Diana:

I know folks will be logging in little by little. I want to welcome everyone here. I have to go to my slides and do that interesting part of the logistics that you all love to hear about. So let me just start there. Welcome everyone to screening for adolescent substance use webinar. This is brought to you by the Northeast Caribbean Prevention Technology Transfer Center or the PTTC. My name is Diana Padilla and I'm the presenter this morning. And so this is the team. This is our team here. This is part of the team [inaudible 00:00:40] other folks, other administrative staff. But these are the folks that are always present with me on every webinar that I do. So this is Patricia Chaple, project administrative at the bottom right. She is the person who is emailing you your registration forms, your certificates, the copy of the slides and other logistically related information. She takes care of that.

Diana:

The gentleman at the bottom of the screen, Clyde Frederick, Clyde is our master tech. He is always behind the scenes in every webinar that I do. And so when you have any type of tech or audio visual issues, you can send him a message in the check box. And in the Northeast Caribbean participant list, he will respond. He should be able to walk you through any one of tech issues that you may have. They're typically simple and he's really good at that. And so my name is Diana Padilla. I am a research project manager here at the Northeast Caribbean PTTC. We are housed at New York State Psychiatric Institute in Columbia University Medical Center at 168th Street in New York. Also, amongst a variety of different things that I do, I provide technical assistance and implementation to organizations seeking to integrate or infuse screening, brief intervention, and referral to treatment.

Diana:

So while I train the topic, I also do a lot of coaching, depending on organizations that want me to work with them and help them understand how they can integrate it within their infrastructure. And so I do the same thing, provide that type of support to organizations seeking to improve or achieve equity and inclusion as well. And so there's a variety of different things that most of us do. That's some of mine. So SAMHSA disclaimer. We always have to have this slide here and let you know that SAMHSA doesn't check absolutely every single little piece of information. But for regarding the Northeast, what I will say is that [inaudible 00:02:44] is current information, is innovative, and is all around bringing you the most recent research and skills [inaudible 00:02:52] interventions, and bringing it to you right away, disseminated as quickly as possible. So we at the technology transfer center, we are across the country.

Diana:

The purpose of SAMHSA's response to workforce development and providing support for that is by funding the technology transfer centers. And so what we do is we provide specialized healthcare and primary healthcare workforce with substance use disorder, mental health prevention, treatment, recovery supports, and all related topics, that type of support to help build your skills and competencies and knowledge base and help you to incorporate or integrate effective practices or best practices. So we have 10 regional centers and we are all across the country. We're everywhere, which is a wonderful thing. So let me ask you. I've gotten pretty good about going into the chat box and coming back and forth and reading out loud for folks who may be uncomfortable. We have a good, comfortable number of folks here. Would it be okay if we kind of have a dialogue instead of just your traditional webinar?

Speaker 1:

Sure. Sounds good.

Diana:

That way you kind of ... I'm not presenting, we can do this together type of thing. Makes it a little bit more enjoyable. It makes it a lot more robust. So I appreciate that. Thanks. That's really good. So the only thing I ask is this. So you have a lot of wonderful information. So what I would ask is that if you don't mind, can you please just raise your hand. If you're not sure how to do it, it's at the bottom of the screen, there's reactions. There's a little button that says reactions, just raise your hand from there. And so what you'll do is you also be able to ... I'll be able to see you when your hand goes up, but I'll also be able to remind you to mute yourself after you finish commenting or adding to the discussion at the time.

Diana:

So that's the only thing. So that way we don't talk about each other. Everybody's voice, everybody's experience is so valuable. And so I just want to make sure that we cover all of that. And the last thing I want to stress is something we remind everybody about. When we send you the registration, we remind you that we want you to be on camera. There's a lot of presentations and webinars that if you are going to attend them and you want your CEUs, you have to be present. And so we're asking you to be present. And so part of this is to help recognize and confirm that we can send you your CEUs. So we are here for all this time. You're committed to being here all this time. And we want to make sure that you're available to get your certificate. Because even though we're in a virtual platform, the challenge we've had as an Oasis provider, particularly in New York state, and this is happening with any state is that when you're a provider for the state for the credentialing offices for addiction counselors, for social work, and for all the other disciplines, what happens is we have to find different creative ways to confirm your attendance. So being on camera is the easiest one. And besides it's our group. It's our group. If we were in person, it would be hard to hide.

