



**CONTINUING EDUCATION (CE) COURSE MATERIAL**

**Course No. CE1201P1 – Prevention and Education: Adolescent Alcohol and Drug Abuse**

**COURSE OBJECTIVE**

An examination of the special considerations in the identification, treatment, prevention and education involved in adolescent alcohol and drug abuse.

**COURSE MATERIAL**

Important issues for working with an adolescent population are trust building, with both the adolescent client and their parent/guardian(s), an understanding of adolescent emotional development and mental health disorders, and adult and adolescent chemical dependency. The counselor must also have the ability to thoroughly assess the individual for appropriateness of treatment modality and have the willingness and professional contacts to facilitate appropriate referrals and coordination of care.

Effective treatment of an adolescent population will involve professionals with experience working with an adolescent population, include parental involvement in treatment, and utilize appropriate, brief, interventions that specifically target chemical abuse issues. Comprehensive aftercare and discharge planning with adequate referrals and on-going case management are mandatory to facilitate positive outcomes.

**Understanding the Differences: Adult vs. Adolescent Chemical Dependency**

Persons who are familiar with treatment of chemical dependency in adults will benefit from understanding that chemical use and dependency as well as the progression of the disease is strikingly different from that of adolescents (Gust and Smith, 1994; Moncrieff, 2002; National Clearinghouse for Alcohol and Drug Information, 1999).

Chemical dependency in the adolescent begins as a psychological dependence, takes only 6-18 months, and retards emotional development (Gust and Smith, 1994). Whereas, a chemically dependent adult will show symptoms of tolerance and withdrawal, the progression of the disease lasts over a 5-10 year period, and only minimally hampers emotional development (Gust and Smith, 1994).

Adolescent use of drugs and alcohol occurs when the opportunity presents itself (Polson and Newton, 1984). Chemical use is often restricted to alcohol and marijuana and adolescents will gather socially on weekends with the primary purpose being to get drunk and/or loaded (Gust and Smith, 1994; Polson and Newton, 1984). At this early stage, they are not using every weekend, they are not purchasing their own alcohol and drugs, and behavioral problems may not be present (Polson and Newton, 1984).

As the progression continues, alcohol and drug use escalates to every weekend and some or several weeknights, will include the use of a larger variety of drugs, and behavioral problems such as lying and stealing may begin to occur as the adolescent now begins to purchase their drugs and alcohol (Gust and Smith, 1994; Polson and Newton, 1984). Grades may drop, the adolescent begins to plan his life around “getting high” and will associate with friends who use drugs and alcohol (Polson and Newton, 1984). The adolescent will begin to lead a dual life, attempting to please coaches, teachers and parents while planning to get high with friends after basketball practice, school, or dinner with the family (Polson and Newton, 1984). Loss of ability to deal with emotions, stress, and fear make getting high the most important thing in the adolescent’s life (Polson and Newton, 1984).



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Continuing to use alcohol and marijuana, the use of “harder” drugs will become more desirable, his dual life will disappear, his appearance will suffer, he will often miss school, and stealing and lying will increase (Polson and Newton, 1984). When confronted, he may readily admit to the use of drugs and alcohol to parents, teachers, and other authority figures, and bring his “less-than-desirable” friends home (Gust and Smith, 1994; Polson and Newton, 1984). He may show physical signs of drug use (red eyes, fatigue, sore throat), his behavior may become unpredictable, he may become physically aggressive, and may not come home at night (Polson and Newton, 1984). At this stage, he is breaking the law, stealing money and belongings, dealing drugs to fund his drug use (Polson and Newton, 1984). Overdoses and suicidal thoughts may become frequent during this stage of chemical abuse (Polson and Newton, 1984).

As drug use has now become extreme and compulsive, the adolescent will be unable to function without getting high and intravenous drug use may begin as a more efficient way to get loaded (Polson and Newton, 1984). Signs of weight loss may be apparent, sexual identity may blur, morals will lose their importance and she may begin offering sex for money (Polson and Newton, 1984). Thoughts and attempts at suicide occur with greater frequency and she will suffer with “chronic emotional pain” (Polson and Newton, 1984). Drug use at this stage is a terminal disease and left unarrested will result in death (Polson and Newton, 1984).

### **Screening and Assessment**

Proper screening and assessment of the adolescent must precede admission into any treatment program and a comprehensive assessment tool that addresses age, culture background, substance abuse, family and social dynamics, physical and mental health issues, and legal and educational issues should be used (Charlebois, 2002; Moncrieff, 2002; National Clearinghouse for Alcohol and Drug Information, 2002). When assessing an adolescent for admission to substance abuse treatment, the counselor is looking for the following: 1) a primary diagnosis of substance abuse, 2) the possibility of a co-occurring mental or emotional disorder, 3) emotional maturity sufficient to succeed in the treatment setting, and 4) parental willingness to be involved in treatment (Charlebois, 2002; Gust and Smith, 1994; Moncrieff, 2002; U.S. Dept. of Health and Human Services, TIP 32, 1999).

