Adolescents and Substance Use Disorders: Fundamentals of Development, Trauma and Best Practices to Inform County Strategies

PRESENTED BY:

Bren Manaugh, LCSW
Mark Varela, Retired – CPO
John Eller, MBA

WELCOME AND INTRODUCTION

Juan Carlos Argüello, DO

Chief Health Policy Officer

Child and Adolescent Psychiatrist

California Office of Youth and Community Restoration (OYCR)

OFFICE OF YOUTH AND COMMUNITY RESTORATION

VISION

- We envision a healthy California that enables all youth to be responsible, thriving, and engaged members of their communities.

MISSION

- Promote trauma responsive, culturally informed services for youth involved in the juvenile justice system that support the youths' successful transition into adulthood.

TODAY'S PRESENTERS

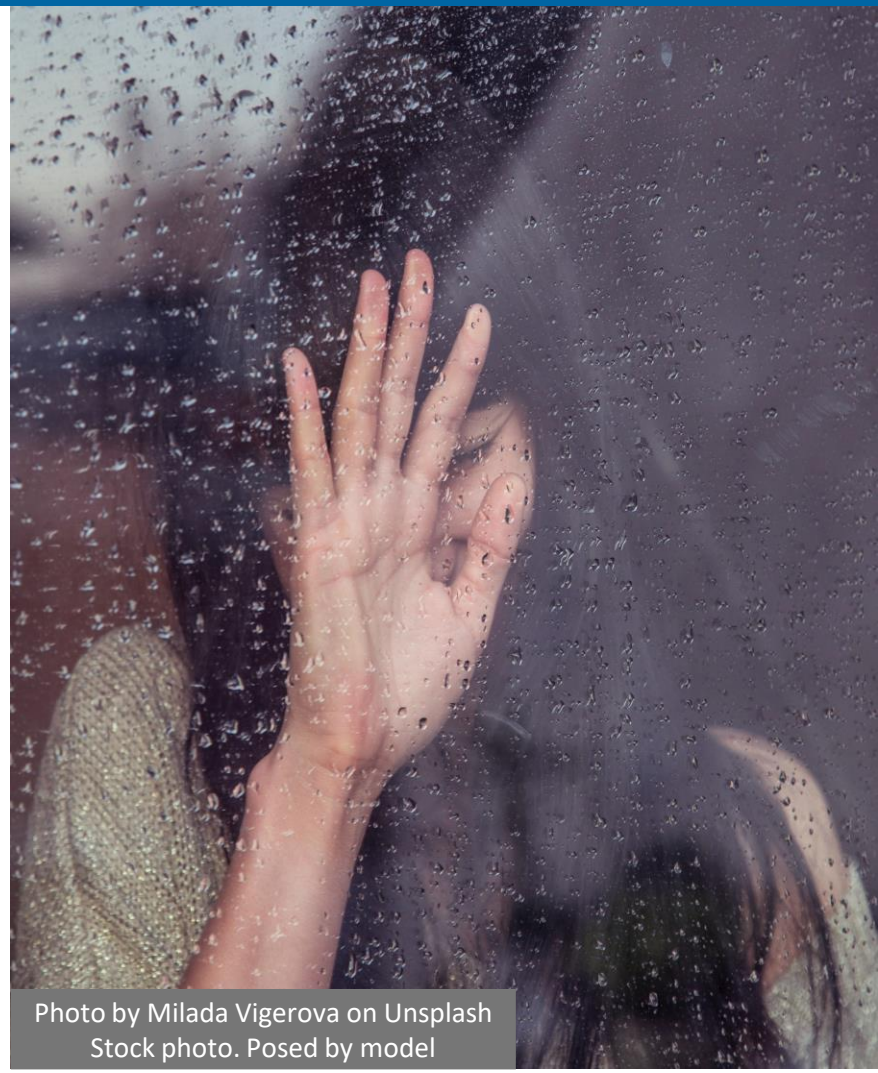
Bren Managh, LCSW
Principal
Health Management Associates

Mark Varela
Retired Chief Probation Officer
Ventura County

John Eller, MBA
Principal
Health Management Associates

ADOLESCENTS AND SUBSTANCE USE DISORDERS (SUD): A GRIM PICTURE

- Deaths due to drug overdose among adolescents continue to steeply rise
  - Adolescents of color – Black and Hispanics – at much greater risk
- Substance use is common among justice-involved youth
- Majority of justice-involved youth have had prior drug involvement
- CA youth opioid-related deaths increasing at a rate more rapid than adult deaths
- The share of adolescents with anxiety and/or depression has increased over time



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ADDRESSING THE NEED – HOW ARE WE DOING?

- Nationally:
  - 44% of adolescents with a co-occurring major depressive episode and substance use disorder (SUD) did not receive any type of treatment
  - Of adolescents with a co-occurring major depressive episode and SUD, 93.5% received only mental health services

TO BE MOST EFFECTIVE – THE WHOLE PICTURE TO SUPPORT RECOVERY

- Substance use
- Mental health
- Medical conditions
- Trauma history
- Developmental history and current stage
- Family of origin and current supports
- Use of evidence-based practices: right time, type

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JUAN

**Fictional, composite profile*

You are trying to interview Juan, but he will not make eye contact, and he takes a long time to respond. When he finally does answer, his responses are very short and not very informative. You feel frustrated with him because it seems he is being uncooperative.

AMBER

**Fictional, composite profile*

Amber is chewing on her nails and staring at the floor. She appears tense and upset. As you begin interviewing her, she bursts into tears, turns very red in the face, starts shaking and shouts “I can’t do this!”

You feel uncomfortable because she is so upset. You also feel impatient because it’s important you get information from her, and your schedule is packed.

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TREVOR

**Fictional, composite profile*

Trevor is slouched down in his chair, and he won't meet your eyes. When he does look at you, it's with hatred and anger in his eyes. The social worker who is in the room chastises him for not being more respectful and he says "f– you! I don't have to deal with this "s---!" You find yourself feeling angry toward him for his behavior.

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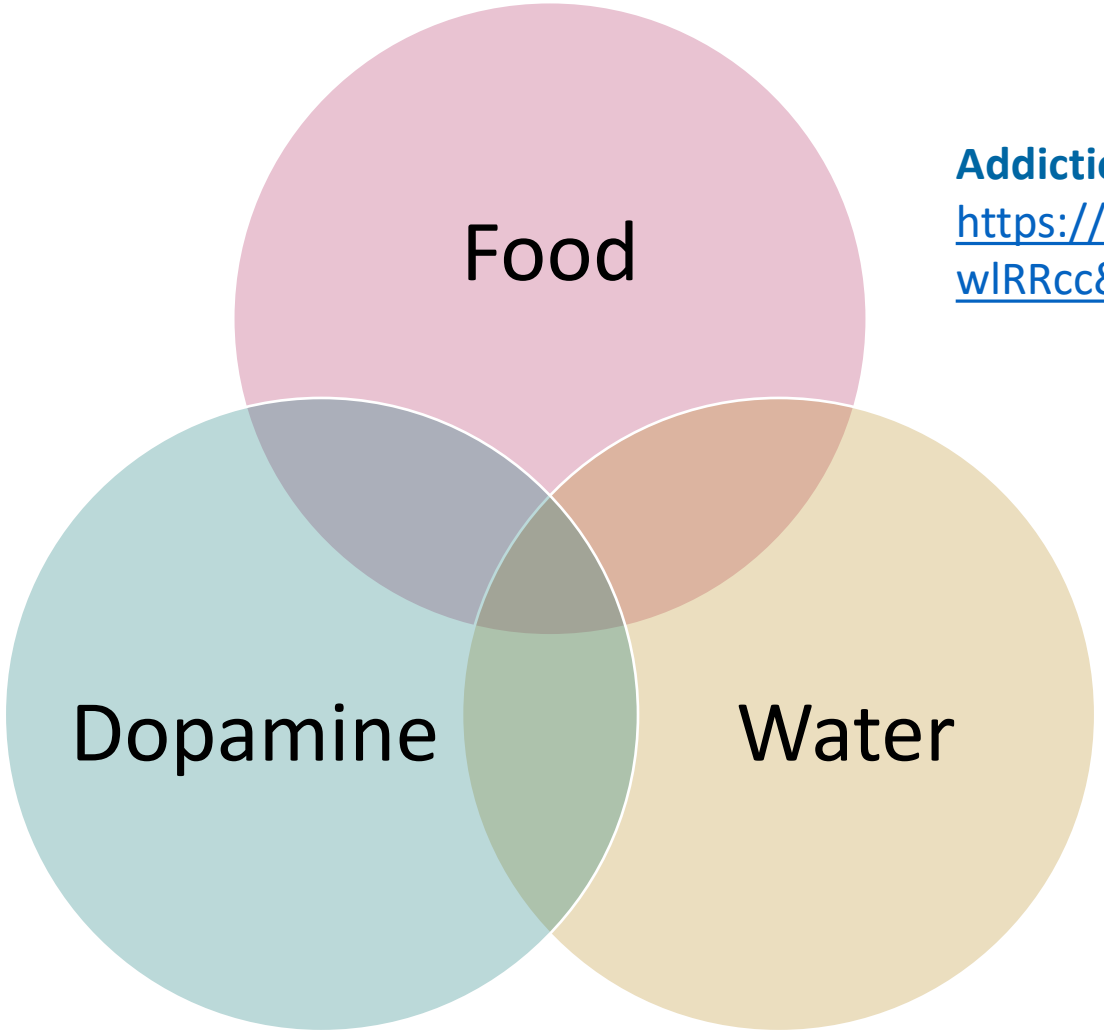
NEUROBIOLOGY OF SUBSTANCE USE DISORDERS (SUD) AS A CHRONIC DISEASE

