



The Provider's Source

A Quarterly Newsletter of the Adolescent Substance Abuse Treatment Initiative

April 2007
Volume 1, Issue 1

Building Bridges, Closing Gaps



What is Evidence Based Practice?

Many of you have heard the phrase evidence based practice and may have even heard the flip of that phrase, practice based evidence. Some of you may even be using these terms in dialogue with your colleagues. In the last ten years, public health, social services, and mental health have all undertaken an effort to practice what the science says, to advance evidence based practice, so it is not surprising that everyone is talking about it.

For many, experience is "science," you really only know how to help someone if you have experienced it yourself or have been in the field awhile. It may be, though, that experience is not the only teacher and that well documented, replicated experience wins the teacher of the year! This would be evidence based practice.

The grant staff recently attended the 20th Annual Research Conference in Systems of Care in Tampa, Florida to learn how to apply the system of care model and philosophy (from children's mental health) to adolescent substance abuse treatment systems as evidence based practice. As we attended the sessions, we had two major epiphanies: we did not know as much as we had led ourselves to believe and the experts

knew more, but still had questions themselves.

What a shock! Are any of you in the same boat thinking you understand and finding out how much there is to learn?

There is a lot of uncertainty these days about how to implement evidence based practice. It may feel like there is no reason to try because the recommendations may change anyway and at least there have been some results with old standby techniques, some of which may actually be evidence based practices. It is just like the barrage of information you get about diet—eggs were bad, now they are good; fat was bad, now some fat is good.

What are we to do, ignore or explore? The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

What is the Substance Abuse Coordination Grant?

You may be wondering what the NC Division of Mental Health, Development Disabilities and Adolescent Substance Abuse (The Division) is doing about evidence based practice. The Division received a grant from The Substance Abuse Mental Health Services Administration (SAMHSA), funneled through The Center for Substance Abuse Treatment (CSAT), to work on the state's infrastructure so that it is better equipped to meet the needs of

adolescents with substance abuse issues. The Substance Abuse Mental Health Services Administration expects all the various divisions, like mental health, public health, social services, juvenile justice, the school system and others to work together to streamline services and reduce duplication so that adolescents in treatment get their needs met.

Many of you may be familiar with the System of Care approach to mental health treat-

and University of North Carolina's Center for Youth, Family, and Community Partnerships are hoping these newsletters, trainings, and other informational products, will help you explore and adopt/expand evidence based skills that will help adolescent substance abusers get better. Look to the newsletter and our listserv updates. We will be releasing trainings geared toward families too, to encourage and support them in becoming actively involved with their adolescent's treatment process. We will be looking for your ideas for future newsletters and for suggestions for trainings and research!

Happy reading!, the grant staff

See "Welcome" on page 5.

ment for children if you are working in a setting that provides both mental health and substance abuse services for adolescents (if you are not, see page 3). If you use the System of Care (SOC) philosophy, then you know that all providers involved with the adolescent work *with* the adolescent, caregivers, and informal supports to help the adolescent get better. Now, imagine that your *agency* is the adolescent or client and that the Division



Inside this issue:	
From the staff...	1
Welcome to the grant!	1
So that's why!	2
Our stories	2
The feedback loop: Parents and providers talk	2
Practice based evidence	3
Spotlight on system of care	3
Trainings and events	3
News you can use	4
Continued, thanks	5

So That's Why: The Latest Research on the Adolescent

See "That's Why" on page 4.

Ever wonder why adolescents seem to be so susceptible to drugs? We did, too, so we did a little digging. Granted, there are probably many reasons why drugs seem so attractive to adolescents. But there are actually some physiological reasons that are just now being thoroughly understood. We reviewed an article by Ken C. Winters, Professor of Psychiatry at the University of Minnesota that does a good job presenting the current understanding of how brain development and metabolism put adolescents at greater risk for initiating drug use than adults.

