



NEWS



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IN THIS ISSUE:

- Ask the Experts
PAGE 2
- The Dangerous Reality of Club Drugs
PAGE 3
- Understanding Adolescent Trauma Resulting from Terrorism
PAGE 4
- Book Review "Treating Adolescent Drug Abuse"
PAGE 9
- Pennsylvania, National and Other State Resources
PAGE 10-11

Announcing the Pennsylvania Practice Improvement Collaborative (PIC)

The implementation of the Pennsylvania Practice Improvement Collaborative (PIC) — funded by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration—is underway at IRETA. The estimated \$967,000 of funding over a three-year period will permit Pennsylvania via IRETA to enter a national arena of fourteen other PIC initiatives. CSAT plans for the PIC initiatives to be a stable part of their portfolio of grant-funded activities. Since its receipt of funding late last year, IRETA has been busy planning the PIC initiatives.

Under the project direction of Dr. Janice Pringle, and through the project oversight of Dr. Michael Flaherty, the IRETA Executive Director, "the PIC project plans to increase the translation of research into substance abuse treatment and to increase the awareness of a variety of Commonwealth stakeholders regarding the need for substance abuse treatment," said Dr. Pringle.

By September 2002, a variety of PIC initiatives will be implemented by IRETA. IRETA's mission is "to act as the vehicle through which research findings related to substance abuse can be effectively translated to practice and policy," said Dr. Flaherty. The first of the PIC activities is a formal public awareness campaign. This initiative will improve the recognition of the PIC and its mission. The CSAT funding will also allow IRETA to enhance its current website (www.ireta.org) by adding new features such as a bulletin board on which the substance abuse treatment field and related stakeholders can post announcements, findings and data. The bulletin board will also provide a means whereby persons may ask designated experts specific questions.

By late summer, a conference is planned to present the experiences of other states in analyzing administrative/clinical datasets related to the substance abuse field, as well as discuss the plans of organizations within the Commonwealth to analyze these data. By late fall, a pilot study is planned to examine ways of improving substance abuse treatment encounter data (a.k.a. the CIS data system). Two training courses, as well as Research in Residence Workshop, is also planned for this year. The first course will be designed for substance abuse treatment providers and will teach basic research methodology, statistics, ethics and human subjects' information. The second course will be designed for parole officers. This course will not only cover ways to link persons on parole with community resources to prevent recidivism, but will also teach parole officers ways to help paroles "to increase their chances on the outside," said Dr. Pringle. A workshop is also planned for Pennsylvania's Single County Authorities (or SCAs). During the workshop, the participating SCAs will be paired with a researcher over a twelve-month period. It is hoped that this linkage will increase the transfer of research findings to and from community based treatment organizations. To learn more about PIC activities, call IRETA at 412/391-4449 or visit its website at www.ireta.org.

Look for future PIC newsletters on the IRETA web site at www.ireta.org

Ask the EXPERTS

This column provides an opportunity to have questions related to the newsletter topic answered by experts from the field. Please submit any questions concerning adolescent drug prevention or treatment services to pondk@ireta.org. Responses will appear in the next issue of PIC NEWS.

1. A gap exists regarding the quality/quantity of 12 step groups for adolescents. How do we fill that gap?

There is a significant gap in treatment and educational approaches for this demographic group. Perhaps we need to focus more on interventions that lie outside of the traditional 12 step approaches to recovery to serve this population. We need a renewed sense of community, where we are all responsible for each other, where individual responsibilities outweigh individual freedoms and where 12 step groups are but a part of the overall solution.

We have identified the ages of 13-23 years as a most vulnerable time period for our young people. We also know that the hours between 3:00 pm and 5:00 pm are times when many adolescents experiment with drugs, alcohol and sex for the first time. The bulk of our energies need to be focused on providing support to these individuals during these vulnerable hours. An extended network of after school programs and activities that include teachers, church, youth groups, YMCA, YWCA, mentors and other community organizations should be part of a comprehensive strategy for our young people. Maxim W. Furek, MA, CAC

2. Recent trends reflect adolescents starting substance abuse in their teen years. Is this due to a lack of education and awareness?

Recent studies have shown incidence is related in part to the level of substance abuse education of the target audience. Education alone is not a solution. A comprehensive approach targeting children and youth from day care through high school is required, as well as guided efforts of the local media, parents and the overall community is necessary.

In May 2001, SAMHSA's center for Substance Abuse Prevention in conjunction with the National Prevention Network and the Community Anti-drug Coalitions of America reported the implementation of (science-based) proven effective prevention model programs attributed to a 26% reduction in hard drug use, a 94% drop in drug related violence arrest, a 65% increase in school attendance and a rise in family stability.

