NCTSN The National Child Traumatic Stress Network

Treatment for Youth with Traumatic Stress and Substance Abuse Problems

"One patient whom I talked to said that she had to lie to be able to get adequate treatment for both disorders. She was told when she went to a PTSD treatment program that she couldn't have substance abuse or she wouldn't be able to get treatment—she had to be clean first."[1]

Lisa M. Najavits, PhD
Assistant Professor of Psychology
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In an ideal world, careful assessment of traumatic stress and substance abuse problems and their effects would be an integral part of the services provided by all agencies and individuals working with adolescents. Each troubled adolescent would receive an individualized treatment plan that took into consideration the links between traumatic stress and substance abuse, and treatment services for each disorder would be integrated and coordinated.

In reality, although much progress has been made in the treatment of both substance abuse and traumatic stress, these fields have grown independently of each other. As a result, despite the clear link between these two clinical areas, very few attempts have been made to integrate the services provided by each group, and each has developed different assessment protocols and treatment approaches.

Few treatment providers are proficient in the multiple areas of need among youth with co-occurring disorders. Substance abuse providers, for example, may not have the tools necessary to identify the impact of trauma exposure, and may not have experience or training in using trauma-informed interventions. Trauma treatment specialists—and mental health providers in general—may overlook signs of increasing substance abuse. They may not have a deep understanding of the process of addiction, or may not be familiar with effective strategies to strengthen

Trauma and Substance Abuse: Myths and Facts

MYTH: Available evidence-based assessment tools for trauma or substance abuse are too long and complicated to be implemented in real clinical practice settings.

FACT: Many of the older evidence-based assessment instruments do have a reputation for being long and complicated, as well as expensive. However, over the past decade the assessment field has produced many more assessment tools that are accessible and clinician-friendly in terms of both degree of complexity and length.

youths' abilities to reduce use or abstain from substances, and therefore fail to target these problems as a central part of the intervention.

Screening and Assessment of Trauma and Substance Abuse

The signs and symptoms of trauma and substance abuse can at times be hard to spot, especially amidst the turbulent lives of teenagers today. Many of the signs of both trauma and substance abuse are similar to problem behaviors that are part of the natural developmental course of adolescence. For this reason, it may be hard to recognize these problems early.

What *is* evident about this group of teenagers is that they often experience a great deal of distress and need considerable help. Proper assessment of trauma and substance abuse is critical in order to provide adequate care. Therefore, all service providers who have regular contact with adolescents should incorporate screening and assessment instruments that address trauma and substance use into their general intake process.

Clarissa's Story*

Clarissa was only five years old when her stepfather started sexually abusing her. She lived in a rural town where everyone knew everyone else. Clarissa's neighbors and classmates noticed that she always kept to herself and was usually "on edge." She was very scared that her stepfather would hurt her or her mother if she told anyone about the things he did to her when they were alone. It wasn't until Clarissa turned 11 that a school guidance counselor found out what she was going through. The Department of Social Services was notified, and Clarissa was removed from her parents' home. She went through several foster placements before settling in with an aunt and uncle who lived in a big city in a crowded apartment with many other relatives.

Clarissa started to get into fights with her cousins and would often refuse to participate in activities with her relatives. When she was reprimanded for her failing grades, Clarissa told her aunt that she wished she didn't exist. Her teachers noticed that Clarissa had trouble managing her emotions, often exhibiting deep sadness, irritability, agitation, and/or intense anger. The social worker assigned to the case told her caregivers that he was concerned that Clarissa displayed a lack of regard for her own safety and well-being, as she was getting involved in several risky activities. She was introduced to marijuana at school when she was 13 and quickly progressed to alcohol use, and later to OxyContin.