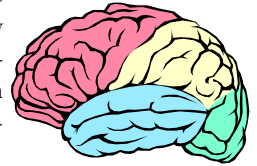
We have provided a summary of Dr. Winters' presentation titled "Adolescent brain development and drug use" here. For the full

presentation, go to http://www.tresearch.org/adolescent_s/adol_projects.htm#parents and click on "View Presentation."

Contrary to earlier thought, many researchers now believe that the adolescent brain is not fully formed at puberty but continues its maturation until about the age of 24, particularly in three parts of the brain: the nucleus accumbens, the amygdala, and the prefrontal cortex. The nucleus accumbens regulates motivation; it controls how much effort a person will put forth to get rewards. Because the nucleus accumbens of the adoles-

cent is immature, he or she prefers activities requiring little effort that yield exciting rewards. Some examples are video games, skateboarding, and substance abuse.

The amygdala integrates emotions with experience (bad or good). Because this process is not fully developed in adolescents, they easily overreact to situations instead of exhibiting more controlled responses. Less ability to control response could be why adolescents report feeling even less social inhibi-



Our Stories: Reprinted with Permission From the Guilford County Substance Abuse Coalition

See "Our Stories" on page 5.

Each newsletter, we want to highlight your success. We plan to offer stories told from three perspectives: the adolescent, the caregiver, and the provider. These perspectives will help illuminate best practice in the therapeutic relationship and how evidence based practice really does make a difference and helps adolescents recover from addiction. If you would like to submit a story, contact us at bestasat@uncg.edu.

For our first issue, it was difficult to find a provider, parent AND adolescent willing to be interviewed, so what follows is an article reprinted with permission from The Guilford County Substance Abuse Coalition about a client who attended the MAJORS Program. Ashley wanted to use her real name because she is

proud of her recovery and wants others to know that is it possible and sustainable. Randolph Reid, formerly of The Guilford Center (Guilford County's LME) interviewed Ashley. Ashley refers to "Chris," who is Chris Townsend, her substance abuse counselor. A big thanks to the coalition for the use of this story. See below.

During my interview with Ashley, she stated, "The first time I used drugs, I was 12. That was with friends, using marijuana. I didn't get too involved with it

until I was about 15. That was when I was living in New York with my father, hanging out with the wrong friends, skipping school, basically drinking and partying all the time." Ashley shared with me that this was a contributing factor to why she was later sent to training school for about six months. "When I got out, I moved back with my dad and started using again. At that time, my dad's ex-wife's brother moved in with us, and that's when I got introduced to crystal meth and cocaine. I did not get hooked on crystal meth, but I

The Feedback Loop: Parents and Providers Talk

In the future, this article will feature feedback we are getting from parents about what will improve treatment for their adolescents from their perspectives. We will also ask you questions about what can improve practice. We hope this newsletter space can serve as a way for providers and parents to help each other help adolescents who need substance abuse treatment.

This time, we need your help selecting topics for fact sheets that will appear on the website, in trainings, and as shorter newsletter articles. If you would like to contribute to a fact sheet, we

would also welcome this collaboration. What follows is a "best guess list" of questions. Please give us your thoughts and send in your questions, too, by e-mailing bestasat@uncg.edu. Let the questions flow! Here are some possible topics to help you think about what you would like to learn about evidence based practice:

- What is the difference between evidence based practice and practice based evidence?
- What is the relationship between

adolescent substance abuse and trauma experience in childhood?

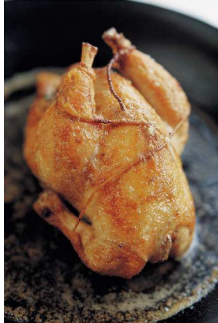
- What is best practice substance abuse treatment for adolescents with co-existing disorders?

"Watch for our fact sheets on best practice substance abuse treatment for adolescents! These are big issues in a small package. Coming soon to the listserv."

Practice Based Evidence: You Can do This!

We like to define this term and its relationship to evidence based practice to cooking. If evidence based practice is Julia Child's recipe for roasted chicken, then practice based evidence is the one you create for yourself after years of cooking it her way and then realizing that the chicken doesn't cook well in your oven.