BASIC MECHANISM OF HOW SUD AFFECTS THE BRAIN



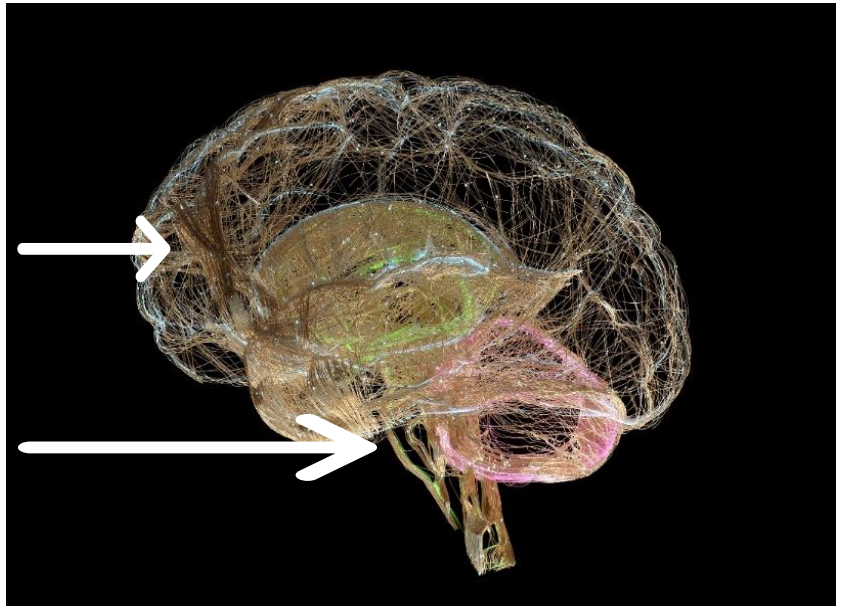
Addiction Neuroscience 101 Video:
https://www.youtube.com/watch?v=bwZcPwlRRcc&t=266s

HOW SUBSTANCES OF ABUSE AFFECT THE BRAIN

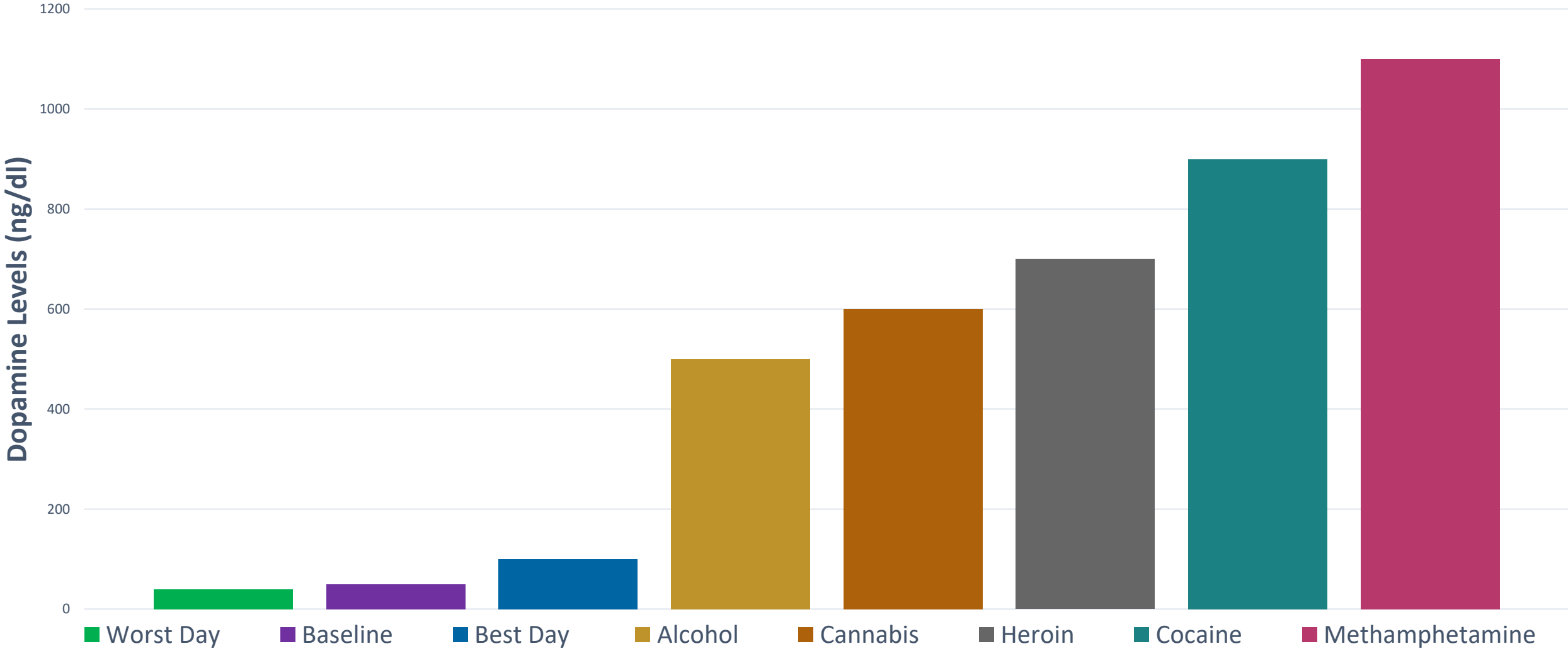
- All substances of abuse result in activation of the *reward pathway*
- The same pathway activated by naturally rewarding substances and events