Diana:

All right. One of the first things I have to address, and I always have to bring up in all my trainings. So I'm going to go back to my slides, but it's really ... and maybe I'll speak to it before I go back to this slide. We have a slide that we include in all our presentations. And that is a words matter slide. So we have the language we've been using in our practices [inaudible 00:06:36]. Are you aware of that? Can you anyone speak to that? What is the changes they've seen in the language that we encourage to use today?

Diana:

You know what, Jill? Thank you. And I should have said that. Even though it's on my screen. My name is Diana Padilla and my pronouns are she, her and hers. Thank you. So I put it on my screen. I should verbalize it. If I were working, if I were doing direct services, that would be essential to engagement, to building that initial reading. You only get one chance to make a first impression. And that is so helpful. Someone who uses drugs versus drug addict. Okay. Culture competence versus cultural sensitivity. Oh, I have a whole lot of topics I can talk about forever. There's never been an agreed to appropriate definition that's culturally related. Cultural competence, cultural humility, cultural ... I use a lot of cultural responsiveness these days. But it's all speaking to certain things. It's speaking to ... for a long time, anybody who's been in person first ... thank you, Meredith.

Diana:

That's exactly right. Anybody who's been in this business, any length of time knows that the terminology we used to use is what we knew, is what we were taught, is what we were trained, it's what the research we've heard used. And of course it became part of our normal or routine dialogue. Well, what we've been learning is in terms of ... and I will be mentioning this every once in a while ... in terms of health disparities or access to resources, we know that [crosstalk 00:08:16]. And so what happens a lot of times is that stigma plays a part in that. So one of the things that SAMHSA has encouraged us to do, and we as a TTC have gone out of our way to try to mirror the very things we encourage you to do is try to practice using words and dialogue that is more empowering and more supportive and more motivating as opposed to any language that's more stigmatic.

Diana:

And so the research has shown that a lot of terminologies that we use, substance abuse, substance abuser really has an impact on how we practice. It also has an impact on the recipient, it has an impact on the clients we work with. And so going forward, and especially when we talk about screening or substance use related initiatives, you want to consider that. And in dialogue, sometimes I can have a conversation with somebody or a client and we're talking about drugs and I get that. But a lot of times, what we want to do is about substances. And what we do is try to take that negative edge off the dialogue. Because what folks are trying to change, what folks are being open and receptive to, the things you're helping them with, we want them to feel like they're supported. And so that's all part of it.

Diana:

And it takes practice. It doesn't happen overnight. I'm still kind of getting the hang of certain things like saying my pronouns when I first introduce myself. Thank you again, Jill. As opposed to just putting it up on my little box. So things like that. And the more we get into the habit, the better we can ... we can become more intentional with our words. That's the best way to put it. So this is the language matters slide.

Diana:

So the goal of the training is to become more familiar with the elements of effective substance use screening with adolescents. It's very fundamental. But at the same time, it can be very comprehensive. Teens use drugs just like adults use drugs for a variety of different reasons. So what are some of those reasons why adolescents use substances? And also think about it from the perspective of their different development stage. So from their perspective, why do you think teens use drugs?

Speaker 1:

To fit in?

Diana:

Okay. Yeah. To fit in. It's so important to understand that the peer acceptance is such a really big deal. It's a very important part of their development. Okay.

Diana:

All right. So I see peer pressure and family use. And it's unfortunate. A lot of times what a lot of my colleagues are dealing with in their treatment centers is they have families, different levels of the same family within the treatment program. We have not seen that the way we've seen that more recently in the last number of years. Self-medicating, coping mechanism. You guys are great typers. Anybody want to speak to it?

