorders and Axis I and Axis II mental disorders
- Comprehend the effects of level of functioning for disorders
- Use integrated models of treatment as opposed to parallel models
- Apply knowledge of relapse (MH & SUD) is not a failure but may need change in treatment plan or level of care.
- Involve the family in cooperative treatment process
- Develop an integrated treatment plan.

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Staffing

- Staff should include not only MH and SA staff but staff that is Co-Occurring Disorder credentialed and trained.
- Support staff also need training in basic evidence-based models

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Co-Occurring Disorder Certifications

- Psychologist and physicians offer specialization in Co-Occurring Disorders
- ADACB-Ga. offers a credential in co-occurring disorders
- Ask if tx professional is certified in co-occurring disorders
- Do they have CCDP Certified Co-Occurring Disorder Professional.

www.adacbga.org

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Categories of mental health and substance use disorders in teens

Mental Disorders

- Major Depression
- Conduct Disorders
- Borderline Personalities
- Bipolar Disorder
- Schizoaffective
- Schizophrenia
- Posttraumatic Stress
- Social Phobia
- ADD & ADHD

Addiction Disorders

- Alcohol Abuse / Dependency
- Cocaine/Amphetamines
- Opiates
- Volatile Chemicals/Inhalants
- Marijuana
- Polysubstance combinations
- Prescription drugs

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Screening Tools

- PHQ 9 Adolescent – Mental Health
- CRAFFT – Substance Use
- Brief Mental Health Screening
- Brief Symptom Inventory
- Full listing at www.ncjrs.gov

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ASSESSMENT FOR COD

- Keep in mind that assessment is about getting to know a client with complex needs. Do not rely on tools alone for a comprehensive assessment.
- Always make every effort to contact all involved parties such as families, other providers, court systems, and other collaterals.
- Don't allow preconceptions about addiction to interfere with learning about what the client really needs.
- COD is likely to be under recognized
- Symptoms of drug use often mimic MH

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DO's and Don't's of Assessment

- **Make every effort to contact other parties, family,other programs, court systems etc.**
- **Do become familiar with diagnostic criteria for mental health disorders**
- **Don't assume that 1 treatment approach is correct (term of evidence based multi-modality.**
- **Do understand what you and your agency are capable of**
- **Do remember that empathy and hope are the most valuable tools in your work with a client.**

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Assessment Tools

- ASAM- American Society of Addiction Medicine
- Quadrants of Care
- ASI- Adolescent Addiction Severity Index
- CAFAS- Child & Adolescent Functional Assessment
- GAIN - Global Assessment of Individual Needs
- GAF- Global Assessment of Functioning
- Criminal Justice Assessment tools
- Texas Christian University assessments

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ASSESSMENT TOOLS

- Assessment information it needs to include client's readiness to change, problem areas, COD diagnosis, disabilities and strengths, background, family, trauma, domestic violence issues, legal involvement, financial issues, health, education, housing status, employment, substance use and history, amount of use, patterns of use, family history of addiction, mental health problems and family history, past medications
- ASI Adolescent is a good tool especially for courts

GAIN is also utilized tool

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Assessment of Co-Occurring Disorders Module 3

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Assessment Tools

- **Global Appraisal of Individual Needs GAIN**

Purpose: Implement model of treatment planning and outcome monitoring
Clinical Utility: Used for substance abuse disorder, ADHD, conduct disorder intoxication, measures core set of clinical status. Used in adults and adolescents. Has 8 areas of review similar to Addiction Severity Index.

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Other Assessment Issues

- Assessment should be done by strong clinician familiar and trained /certified in co-occurring issues
- A screening is not an comprehensive evaluation. Most 15 to 20 minute tools are screening and not a full assessment.
- Clinician should be able to link symptoms with appropriate level of care and understand ASAM levels and mental health needs.
- Consider risk potential for Mental Health & Substance Use

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Steps in Assessment Process

Step 1. Engage the Client

Provide an empathetic welcoming manner and build a rapport to facilitate open disclosure.
Create an environment which is safe and non-judgemental
There is no wrong door.
Person centered assessment determines what the client wants, what they want to change and how they think that will occur
Consider cultural issues

WHAT DOES THE CLIENT WANT?

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Steps in Assessment

Step 2 – Identification of Collaterals

Clients presenting for SA treatment especially those with mental health issues may be unwilling or unable to report information accurately

Follow confidentiality guidelines

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Steps in Assessment

Step 3: Screen for Co-Occurring Disorders

Screen for both MH and SA issues
Screen for safety risk: suicide, violence, HIV, Hep C, and danger of physical or sexual victimization.

Screen for cognitive deficits.

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Steps in Assessment

Step 4: Determine Quadrant of Responsibility

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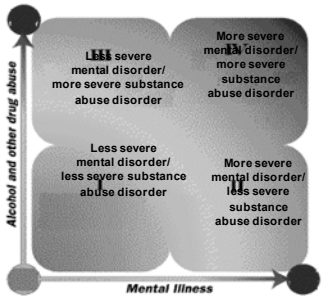
The four quadrant framework for co-occurring disorders



A four-quadrant conceptual framework to guide systems integration and resource allocation in treating individuals with co-occurring disorders

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Steps in Assessment

- Quadrant I – adolescents with low severity substance abuse and low severity of mental health disorders. This level can be accomadated in intermediate outpatient settings with consultation or collaboration.
- Quadrant II – adolescents with high severity MH disorders and low severity SA disorders Normally receive tx in mental health centers using integrated case management

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Steps in Assessment

- Quadrant III – adolescents who have severe SA disorders and low to moderate MH issues. Usually accomadated in SA programs with collaboration.
- Quadrant IV – adolescents with serious MH issues and unstable SA disorders. This area requires integrated comprehensive services for both disorders and can be residential.

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Steps in Assessment

Step 5: Determine ASAM Level of Care

Use of ASAM PPC-2R
Dimension 1: Acute intoxication/withdrawal potential
Dimension 2: Biomedical conditions
Dimension 3: Emotional and cognitive complications
Dimension 4: Readiness to change
Dimension 5: Relapse potential
Dimension 6: Recovery environment

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Steps in Assessment

- Step 6: Determine Diagnosis

Gather as much information as possible and do not assume.

Persons with mood swings and hallucinations can also be linked to drug use such as meth use and mimic other mental health disorders.

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Steps in Assessment

- Step 7: Determine Disability and Function

Assessment of cognitive functioning, social skills, past participation in special education, past testing, ability to live alone, keeping a job, engage in normal social relationships, level of intelligence, learning issues, school placement

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Steps in Assessment

- Step 8: Identify Strengths and Supports

Talents and interest
Areas of educational interest, vocational skills, creative expression, supportive relationships, previous tx for SA and MH and what worked and did not work

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Steps in Assessment

- Step 9: ID Cultural Needs and Supports

In addition to normal cultural issues COD clients often don't fit into normal tx culture. May not feel comfortable in traditional MH or SA tx programs.
Issues with literacy
May not fit into normal 12 step programs
Families see them as different

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Steps in Assessment

- Step 10: ID problem domains

COD clients may have difficulties with medical issues, legal, vocational, family, social, financial, etc.
Determining resolution in these areas also help de-escalate stress and anxiety symptoms.

Steps in Assessment

- Step 11: Determine Stages of Change

Evidence based practices match each disorder with interventions but also to stage of change
For each problem both mental health and addiction
Precontemplation- no interest in change
Contemplation – Might consider a change
Preparation- Getting ready to change
Action- actively working on change
Maintenance- maintaining change

Steps in Assessment

- Step 12: Plan treatment

Treatment plan should be matched to the person
Integrated treatment planning involves helping the client to make the best possible treatment choices.
Counselor also needs to make adjustments as needed.
Plan needs to be logical !

Assessment Issues

- In working with SUD and adolescents must ask specific questions
- 1. Who have you used with in past?
- 2. When did you commonly use?
- 3.What do drugs/alcohol do for you?
- 4. If in prior tx what worked and what did not?

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Adolescents are usually not honest of drug use. Baseline testing helps in treatment planning and care

Use drug testing clinically to monitor drug use or help rule out issues

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BREAK

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Evidence-Based Models in Co-Occurring Treatment Module 4

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Strategies and Evidence Based Practice's for Working with Clients with Co-Occurring Disorders

- What is the biggest key to determining a successful outcome for an adolescent?

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Stages of Change
Prochaska & DiClemente

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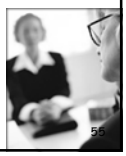
Use of Motivational Interviewing

- Provides clarification
  People with SUD & MH disorders have confusion around issues & often find the process of MI helps to sort things out for them.