### **Effective Treatment**

The adolescent counselor must understand adolescent development, the strong influence of peer pressure, and the differences in their value systems (Charlebois, 2002; Montcrieff, 2002; U.S Dept. of Health and Human Services, TIP 32, 1999). Adolescent chemical abusers may exhibit delayed development of emotional and cognitive functioning and educational deficiencies will need to be addressed during treatment (U.S Dept. of Health and Human Services, TIP 32, 1999).

Treatment should begin with a non-confrontational orientation and include a schedule of daily activities including education, chores, and social activity and interaction as an alternative to drug using (U.S Dept. of Health and Human Services, TIP 32, 1999). Drug testing should be used often and chemical dependency interventions should be brief, consistent, and direct (Montcrieff, 2002; Gust and Smith, 1994).

Knowledge of motivational interviewing techniques and continued screening, evaluating, and assessment of the adolescent while giving appropriate feedback will facilitate a successful intervention (Montcrieff, 2002; U.S. Dept. of Health and Human Services, TIP 34, 1999). Relapse in early treatment should be considered an opportunity for intervention and education by the counselor and the parents and met with brief intervention (U.S. Dept. of Health and



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Human Services, TIP 32, 1999). Focus on goal setting and achievement, the health effects of chemical abuse, and discuss the elements of change, then follow up with review, summary, and closure when conducting a brief intervention (U.S. Dept. of Health and Human Services, TIP 34, 1999).

The U.S. Dept. of Health and Human Services, TIP 34 (1999) further reports that effective brief interventions should embody the following acronym **FRAMES**:

- **F**eedback is given to the individual about personal risk or impairment.
- **R**esponsibility for change is placed on the participant.
- **A**dvice to change is given by the clinician.
- **M**enu of alternative self-help or treatment options is offered to the participant.
- **E**mpathic style is used by the counselor.
- **S**elf-efficacy or optimistic empowerment is engendered in the participant. (p. 13)

In addition to understanding adolescent chemical dependency, and employing brief interventions, and motivational interviewing techniques, effective adolescent counselors understand that part of adolescent development is experimentation with philosophy, manner of dress, and flirtatious interaction and expect this as part of the group peer interaction process (Charlebois, 2002; Montcrieff, 2002; U.S Dept. of Health and Human Services, TIP 32, 1999). Group process can be used to celebrate small and large victories, build positive peer pressure, and to improve socialization as well as to confront issues (Charlebois, 2002; Montcrieff, 2002.)

Conflict resolution and negotiated contracts are necessary and beneficial to address behavioral issues, expectation, consequences, and deadlines for completion (Montcrieff, 2002; U.S Dept. of Health and Human Services, TIP 32, 1999). The process of contract negotiation empowers the adolescent and engages her in her treatment process while defining the expectations, boundaries, and consequences of her behavior (U.S. Dept. of Health and Human Services, TIP 32, 1999).

Parents should be educated and encouraged on the importance of their active participation in the chemical abuse treatment of their children (Gust and Smith, 1994; Moncrieff, 2002; U.S Dept. of Health and Human Services, TIP 32, 1999). Regardless of the emotional maturity level of the parent or their "part" in their child's substance abuse problem, their participation is of paramount importance to the success of the child as they set behavioral expectations in the home environment (Gust and Smith, 1994; Moncrieff, 2002).

Parents should receive education on the seriousness of chemical abuse in adolescents and special attention should be paid to any denial they may have about their child's substance abuse problem (Gust and Smith, 1994; Polson and Newton, 1984). Often, parents are actually relieved that their child **ONLY** has a problem with alcohol abuse and need to be educated that alcohol is as harmful as any other drug abuse in the adolescent (Gust and Smith, 1994).

Issues of shame, perfectionism, and the roles each family member plays within the family should be discussed and all parties educated on the part these roles play in creating and maintaining dysfunction within the family (Polson and Newton, 1984). Parents should insure



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that all siblings have the same rule expectations and consequences and be cautioned to stay away from labeling siblings as “the good kid” and “the bad kid” (Charlebois, 2002; Gust and Smith, 1994). Sibling involvement in treatment should be to address consistency and should encourage a family dynamic of consistency and fairness (Charlebois, 2002; Gust and Smith, 1994). All family members should be encouraged to discuss their feelings and be encouraged to listen to each other without judgment (Charlebois, 2002; Gust and Smith, 1994; Moncrieff, 2002; Polson and Newton, 1984).

