

# ENGAGING Adolescents in Treatment

# 5

Fact Sheet Series for PROVIDERS treating teens with  
EMOTIONAL & SUBSTANCE USE PROBLEMS

NCTSN The National Child  
Traumatic Stress Network



To successfully identify and treat adolescents with traumatic stress and substance abuse, clinicians must continually explore better ways to encourage their participation in treatment. This is particularly important in mental health service systems and substance abuse service systems, as these teens present a unique set of challenges to any service system.

Adolescents with both traumatic stress and substance abuse problems often have complex histories (See section II: Complex Trauma) and numerous additional problems that make this population particularly difficult to treat. Empirically based treatment interventions offer adolescents a good chance of success in overcoming a variety of psychological problems; however, many youth fail to obtain treatment, and those who enter treatment often terminate prematurely. Clinicians who work with adolescents encounter a series of challenges when trying to engage youth who have histories of traumatic stress and substance abuse. Most adolescents do not enter treatment voluntarily and are often apprehensive about the process. Furthermore, substance abusing adolescents, much like their adult counterparts, often have a hard time making positive changes in their use patterns. To provide effective services, these challenges and barriers must be addressed.



This fact sheet offers an introduction to many important issues regarding engaging adolescents in treatment that providers must consider when treating adolescents with symptoms of both traumatic stress and substance use. Topics include identifying and encouraging youth to seek help, getting adolescents into initial treatment sessions, addressing practical barriers to care, getting families involved, building alliances, and enhancing community awareness.

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# Brenda's Story\*



**B**renda, a 16-year-old mother of a 10-month-old boy, was mandated to treatment after a marijuana-related arrest. Born into a chaotic family, Brenda has lived, at various times, with her mother, her father, and other family members; she now spends most of her time with the father of her son at his parents' home. Brenda began drinking and smoking marijuana when she was 10. At age 12, she began selling marijuana and other drugs and became involved in a loosely organized gang. She has attended school only sporadically since she was 14 years old.

Illegal substances were common in the environment where Brenda was raised. Both of Brenda's parents have been intermittent users of heroin and other drugs, and her father spent a significant amount of time in jail during Brenda's childhood. Brenda was sexually assaulted by an adult friend of her father's at age nine. Brenda prided herself on never using heroin, and on "just" using marijuana and alcohol. Even the occasional use of cocaine was of very little concern to her and to most of the important figures in her personal life.

**As you read through the pages that follow, think about adolescents like Brenda, and consider the following questions:**

- **What are some specific challenges related to Brenda's history that might make engaging her in treatment difficult?**
- **How can we identify youth in need early?**
- **Are there ways to encourage adolescents to seek help?**
- **How can we get youth to give therapy a chance?**
- **What are the practical barriers that might keep adolescents out of treatment?**
- **How can we best get families and other caregivers involved in treatment?**
- **What are some ways to build alliances with these youth and their families?**
- **What steps can we take to educate the greater community about the link between substance abuse and traumatic stress?**

Brenda is a watchful, cautious, strong-willed, and outwardly confident girl. She speaks quietly about feeling old, feeling responsible for her younger siblings and her son, and about feeling disillusioned by the world, particularly by her father. Attending school, following the rules, and meeting the expectations that are typical for girls her age hold little meaning for her, and she has few dreams for her future. She is highly suspect of other people's intentions and experiences a sense of profound interpersonal distance. It is not likely that Brenda would have entered treatment without having been mandated by the court.

\* "Brenda's story" was created by the authors as a composite representation of stories heard from real teenage clients struggling with these issues and provides examples of the challenges that clinicians face in providing care for youth with trauma and substance abuse problems. Models portrayed are not representative of cases described.

# Identifying & Encouraging Youth to Seek Help

Teens tend not to seek out professional help for a variety of reasons. They may not believe they need help. They often are not aware of the range of services available. They may be concerned about the stigma of obtaining mental health services or hesitant to seek out an adult for assistance. Researchers and clinicians have developed a variety of ways to overcome these initial hurdles.