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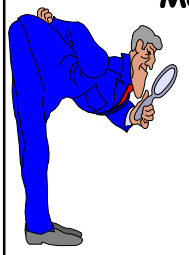
Four Principles of Motivational Interviewing



1. Express empathy
2. Develop discrepancy
3. Avoid argumentation
4. Support self-efficacy

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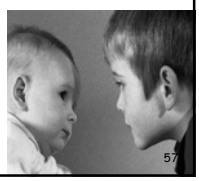
1. Express Empathy

- Acceptance facilitates change
- Skillful reflective listening is fundamental
- Ambivalence is normal



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2. Develop Discrepancy

- Awareness of consequences is important
- Discrepancy between present behaviors and goals motivates change
- Have client present reasons for change
- Elicit Pros and Cons of behavior change versus status quo (helps client explore own ambivalence)

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3. Avoid Argumentation

- Resistance is signal to change strategies
- Resistance is an interpersonal phenomena
- Labeling is unnecessary
- Elicit client's stated concerns
- Clients' attitudes shaped by their own words

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4. Support Self-Efficacy

- Belief that change is possible is important motivator MH & SUD
- Client is responsible for choosing and carrying out actions to change
- There is hope in the range of alternative approaches available
- Built on past successes

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Different from Traditional Approaches

- Counselor can enhance motivation.
- This is different from the notion that the client either is or is not motivated to change.
- It's also different from the notion that you have to hit rock bottom to change.

Contingency Management

- What is contingency management?
- CM has been shown to be effective with all populations, especially adolescents enhancing retention rates and improving outcomes.
- Utilizing rewards systems activates reward system in brain to produce behavioral changes

Cognitive Behavioral Therapy

- A therapeutic approach that seeks to modify negative or defeating behaviors
- Coping by thinking differently
- Teaching new skills

Cognitive Behavioral Therapy

- Cognitive Restructuring
- Learning to change thinking and negative behaviors
- Identifies strategies to replace irrational beliefs with rational beliefs

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Cognitive Behavioral Therapy

- Approaches are educational, active, problem focused, repetitive, time limited
- In addiction it helps clients recognize situations where they are likely to use substances and to learn better ways to cope without drugs. Mental health recognize med non-compliance.

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Cognitive Behavioral Therapy for Co-Occurring Disorder Adolescents

- Use verbal aids, mapping, illustrations, be visual
- Practice role preparation and rehearse for unexpected situations
- Provide specific feedback on techniques
- Use outlines for sessions with learning objective
- Test for knowledge understanding
- Make use of memory enhancement aids, notes tapes, repeat if needed
- Repeat information and ask what they remember from last group.

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Cognitive Behavioral Therapy & Teens

- Working with teens Cognitive Behavioral Therapy must also teach:
- Coping Skills
- Communications skills
- Life Skills
- Consider learning styles in process

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Treatment Continued & Special Issues in Treatment of Teens Module 5

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Relapse Prevention and COD in Adolescents

- RP is an intervention designed to teach individuals who are trying to change behavior how to anticipate and cope with problems of relapse.
- Ensure compliance with Rx meds
- Relapse from substances

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Relapse Prevention and COD Adolescents

- Aspects of Relapse Prevention

Have the client explore both positive and negative consequences
Recognize high risk situations
Help learn new skills to avoid situations
Develop emergency plan
Cope with drug use urges
Use for both Mental Health & Substance Use

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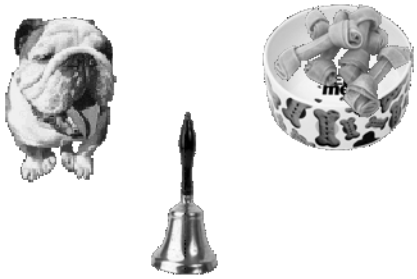
Triggers and Cravings



Pavlov's Dog

Relapse Analysis Chart

Name:_____ Date of Relapse:_____

A relapse episode does not begin when drug/alcohol ingestion occurs. Frequently there are pre-use events that occur, which are indicative of the beginning of a relapse episode. Identifying your individual process patterns will allow you to interrupt the relapse episode before the actual drug/alcohol use and to make adjustments to avoid the full relapse. Using the chart below, note events occurring during the week immediately preceding the relapse being analyzed.

CAREER EVENTS	PERSONAL EVENTS	TREATMENT EVENTS BEHAVIORS	DRUG/ALCOHOL RELATED	BEHAVIORAL PATTERNS	RELAPSE COGNITIONS	HEALTH HABITS STATUS
FEELINGS RELATIVE TO ABOVE EVENTS						

What changes do you need to make to prevent further AOD use?

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Therapy Options

- Groups are the "primary office" for addiction professionals.
- Individual therapy is the primary office of mental health professionals
- Staff need to feel comfortable in both treatment settings.

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Treatment

- Programs should be developed to take into account different developmental needs based on the age of the adolescent. Younger adolescents have very different needs than the older adolescents. Place in age appropriate settings.

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Treatment

- Treatment of a 14 year old should not be the treatment of a 17 year old. The needs and development are much different

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Treatment

- Some delay in normal cognitive and social-emotional development is often associated with Substance use during adolescent period.
- Treatment should identify such delays and their connections to academic performance, self-esteem and social considerations

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Treatment

- In addition to age, treatment for adolescents must also take into account gender, ethnicity, disability status, stages of change and culture

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Group Therapy

- Use groups to provide education, Relapse Prevention and skill building thru Cognitive Behavioral Therapy
- Use individual sessions to address issues not appropriate in group settings
- Know when to address issues such as trauma given cognitive impairments caused by addiction & brain changes

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Outpatient Programs

- Improving Adherence of COD in OP
- E-Therapy (new treatment trend)

Use phone & text messaging for reminders
Provide reinforcement for attendance/behavior change
Increase frequency and intensity of OP services
Develop collaboration with staff
Reduce waiting times for appointments
Have programs that are Co-Occurring Disorder specific
Utilize case managers and recovery coaches
Monitor symptoms of both disorder

Outpatient Program elements

- Emphasizes client responsibility, coaching, and use senior peers to guide the program
- Medication and ensures med compliance
- Builds client rapport due to frequency of staff visits
- Utilize token economy
- Client action plan (treatment plan)
- Preparation for discharge

Consider Labels Kids Place on Themselves and Others

Emos 

Goths 

Jocks 

Cheerleaders 

Mean Girls 

Stoners 

Special Populations: Juvenile / Criminal Justice

- Research indicates that rates of COD in YDC/jail are as high as 80%
- Staff are trained in COD and have COD credentialed staff on site
- Both disorders are treated as primary
- Treatment should be integrated
- Address anti-social or conduct disorders as part of the co-occurring issues

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Juvenile Justice Issues

- Must address negative factors of multiple risk, peer deviance, poor family dynamics
- Address the needs of the family, poor parenting skills, substance use disorders
- Comply with confidentiality laws while getting the needed info
- Overcoming typical lack of motivation to engage teen, as they have not "hit rock bottom"

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Suicidality

- Not a mental disorder in and of itself but a high risk behavior associated with COD. (Depression)
- Most people that kill themselves have a diagnosable mental disorder and substance disorder
- Monitoring of depressive symptoms is critical

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Suicide: Certain populations are at higher risk

Suicide rates among those with

ADDICTION

are 5-10 times higher than for those without addiction….

(Source: Preuss / Schuckit, Am. J. Psych., 2003)

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Trauma & Teens

- Homicide and suicide are 2nd & 3rd leading causes of death among 15-34
- Among youth:
- 60% exposed to violence in past year
- 8% reported prevelance of sexual assault
- 17% reported physical assault
- 39% reported witnessing violence

Source : SAMSHA

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Substance Use Disorders Symptoms and Issues Module 6

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The Scope Of Adolescent Substance Abuse

Todays Drugs of Choice

Alcohol
Nicotine
Cannabis
- Stimulants (Adderall & Ritalin)

Rx drugs (oxycotin & percocet)
Ectasy

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Substance Abuse: DSM-IV Criteria

Maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:

- Failure to fulfill major role obligations at work, school, or home
- Recurrent substance use in situations in which it is physically hazardous
- Recurrent substance-related legal problems
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance

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Substance Dependence: DSM-IV Criteria

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

- **Tolerance**
- **Withdrawal**
- **Using larger amounts or over a longer period than was intended**
- **Persistent desire or unsuccessful efforts to cut down**
- **A great deal of time is spent in obtaining the substance, using, or recover from the substance's effects**
- **Important social, occupational, or recreational activities are given up or reduced**
- **Continued use despite knowledge of having a persistent or recurrent physical or psychological problems caused by substance**

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Drug Induced Psychopathology

- ACUTE WITHDRAWAL– SYMPTOMS THAT OCCUR AFTER NORMAL WITHDRAWAL, UNCLEAR THINKING, COGNITIVE DEFICITS, POOR JUDGEMENT, INABILITY TO DEAL WITH STRESS
- 7 TO 14 DAYS FROM CEASING DRUG USE.
- PROTRACTED WITHDRAWAL – ANXIETY, POOR MEMORY CONCENTRATION, INSOMNIA, PAIN IN LIMBS,
- COGNITIVE DEFICITS OFTEN CAUSE ISSUES IN TX. SYSTEM OFTEN SETS UP FOR FAILURE

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DIFFERENCES

Using Teens

- ✓ "stop where they start"
- ✓ Have limited coping skills
- ✓ "Chaos" is comfortable
- ✓ Must be "high" to feel balance
- ✓ Thrill seeking to extremes-no boundaries

Non-Using Teens

- ✓ Develop within stages
- ✓ Learning and testing out new coping skills
- ✓ Figuring it out is half the fun
- ✓ Occasional Adrenaline rushes bring balance
- ✓ Thrill seeking within boundaries set

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Is there a Problem?