When she turned 15, Clarissa told her friends that she felt worthless and unimportant. One of the ways she responded to conflict and tensions in the home was by going into her room and making superficial cuts on her arms with a razor blade. Her teachers wondered why she wore long sleeves all the time. Clarissa tried to stay away from home as much as possible, spending a lot of her time with peers in unsafe neighborhoods. On her way back from a party with friends late one night, Clarissa was attacked by a group of teens on the train, but none of her friends tried to help her because they were high at the time. She felt betrayed by her friends, whom she felt hadn't stood up for her. Clarissa was already failing in school, had lost trust in her friends and family, and did not feel that she had anyone to go to. She started considering the possibility of ending her life.

**"Clarissa" is a composite based on real teenage clients struggling with traumatic stress and substance abuse.*

Numerous tools are available for the assessment of traumatic stress and of substance abuse. **Table 1** provides information about some well-validated assessment resources. A more comprehensive list of trauma assessment and screening tools can be found at The National Center for Child Traumatic Stress Network's online Measures Review database (www.NCTSN.org/measures).

To optimize assessment accuracy and ensure appropriate treatment, providers should try to incorporate information from multiple sources. Such a multi-faceted approach will help providers generate a treatment plan that is based on complete evaluation of the signs and symptoms of trauma and substance abuse, as well as the degree of functional impairment caused by these problems.

Treating Youth with Substance Abuse and Traumatic Stress

There is a dearth of research evaluating integrated treatment approaches for youth with substance abuse and traumatic stress problems. However, a review of the adolescent substance abuse treatment literature suggests that traumatized youth do not do well in treatment focusing only on substance use.[7–9]

Adolescents who have experienced trauma and adversity often turn to alcohol and drug use in order to cope with painful emotions. Youth with both substance abuse and trauma exposure show more severe and diverse clinical problems than do youth who have been afflicted with only one of these types of problems. When these problems are treated separately, youth are more likely to relapse and revert to previous maladaptive coping strategies.

Trauma and Substance Abuse: Myths and Facts

MYTH: Manualized interventions are too rigid and simplistic to address the complex needs of adolescents suffering from traumatic stress and substance abuse problems.

FACT: Most of today's evidence-based interventions are manual-guided rather than manualized. This distinction reflects a movement away from scripted, inflexible session content and structure and toward a therapeutic model with flexible session content and structure.

Although the research on integrated treatment approaches for this population is limited, there are guidelines that providers can follow to better serve this population. Given the multiple and complex needs of youth with co-occurring traumatic stress and substance abuse problems, several investigators have proposed the following recommendations:[10–13]

- Include assessments of substance abuse problems and traumatic stress as part of routine screening and assessment procedures
- Provide youth and families with more intense treatment options to address the magnitude of difficulties often experienced by this population

Table 1. Validated Assessment Instruments for Traumatic Stress and Substance Abuse Disorders

Resource	Brief Description	Source
Adquest[2] Adolescent Intake Questionnaire[2]	This self-report measure allows adolescents to identify various issues of concern, which the therapist can then use to engage adolescents in discussion on a variety of topics including health, sexuality, safety, substance abuse and friends.	Peake, K., Epstein, I., and Medeiros, D. (2005). *Clinical and research uses of an adolescent mental health intake questionnaire: What kids need to talk about.* Binghamton, NY: The Haworth Press, Inc.
CANS-TEA Child and Adolescent Needs and Strengths-Trauma Exposure and Adaptation Version	This clinician-report instrument assesses a variety of domains including trauma history, traumatic stress symptoms, emotional and behavioral regulation (e.g., anxiety, depression, self-harm, substance abuse), environmental stability, caregiver functioning, attachment, child strengths and child functioning.	For information on the guidelines for use and development contact Cassandra Kisiel: (312) 503-0459 c-kisiel@northwestern.edu
GAIN Global Appraisal of Individual Needs[3]	The GAIN is a series of clinician-administered biopsychosocial assessments designed to provide information useful for screenings, diagnosis, treatment planning, and monitoring progress. Domains measured on the GAIN-Initial (GAIN-I) include substance use, physical health, risk behaviors, mental health, environment, legal and vocational. Several scales are derived from the GAIN-I, including substance problem, traumatic stress, and victimization indices.	Dennis, M., White, M., Titus, J., and Unsicker, J. (2006). *Global Appraisal of Individual Needs (GAIN): Administration guide for the GAIN and related measures (Version 5.4.0).* Bloomington, IL: Chestnut Health Systems. Retrieved April 17, 2008, from http://www.chestnut.org/LI/gain/GAIN_I/GAIN-I_v_5-4/Index.html.
TSCC Trauma Symptom Checklist for Children[4]	The Trauma Symptom Checklist for Children is a self-rating measure used to evaluate both acute and chronic posttraumatic stress symptoms.	John Briere, Ph.D. Psychological Assessment Services http://www3.parinc.com/products/product.aspx?Productid=TSCC
UCLA PTSD RI for DSM-IV University of California Los Angeles Posttraumatic Stress Disorder Reaction Index[5]	This scale is used to screen for exposure to traumatic events and DSM-IV PTSD symptoms. Three versions exist: a self-report for school-age children, a self-report for adolescents, and a parent report. An abbreviated version of the UCLA PTSD RI is also available. This nine-item measure provides a quick screen for PTSD symptoms.	UCLA Trauma Psychiatry Service 300 UCLA Medical Plaza, Ste 2232 Los Angeles, CA 90095-6968 rpynoos@mednet.ucla.edu