How do we apply this analogy to substance abuse treatment? Evidence based practices are treatment methods like cognitive behavioral therapy or motivational interviewing that have been well tested in clinical trials and perform well in



terms of adolescents staying substance free . Practice based evidence is realizing that not all treatment, developed in a controlled setting (like a clinical trial) works the same way in the real world. Well trained providers know this intuitively, but many of you may feel lost as to what to do about it .

This is where practice based evidence comes into to play. Many times the clinical trial version of an intervention does not work as predicted in the field because there are many factors like, the adolescent's school, home, and neighborhood environment that cannot be well controlled in a clinical trial. Practice based evidence, then, is applying the evaluation of your own practice and outcome data into your current practice. The culture and values of families are also not addressed in clinical trials, so the program may work well with the people

who were the subjects, but it may not work so well with families with diverse values and cultures. There are ways this issue is being addressed (see article on System of Care). Here is what you can do to address practice based evidence in your work:

- Practice self-evaluation after each session. Be honest with yourself. How did you do?;
- Ask your clients and their caregivers to evaluate your work regularly. Ask them to be specific, "What could you do better?";
- Use your agency data to evaluate the progress of your clients as a whole. Use this information to improve your agency's practice.

Spotlight on System of Care: The Best of the Best Treatment Available

Many of you may have heard of System of Care (SOC) since you may work in an agency that is licensed to provide substance abuse treatment and mental health treatment, and SOC is the philosophy that drives children's mental health care. Chances are that a lot of you don't know. So what is System of Care?

It is a philosophy of providing care to children with mental illness that represents a major change in the way children and families get treated by the mental health system. This approach has been used by mental health professionals since 1986 in response to an act of The United States Congress

called The State Comprehensive Mental Health Services Plan Act that required all states to focus children's mental health services in the community rather than in the hospitals. This move has increased a family's access to mental health services for their children. There is now interest among substance abuse professionals to apply this system to substance abuse treatment for youth. This part of the newsletter will be your opportunity to learn all about System of Care and how you can advocate for it as you go through the treatment process with your young person. As a start, here are the three core values of System of Care. Tell your clients about them, both adolescents and their care-

givers! System of Care should be:

- Child centered and family focused, with the needs of the child and family dictating the types of services provided;
- Community based, with the occurrence, management, and decision-making for services housed in the family's community ;
- Culturally competent, with agencies, programs, and services that respect and honor the cultural, racial, and ethnic difference of the populations served.

Trainings and Websites

Trainings

- **Joint Meeting on Adolescent Substance Abuse Treatment Effectiveness (JMATE)**, April 25th-27th, Washington DC. Visit <http://www.mayatech.com/cti/jmate/agenda.cfm> to register.
- **North Carolina Substance Abuse Professional Practice Board:** <http://www.ncsapcb.org/>
- **The McLeod Center:** http://www.mcleodcenter.com/index_files/Page935.htm

- **The Governor's Institute on Alcohol and Substance Abuse Summer School:**

<http://www.governorsinstitute.org/>

Websites

- **State Collaborative for Children and Families:** nccollaborative.org
- **DrugfreeNC:** <http://www.drugfreenc.org/enewsletter/summerfall06/toc.htm>
- **The Treatment Research Institute:** <http://www.tresearch.org/>
- **The Addiction Technology Transfer Center:** <http://www.nattc.org/resPubs.html>

- **SAMHSA's National Registry of Evidence-based Programs and Practices:** www.nrepp.samhsa.gov.



That's Why, Continued From Page 2

tion when drinking alcohol than adults.

If those two strikes were not enough, the third is truly the final blow. The prefrontal cortex is responsible for complex information processing, including making judgments, controlling impulses, foreseeing consequences, and setting goals and plans. Simply put, this means adolescents have difficulty controlling their behavior and connecting their behavior to the logical consequences.