Speaker 2:

I was going to say the media. With the media, just like social media and seeing things on TV. I mean, that's old. I think everyone's ... that's been around for a while. But just with the developmental aspect of it, they see that other people are doing it.

Diana:

I think you bring up a really great point. There was this one training that I used to do with drug court or treatment court professionals. One of the content that we used to always reflect was the media, how they promote alcohol. And in certain communities, they promote it very specifically. And so we were doing culturally related training to be more effective with diverse communities. And in black and African-American, Hispanic, Latino community in certain states that we were going to, it was very relevant to use the picture that was advertising a particular liquor. But it had ... and this is kind of old now. It had a picture of a the fly girl, a very beautiful young woman who is on this car, which is a jazzy, beautiful car with big rims. He's wearing a FUBU leather jacket.

Diana:

It's like, excuse me, he's got it going on. He really had it all going on. And the biggest thing out of everything on the side was a big bottle of a liquor. And it gives the impression to a lot of adolescents [inaudible 00:12:59] internalizing all the stimuli from their environment. It gives the impression that being able to drink and being able to have all these things is part of who you can grow up to be or who you may want to be like. And so it's misleading information. And this is done intentionally just to promote product. So yeah, the media can be very, very influential. So I see a lot of to reduce stress, trauma at home, self-medicating, TikTok challenge. I am not a TikTok visitor. I don't see TikTok too much. Jill, do you want to tell me?

Jill:

Yeah. I work in a school with middle and high school kids. And especially the middle school kids, they see something on TikTok and then they ... it's like a TikTok challenge. You're supposed to go do it. So they do it no matter how stupid it is. And I mean, things like rip the towel dispenser out of the bathroom, really destructive things. And some of those things are with drugs and alcohol too. So I don't know if parents realize as much that their kids are exposed to that kind of stuff on TikTok.

Diana:

Thank you for that. Hmm. We have an opportunity to maybe inform the parents or provide the public PSAs about different influences like that. So thank you for that. Yeah. So let me bring up this slide. And I have a lot of the ones that you kind of brought up. Sometimes I have graphic slides. And please excuse me if it's too much for you. Just turn off the video for a little bit and listen for a while. But I'll go through these slides kind of quickly so I don't stay on the graphics too much. So I have a variety of different reasons why teens use drugs. And you've covered most of them. Boredom is one of them. And I want you to consider this within the current environment.

Diana:

The current environment within the last almost two years now, we've been dealing with this pandemic era. And it has changed things quite a bit for everyone. But it's particularly impacting with the adolescent community. So boredom is a reason why sometimes teens use drugs. Bonding experiences. If someone wants to experiment or try something out at the same time as other peers, and they're all checking it out at the same time that actually liaisons or alliances with other folks. So yeah, we have that as well. Curiosity and see how feels, what they heard about, to deal with stress. Adolescents do things very similar that adults do when depression symptoms come up, when anxiety disorders symptoms come up. Whether they are aware they have mental illness or not, a lot of times symptoms are mitigated by using substances. And so sometimes low self-esteem.

Diana:

And the other thing about peers is also the pressure. Sometimes when you want to be accepted, you want to do what everybody else is doing. If you're not, you might be outcasted. And that's not necessarily an option for some kids while they're developing during their 13, 14, 15 years of age. And so there's a variety of different reasons why teens use drugs. But let me just share something, just a couple of points for substance use during COVID. And so a lot of folks, because we think we had the safety in place guidelines, do you have to be secure as for when the pandemic first started in 2020, adolescents ages 10 to 14, the overall rate of drug use remained just about the same in the first six months of the pandemic. There was a decrease of alcohol, but there was an increase of nicotine and misuse of prescription drugs.

Diana:

And nicotine can be used in different ways. It's not just smoking cigarettes. It could be vaping. And so in families that experienced the extra stressors that the pandemic had caused, all these extra pressures that families were feeling in terms of loss of income or even just their fear of bringing back an infection or how to deal with the lack of resources, substance use was higher with youth who were part of families that were engaged or going through experiencing these different situations. I cited here, there wasn't a lot of adolescent specific or adolescent focused research during the time of COVID. A lot of the energy has gone into what keeps folks safe from COVID. There was a lot of energy going into adults because of opioids. And that was later sometime into the pandemic.