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SIGNS – THE A B C's

A Academics and Activities?
B Behavior?
C Changes in Habits?
D Demeanor and Mood?
E Energy?
F Friends?

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Do we all "USE"

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Statistics

- "1 in 6 teens has abused a prescription pain medication"
- "1 in 10 report abusing prescription stimulants and tranquilizers"
- "1 in 11 has abused cough medicine"
- "Many teens think these drugs are safe because they have legitimate uses"

http://www.usdoj.gov/ndic/pubs1/1765/

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Why does the drug abuse start?

Family Influence

- Lack of attachment and nurturing by parents or caregivers
- Ineffective parenting
- A caregiver who abuses drugs.
- Escaping boredom
- Abusive relationships

School

Influence of peers or formation of a romantic relationships often pushes children and adolescents into drug use. They may think that prescription drugs they are safer to use.

http://www.drugabuse.gov/Prevention/examples.html

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"Stages" of use

- **Stage 1- Potential for Abuse**
  - Do parents use?
  - Do they have older siblings that use?
  - Can they get it easily?
  - Are there mental health issues?
  - Has there been or is there abuse issues?
  - Are their self-esteem issues? Do they feel like a "misfit"?
  - Is there a family history?
  - What is supervision like?

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- **Stage 2- Experimentation**
  - "Testing the waters"
  - Asking lots of questions
  - Trying to associate with others who have questions
  - THIS IS A SHORT STAGE-you either like it and advance to next stage or stop

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- **Stage 3- Use to Preoccupation with Use**
  - Will start to possess paraphernalia
  - Spends more time with friends that use
  - Starting to see signs of poor grades, decrease in extra-curricular activities, increase in irritability, poor relationships with authority figures and friends that don't use

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- **Stage 4- Addiction**
  - Compulsion to use substances
  - Plans activities around substance use
  - Will chose substance use over family or friends who do not use
  - preoccupation with procuring
  - Physically -signs of not eating or sleeping well

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- **Stage 5-Deterioration of Self**
  - Physically
  - Emotionally
  - Spiritually
  - Intellectually
  - Socially

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LUNCH

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Common Drugs of Choice in Teens Module 7

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What Do They Do? By Gender

Girls
- Alcohol
- Tobacco
- Prescription Drugs

Boys
- Alcohol
- Marijuana
- Tobacco

 95 105

Why do they do it?

- Girls
  - Their significant others are using
  - They are trying to escape trauma- past or present
  - They are trying to feel better about themselves
  - Feel balanced
- Boys
  - Their friends are using
  - It heightens the "nerve" factor
  - They are trying to make others feel better about them
  - The thrill

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Some Physical Symptoms

- Bloodshot eyes
- Dull-looking/glazed eyes
- Watering eyes
- Drowsiness
- Manic/hyper behavior
- Runny nose
- Coughing
- Needle marks
- Weight loss
- Constant desire for junk food
- Malnutrition
- Some form of acute acne
- Tremors
- Hallucinations
- Delusions

107

Some Behavioral Symptoms

- Irresponsible behavior
- Argumentative
- Lack of motivation
- Solitary behavior
- Doesn't want to be home
- Non-participation
- New friends
- Forgetfulness
- Lying
- Changes in speech- rapid, slowed, slurred
- Legal problems

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Other Symptoms

- Secretiveness
- Falling grades
- Truancy
- Car accidents
- Fascination with light
- Auditory (hearing) problems
- Use of eye drops
- Use of mouthwash, mints, gum, PButter
- Odd small containers
- Charm necklaces
- White specks on nostrils or clothing
- Frequent trips to the bathroom or locker

  109

Alcohol and Teens

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HS Alcohol Use

By their Senior year 76% acknowledge they have tried alcohol, 48% admitting use within the past month. These figures in the 8th grade are 50% and 21% respectively

111

"Drinker" Definitions(1)

- Binge drinking: Four or more drinks for a female and five or more drinks for a male at one sitting

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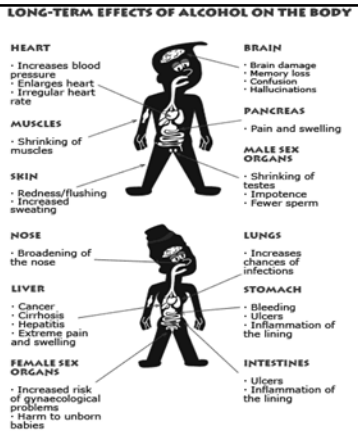
"Drinker" Definitions(2)

- Chronic drinking: Daily or almost daily alcohol consumption (60 drinks per month)

113



114

The brain images below show how alcohol may harm teen mental function. Compared with a young non-drinker, a 15-year-old with an alcohol problem showed poor brain activity during a memory task. This finding is noted by the lack of pink and red coloring.

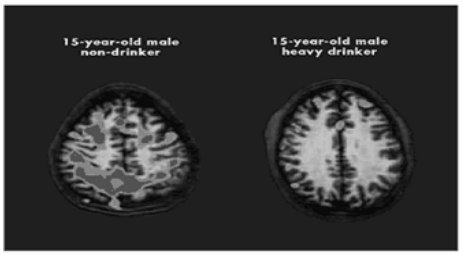
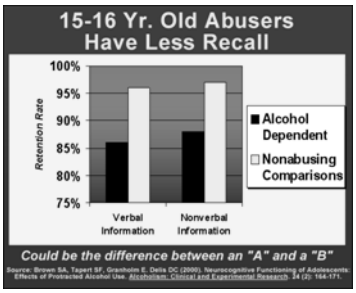


Image from Susan Tapert, PhD, University of California, San Diego.

115

Studies on Teen Drinking



116

Alcohol

Duration of Action	Rapid onset with oral ingestion; higher blood level in women, drink for drink.
Acute Behavioral Effect	User notices light-headed, dizzy feeling that may progress through drowsiness and onto unconsciousness. The user may hallucinate and report visions.
Post-Use Appearance	A moderate to severe hangover starts almost immediately following the termination of drug effect. This can last for days. User appears agitated and irritable during this period with mood swings.
Toxicity	Rapid loss of consciousness, vomiting, respiratory depression.
Long-Term Effects	May cause permanent damage to the liver and kidneys. Behavioral changes may be diagnosis as an organic cognitive condition or mood disorder.
Addiction	Highly addictive in the predisposed user.

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Alcohol and Teens

- Tips to consider:

Alcohol abuse/dependence often causes depressive symptoms and often alcohol is used to self-medicate

RULE OUT; DEPRESSIVE DISORDERS

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Marijuana & Teens

What's the problem with pot?

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Marijuana

- Street names include *pot, herb, weed, boom, Mary Jane, and blunt*
- Average age of first use is 14
- The amount of tar inhaled and the level of carbon monoxide absorbed are 3-5 times greater than cigarette smokers.

120

Withdrawal From Marijuana

- Heavy MJ smokers meet by report more than 6 of the 9 Criteria for substance dependence in a recent study (3 Req)
- Most severe withdrawal at day 2-3.
- Symptoms subside at 3 weeks.
- Craving
- Decreased appetite
- Sleep difficulty
- Weight Loss
- Aggression
- Anger
- Irritability
- Restlessness
- Strange Dreams

121

Marijuana & Formaldehyde

Duration of Action	Rapid onset of drug action occurs following smoking of leaves dipped in formaldehyde and dried. Effects may last for hours with long-term effects seen for weeks following use.
Acute Behavioral Effect	Feeling of being "stuck" and intoxicated is commonly reported. People describe action as combing alcohol and marijuana. Person displays and inattention to environment, speech and language disruption with agitation
Post-Use Appearance	Individual may appear severely behaviorally disturbed for days or weeks following use.
Toxicity	Severe states of agitation may occur with upper extremity weakness and depressed reflexes. Tachycardia, tremor, sweating and hypersalivation may occur; seizures and pulmonary and cerebral edema may follow.
Long-Term Effects	Unknown, suspected long-term effect may be damage to nervous system. Behavioral disturbances may be confused for psychotic disorder, bipolar disorders.
Addiction	Clearly addictive in the predisposed user.