Thinking part of the brain

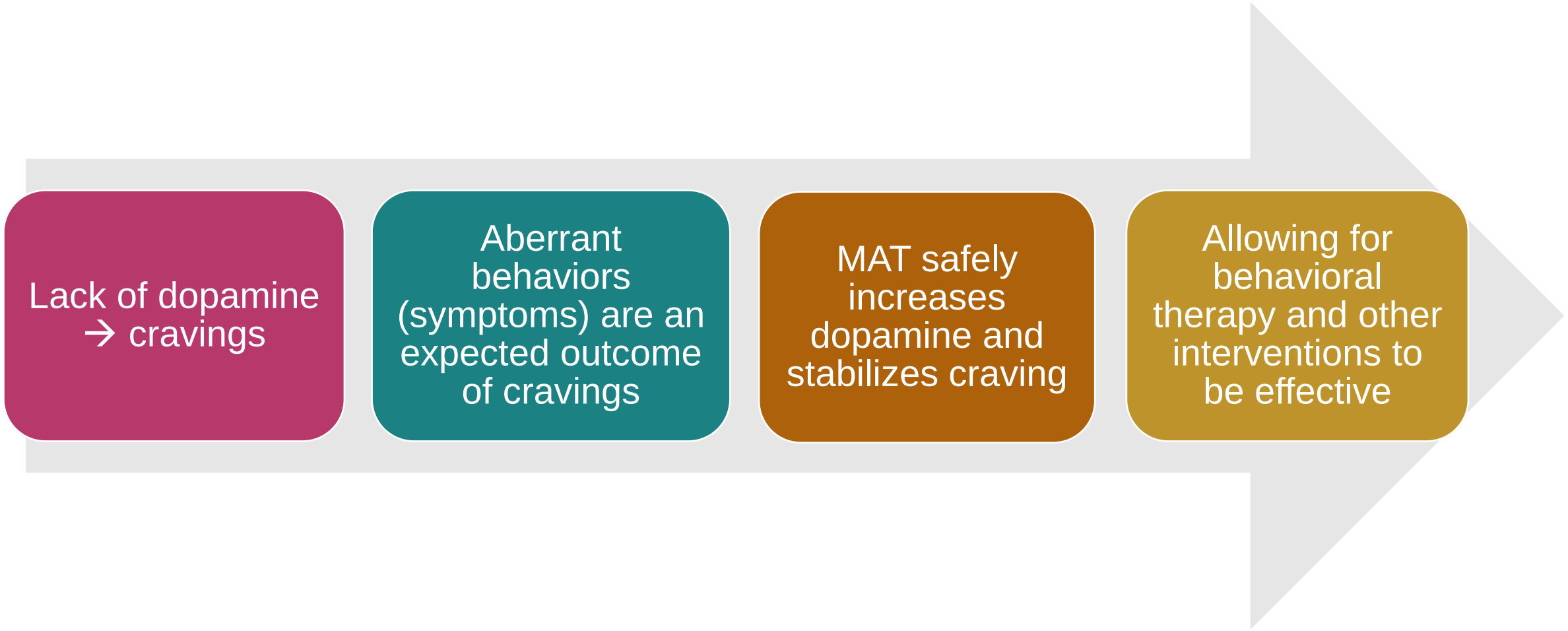
Primitive part of the brain

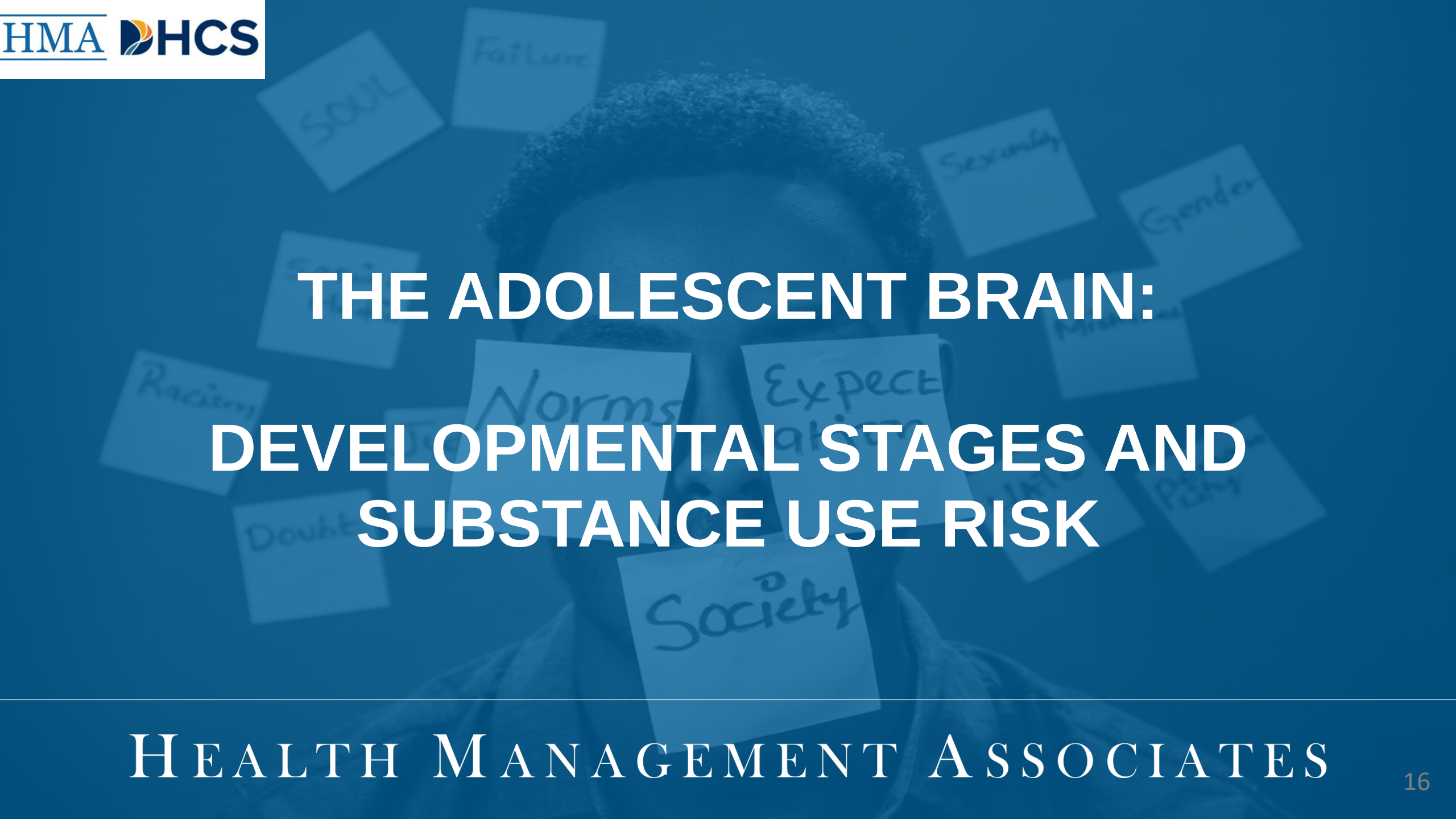


DOPAMINE RESPONSE



UNDERSTANDING ADDICTION TO INFORM TREATMENT

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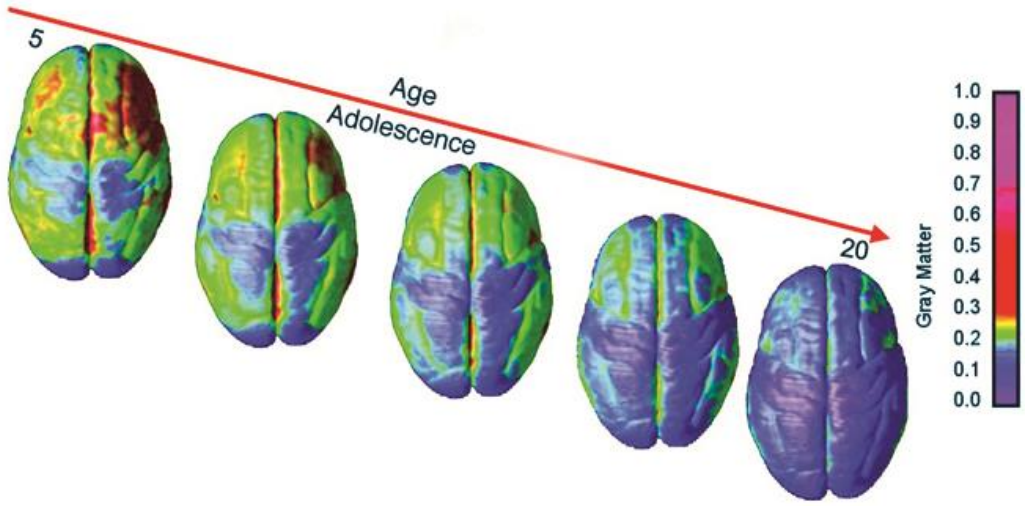
THE ADOLESCENT BRAIN:
DEVELOPMENTAL STAGES AND SUBSTANCE USE RISK
HEALTH MANAGEMENT ASSOCIATES
16

ADOLESCENT BRAIN DEVELOPMENT: ALL GAS AND NO BRAKES



Copyright (2004) National Academy of Sciences, USA Gogtay et al (2004). P Nat Acad Sci. 101(21):8174-8179

- Mid-brain areas are highly active during adolescence
  - Reward, motivation, moods/emotions, addiction
  - Dopamine-mediated (largely)
- Pre-frontal cortex (the rational/thinking part of the brain) develops much later (20s-30s)
- Pubertal hormones are implicated in development of areas of the brain that drive risk-taking
- Brain in transition is “pruning” to develop greater efficiency and specificity (resilience)

THE ADOLESCENT BRAIN

- Adolescents are more likely to:
  - Act on impulse
  - Misread or misinterpret social cues
  - Get into accidents
  - Engage in risky behaviors (bingeing)
- Adolescents are less likely to:
  - Think before they act
  - Pause to consider consequences
  - Change their dangerous or inappropriate behaviors
  - Realize that their rapid performance is impaired
  - Perceive risk

ADOLESCENT DEVELOPMENT: THERE ARE MEANINGFUL DIFFERENCE IN THE POPULATIONS

	Ages in years	General Developmental Considerations	Practical and Legal Considerations
Adolescence	12 thru 17 years: Moving to independence Future Interests - Cognitive development Sexuality Ethics and Self-direction Physical Changes		

• Early adolescence	10* thru 13	• Physical changes – worries about being normal
		• Mood swings
		• Limit testing
		• Sense of invulnerability
		• Close relationships gain importance (searching outside of family)
			• Familial Context
			  • Financial dependent
			  • Health coverage dependent
			  • Emotional evolution
			• Must be enrolled in school
			• Minor Consent laws in some states (unable to consent for treatment with MAT)
			• *Emancipation is the exception not the rule*

• Mid-Adolescence	15 thru 16	• Strong peer attachment • Concerns about appearance and sexual appeal • Interest in ideals, role models, moral reasoning • Asserting independence → deeper conflicts • Risk-taking	
• Late Adolescence	17 thru 18	• Mainly independent decision-making • Ability to delay gratification • Defining realistic adult role in society and family • Capable of insight, self-regulation of self-esteem • Realization of vulnerability and limitations	
Emerging Adults	18 thru 25	Do I have a role and place in this world?	Legal age for most decision-making

WHAT WE KNOW ABOUT TRENDS IN SUBSTANCE USE AMONG ADOLESCENTS

Individuals are most likely to begin using drugs during adolescence and young adulthood

- By the 12th grade, 70% of students have tried alcohol, half will have taken an illegal drug, 40% will have smoked a cigarette, AND 20% will have used a prescription drug for NONMEDICAL reasons (YRBS, 2019)

Fortunately, most adolescents who do experiment do NOT develop an addiction or other SUD

But SUD among youth is part of other risky behaviors

However, the population we are focusing on today we know is at much higher risk in all categories of risk including substance use.