Effective programming is the key to raising the age of first use. Many of these programs are beginning their implementation in Pennsylvania. Ready to get involved? Contact the Bureau of Drug and Alcohol Program or your local Single County Authority. Joseph Powell, Director, Division of Prevention, Pennsylvania Department of Health, Bureau of Drug and Alcohol Programs.

3. In our center we are racially divided—dark skin and white skin. How do you prevent an impending riot?

If we assume that the center is an inpatient MH or D & A facility, and that the impending conflict is between whites and persons of color the following issues need to be reviewed or addressed:

- Have staff been trained in regards to cultural diversity matters?
- Have staff been trained in conflict resolution techniques?
- Have staff met with clients or residents to ascertain the concerns or issues in question?
- If staff are untrained, is the center willing to hire outside resolution and/or cultural diversity and/or cultural competency?

A proactive strategy of intervention utilizing expert assistance from the outside, if necessary, is strongly recommended. If possible, take the group to a neutral place to deal with thoughts, feelings and emotions. In the long term, include cultural competency training and conflict resolution into pre-training when staff is hired and have periodic on-going training. Curtis Upsher, M.S. Community Care Behavioral Health Organization, Amy Jones-Barlock, Ph.D., University of Pittsburgh.



EDITORS:
Michael T. Flaherty, Ph.D
Janice Pringle, Ph.D

CONTRIBUTORS:
Maxim W. Furek, MA, CAC
Donna J. Keyser, Ph.D, MBA

Regional Enterprise Tower
425 Sixth Avenue, Suite 1710
Pittsburgh, PA 15219
Voice: (412) 391-4449
Fax: (412) 391-2528
web site: www.ireta.org

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The Dangerous Reality of Club Drugs

The rave culture of "Generation X", which eerily parallels the youth culture of the 1960's, has etched out their unique identity through music, dress and an array of dangerous street substances. Substances of abuse among Generation X (for our purposes, those individuals born between the years 1965–1978,) have been easily available and acceptable.

The following is a brief overview of Club Drug substances, many of which are taken in combination with other substances. Most of these exotic drugs are perceived to be benign and harmless. We, as Drug and Alcohol counselors and Prevention Specialists, must break through the denial and educate our clients about the real dangers of these substances.

1. MARIJUANA:

The popularity of marijuana waxes and wanes with the media anti-drug message. Marijuana use has noticeably decreased since its peak in 1997, yet the popularity of smoking marijuana blunts with PCP and ketamine has not gone unnoticed. The 1999 National Household Survey on Drug Abuse demonstrated a decline in the rate of past-month drug use for members of Generation Y. Youth ages 12 – 17 decreased their past-month use from 9.4 percent (1997) to 8.3 percent (1998) to 7.0 percent (1999.) Still, there is much to be concerned with as marijuana remains the most widely used illegal substance.

Dangers: The amount of THC content in current marijuana is higher than that of the 1960's. Chronic use of marijuana can lead to the amotivational syndrome, psychological addiction and irrational, dangerous behaviors. It is believed by some researchers to be a "Gateway Drug" leading to harder substances. A 1999 report by the National Center on Addiction and Substance Abuse concluded "children 12 to 17 who smoke marijuana are 85 times more likely to

use cocaine than those who do not."

2. HEROIN:

Because this narcotic has increased purity, lower cost and underworld allure, it has gone mainstream. Fueled by grunge rockers such as Nirvana's Curt Cobain and the heroin chic of the 1990's, the substance has increased in popularity since 1992. It is the most dangerous and most powerful of the substances listed here. Although not recognized specifically as a club drug, is often found as an adulterant in ecstasy capsules.

Dangers: Many individuals continue to erroneously believe that heroin is safe to use if snorted or smoked. The reality is that increased tolerance and rapid addiction follow casual use. Due to the purity of the drug currently on the street, there is also a very real possibility of death from overdose. A survey of nationwide overdoses in 42 major cities revealed a 17 percent increase from 3,653 (1994) to 4,270 (1997.) The incidence of 12th grade students using heroin doubled between 1996 and 1999 to 1.8 percent. Overdoses are common with this pain-killing narcotic as muscles become rigid, breathing slows and the heartbeat is dramatically lowered.

3. ECSTASY:

This stimulant/hallucinogen has helped generate a counterculture, based on "being real," accepting all peoples and rejecting the hypocrisy of mainstream society. The anger, rebellion and idealism is much the same as we have witnessed from previous groups of teens and adolescents; the difference is in the trappings: the music, dress, raves, etc. Just as LSD became a religious sacrament used by hippies to expand their spiritual consciousness, ecstasy, too, has been viewed by some in the same context.