Increased susceptibility is not just about the brain. It is also about metabolism. Have you ever wondered why an adolescent can consume a large pizza at midnight and not gain any weight while it would cost you a month's worth of dieting? Adolescents burn calories at a higher rate than adults which

allows them to consume larger amounts of alcohol without feeling as intoxicated as an adult might feel.

For hundreds of years, scientists have spent their entire careers studying the brain and trying to understand how it works. We have reached many milestones in this study: the identification of the parts of the brain and their functions, the development of medications and therapies to help with mental illness, and the discovery of neurotransmitters. We can now add to the list the growing body of knowledge about the brain's intricate development throughout the life span, and in particular childhood and adolescence. As we continue to discover, we will better understand

how to treat adolescents who suffer from substance abuse issues.

What are the implications for treatment? Knowing the specific biomechanics of addiction will help us develop appropriate therapies specifically for adolescents. For instance, if we know adolescents have a high need for immediate and big rewards, we need to reinforce positive behavior with positive, exciting rewards. There are many other ways we can adjust our treatment strategies; the ultimate goal should be treatment tailored to adolescents and their families.

Citation: Winters, C. (November, 2004). Effects of Drug Abuse on the Brain. Available through http://www.tresearch.org/adolescents/adol_proj

News You Can Use on Evidence Based Practice: The Brain and Trauma

There is a lot of news in the mental health arena regarding trauma treatment for young children. Essentially, researchers are discovering that trauma is much more widespread than originally thought and that untreated trauma impacts adolescent risk taking behavior, including substance abuse. In the mental health field, there is a move to incorporate trauma screening as a routine part of mental health care for children and it is probably not a bad idea for substance abuse treatment providers to do the same. At the very least, providers should have a thorough understanding of brain development in both childhood and adolescence as a way to better understand developmentally appropriate treatment as well as the origins for substance abuse. Here is an excerpt from "Traumatized children: How childhood trauma influences brain development" published in *The Journal of California Alliance for the Mentally Ill* (11:1, 48-51, 2000).

"All experiences change the brain—yet not all experiences have equal 'impact' on the brain. Because the brain is organizing at such an explosive rate in the first years of life, experiences during this period have more potential to influence the brain—in positive and negative ways. Traumatic experiences and therapeutic

experiences impact the same brain and are limited by the same principles of neurophysiology. Traumatic events impact the multiple areas of the brain that respond to the threat. Use-dependent changes in these areas create altered neural systems that influence future functioning. In order to heal (i.e., alter or modify trauma), therapeutic interventions must activate those portions of the brain that have been altered by the trauma. Understanding the persistence of fear-related emotional, behavioral, cognitive and physiological patterns can lead to focused therapeutic experiences that modify those parts of the brain impacted by trauma.

Our evolving understanding of neurodevelopment suggests directions for assessment, intervention and policy. Primary among these is a clear rationale for early identification and aggressive pro-active interventions that will improve our ability to help traumatized and neglected children. The earlier we intervene, the more likely we will be to preserve and express a child's potential."

Now that we know this about brain development, and considering that many adolescents who use drugs have some sort of mental illness and/or exposure to trauma, what can a practitioner do?

- Develop a trauma response plan for your agency;
- Get educated (personally and as an agency) about how trauma affects the brain and substance abuse treatment (stay tuned for more information on this!).
- Get input from all sources of care to improve treatment, including the adolescent's primary caregiver (unless he or she is the perpetrator), the informal supports (like family friends), the mental health provider (refer if needed), juvenile justice providers (if applicable), the adolescent's medical provider, and social services provider (if applicable).



Welcome, Continued From Page 1

and all of those other partners (like public health) are your providers. Also imagine that all the parent organizations, like NC Families United, Positive Youth Families United, the North Carolina Foster Adoptive and Parents Association are there to help you succeed. We become a team that decides together how to infuse evidence based practices into the care and services we. Our collaborate work then becomes more efficient, effective, and meaningful for youth, their families, and their providers.