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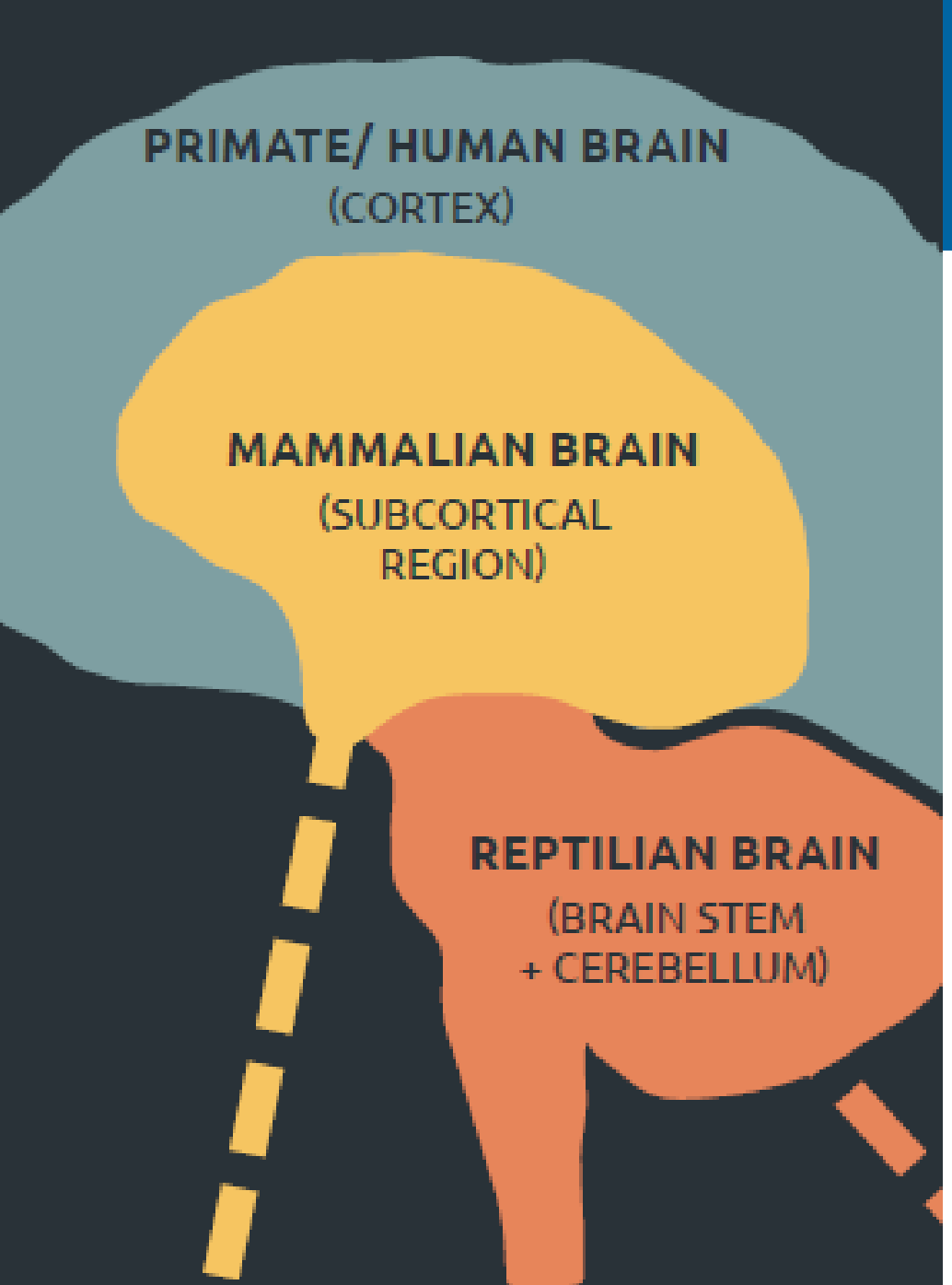
OBSTACLES TO EFFECTIVE HARM REDUCTION FOR YOUNG ADULT USERS

- Stage of development - "I am invincible"
- Stigma and denial
- Fear of law enforcement
- Lack of youth-friendly services
- Disconnection from networks traditionally reached by harm reduction services
- Lack of knowledge about safer injecting practices, harm reduction and HIV programs in their communities

SEEING THROUGH A TRAUMA-INFORMED LENS

- Trauma brain pathways and behaviors
- Adverse Childhood Experiences (ACEs)
- Impact
- Principles of being trauma-informed



Source - https://www.nicabm.com/

TRIUNE BRAIN

PAUL D. MACLEAN, MD

Primate/Human

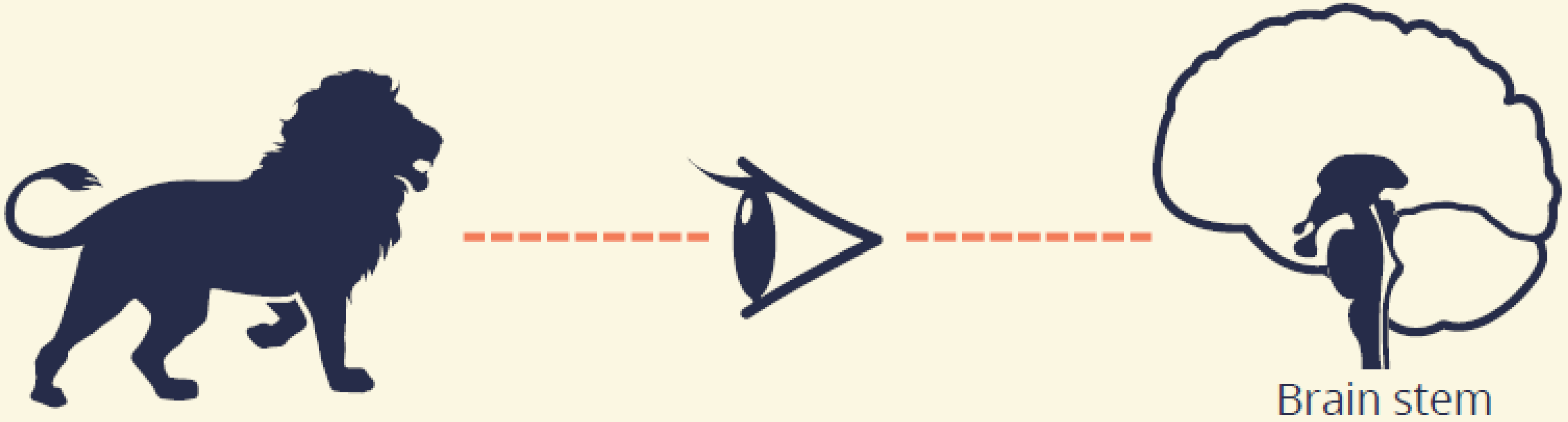
- Higher mental functioning
- Complex thought, creativity
- Language, feelings, empathy