Diana:

The opioid overdose is really, really rock [inaudible 00:17:58]. Our communities started to [inaudible 00:18:01] and effort and energies were put into there. But there wasn't a lot of adolescent specific research. There is this one research that is looking at the effects of how the pandemic affected the adolescent community. And it's called the ABCD study. And it began some years ago. But what they did find is that during COVID, 8% of substance use in the past 30 days was reported by adolescents, 3.5% were reported using alcohol. And alcohol was pretty much one of the first three substances that adolescents and teenagers tend to use the most, even though you're supposed to be 21 to access alcohol. That was used either the first or the second or the first three substances commonly used.

Diana:

And now what they saw was the decrease in alcohol, 3.5% percent reported using alcohol, 3.5% percent reported using nicotine. But the alcohol decreased while the other substances increased, other substance use increased. So there's some suggestions, there's some ideas, there's nothing conclusive just yet. But researchers do believe that it has to do with the fact that when you're locked down together, it's kind of hard to access alcohol. But it might be easier for you to vape nicotine or to use prescriptions, drugs, and try to hide it even in front of other folks that you are living with. The thing is [inaudible 00:19:40] of young people, when it comes to as young folks are growing, it can be a challenge to see how choices can affect them later. Consequential thinking is an evolving process on all on its own.

Diana:

So early substance use, we know increases the risk of substance use disorder in adolescents and young adults. And the earlier someone starts to use substances and engage in substance use and even related behavior, the more likely they are to use in later adulthood. And so recognizing the risk and protective factors that influences youth's relationship with substances can help cultivate an environment where they thrive. And that's part of what the study is doing, is looking for. Thank you, Lori. I wanted to read this too. There could be lack of parental supervision and access to prescription drugs. Yes. And that's another aspect of the challenges during the pandemic that I didn't mention. A lot of parents who need to go to work, that cannot be at home, that have to take the risk of going into work.

Diana:

And I'm talking not now where the vaccines were made available, but I'm even thinking back when vaccines weren't available and a lot still was unknown about the COVID-19 disease. And so folks were not necessarily able to stay at home because they still had to find ways to provide for their families or keep a job if they had, otherwise they couldn't provide for their families. So thank you for mentioning that. So I want to ask, I'm going to read, or maybe not ... maybe I'll ask someone to read. I have a case here, Louis. I'm going to ask Jill, would you mind reading this for all of us, please?

Jill:

I can do that. Okay. Can you hear me okay?

Diana:

Yes. Thank you.

Jill:

Louis is a 15 year old boy who is furious with the world. For the past two years, he has lived with his mother and his two younger siblings. Louis' mother, Adelia has been in recovery for the last two years. She had always managed to provide for Louis and his siblings and works two jobs, keeping her out of the house from 7:00 AM to midnight. Louis' father is rarely around and has never helped his mom out, who does the best she can. Sometimes Louis thinks he could just quit school and get a job and help his mother take care of his brother and sister. During weeknights, while mom is working, Louis hangs out with his friends who like to drink and smoke. He's angry often and argues a lot with teachers, but his friends like him most when he gets high.

Diana:

Thank you, Jill. And let's start to consider Louis ... I'm not sure if this is a case that has similar something, some issues that you are familiar with, with other adolescents that you work with or have worked with. But what can you say? What can you to be the concerns around Louis? What are a couple of the things that just are very obvious that kind of stand out?

Speaker 3:

Lack of supervision.

Diana:

Okay. The lack of supervision. That's right. What other risk factors does Louis seem to present with? And I'm going to say seem because I don't want to make assumptions. We have certain protocols that we-

Speaker 4:

Peer pressure.

Diana:

Okay. Peer pressure. Okay. There may be an influence from peers. Okay.