Resource	Brief Description	Source
Screening and Assessing Adolescents for Substance Use Disorders: Treatment Improvement Protocol (TIP) Series 31[6]	This guide provides information regarding screening and assessment of adolescents with substance use disorders including descriptions of specific assessment instruments.	Substance Abuse and Mental Health Services Administration. (1999). *TIP 31: Screening and assessing adolescents for substance use disorders.* Rockville, MD U.S. Dept. of Health and Human Services. Retrieved April 18, 2008 from http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.54841.
POSIT Problem Oriented Screening Instrument for Teenagers	This scale was designed to identify potential problems in need of further assessment, and potential treatment or service needs, in 10 areas including substance abuse, mental health, physical health, family relations, peer relations, educational status, vocational status, social skills, recreation, and aggressive behavior/delinquency.	National Institute on Drug Abuse (NIDA), National Institutes of Health Elizabeth Rahdert, Ph.D., 6001 Executive Blvd, Bethesda, MD, 20892 Email: Elizabeth_Rahdert@nih.gov
CPSS Child Posttraumatic Stress Disorder Symptom Scale	The CPSS was adapted from the adult Posttraumatic Diagnostic Scale (PTDS). The CPSS is a self-report measure that assesses the frequency of all DSM-IV-defined PTSD symptoms and was also designed to assess PTSD diagnosis. The measure yields a total Symptom Severity score as well as a daily functioning and impairment score.	To obtain the CPSS, contact: Edna Foa, Ph.D. Center for the Treatment and Study of Anxiety University of Penn. School of Medicine Department of Psychiatry 3535 Market Street, Sixth Floor Philadelphia, PA 19104
CRAFFT	The CRAFFT is a six-item measure that assesses adolescent substance use. The measure assesses reasons for drinking or other substance use, risky behavior associated with substance use, peer and family behavior surrounding substance use, as well as whether the adolescent has ever been in trouble as a result of his or her substance use.	The CRAFFT questions were developed by The Center for Adolescent Substance Use Research (CeASAR). To get permission to make copies of the CRAFFT test, email info@CRAFFT.org.