Mammalian

- Feelings
- Learning and memory formation
- Motivation, reward

Reptilian

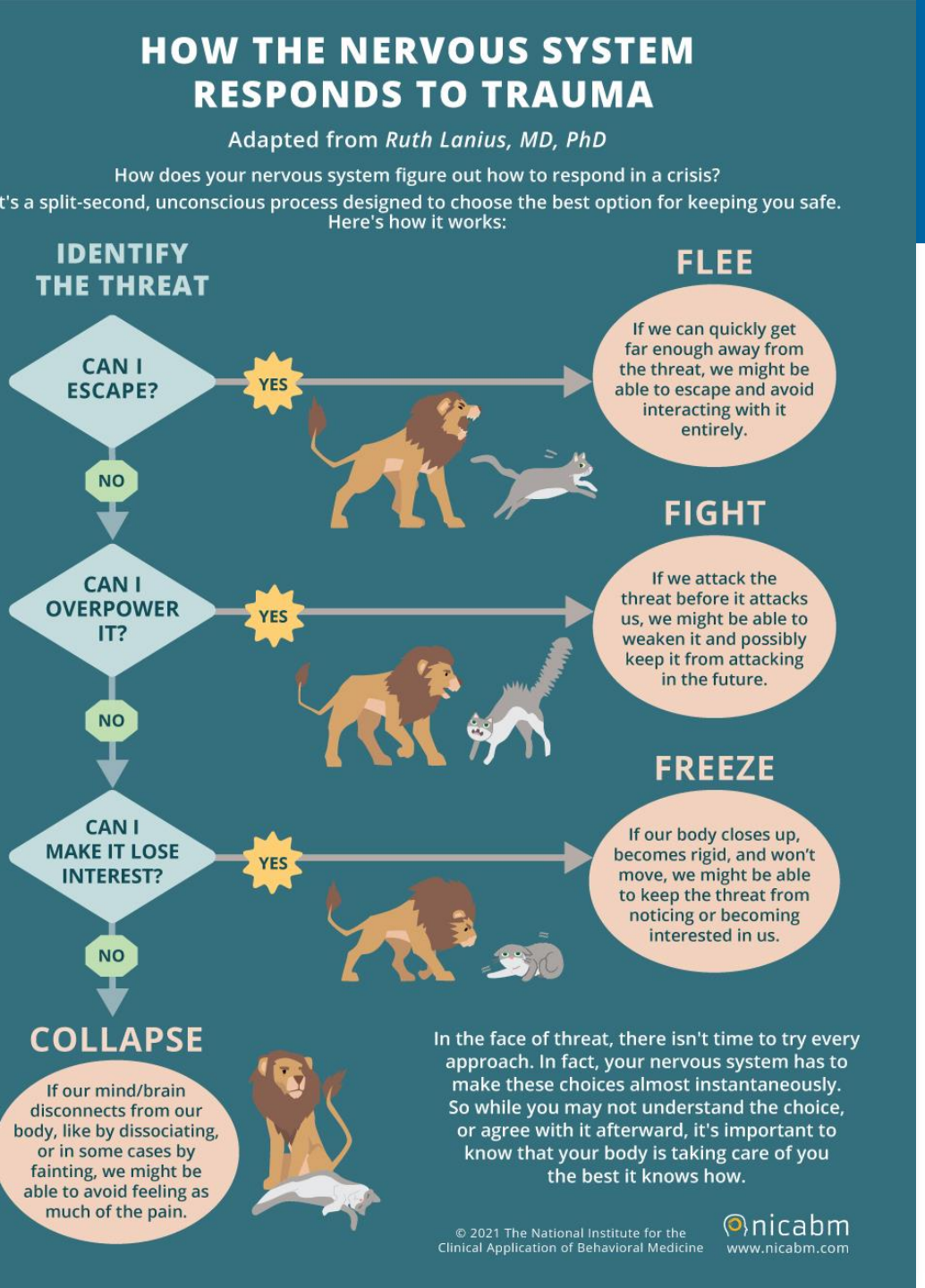
- Survival and maintenance
- Regulating heartbeat, breathing and other vital organs
- Safety, avoiding harm



www.nicabm.com

- Brain stem (“reptilian brain”) connected directly to the retina; sends threat-related messages immediately before higher brain functions are aware/involved

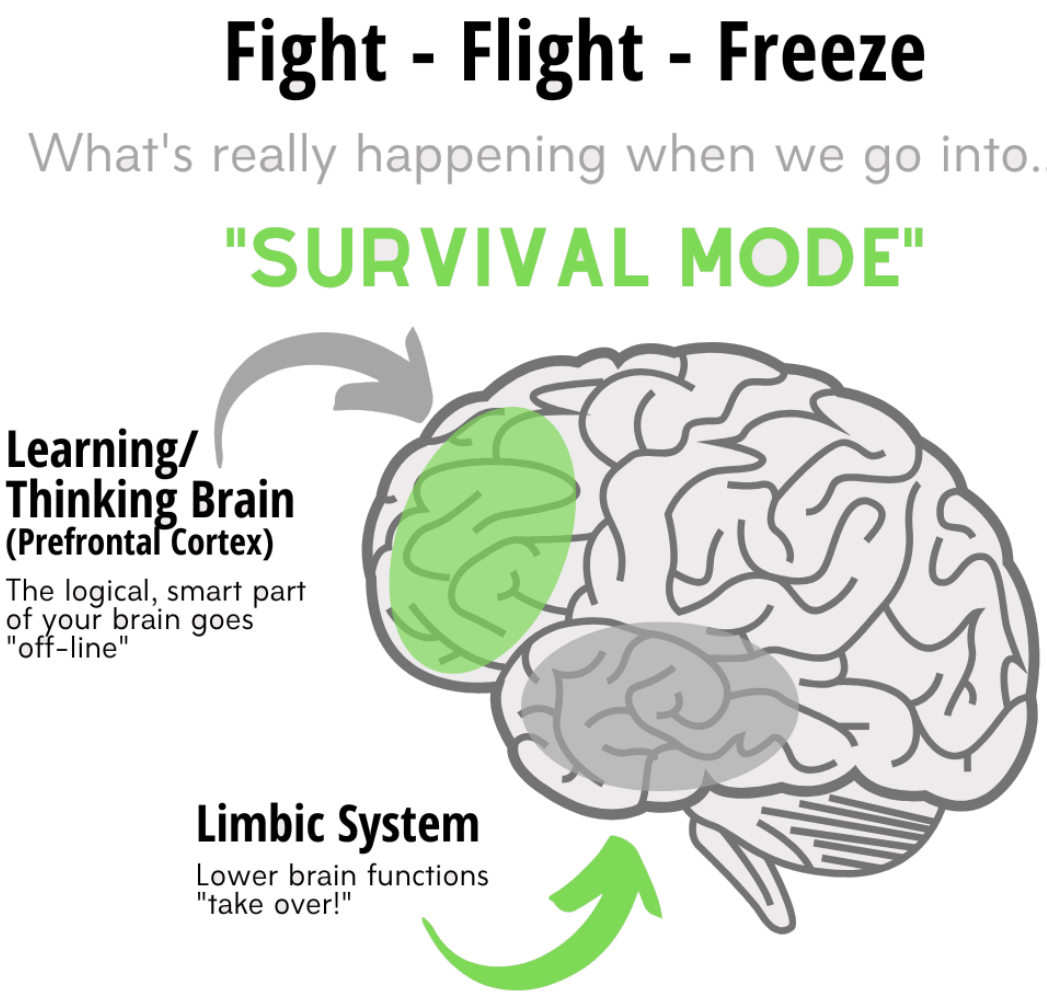
RESPONSE TO TRAUMATIC EVENTS



- Flee, Fight, Freeze, Collapse
- Nervous system makes this choice for us – no conscious choice involved
- Current/"real" threat – direct to the reptilian brain
- *Perceived threat – with changes due to trauma on board – also follows this pathway*

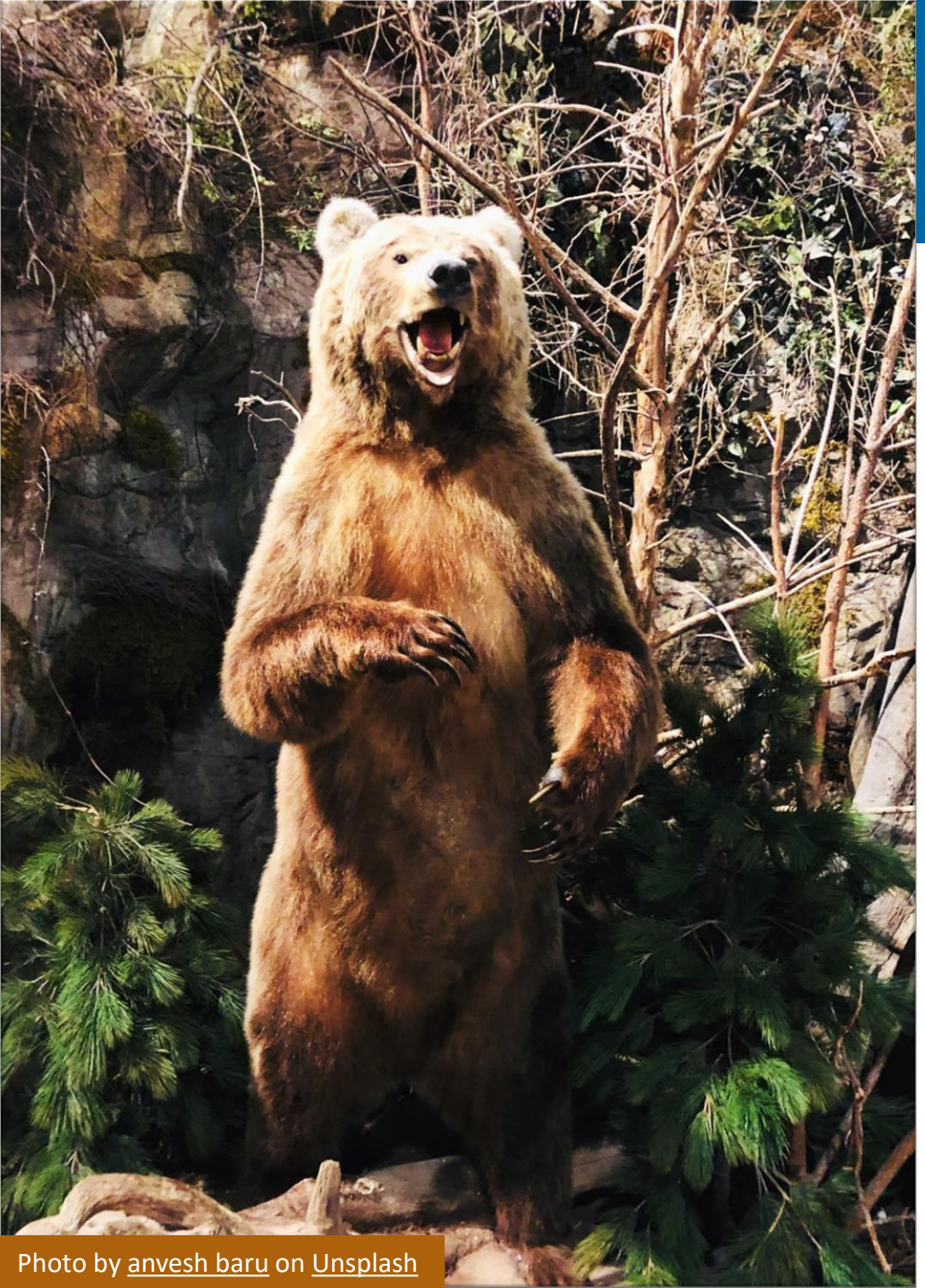
Source for Image - https://nicabm-stealthseminar.s3.amazonaws.com/Infographics/Trauma-Flow-Chart/NICABM-InfoG-How-the-Nervous-System-Responds-to-Trauma.jpg