Dangers: Because of dubious quality control, chemical analysis of ecstasy has revealed adulterants such as



Maxim W. Furek, MA, CAC

PCP, methamphetamine and heroin. Feelings of confusion and depression are common in users. Malignant hyperthermia can produce elevated body temperatures, as high as 107 degrees, which can trigger stroke, convulsions and death. Some researchers have warned that we may have a generation of depressed individuals with memory impairment and damaged serotonin-releasing neurons, a phenomenon known as "Suicide Tuesday."

4. KETAMINE:

This cousin of PCP (phencyclidine) is used to produce a mystical, out of body experience. A common animal anesthetic, ketamine is usually stolen from veterinary offices. The substance leaves the user in a zombie-like "K hole" and has been used to facilitate sexual assault. It has fostered a cult-like fascination which is illustrated by the Chemical Brothers CD, "Dig Your Own Hole" and several episodes of the "X-Files" TV series.

Dangers: Ketamine, or "Special K," promotes feelings of a dream-like, "out of body" experience. Like PCP, the substance is unpredictable and can trigger flashbacks, as well as feelings of delirium, amnesia, impaired motor function and potentially fatal respiratory problems.

5. ROHYPNOL:

An illegal benzodiazepine, this substance was popular on Southern college campuses as a date-rape substance and popular with heroin addicts (along with valium) to boost the impact of their drug.

CONTINUED ON PAGE 9

Understanding Adolescent Trauma Resulting from Terrorism

DONNA J. KEYSER, PH.D., M.B.A.

ASSOCIATE DIRECTOR RAND-UNIVERSITY OF PITTSBURGH HEALTH INSTITUTE

The terrorist attacks of September 11 have brought a new and sometimes frightening reality to the lives of many Americans. It is estimated that well over 100,000 people directly witnessed the catastrophic events, and countless others were exposed through the media. Research has shown that adults and children who are confronted with such unprecedented levels of interpersonal violence, large-scale damage, and loss of life show a wide range of reactions (Yehuda et al, 1998; Smith and North, 1993). Some suffer only short-term worries and bad memories; others are more deeply affected and experience longer-term problems. In general it is believed that the more direct the exposure to the traumatic event, the higher the risk for emotional harm (March et al, 1997). But even second-hand exposure to violence can cause stress reactions. According to a RAND survey conducted 3 to 5 days after the 9/11 attacks, Americans across the country, including children, evidenced substantial symptoms of stress (Schuster et al, 2001).

In a recent review of the empirical literature on the mental health consequences of disasters, 74 percent of 130 distinct samples, including over 50,000 individuals who had been exposed to 80 different disasters, experienced specific psychological problems. Post-traumatic stress disorder (PTSD) was found in 65 percent of the samples, depression or major depression disorder was found in 37 percent of the samples, and anxiety or generalized anxiety disorder was found in 19 percent of the samples. Importantly, school-aged youth were identified as the most likely to suffer serious mental health effects from disasters, with 62

percent evidencing signs of severe impairment versus 39 percent for adults and 7 percent for rescue/recovery workers (Norris, 2001).

Despite growing evidence of the impact of trauma upon youth, there is scant research to date that examines the nature and extent of adolescent trauma related to terrorism. In general, we know that when trauma occurs or life has been threatened or lost, our view of the world shifts. This shift includes how we see others and ourselves, and how we perceive life around us. In shifting our belief and emotional response systems, trauma can affect our ability to adapt or cope (Crimmins et al, 2000). Since adolescence is a critical development period during which youth acquire social, educational, and behavioral skills needed throughout adulthood (Parrish, 1994), living in a state of chronic threat, particularly during childhood, may have important ramifications for how things are perceived, felt and dealt with during later stages of life (Giaconia et al, 2000; Crimmins et al, 2000).

The purpose of this article is to review what is known about the risk factors, nature and extent of outcomes, and proper treatment for adolescents suffering from psychological trauma caused by terrorism and related events.

What Are the Risk Factors for Adolescent Trauma?

Although a substantial amount of research relevant to understanding risk factors for trauma resulting from disasters has been published over the past 20 years, the research base is larger and more consistent for adults than it is for youth. However, we do know that for both popula-

tions more severe psychological reactions following traumatic events are associated with (Norris, 2001; Goodman et al, 2001):

- A higher degree of direct impact from the disaster, especially injury, threat to or loss of life, and extreme loss
- Closer proximity to the situation
- Pre-existing risk factors such as prior traumas or prior mental health problems
- Female gender
- Physical and emotional functioning of the surviving adults /parents
- Secondary stress and resource loss
- Support services and networks provided and available before, during, and after the traumatic event.

