

When Adolescents and Young Adults won't Change: Engaging Families of Adolescents and Young Adults in the Planned Intervention Process

19th Annual Conference

2018

ASAP

September 24, 2018

Integration and Innovation: Families, Providers,
Communities, Forging Partnerships for Recovery

Deacon Steven DeMartino, Director of Priest Wellness, Archdiocese of NY,
wellnesssupport@archny.org

Ellen Morehouse, LCSW, CASAC, CPP, Executive Director, Student Assistance Services Corp.,
sascorp@aol.com

Andrea Fallick, Director, School Based Programs, Student Assistance Services Corp.,
andrea.Fallick@sascorp.org

SAS Planned Intervention Service

- **Began January 2015**
- **44 Families**
- **Free for youth under 21**
- **Parents**
 - **Married, divorced, single parent, partnership**
 - **All have tried to get help for their teen**
 - **All love their teen**
 - **All are scared (overdose, jail, failure, car crash, etc.)**
- **Adolescents and Young Adults 15-21**
 - **Diverse, income, school attendance, academic performance, onset of use, trauma history, drug(s) used, race, ethnicity, involvement with the law, length of use**

SAS Planned Intervention Service

- Referrals from anyone
- Parent calls for appointment and provides preliminary information:

Referral made to
community agency

First Appointment

- Current Situation
- Background
- Description of Intervention Process

Referral made to
community agency

Second Appointment
Discuss intervention participants

Orientation of participants

Practice

Intervention

What we Know About Adolescent Substance Abuse/Addiction

- **Key Factors contributing to abuse/addiction**
 - **COSAP risk factors (Biochemical vulnerability, inconsistent parenting, role models)**
 - **Age of onset**
 - **Trauma**
 - **Presence of psychiatric disorder**
 - **Prescribed pain medication**
 - **Substance of abuse/Route of administration**
 - **Environmental Factors**

Making the Connection: Trauma and Adolescent Substance Use

- **Approximately 25% of adolescents in the US experiences at least one potentially traumatic event before the age of 16** (The National Child Traumatic Stress Network, ACE Study 1998)
- **More than 70% of adolescents receiving treatment for SUD have a history of trauma exposure** (J. of Traumatic Stress April 2004, Vol 17, issue 2 P. 115-122)
- **Up to 59% of young people with PTSD subsequently develop substance abuse problems** (The National Child Traumatic Stress Network)

Co-Occurring Substance Use and Psychiatric Disorders

- **In adolescent SUDs, *co-occurring* psychiatric disorders, is more common than not** (Child Adolescent Psychiatry Clin N Am. 2010)
- **Adolescents with co-occurring disorders have been increasingly identified in substance abuse treatment programs** (Journal of Substance Abuse Treatment, 2008)
- **Adolescents with substance use disorders (SUDs) have the highest proportion of co-occurring psychiatric disorders than other age groups.** (The Oxford Handbook of Adolescent Substance Abuse, January 2016)
- **Prevalence of past year substance use problems and co-occurring externalizing problems has been cited as high as 64%** (Journal of Substance Abuse Treatment, 2008)

Reflection Point #1:

7

The Planned Intervention Process with adolescents is designed to interrupt the progression of drug use behavior and minimize the possibility of addiction taking hold; i.e., to break the cycle before a person is saddled with brain disease.

Repeated offers of help and intervention are not the exception, but the rule.

The Harm Reduction Model for Adolescents and Young Adults

- Abstinence is understood as a long term goal and NOT as a short term goal.
- Substance use is seen as destructive and dangerous behavior, shaped by living in an environment of multiple mental health and psychological concerns and/or socio-economic oppression.
- The focus is on facilitating a process that leads to **CHANGE**.
- This model is also developmental, and recognizes a cycle of *stages of change* as many
- Adolescents and young adults do not recognize the losses as a result of the substance use