TRAUMA AND THE BRAIN



- With severe or prolonged exposure to trauma the brain's baseline and pathways for neurohormones "reset", leading to ongoing physiological trauma response

Image Source: https://www.simplypsychology.org/limbic-system.html



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WHAT IF THE BEAR IS THERE EVERY DAY??

- Living in a state of trauma – or without having healed from previous significant trauma – triggers trauma physiology in the body with related thoughts, feelings *and behaviors*

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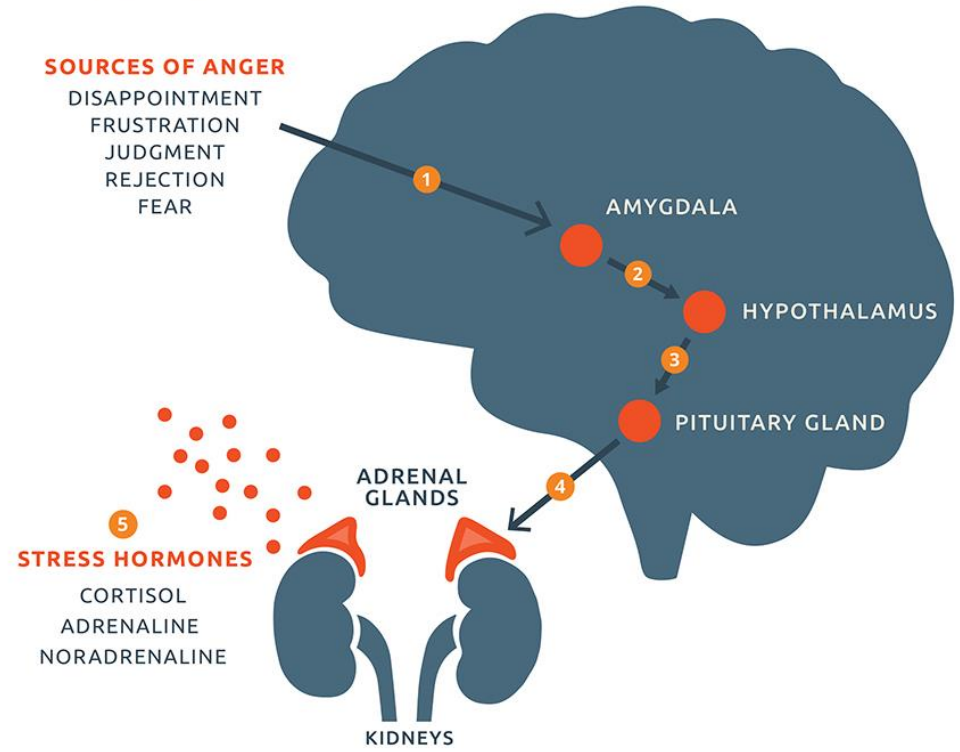
ANGER AND THE BRAIN

- No opportunity to “calm down”, “count to ten” – “think it through”… The rational, thinking part of the brain is not engaged
- Trauma-focused EBPs are critical to heal and re-integrate the thinking part of the brain in day-to-day life

1. The first spark of anger activates the amygdala before you’re even aware of it.
2. The amygdala activates the hypothalamus.
3. The hypothalamus signals the pituitary gland by discharging corticotropin-releasing hormone (CRH).
4. The pituitary activates the adrenal glands by releasing adrenocorticotropic hormone (ACTH).
5. The adrenal glands secrete stress hormones like cortisol, adrenaline, and noradrenaline.



HOW ANGER CHANGES YOUR BRAIN

Source: https://www.nicabm.com/

FLIGHT

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AMBER: A BIGGER PICTURE

**Fictional, composite profile*

- 16 years old; had a child at age 15 who is in foster care with Child Protective Services – was placed due to being born substance-exposed and because of Amber's circumstances
- Grew up in poverty and experienced childhood abuse – emotional, physical and sexual. Frequent runaway and while on the streets was sexually exploited.
- Of Filipino and African American descent and has experienced racial discrimination
- History of justice system involvement including aggressive behavior at school leading to expulsion and placement in alternative school; theft (shoplifting) and charges for possession
- Polysubstance use since age 12; heavy meth use currently

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JUAN: A BIGGER PICTURE

**Fictional, composite profile*

- 17 years old. Came to the US from Guatemala illegally at the age of 13 with his older brother, age 16 at the time, after experiencing assaults by criminal gangs, and witnessing his father being killed. Prior to this his family struggled to have enough to eat and a place to live
- Has never had stable housing and has primarily lived with friends, couch-surfing or in motel rooms when he and his brother were able to work menial jobs to make some income. Has a gang affiliation
- Has experienced multiple instances of being called racial epithets by job supervisors, other workers and random people he encounters. He still has significant problems with pain because of the physical beatings he experienced
- History of cannabis and alcohol use since age 10; currently use of illicit opioids

FREEZE

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TREVOR: A BIGGER PICTURE

**Fictional, composite profile*

- Trevor is 16 years old and in foster care. This is his 7th foster placement since he was originally placed in care at the age of 6 when his mother surrendered parental rights. He doesn't know who his biological father is. His mother frequently left him alone or with paramours, one of whom repeatedly sexually molested him.
- While some foster placements have felt safe and supportive, Trevor has experienced times when he hasn't had enough to eat; been called names, physically attacked or punished, and otherwise treated poorly by foster parents and other kids in the placement.
- Trevor has been moved to multiple schools and struggles with grades and peer relationships. He has spent a lot of his educational "career" in alternative placements where he has experienced bullying.
- He has history of inpatient psychiatric admissions and polysubstance use since age 12. Denies current use.

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SUBSTANCE USE DISORDER (SUD), OPIOID USE DISORDER (OUD), AND TRAUMA

- Chicken or egg?
- Which to treat first?
- The ideal is, you should treat both…together.
- The reality is very challenging!