Speaker 1:

Predisposition to substance misuse because the mother is in recovery.

Diana:

Ah, that might be. That's right. That's a good point too. Okay. Predisposition.

Speaker 5:

Angry because his dad doesn't express an interest in his life.

Diana:

Yeah. Angry. He is very angry at his dad. What else?

Speaker 6:

He may have a sense of helplessness because he feels like his mother is doing all of this work and he can't find a way to assist her.

Diana:

That's true. That's right. Okay. So a sense of helplessness. So it seems like ... and let me just read what's in the chat. Financial stress. Okay. That's good that you picked up on that because what the family is experiencing can have different effects on the individual members. Yeah. Okay. So we have several risk factors that were pretty easy to recognize. What about protective factors? What are some things that can be strengths within this whole case for Louis? Anybody see any strengths?

Jill:

His mother being in recovery is a strength.

Diana:

Okay. Mom being in recovery. Right. And what else does? What else can you see from what you read here?

Speaker 1:

He wants to work. He has a strong desire to help his mom.

Speaker 6:

His mom is showing him work ethics too.

Diana:

Yeah. So he wants to work. He wants to provide, help his mother. So there's obvious emotional commitment and loyalty there. All right. So let's go here. So what do you think, what would be your first approach in working with Louis? If Louis' case came to you, you're guidance counselor in a school setting, and you start to learn, and you learn about these details, what would be your approach? His younger siblings are a support. Thank you for including that. We need that from the chat.

Speaker 1:

I think if he has a motivation to work, really honing in on the fact that making sure he stays in school, but how can we still get some extra income so that he can help support himself or his family, even though he shouldn't be in that role? But obviously that's a motivator for him.

Diana:

Okay. He obviously wants help his mom. He obviously wants help the family. Also consider he may want to be the man of the family because the male role is not there. He's angry at that male role. He wants do that different. Right? So sometimes when I'm saying ... I'm sorry, go ahead. You were going to say something.

Speaker 7:

I was going to say, just acknowledging that there's a lot of stress with him being the oldest sibling. I'm just making him aware that people acknowledge that the father is not at home. So there's a lot of pressure on him to be a good role model for the younger siblings. And acknowledging that, that's got to be difficult, but you're doing a good job or trying to help him, let him know it's important for you to set a good role model for your younger siblings.

Diana:

That's true. Acknowledging and recognizing those strengths and those abilities that he is showing it. It's a full plate that he's carrying. It's already a full plate that adolescents carry. When we think about the developmental stages. And when we think about the load they have to carry when it comes to school, if she's a mom by herself and she is just in COVID two years, and she's working all the time, and he's probably the big brother that he's supposed to be likely responsible for the two kids. So there's a lot of things that's correlated here that, yeah, it's pretty heavy for him. So recognizing that is huge. Okay. So there are lot of different and things and different stressors that can be happening at any given time for a given adolescent. Louis is just one of great many kids who may be having these challenges to certain degrees, and not necessary to a lot of these extremes that we tend to see here. But a lot of times what we don't see may be happening. And sometimes what ...

PART 1 OF 4 ENDS [00:28:04]

Diana:

We don't see maybe happening and sometimes the only way we do see it is, be it through behavior. Sometimes we need to look at behavior, we need to understand where it comes from. Sometimes these are the very things that help young folks to kind of, to use substances. Maybe it's not just accepting as fear, but maybe it's a break from the reality of his life. That's not unusual for anybody who uses substances sometimes and if that is... And then the other thing about the detail in the case study, it was really interesting... So I borrowed this case study from a friend and his client, his patient rather, because he's a therapist. His patient is this person, I changed the name, the interesting thing about this young man is that his friends like him, but only when he's high, because he's a nice person when he is high.