Both clinical and community research has established a linkage between serious traumatic events and subsequent development of PTSD (Cuffe et al, 1998; Giaconia et al, 1995). On the basis of data obtained after the Oklahoma City bombing, which was previously the deadliest act of terrorism in America, we can expect that PTSD will develop in approximately 35 percent of those who were directly exposed to the September 11 attacks (North et al, 1999). In studies of children and adolescents who have experienced a trauma, 3 to 15 percent of girls and 1 to 6 percent of boys meet criteria for PTSD (Hamblen, 2001). The impact of age at time of exposure is less clear. While some studies find a relationship others do not. Differences may be due to variations in the way PTSD is expressed in children and adolescents of different ages or developmental levels (Hamblen, 2001).

How Do Adolescents React to Trauma?

Reactions to trauma may appear immediately after the traumatic event or days and even weeks later (NIMH, 2001). Loss of trust in adults and fear of the event occurring again are responses seen in many children and adolescents who have been exposed to traumatic events. Other reactions vary according to age. Below are some common symptoms that pre-adolescents and adolescents (12-18 years) may display when traumatized (DeWolfe, 2001; Pynoos and Nader, 1993):

- Self-consciousness
- Life-threatening reenactment
- Rebellion at home or school
- Abrupt shift in relationships
- Depression, social withdrawal
- Decline in school performance
- Trauma-driven acting-out behavior
- Effort to distance from feelings of shame, guilt, and humiliation
- Flight into driven activity and involvement with others or retreat from others in order to manage inner turmoil
- Accident proneness
- Wish for revenge and action-oriented responses to trauma
- Increased self-focusing and withdrawal
- Sleep and eating disturbances; nightmares.

Within a few weeks most children and adolescents will recover almost completely from the fear and anxiety caused by a traumatic experience (NIMH, 2001), but others will have prolonged problems. One serious and potentially long-lasting problem is post-traumatic stress disorder. PTSD may arise weeks or months after the traumatic event. Although some children and adolescents show a natural remission on PTSD symptoms over a period of a few months, there are a significant number for whom PTSD persists for years if untreated. Fortunately, it is

more common for such traumatized individuals to have some of the symptoms of PTSD than to develop the full-blown disorder (Breslau et al, 1998).

PTSD is diagnosed when the following symptoms have been present at a clinically significant level for more than a month (NIMH, 2001):

- Re-experiencing the event through play or in trauma-specific nightmares or flashbacks, or distress over events that resemble or symbolize the trauma
- Routine avoidance of reminders of the event or a general lack of responsiveness (e.g., diminished interests or a sense of having a foreshortened future)
- Increased sleep disturbances, irritability, poor concentration, startle reaction and regressive behavior.

Adolescents with PTSD are more likely than younger children or adults to engage in traumatic reenactment in which they incorporate aspects of the trauma into their daily lives. They are also more likely to exhibit impulsive and aggressive behaviors. A number of associated psychiatric disorders are commonly found in children and adolescents who have been traumatized. One commonly co-occurring disorder is major depression. Other disorders include substance abuse, other anxiety disorders, and externalizing disorders such as attention-deficit/hyperactivity disorder and conduct disorder (Hamblen, 2001).

Adolescents with comorbid PTSD and substance use disorder (SUD) have been shown to exhibit the poorest functioning, including significantly greater externalizing behavior problems (e.g., delinquent and aggressive behavior, poorer school performance, and arrests) as well as serious suicidal behavior. Impairments unique to adolescents with comorbid PTSD and SUD include internalizing problems such as anxiety and withdrawn behavior. Compounding these difficulties, the comorbid youth tend to have greater problems in communicating with

others in their lives, view their health as poorer, and are more likely to report somatic complaints such as headaches (Giaconia et al, 2000).

Helping Adolescents Suffering from Trauma

Early intervention for those who have suffered trauma from violence, disaster, or terrorism is critical in order to limit the longer-term effects. In helping children and adolescents to recover from trauma, emphasis should be placed on establishing a feeling of safety, explaining the episode of violence or disaster, and encouraging adolescents to express their feelings. Adolescents need to know that their fears and concerns are normal, and that what has happened is not their fault. Encouraging young people to develop coping skills and age-appropriate methods for managing their anxiety is also helpful.

In the immediate aftermath of a traumatic event, and in the weeks following, it is important to identify those who are in need of more intensive support and therapy.