## Offer multiple types of assistance

Teens are far more likely to seek assistance with issues concerning employment, relationships, and family than they are for mental health or emotional issues like posttraumatic stress or substance abuse. An agency that can act as a resource center and can offer the variety of services that might be sought by teens themselves, is more likely to be in a position to help an adolescent with multiple problems including those related to trauma and/or substance abuse.

## Identify youth in schools

The school is a key access point for early identification of at-risk youth (See section 4: e.g., CBITS; SAPS). Two of the successful methods are:

**Via peer networks:** School-based support programs offer a promising pathway to reach at-risk youth. Programs that identify and train student leaders to provide peer assistance can help clinicians recognize at-risk students and provide needed support and referrals. By utilizing in-school student support resources, clinicians are more likely to be able to identify youth who would otherwise not have approached an adult for treatment. Programs that employ peer support networks to identify youth at risk should provide close adult supervision to peer supporters and have counselors readily available to provide assistance to the youth identified by the peer supporters.

**Via standardized screening:** Youth at risk can be identified by screenings and evaluations conducted in school or after-school settings. Clinicians administering annual or semiannual mental health or substance abuse screenings at a school can help identify youth who would not have sought treatment or otherwise been identified, thus facilitating youths' engagement in treatment or services. Multiple schools have screened their adolescent students for substance abuse problems using the CRAFFT (Children's Hospital Boston, 2002), a brief and adolescent-appropriate instrument. Programs that employ the Cognitive-Behavioral Intervention for Trauma in Schools (CBITS), Stein et al. (2003), have successfully screened large numbers of students for traumatic stress within high-school populations. (See also Section 4: CBITS.)

# Getting Adolescents In the Door

**N**o-show rates for initial sessions at substance abuse clinics are reported at about 50% (Lerman and Pottick, 1995). Factors associated with missed appointments include active substance abuse, young age, and antisocial behavior. Listed below are some of the ways clinicians can increase the likelihood that an adolescent will attend the first session and continue coming thereafter:

## Make reminder calls

**Call the adolescent's home prior to the appointment and speak with both the youth and a parent. Tell them that you look forward to meeting them. Discuss the importance of arriving to the sessions on time; mention a couple of success stories of previous clients; and ask about any obstacles they anticipate to attendance.**

## Be especially welcoming at the first session

**Praise the teen and family for just making it to the first session — let them know that you're glad to see them.**

## Use your cultural knowledge (Discussed in section IV: e.g., Considering culture and context; TST) of diverse youths and families to better relate

**When engaging youths—and especially their caregivers—from diverse backgrounds, it is essential to use what you know about the cultural values and expectations that guide social interaction, mental health/substance abuse treatment, and salient themes in their communities. Establishing the trust of youths and families from diverse backgrounds is an important factor in determining whether they will continue to show up for appointments; and the quality of the initial interaction will greatly influence this decision. Remember that one's cultural community extends far beyond their racial/ethnic groups, and can also be defined by sexual orientation, homelessness, disabilities, socioeconomic status, and immigrant/refugee status, to name a few. If any staff members are unaware of the cultural backgrounds of the youths and families they are likely to assist, make sure they receive training in cultural competence; this will greatly contribute to successful treatment engagement and delivery.**

## Reach out to the family

**Make an intense outreach effort starting with the very first session. Obtain several ways to get in touch with the youth and family and get contact information for those involved in their care. Make follow-up phone calls, letting them know that you care and that you want to continue to see them. This is particularly important for adolescents who are mandated for treatment.**

# Engaging Homeless Youth

**D**rug use by homeless youth is reported to be double that of youth in school (Forst & Crim, 1994). Furthermore, homeless adolescents who abuse substances engage in more high risk behaviors, are more resistant to treatment, and have higher rates of psychopathology and family problems than substance-using adolescents who are not homeless. While engaging this overlooked population in treatment is particularly important, it is also an especially challenging endeavor. Homeless youth are very unlikely to self-refer to treatment and, as they are frequently not in touch with caregivers, are rarely referred by motivated family members who may have otherwise initiated treatment. Although shelters are the primary intervention for these adolescents, many are not equipped to provide treatment for the multiple areas of need and various co-occurring conditions often characterizing this population. (Slesnick, Meyers, Meade, & Segelken, 2000).