122

Effects of Marijuana Use

- **Physical Effects of use:** Dry mouth, nausea, headache, decreased coordination, increased heart rate, reduced muscle strength, increased appetite and eating
- **Mental Effects of use:** Anxiety, paranoia, confusion, anger, hallucinations, tiredness, possible suicidal thoughts

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Other effects of Marijuana

- **Reproductive Problems in Guys:** smaller testicular size, lower testosterone hormone levels, impotence, decreased sexual desire, change in sperm size, amount and strength.
- **Reproductive Problems in Girls:** Period problems, abnormal eggs, decreased sexual desire, reduced fertility in your future children
- If used during pregnancy, it can decrease the size of the baby and increase the risk of the baby illness

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Marijuana and Teens

- Tips for consideration:
- Marijuana often displays symptoms of depression and is often used to self medicate anxiety disorders. Teens predisposed to depression and suicidal tendencies, marijuana will often exacerbate or trigger on set of those MH symptoms
- RULE OUT: Depression and anxiety

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Drugs of Choice Continued Module 8

126

Inhalants

- Chemicals that are "huffed" or "sniffed" like paint thinners, gasoline, glue, butane lighters, propane tanks, aerosol sprays, nail polish remover, etc.
- **Effects of Use:** Slows down the body's functioning, loss of body control, passing-out, permanent hearing loss, permanent muscle spasms and twitches, cancer, brain damage, bone damage, liver & kidney damage, heart failure and possible death.
- The vast majority of teens aren't using inhalants. According to a 1998 study, only 1.1% of teens are regular inhalant users and 94% of teens have never even tried inhalants.

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Inhalants and Teens

- Due to the damage inhalants can cause on the brain symptoms of schizophrenia may be noticed
- RULE OUT: Early onset of schizophrenia

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Inhalants "Huffing"

They are chemicals which cause intoxication when sniffed or inhaled. They include common, household solvents, aerosols, and gases such as paint thinner, dry-cleaning fluid, gasoline, glue, felt-tip marker fluid, deodorant and hair sprays, spray paint, air fresheners, butane lighters, and propane tanks.

Prolonged inhalant abuse can also cause damage to the brain and other organs of the body. But the biggest risk involved with inhalant use is death by overdose. Inhalant use can cause sudden heart failure, or "sudden sniffing death syndrome," even in individuals who are young and healthy.

National Surveys on Drug Use & Health found an annual average of 1.1 million (4.5%) youths aged 12 to 17 used an inhalant in the 12 months prior to being surveyed. About 2.6% of all youth who had not used inhalants before were new users (that is, had used an inhalant for the first time in the past year). The annual average of new users was 600,000 youth (289,000 males and 311,000 females).

http://www.helpguide.org/mental/drug_substance_abuse_addiction_signs_effects_treatment.htm#downers

http://www.drugabusestatistics.samhsa.gov/2k7/inhalants/inhalants.cfm

129

What are the commonly abused drugs?

-Pain Killers (narcotics such as oxycodone, percoset and hydromorphone)

-Uppers (Ritalin and Adderall)

-Downers (Sleeping pills and prescription medications such as Xanax and Valium)

-Inhalants (paint thinners, gasoline, glues, hair spray, spray paints)

-Dextromethorphan (cough medicine)

http://www.usdoj.gov/ndic/pubs1/1765/

130

Pain Killers-Oxycodone

The abuse of opioids/pain relievers by young people is a particular concern. According to the 2000 NHSDA, 8.4 percent of 12- to 17-year-olds reported having abused pain relievers at least once in their lifetime.

-Oxycodone is the most abused prescription pain killer. OxyContin, which has heroin-like effects that last up to 12 hours, is the fastest growing threat among oxycodone products.

Health risks related to painkiller abuse include lack of energy, inability to concentrate, nausea and vomiting, and apathy. Significant doses of painkillers can cause respiratory depression and in rare cases death.

http://www.theantidrug.com/drug_info/prescription_classes.asp)

131

But it is hard to get narcotic pain killers without prescription right?

Google Search!

- *Buy OxyContin **online** in 40mg, 10mg, 20mg, 80mg 12 hour tablets ...*
- Buy OxyContin **online** in 40mg, 10mg, 20mg, 80mg 12 hour tablets; cheap drug prices and information. www.drugstore.com/qxd/OxyContin_333181_sespider/oxycontin/oxycontin.htm - 42k - Cached - Similar pages
- ***oxycodone** - **Online** Pharmacy =>> You **oxycodone**!!!*
- **oxycodone** --> The Cheapest price for you! Free Deverli! Save you $$$$! Low price! **oxycodone**! All pharmacy cheap! **oxycodone**. www.bagchee.com/img/aplus/wr/ph/**oxycodone**.html - 7k - Cached - Similar pages
- ***Oxycodone** - Buy **Online** Cheap, Generics and Brand!*
- **Oxycodone** - Order **Oxycodone** from Home - Best **Online** Pharmacy Prices, Order Prescriptions Today ! -- SEE THIS BEFORE YOU BUY **ONLINE** !!
- Just how much does it cost to buy it over the internet?
- **Hydrocodone Pain Pills 10mg 100 tabs = $34.99**

(Retrieved from Google search engine)

132

Stimulants

Ritalin (methylphenidate) is one of the stimulants most commonly abused by young people. It is an amphetamine-like central nervous system stimulant with properties that are similar to cocaine. Individuals abuse Ritalin to increase alertness, lose weight, and experience the euphoric effects resulting from high doses.

Health risks related to stimulant abuse include increased heart and respiratory rates, excessive sweating, vomiting, tremors, anxiety, hostility and aggression, and in severe abuse suicidal/homicidal tendencies, convulsions and cardiovascular collapse.

http://www.usdoj.gov/ndic/pubs1/1765/
http://www.theantidrug.com/drug_info/prescription_classes.asp

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Stimulants

While stimulants will initially boost energy and confidence, their use over time leads to symptoms such as anxiety, aggression, sleep difficulties, hallucinations, and paranoid thinking. As uppers wear off, users experience a "crash," characterized by depression, fatigue, and irritability. Overdose can result in heart failure, stroke, and death

http://www.helpguide.org/mental/drug_substance_abuse_addiction_signs_effects_treatment.htm#downers

134

Stimulant Toxicity

- Signs of toxicity
  - Movement disorder
  - Hyperfocused attentional state
  - Stereotypic behavior
  - Paranoid thought
  - Hallucinations

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Prolonged Depression Following Cessation of Use

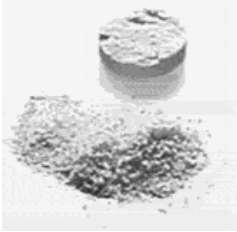
- Use of methamphetamine has been found to produce a reduction in seratonin and dopamine.
- This reduction in serotonin has been found to continue for several months following the last use of the drug.
- A consequence of this depression in serotonin is that mood remains anhedonic for several months following abstinence.

Stimulants and Teens

- Stimulants will often mimic numerous mental health symptoms such as depression, bi-polar disorder and schizophrenia
- RULE OUT: Bi-polar, Depression and schizophrenia

Ecstasy (XTC, Adam, "X")

- Derivative of Meth-amphetamine
- Addictive Risk: High
- Physiological Risk:
  - Cardiovascular
  - Neurological
  - Psychiatric



Ecstasy: Summary of Effects

Duration of Action	4 to 6 hours; onset within 20 minutes of use
Acute Behavioral Effect	Warm glow at low doses; increased dose results in anxiety/panic. Regular use results in sleep problems. User appears to be "giddy", jaw clenched, enhanced sense of touch, highly emotional, elevated level of movement.
Post-Use Appearance	User may appear to be depressed, moody, irritable and hungry. May consume large amounts of fluid. This can last several days.
Toxicity	Severe effects, including death, may result from the use of one or two doses. These include dehydration with the following symptoms: failure to sweat, heat cramps in legs, arms, & back, fatigue, vomiting, fainting, desire to urinate but unable to do so, urine excreted is very dark.
Long-Term Effects	Damage to the nervous system, impairment in memory and judgment; emotional regulation; depression and psychiatric problems may appear following use.
Addiction	Addiction to Ecstasy does occur and is similar in nature to that seen with methamphetamine in predisposed individuals.

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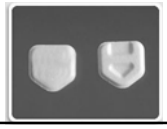
Depressants

They are prescribed to treat a variety of health conditions including anxiety and panic attacks, tension, severe stress reactions and sleep disorders. Also referred to as sedatives and tranquilizers, depressants can slow normal brain function. Such medications can include Xanax and Valium

Health risks related to depressant abuse include loss of coordination, respiratory depression, dizziness due to lowered blood pressure, slurred speech, poor concentration, feelings of confusion, and in extreme cases, coma and possible death.

http://www.theantidrug.com/drug_info/prescription_classes.asp
http://www.helpguide.org/mental/drug_substance_abuse_addiction_signs_effects_treatment.htm#downers



140

Dextromethorphan

- **Since the late 1990s, dextromethorphan abuse has increased among adolescents, in part because the drug is easily accessible and is perceived to be safe. Severe side effects have been reported at high doses, including rapid heartbeat, high blood pressure, agitation, loss of muscle control and psychosis (a loss of contact with reality).**
- **About three-quarters of the reported cases were among individuals were age 9 to 17.**
- **Pharmaceuticals are often more available to 12 year olds than illicit drugs because they can be taken from the medicine cabinet at home, rather than marijuana which necessitates knowing someone who uses or sells the drug. Also, pills may have a perception of safety because they are easier to take than smoking pot or drinking alcohol and are professionally manufactured in a lab.**

http://www.drugfree.org/portal/drugissue/features/prescription_medicine_misus
http://www.medicalnewstoday.com/medicalnews.php?newsid=58177

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Spice

- Spice or K2 is a synthethic cannabinoid designed to give cannabis effects.
- Sold in shops, on-line as incense
- Effects such as anxiety attacks, hallucinations, nausea and now believed to have chemical dependency properties

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Salvia

- Hallucinogenic herb native to Mexico, can be found on line and has been sold legally as an herb.
- Plant that can be chewed, eaten or smoked. Effects in 10 minutes symptoms include bright lights, vivid colors, object distortions, sense of loss of body and hallucinations.