- Emphasize management and reduction of both substance use and PTSD symptoms early in the recovery process
- Start relapse prevention efforts—targeting both substance and trauma-related cues—early in treatment (e.g., problem solving, drug refusal, and safety skills and desensitization to trauma reminders)
- Establish a therapeutic relationship that is consistent, trusting, and collaborative
- Focus on stress management skills such as relaxation and positive self-talk
- Help clients develop emotional regulation skills such as the identification, expression, and modulation of negative affect
- Incorporate cognitive restructuring techniques such as recognizing, challenging, and correcting negative cognitions
- Provide social skills training and consider referral to adolescent self-help groups as needed
- Provide psychoeducation for both youth and their families about trauma and substance abuse problems, and encourage parental involvement in treatment with the goal of increasing parenting skills, communication, and conflict resolution
- Make use of school-based treatment programs to reach at-risk youth

For some adolescents, effective treatment may also require random urine drug screens to monitor abstinence from drugs or alcohol, and adjunct psychopharmacologic treatment to relieve acute symptoms of drug withdrawal or traumatic stress.

Considering Culture and Context

It is important to remember that adolescents with co-occurring traumatic stress and substance abuse can belong to any number of cultural communities. Cultural background goes beyond ethnicity and race, and can include identities associated with disability, socioeconomic status, sexual orientation, homelessness, immigration/refugee status, spiritual or religious groups, foster care, and others.

Providing services that are culturally competent lays the foundation for establishing a safe, respectful environment that tells adolescents and families that they are respected and valued. Culturally competent service providers are specially trained in—and are aware and respectful of—the values, beliefs, traditions, customs, and parenting styles of the youths and families they serve. Key characteristics of culturally competent care include:[14,15]

- Understanding and respect for diverse worldviews
- The presence of staff who reflect the cultural diversity of the community served
- Use of interpreter services or, preferably, bilingual providers for clients with limited English proficiency
- Ongoing cultural competency education and training for staff
- Use of linguistically and culturally appropriate educational materials
- A physical environment that reflects the diversity of communities served, including artwork, accessibility, and materials
- Culturally relevant assessments
- Working within the family's defined structure (e.g., the family may include elders or other relatives)
- Understanding and respect for the social mores related to interactions by gender and age

Whatever the cultural or social background of the adolescent, it is important to adopt a "strength-based" approach that capitalizes on individual, family, and contextual factors that can serve to promote healthy coping and adjustment. These factors can include a family's religious or spiritual beliefs, extended families and available social support networks, positive role models in the community, opportunities for participation in positive recreational, artistic, or academic activities, and adolescents' built-in capacity to grow and flourish in the midst of adversity.

Special Treatment Considerations When Working with Homeless Youth

Given the high rates of trauma exposure and substance use among homeless youth[16,17], it is particularly important to be aware of treatment considerations specific to this population.[18] The lives of homeless youth are often characterized by high levels of personal and environmental instability, including uncertainty about basic needs such as having access to a meal or a place to sleep. Even the most elemental therapeutic processes, such as engaging youth in treatment, and attempting to develop a trusting relationship between the adolescent and service providers, can be quite challenging. In addition, it might also be difficult to safely conduct more involved therapeutic strategies such as exposure-based treatment, particularly when access to environmental supports and the possibility of regular attendance is limited.

For this reason, it is important to prioritize homeless youths' immediate and primary needs, and to provide access to complementary services that address additional psychosocial needs. Brief interventions employing motivational interviewing[19] as well as skill-based cognitive-behavioral approaches appear to be best suited for this population. These approaches are described in the sections that follow.

Integrated Treatment Approaches for Adolescents

Although there is strong evidence to support the need for integrated treatment models, there are few treatment models available that address both trauma and substance abuse problems among adolescents. Some of these models are highlighted below:

Seeking Safety

Seeking Safety[20,21] is a manualized treatment for co-occurring substance abuse disorder and PTSD in adults developed by Lisa Najavits, PhD at Harvard Medical School/McLean Hospital. The focus of Seeking Safety is to eliminate or reduce risky or dangerous behaviors, situations, or symptoms, including substance abuse, dangerous relationships, severe psychological symptoms, and self-harm behaviors. The treatment model posits a meaningful connection between past trauma and current self-abusing behaviors, and it utilizes 25 topics or modules divided among cognitive, behavioral, and interpersonal themes that can be selected based on the individual's need.[20]

