Adolescents and Family- Focused Treatments

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I would like to begin my remarks by placing the adolescent between 2 family environments – the adolescent's family of origin and the adolescent's (possible) own pregnancy and/or post-partum environment. If the adolescent has a parent (or two) who has substance abuse problems or mental illness, the adolescent is at higher risk for his/her own substance abuse and/or psychological problems. In a recent study (National Household Survey 2004-2005), 26.7% of youth who had a mother with serious mental illness (SMI) used alcohol or other drugs (AOD); while only 18.8% of the youth who had mothers without SMI used AOD.

If the adolescent uses AOD and also has psychological problems (which is quite common, not the exception) - - which is what we mean by co-occurring problems - - her/his child is at high risk for AOD use, depression, anxiety, attachment disorders, and trauma-related problems. You, of course, have heard about studies that suggest that children living in households in which substance abuse and mental health problems are present are considered at high risk for a range of physical, development, psychological, and behavioral problems. In addition, exposure to domestic violence and other traumas is also associated with a wide range of behavioral, social, psychological and school-related problems. However, not all children raised in families affected by substance abuse, mental illness, and/or violence/trauma, experience those outcomes. Thus, it is critical to examine both risk factors and protective factors that contribute to resilience against serious problems in children. Resilience can be nurtured and developed

through ongoing support and strength-based interventions. A strong relationship with a caring and competent adult is one of the most important protective factors for children living in stressful environments.

Failing to capitalize on an opportunity to interrupt the intergenerational cycle of substance abuse, mental illness and/or violence is shortsighted. Cultivating the opportunity to intervene with these children by offering screening and assessment for socio-emotional delays or disorders and providing services as indicated, may save both money and lives. Parental treatment offers a window of opportunity to reach children early in the development of childhood problems, especially during a time when the parent is motivated to make dramatic life changes.

Substance abuse and mental health treatment providers serving parents have a unique opportunity. The expansion of services for clients' children will require paradigm changes; there is a need to change the existing bifurcated child and adult systems. It will also require new resources and additional funding, but building on the existing parental treatment infrastructure may minimize the costs. We recommend that funding agencies and service providers dedicate resources to expanding available screening, assessment and treatment services to these children to militate against the long-term effects of substance abuse, mental illness and violence. This expansion of efforts will likely require collaborations across traditionally separate systems of care, including substance abuse prevention and treatment services, adult and children's mental health services, child welfare services, the educational system, domestic violence prevention and intervention services, and the criminal justice system.

The President's New Freedom Commission on Mental Health (2003), emphasized that "…early detection, assessment, and linkage with treatment and supports can prevent mental health problems from worsening". The Commission recommends that screening and early

intervention should occur in readily accessible, low-stigma settings. In fact, any setting in which a parent with substance abuse, mental health, and/or trauma issues receives services needs to be capable of providing screening and referral services for the children as well as the parents. For children whose mothers experience mental health and substance abuse problems as well as violence, early intervention can reduce the possibility of childhood disorders developing, worsening, or leading to more serious adolescent and adult disorders. Treating the parent's mental health and substance abuse problems clearly benefits the child, but it may not be enough. Specific services delivered to children can provide significant additional benefits. It should also be noted that screening and assessment services need to be useful to the adolescent parent (and any parent), not just the provider.

Pioneering work in addressing true integration of services for child, mother and families has been done by women and children's substance abuse residential and intensive outpatient programs. These programs have focused on the direct links between family substance abuse, mental illness, trauma, and negative health and social outcomes in children and adolescents that lead to worsening outcomes in adulthood. These efforts can serve as models for other systems of care.

There is also a need for ongoing family recovery supports. Youth and families in recovery need safe and familiar cultural environments that are readily accessible, and that provide ongoing support.

Other challenges include:

1). Focus on adolescents and depression. SAMHSA'S recent National Household Survey has shown that there are significant major depressive episodes in youth 12-17 y.o.; and that biracial youth appear to have the highest rates. Suicide rates, particularly attempts, are quite high in this age group; among young Latinos, 1 in 5 depressed girls have made suicide attempts. In preventing suicide, substance abuse, and worsening mental health problems, it is important we put a particular focus on early identification of depression. In the adolescent with COD, depression may manifest itself as irritability rather than sadness. In adolescent parents, depression may have serious impacts on their infants/children. In a recent study we have been conducting at PROTOTYPES on postpartum depression in young women in our residential program, of the first 28 young women screened, 60.7% screened positive for major postpartum depression. Of these 28 women, 24 had enough symptoms that a longer form of the instrument used, and 67.9% had elevated scores on the measure of suicidal thoughts. Again, to focus on this area (depression and adolescents) we need to systematically screen, train staff to respond, and track depression and trauma in diagnosis and the treatment plan.

2). Focus on High Risk Adolescent Populations. As just discussed one priority population is adolescents with depression and trauma, including pregnant and postpartum teens. Another priority population is incarcerated youth who have some of the highest rates of COD and trauma. The third priority population is youth in foster homes/foster care who also have high rates of COD and trauma. The fourth population is homeless and runaway youth.

3). Family- Focused Treatments and Choice. There is an important issue of choice that should also be discussed. When we discuss strengthening resiliency and empowerment of our adolescent clients, it is important that we allow them to tell us who they want to include as part of their

family. Sometimes in our eagerness to integrate all family members into treatment, we may forget that the adolescent may not want all family members present—for example, the youth may exclude an abusing parent or sibling. Respecting who they want in treatment and who they do not want in treatment is another important step in our screening and assessment.