Diana:

So he's carrying anger, but he's probably carrying some trauma too. So separations can because a lot of traumatic feelings for experiences for a lot of young folks and so there's a lot to explore and a to unpack here, but there's a lot of different things that can be happening in a person's life that can lead them to use substances that can put them at risk of using substances and then if you kind of blend that with the developmental stage that they're at with experimentation and curiosity is kind of part of them growing up kind of blends in together makes for opportunities to try stuff out and sometimes kind of stay there if they find that if it brings them a benefit, like a break from life. So let me go back to my slides.

Diana:

Thank you everybody. That was great. So hazardous consumption during teen years. Alcohol use can have lasting effects on the developing adolescent brain, including impaired memory, attention processing functions. Makes it very hard to remember things and it just kind of slows down the development process. Age of first use is inversely correlated with lifetime incidences of developing a substance use disorder, which we've heard about and I mentioned earlier.

Diana:

Drinking during the adolescent years is associated with other unhealthy behaviors like high school students who report poor performance or health risks and as people move into adulthood, these risk factors for use in addiction can change but sometimes the consumption of substances during teen years is strongly associated with a high mortality rates and so at each new stage of life, new and different circumstances can create stress and added pressure and increased vulnerability to substance use and addiction and part of this is the reason and why I included the most recent study, recent information incited so you can look for more information for yourself, is the couple of studies that are being done now with youth and so studies that are looking at the impact of the environment and the stress and the worry and the potential to lose friends.

Diana:

Remember at the beginning of the pandemic, the CDC and most people with the limited knowledge and limited details that they did know about the COVID-19, the focus wasn't on the young folks, the focus wasn't on young folks getting affected or ending up in a hospital, but after a while... And what tends to happen when diseases do mutate within communities within populations is that then they became a risk and at first they didn't have to be vaccinated and then after a while, yes, it was recommended that they get vaccinated. The more we learn, the more we've got, the more we can make the appropriate treatment recommendation.

Diana:

So during that time, young folks who are learning, who have limited capacity or limited experiences may not have been able to understand the gravity of the situation and when they did start to understand when they did start to see that people were losing the fight to COVID, who were no longer being available and having changes in their life where they're no longer seeing their friends readily, they're not going to school the way they used to go to school. All of these are different pressures that they've had to, that they were challenged with.

Diana:

So, vulnerability to addiction. Family history of addiction, and you mentioned it before, mental health concerns, behavioral impulse control problems and that is not just what kind of gets learned or what adolescents get better with over time. There are certain neural logical reasons for impulse control problems or of some behavioral problems and so that increases the propensity for substance use disorder. Exposure to trauma and environmental factors and influences and we had a whole discussion about that. The age of first use, as we said before. So one of the information I wanted to give you is some of the data that we have alcohol use right now.

Diana:

So alcohol lifetime, past year, past month, alcohol use and binge drinking continue to show significant five year declines in 10th and 12th graders and one of the nicest sources of information is the Monitoring the Future Survey and I think the most concrete information that has come on has gone up to 2019 because the pandemic started in 2020 and the research has been very limited with the used cohort and so in 2019, when this Monitoring the Future Survey reported was that about 8% of 8th graders and 30% of 12th graders drank during the past 30 days and so when we see a decline in the 10th grade and the 12th grade, you can also talk about, we can also see that there's been an increase.

Diana:

I think that should have said just declines in the 10th grade, because the 2019 report is showing that there was a huge increase in 12th graders and so what we're seeing is a lot of 8th graders and 12th graders binge drinking in the past two weeks from when the survey was done and then sugar and coolers, you know the sweetened coolers they are made sweets so they can be more appealing and be more marketable and sell better. So sugar and sweetened coolers help to mask the taste of alcohol. So it's more appealing, it can be more appealing to young people. So it's no surprise that that gets done because marketing is done very intentionally.

Diana:

So e-cigarettes and vapors, vaping is the act of inhaling and exhaling vapor from an electronic cigarette device, electronic cigarette, rather. It is a device, and I've just got a couple of pictures right there, it looks like a pen, it could look like a USB travel storage unit. It just very elusive packaging. The actual device used for vaping is a small battery powered device that heats a liquid and that inhales the vapor and it's similar to how steam is formed. So e-liquids tend to come in a variety flavors and we know that a lot of the flavors is marketing, again or targeting the youth, even though a lot of companies do work within the legal parameters of what they can and can't do they're still targeting folks, communities that are more likely to use these products and that's the use.