The Planned Intervention Process

- Rev. Vernon Johnson, c. 1986, MN and the *Johnson Institute*
- Johnson: “AA says that alcoholics seek help when they hit bottom. Many die before they hit bottom. I wanted to find a way to reach out to someone who can’t quit and **RAISE THEIR BOTTOM**, so they get help before they die”.
- Major influences of the Johnson Intervention Model: Wilson/AA; and Virginia Satir/Family Systems Theory.
- The planned intervention process is a highly structured, directive, solution focused, and time limited model; it is **NOT** family counseling. It has a dual focus of brief clinical work and intensive case management work (practical planning).
- The model’s clinical success is rooted in accessing the *relational bonds* between the person struggling with their drug use behavior and their family members and “concerned persons”. This experience of love/compassion/caring/intimacy is typically strained throughout the persons relational system at the time of referral, however, accessing these bonds is crucial to the model’s success, and is the focus of the initial clinical work with the family and “concerned persons”.

Goals of the Planned Intervention Process:

➤ Goal #1:

- The first goal is centered upon the family members and concerned persons. The intervention process challenges them to more fully understand, and then make a commitment to address, how the behavior of the person they are concerned about has impacted their lives and affected the dynamics of their family/kinship/friendship/work systems (or vice versa).
- This is often a difficult insight to take hold, but essential to the success of the treatment process they are asking someone they love to embrace.
- Facilitating understanding and acceptance of this second goal often requires at least some of the family/concerned persons to make a commitment to their own need for outside support and/or treatment, albeit in a different setting.
- Many people are uncomfortable with Al-anon and/or ACOA self-help support as it is contrary in its precepts to their ethical and/or religious sensibilities. The Interventionist must be sensitive to this possible posture and be sure to make referrals for support that are sensitive, e.g., *Rational Recovery*, faith-based support groups, *Narcanon*, *SMART Recovery* (Self Management and Recovery Training, which emphasizes a four-point system that is based on scientific knowledge about addiction, i.e., *staying motivated; dealing with urges; managing behavior and thought appropriately; and living in a balanced manner*), etc.

Goals of The Planned Intervention Process with Adolescents:

➤ Goal #2:

- The second goal is centered on the adolescent who is struggling with their behavior and its consequences; i.e., inviting that person to embrace a change process and accept the need for assistance and treatment.

Reflection Point #2:

- **The Interventionist is responsible for facilitating and achieving both goals by assuming leadership for the clinical and practical planning process.**
- **It is hard work and time consuming, requiring a comprehensive skill set of clinical acumen, case management experience, and established relationships with treatment programs.**

The Components of the Planned Intervention Process: Observations on Structure and Clinical Realities

- Initial contact, brief assessment, coaching toward “buy-in” of the process:
 - Is there a real problem?
 - Are there enough resources (human and other) to build a team?
 - Is there enough clinical insight/ego strength present within the family/concerned persons to engage in the intervention process?
 - Are the system boundaries strong enough to ensure privacy and confidentiality, and maintain the integrity of the planning process?
- Building a “concerned persons” team: identification, selection, invitation, boundaries, confidentiality
- Concerned Persons Team composition: biological family (both nuclear and extended), friends, peers, coaches, teachers, etc.
- Second brief assessment: what practical resources are in place to insure that a realistic, concrete plan can be generated?

Components, Continued:

- **Team meetings: forming, norming, storming, performing; confidentiality; self-help referrals; team meetings vs. family counseling (boundary maintenance)**
- **Counter-transference Issues**
- **Psycho-educational process: listening; offering information; supportive confrontation; exhortation to embrace responsibility for support, care, and healing; coaching, etc.**
- **Logistics: number of team meetings, finalizing the plan (what will we offer the person?), planning all the details, pre-intervention tasks, assigning tasks to team members, maintaining healthy communication patterns, etc.**
- **The role of the Interventionist: facilitator, coordinator of communications, case manager, liaison to potential treatment providers, expeditor with insurance companies, leading conflict resolution, etc.**

Pre-Intervention Checklist:

- I. Reviewing concerned persons data
- II. Presentation Outline:
 - A. opening statement
 - B. closing statement
 - C. consequences
 - D. responding to protestations/objections
 - E. maintaining an attitude of caring, love, respect, dignity and non-judgment
 - F. finalizing scripts