Unfortunately, early identification of adolescents at risk for long-term psychological effects is complicated by the fact that near-term symptoms following a traumatic event have been shown to have low predictive validity by themselves for later psychiatric outcomes (The National Academy Press, 2000). Nevertheless, schools and primary care providers can play an important role in identifying youth whose unexplained behavior or physical symptoms may be resulting from trauma, PTSD, and/or other disorders.

Although few studies have been conducted examining which treatments are most effective for children and adolescents experiencing more serious problems, a review of adult treatment studies for PTSD suggests that cognitive behavioral treatment (CBT) may be an effective approach (Hamblen, 2001). CBT for children and adolescents generally includes:

CONTINUED ON PAGE 6

Understanding Trauma Resulting from Terrorism (CONTINUED)

exposure; anxiety management techniques such as relaxation and assertiveness training; and correction of inaccurate or distorted trauma. CBT is often accompanied by education about PTSD symptoms and its effects and parental involvement. Specialized interventions may be necessary for adolescents exhibiting particularly problematic behaviors or symptoms. Since the symptoms of PTSD may last from several months to many years, and youth with PTSD are at continued risk for other disorders for more than one year following the onset of PTSD, continued follow up is essential (Giaconia et al, 2000).

Clearly, more information is needed on adolescents' psychological responses to terrorism. Data specific to this population, including longitudinal designs that integrate short- and long-term effects and research to test ideas about risk and protective measures and the efficacy of various treatment methods would be particularly useful. Improved public information and education regarding how to prepare our children for future traumatic situations, what to do for them in case of an attack, and how to cope with their emotions in the aftermath would help lessen the suffering that terrorism can impose on adolescents and their families.

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Have a question? Visit the PIC or IRETA on the web:
www.ireta.org

"Knowledge at your fingertips."

Drug Use Screening Inventory (DUSI):

An Effective Tool in Identifying and Quantifying Substance Use in Adolescents

The Drug Use Screening Inventory (DUSI) (Tarter, 1990) was developed in response to the need for an objective, accurate, and brief instrument to detect youths who use drugs. According to (Tarter, Kirisci & Mezzich, 1996), this instrument consists of 149 items which are answered either "yes" or "no" in a self-report format. Item composition was initially determined through consensus by an expert panel and subsequently refined through a number of iterative analyses and exploratory studies.

The DUSI can be individually or group administered using either paper-and-pencil or interactive computerized format. Scoring and profiling of results can be conducted either by computer or manually in 5 minutes. Information that quantifies problem severity in ten domains is obtained through this instrument. They are: 1) substance use; 2) psychiatric disorder; 3) health status; 4) behavioral problems; 5) peer relations; 6) social competence; 7) family; 8) school; 9) work; and, 10) leisure and recreation. Each domain yields a score ranging from 0% to 100%, thereby enabling easy comparison of scores across areas. The DUSI has the advantage over existing instruments not only in index-

ing the presence and severity of an alcohol and drug abuse problem, but also by quantifying focal areas of disturbance.

The DUSI is used in a variety of settings and for many purposes (Tarter, 1995). The most common applications involve detecting problems of adolescents in the school, forensic, and medical settings. In addition, the DUSI has been recommended for use as a method to monitor and track changes, such as improvement in psychosocial adjustment occurring as the result of counseling or other interventions.

The school is the most opportune location for using this broad-based screening instrument. The classroom setting affords the opportunity to perform screening of a school's population in the context of a formal drug abuse prevention program or a health education curriculum. Results of mass screenings can be used to determine the prevalence of alcohol and other drug use to guide prevention programming needs within a particular school or within a school district. In addition, because alcohol and drug use are commonly associated with behavior, academic, and emotional problems, documentation of the presence and severity of alcohol and

drug use at the individual level enables efficient referral to a counselor or health professional for intervention before the manifestation of severe and intractable medical or emotional disturbance.

For additional information on the DUSI or to obtain a copy of this screening tool contact:

Ralph Tarter, Ph.D.
Professor of Pharmaceutical
Science
University of Pittsburgh
711 Salk Hall
University of Pittsburgh
Pittsburgh, PA 15261
412-624-1070

References:

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UPCOMING EVENTS

July 7-9, 2002

Hershey Lodge, Hershey, PA
Secondary Data Conference

Substance Abuse Treatment Today: Using Data to Empower the Treatment System

CALL FOR POSTERS

Look for specific information on the IRETA web site at www.ireta.org

Prevention Principles for Children and Adolescents

- Prevention programs should be designed to enhance “protective factors” and move toward reversing or reducing known “risk factors.”

Prevention programs should target all forms of drug abuse, including the use of tobacco, alcohol, marijuana, and inhalants.