The family dynamic should be studied and parents should receive education and examples of enabling and co-dependency and taught the difference between intervention and rescuing (Fossum and Mason, 1986; Polson and Newton, 1984). Many parents think they are protecting their child when helping them to avoid the consequences of their actions when instead they are enabling the child to continue repeating the same behavior (Polson and Newton, 1984).

Parents should be given instruction, examples, and education on how to be concise and consistent in setting rules for acceptable conduct from their children and discussion of appropriate boundaries, rules and consequences may take place in a parent orientation meeting (Charlebois, 2002; Gust and Smith, 1994; Moncrieff, 2002; Polson and Newton, 1984). Bargaining over behavior and compromising by allowing alcohol or other drug abuse under certain conditions is counterproductive to adolescent health and recovery and should be discouraged (Polson and Newton, 1984).

Case management will include collaboration with the adolescent’s physician, mental health professionals, parents, the school, assistance with vocational planning and training, job search assistance or referrals, and employ ongoing re-assessment and treatment plan revision (Charlebois, 2002; Gust and Smith, 1994; Moncrieff, 2002; U.S Dept. of Health and Human Services, TIP 32, 1999).

### **Relapse Prevention**

Relapse prevention should include referrals to 12-step programs and continued follow-up and co-ordination of care (Charlebois, 2002; Gust and Smith, 1994; Moncrieff, 2002; U.S Dept. of Health and Human Services, TIP 32, 1999). An aftercare plan should be developed with input from the adolescent, her parents, and the substance abuse counselor (Charlebois, 2002; Gust and Smith, 1994; Moncrieff, 2002; U.S Dept. of Health and Human Services, TIP 32, 1999). Social, educational, medical, and legal issues should be included along with relapse prevention and aftercare planning (Charlebois, 2002; Gust and Smith, 1994; Moncrieff, 2002; U.S Dept. of Health and Human Services, TIP 32, 1999). Simple, concise goal planning, such as eating properly, getting enough sleep, and daily attention to homework should be addressed along with plans for clean and sober social contact and activities, employment, and sustained abstinence (Charlebois, 2002; Gust and Smith, 1994; Moncrieff, 2002; U.S Dept. of Health and Human Services, TIP 32, 1999).

### **Conclusion**

Adolescent chemical dependency and treatment approaches are very different from the progression and treatment of chemical dependency in adults. The counselor must understand these differences and apply proven treatment techniques when working with adolescents. They must also understand adolescent development and expect adolescents to experiment with philosophy, clothing, and flirtation when treatment occurs in a group setting.



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A comprehensive assessment should be conducted prior to treatment including substance abuse history, mental, and emotional health. Evaluation of emotional maturity prior to deciding a level of treatment helps to insure success in the treatment setting. Parental willingness to be involved in treatment and their willingness to actively participate in the treatment of their children should also be evaluated.

Treatment should utilize parental involvement, brief interventions, and motivational interviewing techniques. The counselor should educate the family on addiction, relapse prevention, boundary setting, and the importance of expecting and respecting small victories. Group process can improve socialization, build positive peer pressure, is useful when confronting issues, and in celebrating successes. Treatment should include negotiated contracts to address behavioral expectations, consequences, and deadlines for completion of goals as well as alcohol and drug education and relapse prevention. Treatment plans should emphasize simple, concise, and achievable goals.

Aftercare planning will involve the adolescent's physician, mental health professionals, parents, the school, and address vocational plans and training, job search assistance or referrals, and employ ongoing re-assessment and case management.

#### **BIBLIOGRAPHY AND SUGGESTED ADDITIONAL RESOURCES**

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- ❑ **Brief Interventions and Brief Therapies for Substance Abuse** (1999). U.S. Department of Health and Human Services. TIP 34
- ❑ Charlebois, Lisa. Private Practice, LCSW. Interview. 18 Sept. 2002.
- ❑ Fossum, M. and Mason, M. (1986). **Facing Shame**. New York: Norton
- ❑ Gust, D. and Smith, T. (1994). **Effective Outpatient Treatment for Adolescents**. Florida: Learning Publications, Inc.
- ❑ Moncrieff, Michael. Adolescent Program Manager, New Dawn Recovery Center. Interview. 7 Sept. 2002.
- ❑ The National Clearinghouse for Alcohol and Drug Information, (1999). **Alcohol Treatment and Adolescents**. Retrieved September 29, 2002, <http://www.health.org/govpubs/rpo996>
- ❑ Polson, B. and Newton, M. (1984). **Not My Kid**. New York: Arbor House
- ❑ **Treatment of Adolescents with Substance Use Disorders** (1999). U.S. Department of Health and Human Services. TIP 32

#### **ACKNOWLEDGEMENTS**

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This course material was prepared by Sally Wynn, Program Manager for New Dawn Recovery Center, a CARF (Commission on Accreditation of Rehabilitation Facilities) -accredited recovery center. A Certified Alcoholism and Other Drug Addictions Recovery Specialist (CAS) and California Certified Gambling Counselor (CCGC), who has served as a Group Home Counselor for Right Way Homes (Susanville, California) and for Volunteers of America – Boys and Girls Adolescent Recovery Centers (San Jose, California), Ms. Wynn is also an instructor for the California Association of Addiction Recovery Resources (CAARR). Breining Institute has edited the original material for the purpose of presentation in this course.