That system is our vision. It will require extensive preparation and support, and there is a plan. We will provide trainings, research briefs, fact sheets, newsletters, and other resources to support providers' further adoption of evidence based practice in local communities. We are also designing similar trainings and materials for families.

We cannot, however, develop these materials and trainings alone. We need parent and provider input and will

be offering formal and informal opportunities for you to do so. In the meantime, contact us at bestasat@uncg.edu to offer your suggestions and join the listserv which will provide you with the latest news and an opportunity to chat with each other.

This is a quarterly newsletter, so there is lots of time in between to provide feedback and suggestions. We will offer regular features like you see in the table of contents in this newsletter: So That's Why, Our Stories, News you can Use, etc. All of these regular features will address evidence based practice, system of care, and practice based evidence. We will also have a website available soon at www.uncg.edu/csr. You may also want to visit the Statewide Collaborative for Children and Families new website at ncclaborative.org.

We are excited about partnering with you to get the word out about evidence based practice.



Our Stories, Continued From Page 2

did on cocaine. I did powder from the time I was 16 to about 18. I was using about an 'eight-ball' a day. I tried crack about three times, it was more of a social thing. That's really how I started with everything." During this period of Ashley's life, she stopped going to school, stopped dealing with her family, and stopped participating in healthy, positive social activities with her friends. She stated that her father had his own life, leaving her alone during days and evenings to do as she pleased without instructions or directions on how to conduct her life.

Her family's history with alcohol and drugs revealed that her mom is an alcoholic, her dad is a recovering alcoholic; she has two younger siblings, a brother and sister who do not live with either parent. Ashley describes her mother as "she's just out there" and continues to live in New York. "She has no legal rights to any of us." When asked to reflect on her relationship with her parents, she remembered that her dad began to drink heavily. Little attention was given to her, and "that's when I started to use more." When asked what role her father plays in her life now, she explains that, "My dad, he's in my life, but he's not in my life. Like, he doesn't help me to do anything; he has his own life, and I have my own life. When I'm convenient, then it's convenient for him. That's why I think I used so many drugs and fell for so many guys. I didn't have either of my parents there to give me guidance to tell me no; so when a guy came along and showed me attention, I would go that way."

Later in the interview, I asked Ashley to tell me about the turning point in her life. She explained that it was difficult. "Everybody tried to tell me; Chris (Townsend) would tell me for years, 'Ashley, you have to do something. You can't keep doing this'... Ashley revealed that she finally made up her mind that "this has to stop." She explained that the MAJORS Program was a primary resource in encouraging her to change her life. "It's not that they understood where I was coming from, but they cared about what I was going through. They wanted to know about me; they wanted to help me."

Ashley continued to explain, "Chris helped me to get back in school at one point. They didn't push me. Like, you give a dirty urine, you're out of the program. They worked with me like an individual in the group." After completing treatment from the MAJORS Program and acquiring a new lifestyle without drugs and alcohol, Ashley was able to find a job and enrolled in High Point University. She explained that she was able to transfer to Guilford Technical Community College, where she is currently enrolled as a student.

I asked Ashley, "What do you think your future will look like?" She answered with a huge smile on her face, "I plan to finish school! Right now, I'm not sure. I want to work with kids. I don't want to be a teacher of older kids, so I think I want to be an elementary school teacher or a counselor." She continued, "I want to get married and have only one child and that's it. You know, I want to do the things that my parents didn't help me with. I want to be able to understand my kids; let them know that there are consequences. Basically, my future is to do things that my parents didn't; don't be like that. That's what my future plans are."

~Submitted by Randolph Reid, The Guilford Center, Behavioral and Disability Services

Published by the UNCG Center for Youth, Family, and Community Partnerships in collaboration with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services with financial support from the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), US Department of Health and Human Services (grant number 6 J79 T117387-02-2).

NC DHHS
DMH/DD/SAS
Community Policy Management
Substance Abuse Services

3005 Mail Service Center
Raleigh, NC 27699-3005
919-733-4670
919-733-4556 (fax)