- Prevention programs should include skills to resist drugs when offered, strengthen personal commitments against drug use, and increase social competency (e.g., in communications, peer relationships, self-efficacy, and assertiveness), in conjunction with reinforcement of attitudes against drug use.
- Prevention programs for adolescents should include interactive methods, such as peer discussion groups, rather than didactic teaching techniques alone.
- Prevention programs should include a parents’ or caregivers’ component that reinforces what the children are learning—such as facts about drugs and their harmful effects—and that opens opportunities for family discussions about use of legal and illegal substances and family policies about their use.
- Prevention programs should be long-term, over the school career with repeat interventions to reinforce the original prevention goals. For example, school-based efforts directed at elementary and middle school students should include booster sessions to help with critical transitions from middle to high school.
- Family-focused prevention efforts have a greater impact than strategies that focus on parents only or children only.
- Community programs that include media campaigns and policy changes, such as new regulations that restrict access to alcohol, tobacco, or other drugs, are more effective when they are accompanied by school and family interventions.
- Community programs need to strengthen norms against drug use in all drug abuse prevention settings, including the family, the school, and the community.

Schools offer opportunities to reach all populations and also serve as important settings for specific subpopulations at risk for drug abuse, such as children with behavior problems or learning disabilities and those who are potential dropouts.

- Prevention programming should be adapted to address the specific nature of the drug abuse problem in the local community.
- The higher the level of risk of the target population, the more intensive the prevention effort must be and the earlier it must begin.

Prevention programs should be age-specific, developmentally appropriate, and culturally sensitive.

- Effective prevention programs are cost-effective. For every dollar spent on drug use prevention, communities can save 4 to 5 dollars in costs for drug abuse treatment and counseling.

*Source: NIDA Prevention brochure, access at: www.nida.nih.gov/Prevention/PREVPRINC.html.
For additional information about NIDA send e-mail to Information@lists.nidQ.nih.gov*

Publication Addresses Adolescent Treatment

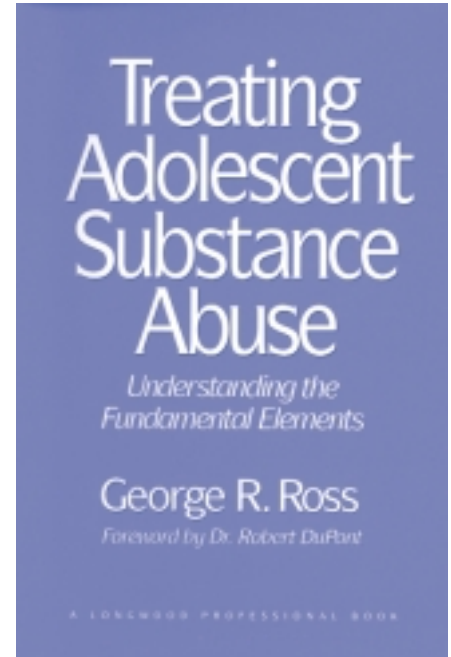
Treating Adolescent Substance Abuse: Understanding the Fundamental Elements
Author: George R. Ross

This book was written to introduce practitioners in the field to chemical dependency and related professions to eight fundamental elements for treating substance abuse. The eight fundamental elements Dr. Ross addresses are detailed in ten chapters packed with practical ideas, suggestions, and techniques based on both the opinions and research of other professionals in the field and the authors' extensive experience over the past fifteen years. These eight fundamental elements of an effective treatment program for adolescent substance abusers include: (1) a sound rationale for diagnosis and treatment, (2) appropriate screening, as-

essment, and diagnostic procedures, (3) a continuum of care, (4) a healthy treatment environment, (5) effective treatment strategies, (6) active family involvement, (7) competent staff, and (8) efficacy and efficiency of treatment.

Dr. Ross integrates the twelve-step program and the disease concept of addiction into every facet of his work. The time-proven steps of Alcoholics Anonymous and spiritual components such as meditation, prayer, and higher power are incorporated with cognitive-behavioral techniques. This book is intended to be used as a practitioner's guide, a college text, and as a resource book for professionals interested in treatment of adolescent substance abuse and related disorders as well as other forms of addiction. The book is complimented with two appendices: (1) a ready-to-use psychosocial assessment form and (2) a listing of the 12 steps of Alcoholics Anonymous, and references. "George Ross's book is a giant step forward for everyone who wants to

understand teenage addiction and wants to know what to do about it. Here are the nuts-and-bolts needed to help addicted teenagers and their families get well." – From the Foreword by Robert L DuPont, M.D., founding Director of the National Institute of Drug Abuse (NIDA)



The Dangerous Reality of Club Drugs

CONTINUED FROM PAGE 3

Dangers: Rohypnol is ten times more potent than valium. The potential for overdose is great, especially when mixed with other depressants. Dangerous side effects include confusion, dizziness, decreased blood pressure and impairment for up to 12 hours. The prison sentence for using rohypnol or any other substance to facilitate sexual assault is costly.