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Teens & Mental Health Disorders Module 9

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Psychiatric Disorders and Substance Use Disorders

- Comorbidity is the rule rather than the exception
- Psychiatric disorder can precede or follow onset of SUD
- Questions:
  - If psychiatric disorder precedes, does this lend credence to "self-medication" hypothesis?
  - If substance use comes first, does this mean that substance use caused psychiatric disorder (e.g., Substance-Induced Mood Disorder) or does it just unmask predilection?
  - Are these phenomena causal or just correlated?

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Psychiatric Disorders and Substance Use Disorders

- Abram et al (2003) surveyed 1829 youth aged 10-18 in the juvenile justice system and reported the following:
  - 25% reported that their major mental disorder (MMD) preceded their substance use by > 1 year
  - 10% reported that their SUD(s) preceded their MMD by > 1 year
  - 65% developed their SUD(s) and MMD developed in the same year

Abram KM, *et al.* (2003). Comorbid psychiatric disorders in youth in juvenile detention. *Arch Gen Psychiatry* 60 (11), 1097-1108.

146

Psychiatric Disorders and Substance Use Disorders

- In general population, most common disorders in children/adolescents are ADHD and anxiety disorders
- Most frequent disorders comorbid with substance use in children/adolescents are Conduct Disorder, ADHD, and Anxiety Disorders, depression
- Girls tend to have more internalizing disorders while boys have more externalizing disorders

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Recognizing the Signs

- Mental health disorders emerge during ongoing development and at times may look like misbehavior but are NOT the same.
- Disorders in infancy, childhood, and adolescence may not have the same symptoms as in adulthood.

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Recognize Warning Signs

- Consider three things if you suspect a child may be experiencing an emotional problem:
  - **Frequency:** How often does the child exhibit the symptoms?
  - **Duration:** How long do they last?
  - **Intensity:** How severe are the symptoms?

149

Influences on Children's Mental Health

- Genetics
- Brain physiology
- Disruption in neurochemical transmission
- Environmental factors

- Family stress
- Abuse
- Deprivation of Basic Needs
- Stressful life events
- Cultural norms
- Personality traits

150

Clinical Definition of ADHD
Attention Deficit Hyperactive Disorder

AD/HD is a condition characterized by:

- Poor short term memory
- Hyperactivity
- Impulsivity
- Poor time management

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Clinical Qualifiers

1. Onset before age 7 yrs.
2. Diagnosis often delayed until problems in school
3. In two of three settings - home, school, office
4. Rule out other potentially "look-alike" psychiatric disorders such an oppositional disorder, sensory integration disorder, central auditory processing disorder, learning delays, schizophrenia, stress disorders, psychosis or trauma.

Source: DSM-IV-TR, 2000

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ADHD Behaviors/Symptoms

- Poor short-term memory
- Weak at following directions
- Asking another what was just said
- Looking at others to figure out what was said
- Late for time commitments
- Desk is a mess--poorly organized
- Forgetting about promises made
- Knowing *what and how* but **not** knowing *when and where to do it--it's appropriateness*

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More AD/HD Behaviors/Symptoms

- Spacey, poor concentration
- Weak time orientation
- Cannot plan ahead
- Poor at reflecting on past
- Makes the same mistakes over and over
- Poor time management

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BREAK

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Mental Health Disorders and Teens Continued Module 10

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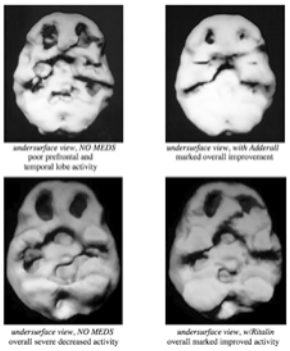
Before and After Treatment: A Tale of Two Brains

Using SPECT scans, we are seeing the underside of two brains (the top two are the same brain and the bottom two are the same brain). The scan on the left was taken before an intervention and the one on the bottom was taken a year later after meds and behavioral therapy. The dark "holes" are areas of metabolic under activity, not actual missing chunks of matter.



images courtesy of Daniel Amen

157

Most-Prescribed Stimulants

- Ritalin® -one dose lasts up to 4 hours
- Metadate® – Ritalin – once a day lasts up to 12 hrs
- Focalin® –Ritalin derivative lasts up to 4 hours
- Attenade®-Ritalin derivative-lasts 6 hours
- Straterra® –lasts for up to 12 hours
- Concerta®- once a day lasts up to 12 hours
- Dexedrine®-last 4 hours-spansule lasts 10 hours
- Adderall®- once or twice a day, lasts longer than Ritalin

158

Stimulants and Substance Abuse

A review of the literature shows that with appropriate treatment and therapeutic medication levels, substance use disorders are decreased

If there is a believe or prior abuse of stimulants must monitor levels with urine analysis to ensure compliance !!!

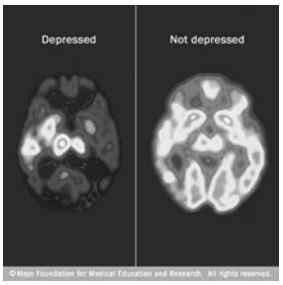
159

Depression and Adolescents

- Loss of interest in usual activities
- Low self esteem, self deprecating remarks
- Lack of energy
- Changes in eating patterns
- Difficulty concentrating
- Sleep problems
- Irritability, restlessness, distracting others
- Change in attitude or behavior
- Symptoms last for more than 2 weeks

160

PET scan of brain for depression



A PET scan can compare brain activity during periods of depression (left) with normal brain activity (right). An increase of blue and green colors, along with decreased white and yellow areas, shows decreased brain activity due to depression.

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Depression Interventions

- Depression is very serious and should be treated immediately
- Encourage a response team approach involving parents, teachers, counselors, & physicians
- Chemical dysregulation may require prescription medication
- Exercise, sunlight, & teaching coping skills are helpful in reducing symptoms

- RULE OUT: Substance use

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Depression Medications

Prozac (only approved FDA medication for under 18)
Paxil
Zoloft
Celexa
Lexapro
Luvox
Effexor

Caution: Some anti-depressants have been found to have substantial side effects in Adolescents and have Black Box warnings for adolescents. Close monitoring is required

163

Definition of Post Traumatic Stress Disorder

Exposure to a traumatic event in which the person:

- experienced, witnessed, or was confronted by death or serious injury to self or others AND
- responded with intense fear, helplessness, or horror

(Source: American Psychiatric Association - *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. 1994.)

164

PTSD

Avoidance of stimuli and numbing of general responsiveness indicated by 3 or more of the following:

- avoid thoughts, feelings, or conversations
- avoid activities, places, or people
- inability to recall part of trauma
- ↓ interest in activities
- estrangement from others
- restricted range of affect
- sense of foreshortened future

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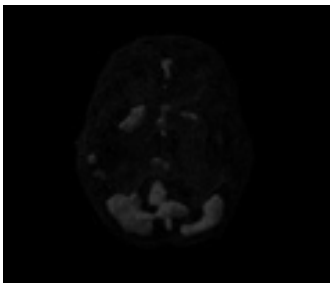
Guidelines for Staff

- Take the trauma into account
- Avoid triggering trauma reactions and / or re-traumatizing the individual
- Adjust the behavior of counselors ,case managers, other staff, and the organization to support the individual's coping capacity
- Allow survivors to manage their trauma symptoms successfully so that they are able to access, retain, and benefit from the services

166

Anxiety Disorder



19 year old with chronic anxiety, conflict avoidance shows marked increased focal activity in the right side of her basal ganglia.

167

Anxiety (warning signs)

- Excessive and irrational fears
- Feels worthless or guilty a lot
- Has worries that last for long periods of time
- Anxious or worried a lot more than other children
- Somatic complaints
- Low self-esteem

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Warning signs of anxiety

- Frequent absences
  - Refusal to join in social activities
  - Isolating behavior
  - Many physical complaints
  - Excessive worry about homework or grades
  - Falling grades
  - Frequent bouts of tears
  - Frustration
  - Fear of a new situation
  - Separation anxiety

169

Meds Used in Tx of Anxiety

Low Abuse Potential
- Vistaril
- Benadryl
- Luvox (most recommended for adolescents)

High to moderate abuse potential
Ativan
Klonopin
Serax
Xanax
Some of these medications are not recommended for adolescents but have been Rx by some physicians for older adolescents

Source:NIMH

170

Defining Bipolar Disorder

Bipolar Disorder - is characterized by episodes of major depression as well as episodes of mania - periods of abnormally and persistently elevated mood or irritability accompanied by at least three of the following symptoms: overly-inflated self-esteem; decreased need for sleep; increased talkativeness; racing thoughts; distractibility; increased goal-directed activity or physical agitation; and excessive involvement in pleasurable activities that have a high potential for painful consequences.