**CONTINUING EDUCATION (CE) EXAMINATION QUESTIONS**

**Course No. CE1201P1 – Prevention and Education: Adolescent Alcohol and Drug Abuse**

You are encouraged to refer to the Course Material when answering these questions. Choose the best answer based upon the information contained within the Course Material. Answers which are not consistent with the information provided within the Course Material will be marked incorrect. A score of 70% correct answers is required to receive Continuing Education credit. GOOD LUCK!

**QUESTIONS**

1. Whereas, the progression of the disease for an adult generally takes from 5 to 10 years, chemical dependency in the adolescent make take only:
  - a. Two to 3 months.
  - b. Three to 3 months.
  - c. Six to 18 months.
  - d. Eighteen to 24 months.
  
2. The difference between the early and later stages of adolescent use of drugs and alcohol include which of the following:
  - a. Early use is when the opportunity presents itself, such as when adolescents gather socially.
  - b. Later stages include escalated use to every weekend and some or several weeknights.
  - c. Both A and B above.
  - d. Neither A nor B above.
  
3. As the chemical dependency progresses, all of the following may occur (according to the Course Material), except:
  - a. Grades may drop.
  - b. The adolescent begins to plan his life around “getting high” and will associate with friends who use drugs and alcohol.
  - c. The adolescent begins to improve his/her ability to deal with stressful situations.
  - d. The adolescent attempts to please coaches, teachers and parents, while planning to get high with friends.
  
4. Further use may result in physical signs of drug use, including all of the following except:
  - a. Red eyes.
  - b. Swollen tongue.
  - c. Sore throat.
  - d. Fatigue.
  
5. When drug use becomes compulsive, the adolescent may be unable to function without getting high, and intravenous drug use may begin to be a more efficient way to get loaded, and the adolescent may concurrently experience:
  - a. Weight loss.
  - b. Loss of value of morals
  - c. Thoughts and attempts at suicide.
  - d. All of the above.



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6. When assessing an adolescent for admission to substance abuse treatment, the counselor is looking for all of the following, except:
  - a. A primary diagnosis of substance abuse.
  - b. The possibility of a co-occurring mental or emotional disorder
  - c. The presence of adequate insurance coverage for the anticipated treatment.
  - d. Emotional maturity sufficient to succeed in the treatment setting.
  
7. Adolescent chemical abusers may exhibit which of the following that will need to be addressed during treatment:
  - a. Delayed development of emotional and cognitive functioning
  - b. Educational deficiencies.
  - c. Both A and B above.
  - d. Neither A nor B above.
  
8. The U.S. Dept. of Health and Human Services, TIP 34 (1999) reports that effective brief interventions should embody the acronym **FRAMES**, which includes each of the following except:
  - a. **F**eedback is given to the individual about personal risk or impairment.
  - b. **R**esponsibility for change is placed on the participant.
  - c. **M**enu of alternative self-help or treatment options is offered to the participant.
  - d. **E**conomic responsibility of the participant helps develop sense of self-worth.
  
9. The process of contract negotiation empowers the adolescent and engages her in her treatment process while defining which of the following relating to her behavior:
  - a. Expectations.
  - b. Boundaries.
  - c. Consequences.
  - d. All of the above.
  
10. An aftercare plan should be developed with input from:
  - a. The adolescent.
  - b. Her parents.
  - c. The substance abuse counselor.
  - d. All of the above.

**This is a ten-question examination. Answer Questions 1 through 10 for full CE credit in this course. Questions 11 through 21 have been omitted.**



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**CONTINUING EDUCATION (CE) ANSWER SHEET**

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**SECTION 3.**  
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Answers (circle correct answer):

- |            |             |             |
|------------|-------------|-------------|
| 1. A B C D | 8. A B C D  | 15. A B C D |
| 2. A B C D | 9. A B C D  | 16. A B C D |
| 3. A B C D | 10. A B C D | 17. A B C D |
| 4. A B C D | 11. A B C D | 18. A B C D |
| 5. A B C D | 12. A B C D | 19. A B C D |
| 6. A B C D | 13. A B C D | 20. A B C D |
| 7. A B C D | 14. A B C D | 21. A B C D |

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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