6. GAMMA HYDROXYL BUTERATE:

GHB is a colorless, odorless and almost tasteless drug that has been used to facilitate sexual assault. It produces a quick, euphoric high. Currently classified as an orphan drug, GHB is not scheduled but is believed to be headed for Schedule III where it will be used as a treatment for narcolepsy. GHB is popular at raves. Mixed with methampheta-

mine and called a "Max Cocktail" it has been common at urban dance clubs.

Dangers: Called "Liquid X" or "cherry meth," there is a lot of GHB on the streets, much of it made by basement chemists following underground internet recipes. Many recreational drug users stay away from GHB, because of the slim margin between the therapeutic and a fatal dose. If taken with alcohol, the combination can be deadly and is the reason why so many GHB users end up in the ER. According to national statistics, GHB has increased from 300 cases (1995) requiring ER treatment to over 3,000 (1999.) Victims of GHB are usually Generation X males (69 percent) with a median age of 29. Negative consequences include nausea, vomiting, loss of consciousness, loss of reflexes,

impaired breathing, slowed heart rate, coma and death.

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National & Other State Resources

Al-Anon/Alateen

www.al-anon.alateen.org

Support group for family and friends of alcohol abusers, based on AA's 12 steps. Their site includes meeting schedules with contact information, teen forum for sharing, resources for professionals, including contact information for clients and a newsletter, and literature/resources catalog with online ordering.

American Council for Drug Education

www.acde.org

Develops and disseminates drug education materials to individuals, professionals, and organizations regarding drug use and abuse – especially geared toward helping children, adolescents, and their families.

Children of Alcoholics

www.coaf.org

A national non-profit that provides a range of educational materials and services to help professionals, children, and adults break the intergenerational cycle of parental substance abuse.

Drinking: A Students Guide

www.glness.com

Awareness and prevention site for college and college-bound students. This site includes alcohol facts, statistics, at risk self-test, guidelines and steps for risk reduction as well as resources for those needing help.

Focus Adolescent Services – Teen Substance Abuse

www.focusas.com/SubstanceAbuse.html

Browse through a compilation of teen substance abuse links. Also learn some common warning signs of teen alcohol and drug abuse.

For Real [Center for Substance Abuse Prevention (CSAP)]

www.forreal.org

This site includes drug facts for teens as well as links to teen substance abuse resources.

Hetrick-Martin Institute

www.hmi.org

The Hetrick Martin Institute (HMI) is the world's largest not-for-profit, multi-service, education, and advocacy organization dedicated to providing services to lesbian, gay, bisexual, transgender, and questioning youth, and all youth who are coming to terms with issues of sexuality. The Institute has over 20 years of experience providing quality youth services.

MADD (Mothers Against Drunk Driving)

www.madd.org

This organization provides awareness, advocacy and prevention of drunk driving and underage drinking. Visit their site for statistics and research, online chapter search and information, discussion forums and moderated chats as well as Driven magazine issues, news and press releases, weekly site update notification.

Monitoring the Future [University of Michigan's Institute for Social Research]

<http://monitoringthefuture.org>

Monitoring the Future is a long-term study of American adolescents, college students, and adults through age 40. It is conducted by the University of Michigan's Institute for Social Research and is supported under a series of investigator-initiated, competing research grants from the National Institute on Drug Abuse. Available is an overview of the key findings from the 2000 survey of 8th, 10th, and 12th grade students, with a particular emphasis on recent trends in the use of licit and illicit drugs covered by this study. Further information on the study, including its latest press releases and a listing of all publications, may be found at their web site.

Parents, The Anti-Drug [The National Youth Anti-Drug Media Campaign]

www.theantidrug.com

This site educates parents about adolescent drug prevention. Site includes parenting advice, interactive tools and a bulletin board for parents to exchange information. Educational activities for teachers of students aged 11-14.

NIDA Club Drugs

www.clubdrugs.org

Responding to the alarming recent rise in use of club drugs, NIDA has initiated a broad-based public initiative to inform and educate teens, young adults, parents, and communities about the dangers of club drugs. Visit their site for extensive information on club drugs, community drug alert bulletins, resources, publications and more.

Partnership for a Drug-Free America

www.drugfreeamerica.org

This site provides parents and kids with information about drugs, including tips to help parents to talk to their children, an information center dealing specifically with ecstasy and party drugs, advice for teens, and bulletin boards for teens and parents.