National Institute of Mental Health, 2005

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Bi-Polar Disorder

Separation Anxiety·Rages & Explosive Temper Tantrums (lasting up to several hours)
Irritability·Oppositional Behavior·
Frequent Mood Swings Distractibility· Hyperactivity
Impulsivity·Restlessness/Fidgetiness·Silliness,
Goofiness Giddiness·Racing Thoughts·
Carbohydrate Cravings·
Aggressive Behavior·Grandiosity·
Risk-Taking Behaviors·
Depressed Mood·Lethargy·
Low Self-Esteem· Social Anxiety
Difficulty Getting Up in the Morning
Oversensitivity to Emotional or Environmental Triggers

Rule out stimulant/substance use

172

Medications for Bi-Polar

- Risperdal
- Abilify
- Lithobid
- Zyprexa

Source: AAPP
Monitoring of meds is again critical.

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Mental Health Disorders Continued and Family Therapy Module 11

174

Disruptive Behaviors

- Oppositional Defiant Disorder-angry, defiant, noncompliant, resentful, annoy and blame others
- Conduct Disorder - aggressive behavior toward people or animals, destruction of property, deceitfulness, theft, serious violations of rules

175

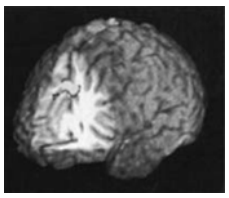
Defining Behavior Disorders

- **Oppositional Defiant Disorder (ODD) tends to manifest as resistance and negativity towards authority figures.**
- **Oppositional behaviors demonstrated in 18-36 month-old children and in teenagers may be part of a normal developmental phase so be alert for intensity and duration of symptoms.**
- **Conduct Disorder (CD) symptoms tend to be broader and represent behaviors that oppose societal rules and/or may represent a violation of the basic rights of others.**

176

Conduct Disorders & Anti Social Personalities

- Research indicates that brain scans of adolescents diagnosed with conduct disorders or later with anti-social personality show lack of development in prefrontal cortex



177

Warning Signs of ODD & CD

- Rage/anger
- Impatience
- Irritability
- Easily annoyed
- Negative thinking
- Perceives slights
- Lacks empathy for others

178

Interventions for disruptive disorders

- Make sure curriculum is relevant and age appropriate
- Avoid arguing and power struggles
- Avoid demands and other escalating prompts such as shouting, touching, nagging or cornering the student.
- Keep rules few, fair, clear, displayed and consistently enforced.
- Teach social skills including anger management, conflict resolution, being appropriately assertive
- Try individualized instruction, cues, debriefing, coaching and positive feedback

179

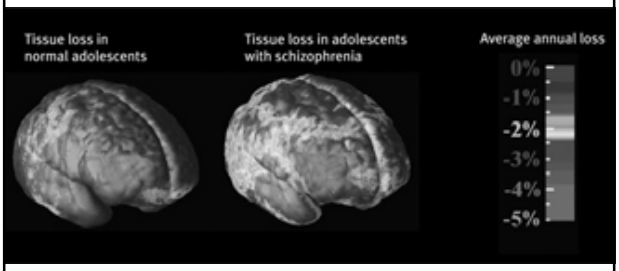
Schizophrenia & Adolescents

- Symptoms include hearing voices, seeing things not there, odd behavior or speech, bizarre thoughts and ideas, extreme moodiness, anxiety, withdrawn and isolating, decline in personal hygiene and talking of odd fears and ideas.
- Rule out substance use

180

Schizophrenia

- Brain scans of teens with schizophrenia show brain lesions in thalamus and frontal cortex



181

Treatment of co-occurring disorders: Areas of promise - Schizophrenia

- Schizophrenia and SA Disorders
  - Differential diagnosis with methamphetamine psychosis can be difficult.
  - Medication treatments may be necessary.
  - Knowledge about medication side effects and the possibility that these side effects can trigger drug use is important.

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Medications for treating schizophrenia

Medications for treating schizophrenia Atypical (or "second generation") neuroleptics:
Resperidol risperidone,
Abilify/aripiprazole,
Zyprexa/olanzapine,
Seroquel/ quetiapine,
Geodon/ziprasidone,
Clozaril/ clozapine.

Usually used in older adolescents over 18, however some of these meds are prescribed and must be monitored closely.

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Family therapy

- A number of family therapy approaches have been found to be very useful in treating youthful substance users

- Approaches include:
  - Family systems therapy
  - Multidimensional family therapy
  - Brief strategic family therapy
  - Network therapy
  - Adolescent Matrix Model

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Family Therapy

When an adolescent is diagnosed with a mental health/substance abuse disorder, the family often feels guilty, does not understand behavior, and often give up on the teen.

Family Therapy is a good place to begin to provide help with feeling of guilt, being overwhelmed.

Often sobriety causes other problems. Family became used to dysfunction, now with sobriety does not really know how to manage the "new child"

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Family Therapy

Family Education and family therapy is critical to successful outcomes.

Due to possible cognitive deficits in early recovery first engage the family in education of Mental Health & Substance Use Disorders

When cognitive deficits improve engage family in family and adolescent in family therapy.

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Adolescent Thinking & Brain Chemistry
Module 12

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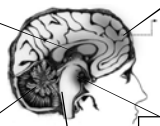
The Adolescent Brain



Corpus Callosum
*Connects Hemispheres
*Creativity & Problem Solving

Frontal Cortex—"*CEO*"
*Planning, Strategizing, Logic, Judgment

Cerebelleum
*Coordinates muscles/ movement
*Coordinates thinking processes

Amygdala
*Emotional and gut responses; fear and anger
*Used more in Adolescents

Hippocampus
***Forms Memories**
***Coordinates thinking processes**

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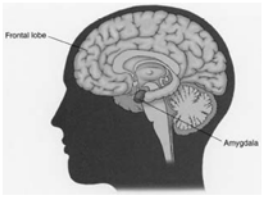
Emotions



Adolescents use the **Amydala** (fight or flight response) rather than the **Frontal Cortex** (used by older adults) to read emotions

Adolescents often misread facial expressions. Adults see fear adolescents may see anger or shock

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Smoking and the Adolescent Brain

- Heavy youth smokers 15x greater risk of developing panic attacks as adults
- Nicotine linked to 10 % smaller **hippocampus**
- Nicotine linked to lower sertonin levels and depression
- Nicotine linked to increased infections and weakened immune systems

Columbia U-New York State Psychiatric Institute Study (2000)

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Why do Youth Engage in Risky Behavior?

Dopamine—brain chemical that creates a sense of well being

- During adolescence dopamine levels decrease in the **nucleus accumbens** (smaller subcortical area involved in pleasure response).
- "Adolescents have a built in urge to live on the edge, to seek thrills, to do things that will enhance chances of survival within the peer group." *Linda Spear—SUNY-Binghamton (2003)*
- High levels of stress reduces dopamine levels.
- Addictive drugs increase dopamine levels and can damage brain chemistry

Prefrontal Cortex

Prefrontal Cortex is the decision maker of the brain involved with judgement and impulse control. Linked to issues with attention, planning, ADHD, Conduct disorders and depression.

Linked to antisocial personality and conduct disorders. Problems with empathy, learning from mistakes.

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Anterior Cingulate

This is the brain's shifter. It helps us shift our attention from one task to another. Usually linked to anxiety disorders, eating disorders, oppositional defiant disorders and compulsions.

Linked to Obsessive Compulsive disorders, Oppositional defiant disorder,

194

Deep Limbic System

Involved in the teens emotional tone. Responsible for negativity, affects motivation and drive. Also linked to mood control, sense of smell, low self esteem and social isolation.

195

Basal Ganglia

Sets the brain's idle or anxiety level. Determines sense of calm, anxiety levels, panic disorders, conflict avoidance and linked to Tourette's Disorder.

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Temporal Lobes

Involved in language, hearing and reading, social cues, short term memory, processing music, processing tone of voice and mood stability. Related to language problems, dyslexia, aggression, depression

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Adolescent Brain Chemistry Cont., Substance Use & Legal Issues Module 13

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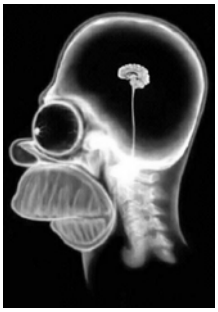
So Now What?!?!?



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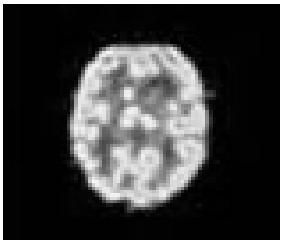
What is going on in there?