Applying Seeking Safety to an adolescent population involves minor modifications of the original manual to suit the developmental level of adolescents. Modifications include offering the information verbally if an adolescent refuses to read the handouts, using hypothetical third-person examples to discuss situations, limited parental involvement with the adolescent's permission, and discussing details of the trauma only if the adolescent chooses to do so.[21]

In randomized clinical trials, Seeking Safety has shown significant improvements over treatment as usual in both incarcerated[22] and community[23] adult females. When implemented with adolescent girls, Seeking Safety showed greater improvements than did treatment as usual in substance abuse domains, PTSD cognitions, and levels of deviant behavior, as well as anorexia and somatization ratings.[21]

Risk Reduction through Family Therapy (RRFT)

RRFT is an intervention developed to reduce the risk of substance abuse and other high-risk behaviors, revictimization, and trauma-related psychopathology in adolescents who have been sexually assaulted. RRFT integrates several existing empirically supported treatments, such as Trauma Focused-Cognitive Behavioral Therapy, Multisystemic Therapy, and other risk reduction programs for revictimization and risky sexual behaviors. Adolescents participating in this treatment may be heterogeneous with regard to symptom expression; thus a clinical pathways approach is taken in the RRFT manual. The manual consists of six primary components: Psychoeducation, Coping, Substance Abuse, PTSD, Sexual Education and Decision Making, and Sexual Revictimization and Risk Reduction. A pilot trial of RRFT is currently underway.[24]

Trauma Systems Therapy for Substance Abuse in Adolescence

TST-SA[25] applies Trauma Systems Therapy (TST)[26] to the problem of adolescent traumatic stress and substance abuse, utilizing existing promising practices for treating adolescent substance abuse, traumatic stress, and emotional regulation problems.

The application of TST to adolescent substance abuse includes several modifications to the existing intervention. Motivational interviewing strategies are included to engage youth in treatment and to establish a commitment to change. Additionally, parents and teens are provided with psychoeducation about substance abuse and its interaction with symptoms of traumatic stress.

This approach incorporates a strong emphasis on behavior management strategies for parents to utilize in order to increase monitoring and appropriate limit setting, particularly around drug use and high-risk behaviors. The model also incorporates substance abuse treatment strategies such as parent-teen communication skills, recognizing and planning for substance abuse cues or trigger situations, cognitive and interpersonal problem-solving techniques, and other relapse-prevention techniques. Careful attention is given to the connection between substance abuse and the negative emotions associated with the experience of trauma. In addition, youth learn skills to manage emotions, behavior, and substance abuse cravings. An open trial of TST-SA is currently underway.

Trauma-Focused Interventions for Adolescents

Several successful treatment programs have been developed or adapted from adult models to help adolescents process traumatic memories and manage distressing feelings, thoughts, and behaviors. These empirically supported manuals are described in detail below.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

TF-CBT is a short-term individual treatment that involves sessions with the youth and parents as well as parent-only sessions. TF-CBT is for youth aged 4 to 18 who have significant behavioral or emotional problems related to traumatic life events, even if they do not meet the full diagnostic criteria for PTSD.[27] Utilizing weekly clinic-based, individual treatment, TF-CBT helps youth process traumatic memories and manage distressing feelings, thoughts, and behaviors. TF-CBT also uses joint parent and youth sessions to provide parenting and family communication skills training. Compared to a nondirective supportive therapy, sexually abused youth aged 8 to 15 treated with TF-CBT demonstrated significantly greater improvement on levels of anxiety, depression, and dissociation at six-month follow up. Youth treated with TF-CBT also showed a significant improvement in PTSD symptoms and dissociation at 12-month follow-up.[28] Online training for TF-CBT is currently available at http://tfcbt.musc.edu.

Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)

CBITS is an intervention program for youth exposed to traumatic events, which can be delivered on school campuses by school-based clinicians. It was developed in collaboration with the Los Angeles Unified School District for students and their families. CBITS utilizes individual and group sessions to teach youth relaxation techniques and social problem-solving skills, as well as how to challenge upsetting thoughts and process traumatic memories. CBITS also includes a parent and teacher psychoeducation component. In a randomized controlled trial comparing this intervention with a three-month wait-list condition, those receiving CBITS reported lower PTSD, depression, and psychological dysfunction symptom scores after three months.[29]

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

SPARCS is a group intervention specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress, are currently experiencing stress, and are experiencing problems in areas of functioning such as impulsivity, affect regulation, self-perception, dissociation, relations with others, somatization, and struggles with their own purpose and meaning in life. The 16-session program can be provided in a variety of settings, including school, outpatient, and residential, and incorporates components of three existing interventions. These components include mindfulness, interpersonal, and emotion regulation skills derived from Dialectical Behavior Therapy for Adolescents[30], problem-solving skills from Trauma Adaptive Recovery Group Education and Therapy (TARGET)[31], and social support enhancement and skills for planning for the future from the School Based Trauma/Grief Group Psychotherapy.[32]

Trauma Systems Therapy (TST)

Developed at the Center for Medical and Refugee Trauma at Boston Medical Center[33], TST acknowledges the complexity of the social environment that surrounds an individual, and the ways in which disruptions in one area of the social ecology may create problems in another. The social ecological model of human behavior—in which the contexts of family, school, peer group, neighborhood, and culture all interact with an individual's development[34]—is applied to youth exposed to traumatic stress, who often live in environments characterized by child maltreatment, parental illness and substance abuse, and domestic violence. TST interventions are designed to work in two dimensions: strategies that operate through and within the social environment to promote change, and strategies that enhance the individual's capacity to self-regulate their emotions.

The TST model involves choosing a series of interventions that correspond to the fit between the traumatized youth's own emotional regulation capacities and the ability of the youth's social environment and system-of-care to help him or her manage emotions or to protect him or her from threat. TST begins with an assessment of both the youth's

level of emotional regulation and the degree of environmental stability in the youth's world. Preliminary data from an open trial of TST demonstrate a significant reduction of trauma symptoms and increased emotional regulation skills among youth, as well as a more stable social environment, after three months of treatment.[33] A controlled trial of TST is currently in progress.

Substance Abuse Interventions for Adolescents

Several successful treatment programs have been developed or adapted from adult models in order to focus on the unique cognitive changes, developmental transitions, and peer and family issues that typically occur during adolescence. Treatments for adolescents incorporate these developmental considerations in different ways. Described below are the current approaches utilized within various types of interventions, as well as empirically supported treatment manuals available for substance-abusing adolescents in an outpatient setting.

Brief Interventions

Interventions that are of shorter duration and less extensive than more traditional substance abuse treatments can be appealing to consumers, service providers, and managed care providers. These treatments have the overarching goal of addressing and enhancing the motivation to change problem behaviors, as well as providing skills to meet these goals. Generally, brief interventions contain between one and five sessions and can be delivered virtually anywhere by a variety of professionals. Two of the most widely used brief intervention approaches include cognitive-behavioral therapy and motivational interviewing.

Cognitive-Behavioral Therapy (CBT)

Cognitive-behavioral models, based on social learning theory, conceptualize substance use and related problems as learned behaviors that are initiated and maintained in the context of environmental factors. This treatment approach incorporates the principle that unwanted behavior can be changed by clear demonstration of the desired behavior, and consistent reward of incremental steps toward achieving it. CBT may incorporate emotional exposure to internal cues in order to inoculate individuals against future relapse. Therapeutic activities include completing specific assignments, rehearsing desired behaviors, experiencing imagined and real exposures to emotions and situations to enhance emotional tolerance, and recording and reviewing progress. Praise and privileges are given for meeting assigned goals. This model can be implemented via individual sessions as well as within a group treatment approach. According to research studies, individual and group CBT can help adolescents become drug free and increase their ability to remain drug free after treatment ends.