SADD (Students Against Destructive Decisions)

www.saddonline.com/Default.htm

The Official site of SADD, Students Against Destructive Decisions, formerly known as Students Against Drunk Driving, helping teens and students to make the right decisions concerning drug abuse, safe driving, teen pregnancy, road rage and other violence issues.

Soy Unica! Soy Latina!

www.soyunica.gov

An interactive web site that engages young Latinas in positive activities and encourages dialog that promotes healthy drug-free lifestyles. This web site is designed to help young Latinas ages 9-14, their mothers and other caregivers build and enhance self-esteem, mental health, decision-making skills and assertiveness, and to prevent the abuse of alcohol, tobacco and illicit drugs.

Pennsylvania Resources

Center for Education and Drug Abuse Research (CEDAR)

<http://cedar.pharmacy.pitt.edu/main.html>

A collaborative research project between the University of Pittsburgh and St. Francis Medical Center, CEDAR's mission is to elucidate the etiology of substance abuse and substance use disorder using a long-term longitudinal research strategy. This research site includes an online reference database and search tool, findings of this long term research study, module components, structure design and goals as well as publications and resource links.

Pennsylvania Commission on Crime and Delinquency

www.pccd.state.pa.us

The mission of the PCCD is to serve as a catalyst for the prevention and reduction of crime and delinquency and to enhance the quality of justice for all Pennsylvanians. The PCCD strives to effect improvements in the criminal and juvenile justice systems by examining problems, proposing solutions, and monitoring and evaluating the impact of those solutions. Visit their web site for information on their organization, funding, grant forms, forums, publications and more.

Pennsylvania Department of Education – Safe and Drug Free Schools/Communities

www.pde.psu.edu/drugfree/sites.html

Publications and resources providing information on safe and drug free schools/communities.

Pennsylvania Department of Health

www.health.state.pa.us

Search the Department of Health web site for specific information regarding substance abuse prevention, treatment, intervention and training in the Commonwealth of Pennsylvania.

Pennsylvania Department of Health Research & Information Clearinghouse

www.padohric.org

The Pennsylvania Department of Health Research & Information Clearinghouse operates as the informational clearinghouse and referral center for the Pennsylvania Department of Health. In a statewide effort to reduce substance abuse and to promote healthy lifestyles for all Pennsylvanians, PADOHRIC's mission is to serve as a resource center and provide a wide range of information regarding drug, alcohol, substance abuse and other health-related issues.

Pennsylvania Liquor Control Board's Alcohol Education & Information

www.lcb.state.pa.us/edu

PLCB has taken a leadership role in the prevention of underage drinking and other forms of alcohol abuse. Their web page is designed to provide information about alcohol and its effects, as well as to share alcohol-related news from within Pennsylvania and the Nation.

Pennsylvania National Guard Counterdrug Program

www.counterdrug.org

The Pennsylvania Counterdrug Program supports the Drug Demand Reduction efforts of Community-based coalitions and educational institutions. The Drug Demand Reduction Administrator (DDRA) has established partnerships with local, state and federal groups that present our youth with alternatives to illegal drug use.

Pittsburgh Adolescent Alcohol Research Center (PAARC)

www.pitt.edu/~paarc/paarc.html

PAARC is one of fourteen alcohol research centers funded by NIAAA. It is the only NIAAA center investigating the effects of alcohol on the development of adolescents.

National & Other State Resources, continued

Substance Abuse Information for Parents Who Think There Might be a Drug Problem

www.commnet.edu/student/GaryOKeefe/drugfacts.html

This grass-roots site helps parents identify specific drug use and includes a comprehensive collection of information and links covering issues such as facts on popular drugs, tell-tale signs of drug use, education and prevention and 12-step programs.

The Center for Treatment Research on Adolescent Drug Abuse - University of Miami (CTRADA)

www.med.miami.edu/ctrada/about.htm

CTRADA's was originally founded in 1991, the first NIDA-funded clinical research center focusing on adolescent drug abuse treatment. Visit their site for programs of study, research training, publications, facilities and resources, announcements and related links.

Wheel Council

www.wheelcouncil.org

A national leader in storytelling for prevention and healing, as well as accelerated, multicultural learning. Their mission is to merge traditional cultural practices with the best information from scientific research to maximize learning, health, and potential for all people.



Institute for Research, Education, and Training in Addictions

The Institute for Research, Education and Training in Addictions is a 501(c)3 not-for-profit entity responsible for coordinating the transfer of all state-of-the-art knowledge to the practice of addiction treatment.

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Regional Enterprise Tower
425 Sixth Avenue, Suite 1710
Pittsburgh, PA 15219