Pre-Intervention Checklist:

III. Intervention format:

- A. opening statement (interventionist)
- B. securing the “contract to listen”
- C. data presentations
- D. request to accept and leave for help immediately
- E. negotiating
- F. managing resistance/anger/baiting
- G. responding to objections
- H. voicing consequences (if necessary)
- I. Interventionist closing statement
- J. review of the plan with the person and team

Pre-Intervention Checklist:

➤ IV. Managing the Environment:

- A. location and arrangement of the room
- B. seating arrangement
- C. speaking order
- D. possible contingencies
- E. logistics
- F. concerned person's arrival time
- G. review and decide plan for ensuring that N. arrives to the gathering
- H. review referral to treatment, to include discussing any final details
- I. review of family/concerned persons follow-up: options for continued counseling, self-help, outside support, etc.

Concerned Persons Data Outline:

➤ Opening Statement:

“I am here today because I care/love you very much and I feel very concerned about your behavior and the safety of you and your family/community”

➤ Presentation Outline: The Core Message and Technique!

- What did I see/hear (be objective, non judgmental, and concrete)?
- How did I feel when I saw/heard...? (anger, frustration, upset are not encouraged).
- Please get help.

Concerned Persons Data Outline:

Incident Tips:

- be clear and concise
- do not ask open ended questions or ask for a response
- allow yourself to feel your feelings of love, fear, compassion and sadness- LET THESE FEELINGS COME OUT
- maintain eye contact
- be supportive and comforting of one another
- do not engage in conversation or cross talk during the presentation- one person at a time
- tears are acceptable and appreciated
- have your consequence(s) ready, but do not speak them until cued by the facilitator
- remember our attitude: LOVE, COMPASSION, CONCERN, SUPPORT
- **Closing Statement:**

“N., I am here today because I care about you and your family very much-this has not been easy for me-but I want you to know that I don’t want to lose you or see this family/community break apart.
- **Please take the risk and get help NOW.”**

Lessons Learned

20

- The importance of our coordinated efforts
- Tapping each of our strengths
- Our successes do not always result in the actual planned intervention
- The overwhelming thankfulness of all the families we have worked with
- The families' surprise at our responsiveness (calling them back, finding resources, following up, advocating for them)
- Knowledge of resources
- Resource networking

Recovery is a process. For adolescents who have used mood altering chemicals over a sufficient period of time to meet the criteria for substance use disorder and have a clear evidence of progression, repeated offers of help and intervention are not the exception, but the rule.

Cognitive Behavioral Therapy ²¹ Techniques

- Focus on the thoughts, perceptions, feelings about behavior
- Provide education how their thoughts have an impact on feelings and behavior
- Increase existing coping skills
- Teach self-regulation and new ways of coping and problem solving through modeling, practice, rehearsal, and role-play. *(Kazdin et al., 1989)*

MOTIVATIONAL INTERVIEWING

(Miller & Rollnick)

A therapeutic approach based on the premise that clients will best be able to achieve change when *motivation comes from within*, rather than being imposed by the therapist.

Avoid Argumentation

Develop Discrepancy

Roll with resistance

Establish Empathy

Support Self Sufficiency

Feedback

Responsibility

Advice

Menu

Empathy

Self Efficacy

Stages of Readiness to Change

- **Pre-contemplation** “I am **not** thinking about change”
- **Contemplation** “I am *thinking about change*”
- **Preparation** “I am *getting ready to make a change*”
- **Action** “I am *ready*”
- **Maintenance** “I am *sustaining change*”

Solution Focused Techniques

“We are not in the business of talking people out of painful realities. But there is reframing to be done...To help develop an attitude, a vocabulary, a story about prospects and expectation, and a picture of a genuine individual lurking beneath a diagnostic label”

Dennis Saleebey, DSW

“The Strengths Perspective in Social Work Practice, 1997

Strength Based Approach

- Be sure to invite the whole student in not only the broken and damaged parts and.....
- Do not ignore the adolescents challenges and problems that need attention, BUT attend to their strengths with the same meticulousness as you attend to problems