Motivational Interviewing (MI)

This treatment approach involves using specific interviewing and discussion techniques to enhance the individual's motivation to change their problematic behavior. MI pertains to both a style of relating to the client as well as to the therapeutic techniques that facilitate the process. Its main tenets include: 1) taking an empathetic, nonjudgmental stance while listening reflectively, 2) developing discrepancy, rolling with the client's resistance, and avoiding argumentation, and 3) supporting self-efficacy for change. Motivational interviewing has been found to significantly reduce drinking and driving in teens with initial low motivation to change.

Motivational Enhancement Therapy and Cognitive Behavioral Therapy for Cannabis Users

The Cannabis Youth Treatment Collaborative developed an empirically tested five-session treatment manual that combines the motivational interviewing treatment approach and cognitive behavioral therapy. The treatment consists of two initial individual sessions designed to increase the adolescent's motivation to deal with their drug use, followed by three group CBT sessions designed to help adolescents develop skills useful for stopping or reducing marijuana use. This brief therapy has been proven effective in reducing marijuana use in adolescents. There is also an option for therapists to utilize an additional seven-session CBT component to provide additional skills training. The complete manuals for both the brief five-session treatment as well as the extended treatment with 12 CBT sessions are available at: http://www.chestnut.org/LI/cyt/products/.

Family-Based Therapies

Family-based treatment is the most thoroughly studied treatment modality for adolescent substance use. Considerable research underscores the influential role played by family relationships and family environments in the development of adolescent alcohol and drug problems. The more thoroughly researched family approaches are outlined below.

Multidimensional Family Therapy (MDFT)

This is an outpatient family-based drug abuse treatment for teenagers. MDFT views adolescent drug use in terms of a network of influences (made up of individual, family, peer, and community) and utilizes this network to reduce unwanted behavior and increase desirable behavior in different settings. Treatment includes individual and family sessions held in the clinic, in the home, or with family members at family court, school, or other community locations.

Multidimensional Family Therapy for Adolescent Cannabis Users

This manual-based treatment integrates family therapy and substance-abuse treatment and has been proven effective with a cannabis-using adolescent population. The treatment

focuses on the adolescent and the parents, as well as on patterns of family interaction, both within the family and with other systems such as schools, courts, and other support networks. The manual is available at: http://www.chestnut.org/LI/cyt/products/.

Brief Strategic Family Therapy (BSFT)

This intervention is used to treat adolescent drug use that occurs with other problem behaviors such as conduct problems, oppositional behavior, delinquency, associating with antisocial peers, aggressive and violent behavior, impaired family functioning, and risky sexual behavior. BSFT is a family systems approach based on the premise that the drug-using adolescent is displaying problem behaviors that are indicative of what is going on within the family system. BSFT holds the principle that patterns of interaction in the family influence the behavior of the adolescent. The role of the BFST counselor is to plan interventions that carefully target and provide practical ways to change the patterns of interaction (e.g., failing to establish rules and consequences) that are directly linked to the adolescent's drug use.

Brief Strategic Family Therapy for Adolescent Drug Abuse

The National Institute of Drug Abuse has made an online version of the BSFT manual available at: http://www.nida.nih.gov/TXManuals/bsft/BSFT2.html.

Multisystemic Therapy (MST)

This treatment approach targets multiple systems that contribute to the development of delinquent behavior in adolescents, including family, peers, school, and the neighborhood. MST is tailored to each individual's needs and may include individual, family or marital therapy, peer group counseling, and case management. Services are provided within the adolescent's natural environment, such as the home or school, which facilitates both the application to and the maintenance of treatment gains in the "real world." MST also helps adolescents and their families develop social support networks through such means as making connections with extended family or religious communities. MST has been shown to significantly reduce adolescent drug use during treatment and for at least six months after treatment. More information regarding the MST approach is available online at: http://www.mstservices.com/text/treatment.html.