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Adolescent Developmental Activities Interrupted by Drug Use

- Cognitive Skills
  - Critical Thinking
  - Abstract Reasoning
  - Judgment
- Social Isolation versus Intimacy
  - Friendships formed while using drugs are very intense
- Mood Regulation
- Physical maturation

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Frontal Lobe Development

The frontal lobes play important roles in a variety of higher psychological processes - like planning, decision making, impulse control, language, memory, and others. There is mounting evidence that neuronal circuitry in the frontal lobes is shaped and fine tuned during adolescence, and that experience plays a prominent role in these changes.

Theory that trying to scare kids out of using drugs does not work!

203

BRAIN DEVELOPMENT

RECENT RESEARCH HAVE GIVEN SCIENTIST AN ESTIMATE OF BRAIN CHEMISTRY DEVELOPMENT:

AGE 11- 50% COMPLETE
AGE 18 – 75% COMPLETE
AGE 22- 32 – 100%
AGE 44 – 75%
AGE 60 – 50

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NEUROTRANSMITTERS

- NOREPINEPHRINE- STIMULANT, ANGER, FEAR, ANXIETY, FIGHT, FLIGHT - COCAINE, METH, ADHD & ADD
- SEROTONIN – DEPRESSANT, SLEEP, CALM PLEASURE- LSD,ETOH, Cannabis (Depression and Sleep Disorders)
- GABA – RELAXANT, STRESS REDUCTION, SEIZURE THRESHOLD – BENZOS, ETOH, BARBITURATES
- ENDORPHINS – PAIN RELIEF, PLEASURE – OPIODS, ETOH
- ACETYLCHOLINE- INVOLUNTARY ACTIONS, MEMORY MOTIVATION – NICOTINE, METH
- ANANDAMIDE-MEMORY, NEW LEARNING, CALMNESS- METH
- GLUTAMATE- ORGANZATION OF BRAIN SIGNALING, MEMORY, PAIN - ETOH METH
- DOPAMINE – PERCEPTION, MOVEMENT, PLEASURE – ALL DRUGS
- NUMEROUS MH ISSUES SUCH AS ADD & ADHD

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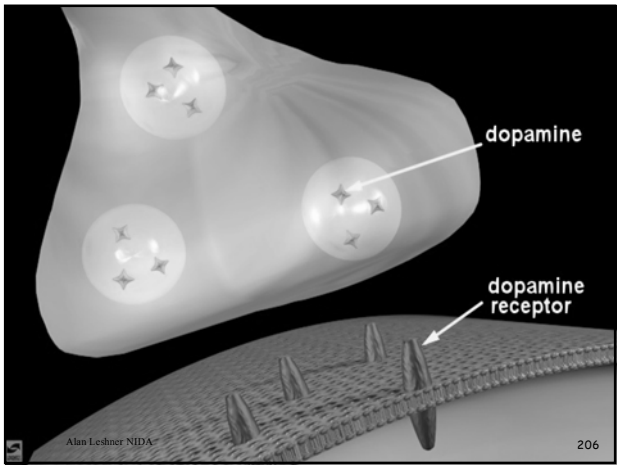

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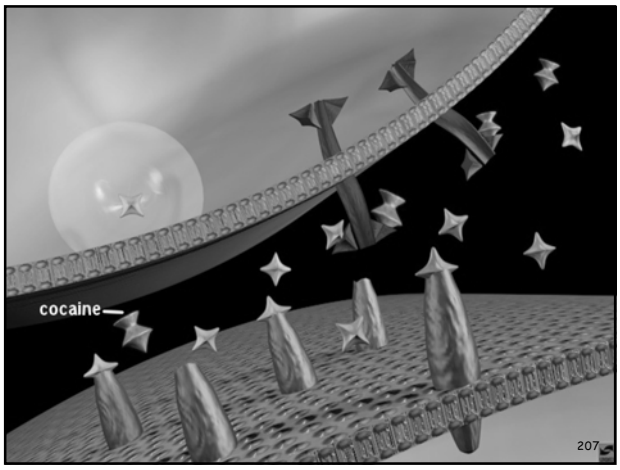

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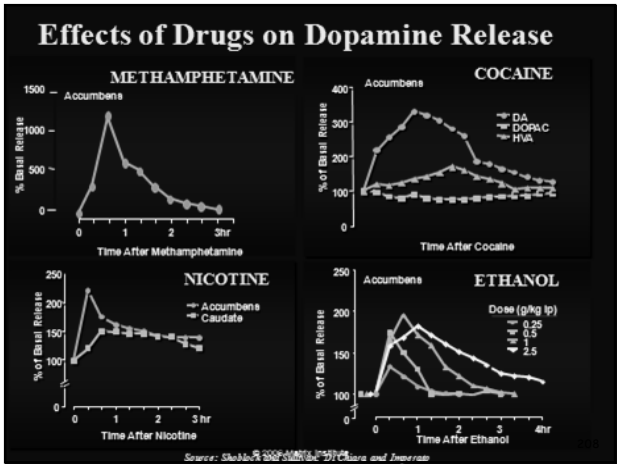

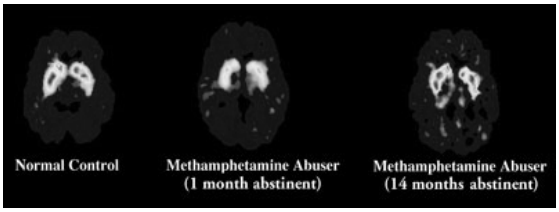

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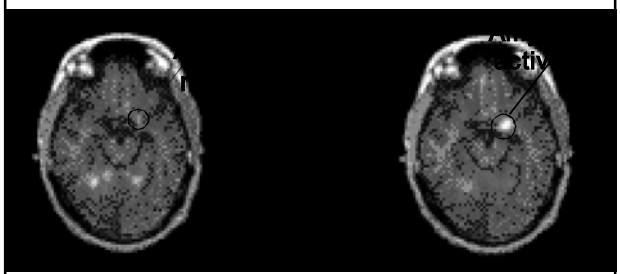
The Memory of Drugs



Nature Video

Cocaine Video

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General Purposes of 42 CFR 2

- Direct or indirect ID of A&D client requires consumer consent.
- Protect consumer from discrimination based on stigma
- Encourage consumer trust in addiction treatment.
- Logic is that persons will seek and succeed in treatment if they have confidentiality.

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Case Study

- Julie is 17 and has been in your program for about 6 weeks. She has told you she was drinking and driving that resulted in an accident that seriously injured the driver of another car. She provides you with information around the accident. The psychiatrist also makes notes regarding her care.
- You receive a subpoena and a court order signed by a judge as a result of court case.
- What are your procedures and what are you legally required to do?

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Georgia Code O.C.G.A.

- 43-39-16- The confidential communications between a psychologist and client are placed in the same basis provided by law between attorney and client and nothing in this chapter shall be construed to require any such privileged communication to be disclosed.

- 37-7-166 (a) 7 – Except for matters privileged under the laws of this state, the record shall be produced in response to a court order issued by a court of competent jurisdiction pursuant to a full and fair SHOW CAUSE HEARING.

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Resource Listing

- **State & National Certification Boards**
  Alcohol & Drug Abuse Certification Board of Georgia (ADACB-GA)','http://www.adacbga.org
  Georgia Addiction Counselors Association (GACA)','http://www.gaca.org
  IC&RC International Credentialing & Reciprocity Consortium','http://www.icrcaoda.org
  National Association Alcohol & Drug Abuse Counselors','http://www.naadac.org
- **Georgia Professional Organizations**
  Georgia Council on Substance Abuse','http://www.gasubstanceabuse.org
  United Way Data Resource 211','http://www.unitedwaycg.org/211
  Addiction Treatment Search','http://www.addictionsearch.com/treatment/GA/georgia.html
  Georgia Government','http://www.georgia.gov
  Georgia Division of Mental Health, Developmental Disabilities & Addictive Diseases','http://www.mhddad.dhr.georgia.gov

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- **Alcohol & Drug Addiction**
  Hazelden','http://www.naacp.org
  Addiction Technology Transfer Center (ATTC)','http://www.attcnetwork.org
  Center for Mental Health and Addiction','http://www.camh.net
  Substance Abuse & Mental Health Services Administration','http://www.samhsa.gov
  SAMHSAs National Clearinghouse for Alcohol and Drug Information','http://www.ncadi.samhsa.gov
  National Abstinence Clearinghouse','http://www.abstinence.net
  Bureau of Alcohol, Tobacco, and Firearms','http://www.atf.treas.gov
  National Institute of Drug Abuse','http://www.nida.nih.gov
  Treatment Facility Locator','http://www.findtreatment.samhsa.gov
  Partnership for Drug Free America','http://www.drugfree.org
  The National Eating Disorders Association','http://www.nationaleatingdisorders.org
  National Alcohol and Drug Addiction Recovery Month','http://recoverymonth.gov
  SAMHSA's Co-Occurring Center for Excellence','http://www.coce.samhsa.gov
  National Center on Addiction and Substance Abuse at Columbia University','http://www.casacolumbia.org
  National Council for Behavioral Healthcare','http://www.thenationalcouncil.org
  Join Together','http://www.jointogether.org