## **Strategies to engage substance-abusing homeless adolescents and their families in treatment (Slesnick, Meyers, Meade, & Segelken, 2000) include:**

- Meeting youth “at their level” when making the first contact. The therapist can facilitate engagement by showing the adolescent that he or she understands the youth’s language and culture.
- Presenting the treatment in a non-threatening, appealing manner. For example, the therapist should avoid asking personal questions, convey the message that youth similar to the client have participated in and benefited from the program, and appear knowledgeable about the issues faced by many homeless adolescents, such as a history of abuse.
- Avoiding blaming the adolescent. Reframe current situations (e.g. drug behavior, living in shelter) in terms of relational factors rather than personal failure.
- Conveying hope throughout the engagement process that change is possible as well as a sense of control over their participation in treatment.
- Respecting the client’s concerns, such as those surrounding confidentiality or engaging primary caregivers, and being open to negotiation.

# Addressing Practical Barriers to Care

**M**any adolescents encounter real barriers to accessing treatment. Parents, caregivers, and adolescents need help to overcome them. Specific barriers and ways to assist include:

## Transportation

Discuss with the youth and family potential obstacles to getting to appointments regularly. Whenever possible, offer to provide bus or transit passes if your center is near public transportation.

## Scheduling

Both parents and adolescents may have difficulty with scheduling appointments. If a family is working with other treatment team members, try to coordinate with these members to schedule as many appointments as possible on the same day, so that the family has to make only one trip to your location. Discuss the possibility of holding sessions before or after usual business hours to enable families to schedule appointments around work and school commitments.

## Address child care limitations

Families may have young children to care for and may not be able to afford child care during family sessions or parent sessions. If your agency has access to volunteers, ask them to assist with child care while parents are in session.

## Address caregivers' treatment issues

Caregivers may need referrals for treatment themselves. Providing independent referrals for caregiver treatment may help to alleviate stress on a family.

# Getting Families Involved

**A**dolescents whose caregivers are involved and engaged in treatment are more likely to have better outcomes than those whose caregivers do not believe that treatment will help and/or are unwilling to work with treatment providers (Dakof, Tejada, & Liddle, 2001). Specific strategies for family involvement in treatment (See section 4: Family-Based Therapies) include:

**Fostering family motivation:** Determine what changes each family member would most like to see and incorporate those changes into treatment goals to increase the family's motivation and engagement.

**Validating parents:** Validate parents' past and ongoing efforts to help their adolescent.

**Acknowledging parental stress:** Acknowledge parents' stress and sense of burden (as both a parent and an individual).



**Being an ally for parent:** In addition to trying to manage their teen's emotional and behavioral problems, parents are often overwhelmed by difficulties in their own lives. Be sure to provide active support and guidance.

**Providing education about the nature of mental health problems:** Families may prefer to see their adolescent's symptoms solely as a medical and/or behavioral problem, and not as a mental health problem, and thus treat it with medical and/or behavioral solutions. In the case of substance abuse, for example, families may believe that once the adolescent is sober, all emotional and/or behavioral problems will disappear. Psychoeducation (See section IV) regarding the nature of substance abuse and emotional problems may help family members better understand their adolescent's issues.

**Addressing complex family dynamics (See section 2: Complex Trauma; section IV: Treatment Options):** Adolescents often come to treatment with complex family backgrounds. It is important to identify the family members and/or caretakers who have legal custody and practical influence over treatment-related decisions. It is also important to identify others who are most likely to be involved in an adolescent's care day to day including close friends and mentors who might support the adolescent's successful engagement in treatment. Be particularly sensitive to situations in which an adolescent does not live with a biological parent.

# Building Alliances

**A**s with any treatment, it is important that youth and caregivers feel that their clinician is an ally. This includes having a set of common goals. The entire family must believe that their work with the clinician and participation in treatment will lead to improvement in issues that are important to them. This kind of alliance can be fostered by doing the following:

## Establishing rapport, setting clear boundaries, and allowing for autonomy:

Many adolescents do not respond to an intervention that they perceive as being imposed upon them, whether by a clinician, parents, or other authority figures. Regardless of the specific treatment approach, it is essential that clinicians get to know an adolescent in the beginning of treatment and develop a solid working relationship. It is also essential that clinicians outline a framework for the therapeutic relationship that establishes clear boundaries but allows for the adolescent to make autonomous decisions.