Community-Based Interventions

Community-based interventions provide mental health services within the normal environment of an individual or population. Service sites may include the home, school, or other neighborhood settings, which increases access to care for underserved populations, particularly for individuals who do not have the resources to travel to specialty clinics. Because teenagers are influenced by many aspects of their environment (such as family,

peers, teachers, cultural norms), community interventions often take place across a number of settings to maximize the social ecological validity of the intervention and to support practice of skills learned in treatment. Community interventions may target specific individuals who have already begun to display high-risk behaviors—such as drug and alcohol abuse, delinquent behavior, and unsafe sexual behaviors—or they may target select groups who may be at greater risk for engaging in these behaviors—such as athletes who are at greater risk for steroid use and teenagers who live in a community with a lot of gang violence. In many community interventions, a social support component for adolescents and their parents is important and may decrease the likelihood of relapse. Three interventions for adolescents displaying high-risk behaviors, which include a community-based component, are described below:

Adolescent Community Reinforcement Approach (ACRA)

This treatment approach recognizes the powerful role the environment plays in encouraging or discouraging drug use. It attempts to rearrange environmental contingencies to make substance use a less rewarding behavior. ACRA blends an operant model with a social systems approach to teach teens new ways of handling life's problems without drugs or alcohol. It focuses on the interpersonal interaction between individuals and those in their communities. ACRA teaches adolescents when and where to implement the techniques learned in treatment as well as how to build on positive reinforcements and use existing community resources that will support positive change. ACRA also guides adolescents in developing a positive support system.

The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users

This 14-session treatment model consists of 10 individual sessions with the youth, two sessions with one or two caregivers, and two sessions with both the youth and caregiver(s). This treatment uses functional analyses to identify triggers for drug use as well as other prosocial activities that compete with drug use, skills training in a variety of areas including relapse prevention, and the "Happiness" scale to monitor progress. The manual is available online at: http://www.chestnut.org/LI/cyt/products/ACRA_CYT_v4.pdf.

Student Assistance Program (SAP)

This substance abuse intervention is a school-based program for identifying, assessing, and treating students with alcohol and/or substance abuse problems. There are more than 1,500 student assistance programs in the country; however, these programs vary widely. For example, some SAPs refer all identified alcohol and drug users to clinics for treatment, while other programs bring trained clinicians to the school to provide intervention on-site. The most effective school-based substance abuse interventions are empirically guided and manualized, and focus on providing psychoeducation and skills training to adolescents. In

addition, effective programs enforce school-wide policies regarding alcohol and drug use. Preliminary analyses of certain programs suggest that adolescents who participate in SAPs can show reduced substance use.

The Residential Student Assistance Program (RASP)

RASP is a residential substance abuse prevention program for high-risk adolescents, modeled after the Westchester Student Assistance Model. More information is available at: http://www.sascorp.org/residesap.htm or http://www.sascorp.org.

Psychiatric Care and Psychotropic Medication

The commonalities between posttraumatic stress disorder and substance use disorders suggest that pharmacotherapies targeting a specific neurotransmitter or neuroendocrine system might be particularly beneficial.[35] An important goal of pharmacotherapies for this population is to decrease PTSD symptoms so that the adolescent does not utilize substances of abuse in order to distance himself/herself from the traumatic event. Some antidepressants have been shown to improve the intrusive and depressive symptoms of PTSD. Furthermore, standard pharmacotherapeutic treatments for substance abuse disorders may be useful for individuals with co-occurring PTSD. Integration of pharmacotherapy and psychotherapy may be beneficial in order to maximize treatment outcomes in this population.

For More Information on Treatment Options for Substance Abuse, see

- Substance Abuse and Mental Health Services Administration (SAMHSA) Model Programs
  http://modelprograms.samhsa.gov/
- Society for Adolescent Substance Abuse Treatment Effectiveness (SASATE)
  http://www.chestnut.org/LI/APSS/SASATE/
- The National Institute of Drug Abuse (NIDA)
  http://www.nida.nih.gov
- The National Institute on Alcohol Abuse and Alcoholism (NIAAA)
  http://www.niaaa.nih.gov

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