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National Resources

Addiction Technology Center www.attcnetwork.org
Center for Mental Health Services http://mentalhealth.samsha.gov
Center for Substance Abuse Treatment http://csat.samsha.gov
National Clearinghouse for Alcohol and Drug http://ncadi.samsha.gov
National Council on Alcoholism and Drugs http://www.ncadd.org
Office of National Drug Control Policy www.whitehousedrugpolicy.gov
Treatment Improvement Series http://tie.samhsa.gov/externals/tips
Center for Addiction Research www.utmb.edu/addiction
Center for Addiction Studies www.caas.brown.edu
New Science of Addiction http://learngenetics.utah.edu/units
Texas Institute for Behavioral Research www.ibr.tcu.edu
Treatment Research Institute www.tresearch.org
Yale University Division of Substance Abuse http://info.med.yale.edu

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Resources Continued

- Annual tracking study report by the Partnership for a Drug Free America (2005). Retrieved on March 22, 2007 from: http://www.drugfree.org/portal/drugissue/features/prescription_medicine_misuse
- How to buy Prescribtion medication without prescribtion. Retrieved on March 22, 2007 from: http://www.get-meds-online.com/?gclid=CJDZtu71iYsCFRTGhgodcX8jEw
- National Drug intervention centre (Jan 1, 2005). *Prescription drug abuse and youth.* Retrieved on March 22, 2007 from: http://www.usdoj.gov/ndic/pubs1/1765/
- NIDA National Institute of drug abuse. (2005). Preventing *Drug Abuse among Children and Adolescents.* Retrieved on March 22, 2007 from: http://www.drugabuse.gov/Prevention/examples.html
- Parents the Anti Drug (2007). *Prescribtion drug abuse.* Retrieved on March 22, 2007 from: http://www.theantidrug.com/drug_info/prescription_classes.asp
- Radiohead (Sept 1, 1997). Vevet Y Music. Retrieved on March 21, 2007 from: http://music.yahoo.com/ar-261564-photos--Radiohead
- SAMHA (2005) Office of applied studies. Retrieved on March 23, 2007 from: http://www.drugabusestatistics.samhsa.gov/2k7/inhalants/inhalants.cfm

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Continued…

- Alcohol and Other Health Risks
  - http://www.hopenetworks.org
- Drug interaction and information
  - http://www.erowid.com
- Drug and Prevention information
  - http://www.health.org
- Drug Prevention Best Practice
  - http://blueprintsconference.com
- Drug and Rave information
  - http://www.dancesafe.org

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- **Step / Self-Help Recovery**

Alcoholic Anonymous','http://www.aa.org
Atlanta Alcoholics Anonymous','http://www.attcnetwork.org
Center for Mental Health and Addiction','http://www.atlantaaa.org
Al-Anon','http://www.al-anon.org
Georgia Al-Anon','http://www.ga-al-anon.org
Narcotics Anonymous','http://www.na.org
Nar-Anon','http://www.nar-anon.org
Georgia Nar-Anon','http://www.nar-anon.org/georgia
Georgia Narcotics Anonymous','http://www.grscna.com
Cocaine Anonymous','http://www.ca.org
Georgia Cocaine Anonymous','http://www.georgiaca.org
Marijuana Anonymous','http://www.marijuana-anonymous.org
Dual Recovery Anonymous','http://www.draonline.org
Overeaters Anonymous','http://www.oa.org
Atlanta Overeaters Anonymous','http://www.atlantaoa.org
Gamblers Anonymous','http://www.gamblersanonymous.org
Debtors Anonymous','http://www.debtorsanonymous.org

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- Self-Help
  Sex Addicts Anonymous','http://www.sexaa.org
  Nicotine Anonymous','http://www.nicotine-anonymous.org
  Crystal Meth Anonymous','http://www.crystalmeth.org
  Codependent Anonymous','http://www.coda.org
  Anorexia and Bulimia Anonymous','http://www.anorexicsandbulimicsanonymousaba.com
  Sex and Love Addicts Anonymous','http://www.slaafws.org
  Sexual Compulsives Anonymous','http://www.sca-recovery.org
  Survivors of Incest Anonymous','http://www.siawso.org
  HIV Anonymous','http://www.hivanonymous.com
  Pills Anonymous','http://www.pillsanonymous.info
  HCV Anonymous','http://www.hcvanonymous.com

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Criminal Justice & Juvenile Justice
National Criminal Justice Reference Center','http://www.ncjrs.org
National Criminal Justice Reference Service','http://www.ncjrs.gov
Center on Juvenile and Criminal Justice','http://www.cjcj.org
NAACP Criminal Justice Project
http://www.naacp.org/advocacy/justice/index.htm
- Bureau of Justice Administration http://www.ojp.usdoj.gov/BJA/
  Drug Enforcement Administrationhttp://www.justice.gov/dea/index.htm
- Department of Justice http://www.justice.gov/
- Juvenile Justice http://www.ncjjservehttp.org/NCJJWebsite/main.html
- Juvenile Justice & MH http://www.ncmhjj.com/
- Juvenile Justice Links
  http://www.criminology.fsu.edu/jjclearinghouse/jjlinks.html
- Juvenile Justice Links http://www.pacer.org/publications/juvenile.asp

Medical
American Society of Addiction Medicine','http://www.asam.org
American Psychiatric Association','http://www.psych.org
American Board of Psychiatry and Neurology','http://www.abpn.com
American Academy of Clinical Psychiatrists','http://www.aacp.com
American Academy of Child and Adolescent Psychiatry','http://www.aacap.org
Medline Plus','http://www.medlineplus.gov
American Medical Association','http://www.ama-assn.org

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- **Adolescence,Co=Occurring, Youth & Prevention**
  Centers for Disease Control: Division of Adolescent and School Health','http://www.cdc.gov/nccdphp/dash
  The Institute for Youth Development','http://www.youthdevelopment.org
  CDC: Tobacco Information and Prevention Source (TIPS)','http://www.cdc.gov/tobacco
  Mothers Against Drunk Driving','http://www.madd.org
  Office of Juvenile Justice and Delinquency Prevention','http://www.ojjdp.ncjrs.org
  Join Together','http://www.jointogether.org
- Adolescent Co-Occurring -http://www.nmha.org/go/information/get-info/co-Girls and Co-Occurring http://www.ncmhjj.com/pdfs/publications/GAINS_Adol_girls.pdf
- Monograph of Adolescent Co-Occurring Disorders
- http://coy.state.va.us/Conference/Pauley%20Tuesday%20Workshop2.pdf
  Parental Involvement in Co-Occurring Adolesents
  http://www.attcnetwork.org/userfiles/file/SouthernCoast/Parent%20Focus%20Group%20Report%20Final.pdf
  Child Guidance and Family Solutions
  http://www.cgfs.org/cms/site/7e64324bcb4d94a1/index.html
  Child Neurology http://jcn.sagepub.com/content/21/8/657.abstract
  Understanding Addictions and Child Trauma
  http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_adol
  Responding to Adolescent Co-Occurring Issues
  http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2215390/
  Co-Occurring Adolescents
  http://arjournals.annualreviews.org/doi/abs/10.1146/annurev.psych.60.110707.163456

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Mental Health

National Mental Health Information Center','http://www.mentalhealth.samhsa.gov
National Institute of Mental Health','http://www.nimh.nih.gov
The Depression and Bipolar Support Alliance (DBSA)','http://www.dbsalliance.org
The Substance Abuse and Mental Health Services Administration','http://www.samhsa.gov
The Anxiety Disorders Association of America','http://www.adaa.org
The American Foundation for Suicide Prevention','http://www.afsp.org

- Mental Health and Adolescents http://www.childtrends.org/files/mentalhealth.pdf
- Teens and Mental Health http://www.athealth.com/Practitioner/Newsletter/FPN_4_15.htm
- Caring for Teens with Mental Health http://www.who.int/mental_health/media/en/785.pdf

Teens and Depression http://helpguide.org/mental/depression_teen.htm
Mental Illness and Teens http://www.actforyouth.net/documents/MentalHealth_Dec08.pdf
Glossary of Terms for Adolescent Mental Health
http://www.aacap.org/cs/root/resources_for_families/glossary_of_symptoms_and_mental_illnesses_affecting_teenagers

Association of Child and Adolescent Psychiatry www.aacap.org
Psycho Services on line http://psychservices.psychiatryonline.org/cgi/content/full/54/10/1339
SAMHSA Youth and Mental Health http://mentalhealth.samhsa.gov/child/childhealth.asp
Teen Help Guide http://www.helpguide.org/mental/depression_teen.htm
National Alliance for Mentally Ill http://www.helpguide.org/mental/depression_teen.htm

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Further Information, training and resources

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www.addictionsolutions.org

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