## Finding out what the adolescent wants to talk about:

Although adolescents may be reluctant to disclose details about their risky behavior, there are several ways to encourage meaningful conversations that will lead to open discussion about what is going on in their lives. These strategies include the following.

- Discovering and displaying both genuine interest in and respect for his/her unique interests, concerns, and worldview
- Showing some understanding of the culture the adolescent is surrounded by.
- Offering wisdom and guidance that can help the adolescent solve his/her life problems as he/she sees them.



## Informing youth about normal behavior

Teenagers benefit from contrasting their behavior to that of the average person their age. Although they might believe that “everyone smokes or drinks,” they will be surprised to know, for example, that in a study only 6.7% of 8th-graders reported having been drunk in the 30 days preceding the study (Johnston, O’Malley, & Bachman, 2003). Provide the teenager with information about the difference between recreational use and problematic use (abuse or dependence).



## Using appropriate assessment tools

Administer assessment instruments that aren't face-to-face in order to encourage more disclosure. Adolescents tend to disclose more about topics such as substance abuse and suicidal ideation when they aren't talking to a clinician. For example, clinicians can use the Adolescent Questionnaire (Adquest), an 80-item self-report measure that includes questions about health, sexuality, safety, substance abuse, and friends, designed to open up many areas of interest and engage the adolescent in conversations involving these topics. (See more about this and other adolescent assessment resources in Section 4, Table 1, of this toolkit).

## Discussing the limits of confidentiality thoroughly

To build trust with an adolescent, discuss the limits of confidentiality at the start of treatment and plan with the adolescent specifically how information will be communicated to parents and other authority figures. Stick to your agreement! There is no surer way to lose the trust of an adolescent than by sharing information without the adolescent's awareness. Reassure the adolescent that if you must disclose information (e.g., if someone's life is in danger), you will make every effort to tell him/her before you do it.

## Employing Motivational Interviewing (discussed in section 4)

Motivational interviewing (MI; Miller & Rollnick, 2002) has been shown to be effective at reducing alcohol and substance use in adolescents with an initial low motivation to change. The scope of this fact sheet cannot address the complexity of MI, but listed below are some of the main principles:

- **Taking an empathic, nonjudgmental stance and listening reflectively.** This involves attempting to understand the teenager's perspective and helping them feel understood, so that they can be more open and honest with others.
- **Identifying how the adolescent's current behavior may affect their goals.** This involves working with adolescents to identify personally meaningful goals, and helping youth evaluate whether what they are doing now will interfere with where they want to be in the future.
- **Rolling with resistance.** Rather than arguing with youth when they hit a roadblock, help them develop their own solutions to the problems that they have identified. Thus, youth are not reinforced when being a devil's advocate for the clinician's suggestions or recommendations about discontinuing use.
- **Supporting self-efficacy for change.** The belief that change is possible is an important motivator for successful change. Help adolescents be hopeful and confident about their ability to impact their own future in a positive way.

## Leaving the door open

When an adolescent wants to terminate treatment, make sure you leave the door open for them so they know that they can come back at any time. Treatment providers note that often it takes awhile for an adolescent to start coming in regularly.

# Enhancing Community Awareness

**C**ommunity members often interact with teens, but they often do not have the training to identify and understand youth at risk. To improve community awareness, providers can:

## **Provide information about symptoms associated with traumatic stress**

For example, help parents, providers and community members understand the effects of traumatic experiences on youth functioning.

## **Provide information about symptoms of substance abuse**

In addition to understanding the negative health effects of substance use, community members should be able to recognize the signs and symptoms associated with abuse and dependence.

## **Provide information about risk and protective factors**

Arming the community with this knowledge will be useful in identifying and treating youth in need, as well as in preventing future difficulties.

## **Provide links to help**

This includes information regarding hotlines to call when a person suspects that a child or adolescent is being abused, contacts for guidance during a crisis, and referrals for meeting additional youth and family needs.