INTEGRATED SUD TREATMENT

EFFECTIVE TREATMENTS FOR SUBSTANCE USE DISORDERS INCORPORATE :

- Location and Level of Care of Treatment
- Medication Assisted Treatment (MAT) and other Evidence-Based Treatments
- Behavioral Therapies and Recovery Supports

PERSON-CENTERED CARE

Amber

Juan

Trevor

Options for evidence-based interventions considered with:

- Severity of SUD and MH conditions
- Stability (including considerations of trauma)
- Functioning (including considerations of current state of brain chemistry due to MH and/or SUD conditions)
- Readiness for Change
- Supports and Coping Skills

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BEST PRACTICE OPTIONS FOR INTERVENTIONS FOR SUD

- Screening, assessment and treatment planning
- Psychosocial and medication education
- Peer and recovery supports
- Case management/ navigation
- MAT, integrated mental health, and healthcare

EVIDENCE-BASED MODALITIES

- Cognitive Behavioral Therapy (CBT)
- Motivational Interviewing and Motivational Enhancement Therapy
- Contingency Management
- Dialectic Behavioral Therapy
- Functional and Family Therapy
- Others…(see appendix)

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INCARCERATION AND YOUTH SUD

- Incarceration can be an opportune time for a youth to obtain treatment for their SUD
- Intervention at this juncture can promote stability and recovery during incarceration and upon release
- Treatment should be comprehensive
  - Counseling: SUD, mental health, and trauma
  - Medications for mental health and SUD
  - Family issues
  - Ancillary supports (peers, education, employment)
- Incorporate robust re-entry planning
- **Needs to be trauma-informed!**

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WE CAN'T TREAT WHAT WE DON'T FIND: VALIDATED SCREENING TOOLS

- Screening tools are validated for use in specific populations including youth
- Screening for co-morbid conditions and suicide is also critical

General Population	Youth
+ National Institute for Drug Addiction (NIDA) – Quick Screen + Tobacco, Alcohol, Prescription, and other Substances (TAPS) + AUDIT (Alcohol only) + *Patient History Questionnaire (PHQ-9)* + *General Anxiety Disorder (GAD-7)* + *PTSD Checklist (PCL-5)* + *Columbia Suicide Severity Rating Scale (C-CCRS)*	+ Brief Screener for Alcohol, Tobacco and other Drugs (BSTAD) (12-17yo) + Screening to Brief Intervention (S2BI) (12-17yo) + Problem oriented screening instrument for Teens (POSIT) + CRAFFT* + *PHQ-9-adapted, Center for Epidemiologic Studies Depression Scale (CESDS)*

MEDICATIONS AND INTEGRATED TREATMENT

- Incarceration/residential setting is an opportunity to provide stabilizing medications to youth with mental health and/or substance use conditions
  - 24/7 observation for side-effects
  - Controlled setting in case of adverse effects
  - Time to adjust and evaluate the efficacy of the medication(s)
- If a youth's mental health symptoms are not stabilized, it's unlikely that they will remain abstinent from illicit drugs – AND a substance use disorder may mirror or mask a mental health condition – **important to screen and assess for, and treat, both**

MAT AND ADOLESCENTS

Treatment of adolescents with opioid use disorder (OUD) with MAT is recommended by:

- American Society of Addiction Medicine
- American Academy of Pediatrics
- Society for Adolescent Health and Medicine
  - *"All adolescents and young adults (AYAs) with OUD should be offered medication for OUD as a critical component of an integrated treatment approach that includes pharmacologic and nonpharmacologic strategies."*

Source: Society for Adolescent, H., & Medicine. (2021).

TREATMENT MUST BE EVIDENCE-BASED, COMPREHENSIVE AND *INTEGRATED*

Screening & Assessment; Treatment Planning	Screening for SUD, MH and Medical; integrated treatment planning and treatment
Medication	Medication Assisted Treatment (MAT) or Medications for Opioid Use Disorder (MOUD) and medications for mental health disorders
Therapy	Group, individual and family therapy
Case Management & Recovery Supports	Case management, aftercare planning and follow up

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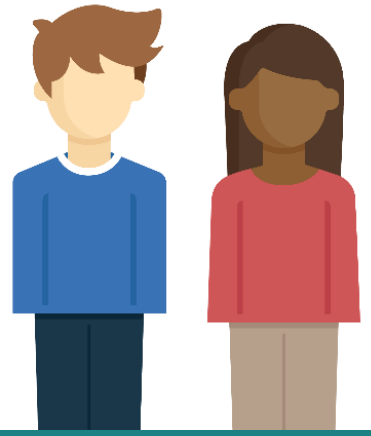
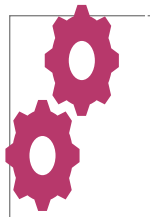


Evidence-based treatment works!

Justice-involved youth who received some type of substance use treatment had levels of post-treatment substance use that were significantly reduced from predicted levels, both at six and 12 months after treatment ended.

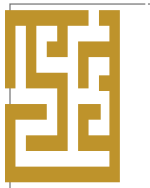
Source: Chassin, L., Knight, G., Vargas-Chanes, D, Losoya, S.H., & Naranjo, D. (2009). Substance use treatment outcomes in a sample of male serious juvenile offenders. Journal of Substance Abuse Treatment, 36(2), 183-194.

STAGES OF CHANGE



Pre-Contemplation

"No problem here"



Contemplation

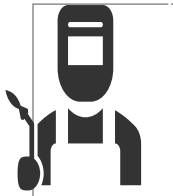
"Could this be a problem?"

Preparation

"What do I do about this?"

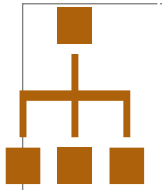
Action

"Let's see if this works"



Maintenance

"Keeping up what works"

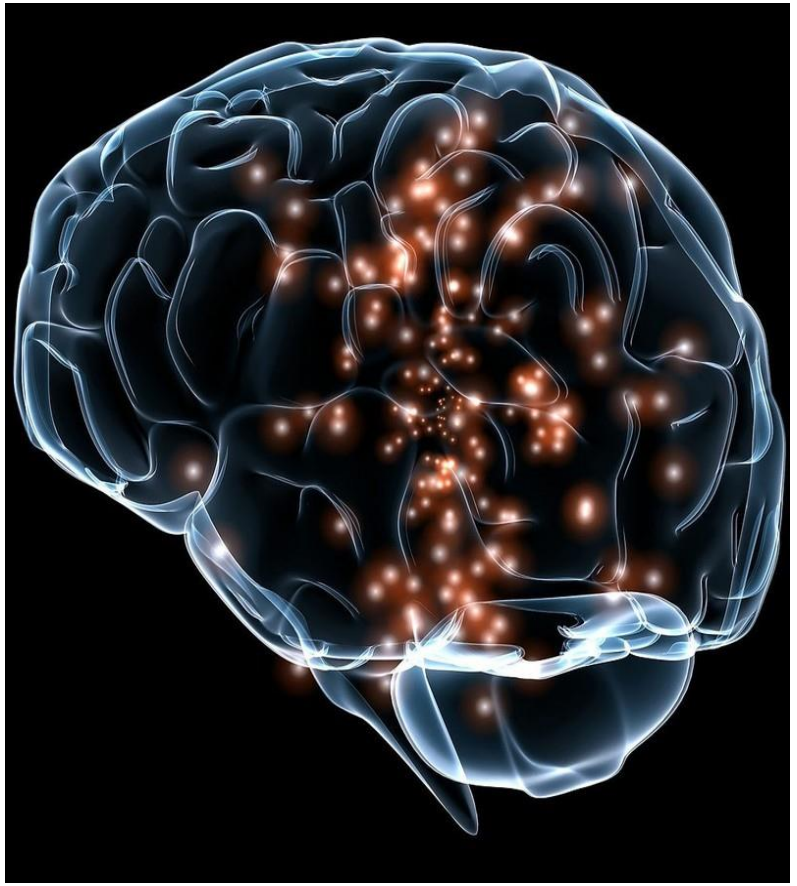


Lapses

"Setbacks are normal, but don't have to be long"

EVIDENCE-BASED PSYCHOSOCIAL THERAPIES

- Example, Cognitive Behavioral Therapy (CBT)
- Shown to be effective in treating substance use disorders.
- Studied extensively; have a well-supported evidence base – effective across many types of substance use disorders and across ages, sexes, and racial and ethnic groups.



CONSIDERATIONS FOR THE "RIGHT" INTERVENTION

- CBT and other cognitive-based modalities are evidence-based and effective **but require the ability to use the higher functioning part of the brain**
- People who have severe opioid and other substance use disorders have brains that are depleted in dopamine and so struggle to think and process; they tend to be in low-functioning and "survival" mode – along with those with serious/prolonged mental health conditions
- This is significantly compounded by trauma

Addiction Overview Video

CONSIDERING THE “WHOLE PICTURE”

- Take stock of what you are doing now. How does it support recovery? Percolate new ideas and possibilities.
- Support building self-efficacy, using strengths and hope.
- Be patient. Cognitive and other impairments are real.
- Be trauma informed - Remember the person is not their crime or other behavior. Most are also survivors of trauma.
- Consider new partners. Who can help “complete the picture” to offer integrated person-centered care?

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WHAT TA NEEDS DOES YOUR COUNTY HAVE?

- Please fill out the following survey by 11/17/2023

Survey Link

- This link will also be included in the email with the webinar recording and slides

LEARNING COLLABORATIVE OPPORTUNITY

- Final application open for *MAT in Jails and Drug Courts* Learning Collaborative, which includes technical assistance for Learning Collaborative **Child Welfare** and **Juvenile Justice** teams
- Counties eligible for participation stipend
- Questions? Please email MATinCountyCJ@healthmanagement.com

Recruitment Flyer with Application Links

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CONTACT US

FOR ANY QUESTIONS OR COMMENTS

MATinCountyCJ@healthmanagement.com

POLLING QUESTIONS

1. Overall, today's webinar was:
   A. Very useful
   B. Somewhat useful
   C. Not very useful
   D. Not useful at all

2. The material presented today was:
   A. At the right level
   B. Too basic
   C. Too detailed

REFERENCES/RESOURCES

- https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications#:~:text=Safety%20Announcement,central%20nervous%20system%20(CNS).
- BJA Withdrawal Management Guidelines
- Chassin, L., Knight, G., Vargas-Chanes, D, Losoya, S.H., & Naranjo, D. (2009). Substance use treatment outcomes in a sample of male serious juvenile offenders. Journal of Substance Abuse Treatment, 36(2), 183-194.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2022). Highlights for the 2021 National Survey on Drug Use and Health. https://www.samhsa.gov/data/sites/default/files/2022-12/2021NSDUHFFRHighlights092722.pdf
- Society for Adolescent, H., & Medicine. (2021). Medication for Adolescents and Young Adults With Opioid Use Disorder. J Adolesc Health, 68(3), 632-636. doi:10.1016/j.jadohealth.2020.12.129

APPENDIX

WHY IS MAT IMPORTANT?

Treat Withdrawal: Prevent Overdose

Symptoms include Muscle pain, dilated pupils, nausea, diarrhea, abdominal cramping, piloerection

- Lasts 3-7 days
- Using methadone or buprenorphine is recommended over abrupt cessation due to risk of relapse, overdose (OD) & death

Address Dopamine Depletion

Reward/motivation pathway

- Depletion persists for months-years after people stop using
- Treated with methadone or buprenorphine

Treat OUD

Abstinence based treatment results in 85% relapse within 1 year vs. 40-60% on MAT

Achieve Results

Increases retention in treatment

Decreases

- opioid use
- cravings
- overdose
- complications IVDU and other risky behaviors
- criminal behavior

HMA DHCS

Sources:
Mattick, RP & Hall W (1996) Lancet 347: 8994, 97-100.
Lobmaier, P et al. (2008) Cochrane Systematic Review.
Kakko et al. (2003) Lancet 361(9358),662-8.
ASAM, (2020) National Practice Guidelines for the Treatment of OUD.
Mattick, RP, et al. (2009) Cochrane Systematic Review.
Krupitsky et al. (2011) Lancet 377, 1506-13.
Rich, JD, et al. (2015) Lancet

INTERVENTIONS NOT REQUIRING CLINICAL FACILITATOR/THERAPIST

Motivational Interviewing (EBP Rating of 1)

- https://store.samhsa.gov/product/advisory-using-motivational-interviewing-substance-use-disorder-treatment/pep20-02-02-014
- TIP 35, Enhancing Motivation for Change in Substance Use Disorder Treatment addresses the spirit, application, and fundamentals of motivational interviewing (MI), and discusses how practitioners can effectively employ MI in SUD treatment, and provides tools that practitioners can use to encourage and promote lasting positive outcomes for their clients.

Seeking Safety (EBP Rating of 2)

- https://www.treatment-innovations.org/seeking-safety.html
- Fully manualized with handouts and strong research base. Most staff can deliver it with minimal training. There is also an option to train staff and follow-up with a series of coaching calls to ensure fidelity and training videos are available.

**This list is not intended to be exhaustive nor is appearance here an endorsement or recommendation.*

APPROACHES TO TREAT TRAUMA

Approach	Description
Multidimensional Family Therapy (EBP Rating of 1)	Combines family and community-based treatment for behavioral issues Family Therapy and/or substance use. The aim is to foster family competency and (Liddle et al., 2018) collaborate with other systems (e.g., school, juvenile justice) to support and integrate the adolescent into the community
Multisystemic Therapy® (EBP Rating of 1)	Involves comprehensive family- and community-based treatment that Therapy® examines substance use in terms of the characteristics of the adolescent, (Henggeler & their family, peers, school, and neighborhood. Multisystemic therapy has Schaeffer, 2016) been shown effective for adolescents with severe substance use and delinquent or violent behavior.
Brief Strategic Family Therapy (EBP Rating of 1)	Originates from the idea that one family member's negative behaviors stem Family Therapy from unhealthy family interactions. The therapist meets with each family (Szapocznik & member to observe their dynamics and then assists the family in changing its Hervis, 2020) interaction patterns.

Source: https://store.samhsa.gov/sites/default/files/pep20-06-04-008.pdf

APPROACHES TO TREAT TRAUMA

Approach	Description
Cognitive Behavioral Therapy (EBP Rating of 2)	Teaches participants to anticipate problems and develop effective coping strategies; explore the positive and negative consequences of substance use; learn to monitor thoughts and feelings to recognize distorted thinking that triggers substance use.
Seeking Safety (EBP Rating of 2)	An evidence-based treatment model that treats co-occurring posttraumatic stress disorder and substance abuse. It was developed in conjunction with the National Institute on Drug Abuse. After a traumatic experience, youths may choose unhealthy coping mechanisms, which may include using substances to escape the pain. Seeking Safety helps youths recover from their traumatic past so they can regain the footing they need to move forward in life. Unlike other trauma-focused therapies, Seeking Safety does not ask youth to delve deep into the recesses and details of the trauma. Rather, the treatment focuses on the present. It asks them to envision what safety would currently feel like in their lives and teaches them coping skills that apply to both trauma and addiction simultaneously to achieve that vision. The main aim of these skills is to help youths attain safety in their relationships, thinking, behavior, and emotions. Seeking Safety therapy can occur in an individual, group, or residential setting.
Family Behavior Therapy (EBP Rating of 2)	Combines behavioral contracts with contingency management to address Therapy (Donohue behavioral issues and/or substance use. The adolescent and at least & Azrin, 2011) one parent plan treatment and choose evidence-based interventions to establish and maintain behavioral goals, which are reviewed and rewarded at each session.

Source: https://store.samhsa.gov/sites/default/files/pep20-06-04-008.pdf

APPROACHES TO TREAT TRAUMA

Approach	Description
Trust-Based Relational Intervention (TBRI®) (EBP Rating of 3)	This is an attachment-based, trauma-informed intervention that is designed to meet the complex needs of children who have experienced adversity, early harm, toxic stress, abuse, neglect, and/or trauma. Because of their histories, it is often difficult for these children to trust the loving adults in their lives, which often results in perplexing behaviors. Children with histories of harm need caregiving that meets their unique needs and addresses the whole child. Focuses on three core principles: (1) TBRI® Connecting Principles, which focus on attachment needs and engaging children and building caregiver mindfulness in order to strengthen relationships; (2) TBRI® Empowering Principles, which focus on strategies to help children learn crucial skills associated with self-regulation and meeting the physical and environmental needs (e.g., structuring the day, managing transitions) of children; and (3) TBRI® Correcting Principles, which focus on disarming fear-based behaviors and building children's social competencies and ability to navigate the social world.
Applied Behavior Analysis (EBP Rating of 3)	An approach to systematically decrease maladaptive behaviors and increase skills. ABA therapy has been proven to improve children/youth ability to communicate and teach behavior that helps them form vital social relationships. The approach is also an effective way to teach skills that support long-term healthy development

APPROACHES TO OTHER THERAPY

Approach	Description
Contingency Management (CM)	Participants receive low-cost incentives (e.g., prizes, cash vouchers) in exchange for participating in treatment, achieving treatment goals, and avoiding substance use. By using positive reinforcement to avoid alcohol and drugs, CM helps retain adolescents in treatment, improve medication compliance, and promote achievement of other treatment goals, such as educational attainment.
Multisystemic Therapy | Family Integrated Transitions (MST–FIT)	Provides integrated and family services to youths in a residential facility who have committed offenses and have co-occurring mental health and chemical dependency disorders (Trupin et al., 2011). Services are provided during a youth's transition from incarceration back into the community to reduce recidivism. The program also seeks to connect youths and families to appropriate community supports, increase youths' abstinence from alcohol and drugs, improve youths' mental health, and increase youths' prosocial behavior.
Residential Dialectical Behavior Therapy	This intervention has been shown to be significantly effective in reducing suicidal ideation and self-harming behaviors, as well as improving children/youth ability to resist acting impulsively in stressful situations. DBT is to help clients create a “life worth living” and then work toward addressing problem behaviors that are barriers to accessing that life.

APPROACHES TO THERAPY

Approach	Description
Motivational Enhancement Therapy	Reduces ambivalence about engaging in treatment or stopping substance use. Using motivational interviewing, the therapist works with the adolescent to motivate their desire to stop using alcohol and drugs and build a plan for change.
Functional and Family Therapy	Engages the entire family in the treatment process and increases their Family Therapy motivation for change. The therapist works to modify family members' (Alexander & behavior through communication and problem-solving techniques, Parsons, 1982) behavioral contracts, contingency management techniques, and other methods.