Diana:

So there's a wide range of choices when it comes to devices, e-liquids, and tanks systems and batteries and so the thing about vaping is that it causes a lot of different problems. Vaping is done, it's not just for nicotine and a lot of the liquids contain a combination of propylene, what I call glycerol, also called glycerin, as a base and these substances can have impact on the biological processes in our bodies. Also, nicotine, marijuana or flavoring chemicals produce different flavors. There's one that I thought it was interesting enough to mention it, it can be called anything from mint to unicorn puke and so things can get pretty complicated when all these flavoring chemicals combined together are inhaled in the body and so actually be being able to express this or present this information or form the youth population about these things is pretty important and so they don't necessarily get that information or they get it, or maybe they don't get it enough. But I think it's really important to understand, especially when vaping is...

Diana:

You have a lot of shops in different states that are legal to sell. Yeah, but it doesn't necessarily come with the information that is readily available for them to be able to process the potential negative effects of vaping. So when constant substance use, I thought it was interesting enough to highlight that a lot of times when a youth is using substances, we tend to see it in the school environment.

Diana:

School environment and family environments are the two biggest areas of situations that can provide potential reasons for us to investigate, to research, to explore and so this diagram highlights what's often the consequent dynamics that impacts substance use for adolescents and so it's not only where we see the effects of substance use on youth but also identifies the school environment as the opportunity where the adolescent substance use can be addressed and so when you see substance use and you can see how the errors go in different way, and if we see challenges with students connecting with teachers and the bonding doesn't happen, or the interactions are not very healthy or very minimal, perhaps there's low parental participation.

Diana:

Perhaps the parents are out trying to keep the job or maybe there's illness in the family. When we see other things like it says deviant peer affiliation, depending who they're hanging out with, who they spend their time with, who they go to places with, those are very influential. So those peers are the ones who are going to school and who are engaged in after school activities, or they're the kids who cut out of school try out different substances and that's kind of where they're at. So contact problems, no parental monitoring, impulsivity attention problems and I was speaking about this yesterday, that a lot of illnesses or attention deficit disorder, ADHD, attention hyperactivity deficit disorder.

Diana:

These type of situations are very hard to actually diagnose accurately and sometimes it's missed or misdiagnosed and so when we see a lot of the situations, some of the behavioral problems, are big indicators that there may be possibly things going on. It could be that a student is just maybe acting out, maybe reflecting challenges in their family environment. It could be that they're using substances. It could be a combination of a lot of different things.

Diana:

So substance use patterns with adolescents include different levels of risk. So there is... According to the American Academy of Pediatrics there are four general patterns, and they're listed here. There's low risk or abstinence, adolescents who report no use of tobacco, alcohol or other drugs, not every kid who goes into school, who is in the school environment or is 13, 14 or 15 is using substances and so we have adolescence who report no use of any substance and that's low risk or abstinence and those are the categorical references and so they report, but do they report that they have not ridden in a car with the driver who has not been using alcohol or other substances.

Diana:

The driving risk, because this is where some of the concerns come is that some adolescents may be around someone who, maybe they get in the car and maybe they're not using, maybe they're not indulging and yet the driver is and so the driving risk, adolescents report driving after alcohol or drug use, or riding with a driver who has been. A moderate risk, and we're going to go over the CRAFT, adolescents who have begun using alcohol or drugs, maybe they're experimenting at stages and then you also have high risk, which is adolescents who use alcohol and other substances and this is according to the CRAFT too. This is the one screening tool that I will highlight here.

Diana:

So asking about alcohol and other substance use with youth population. So regardless of what screening tool that you use asking about alcohol and other substances may be especially difficult with adolescent who may not want to admit or discuss substance use. So then you want to consider. So if those dynamics may present, how do you work around that? So successful screening can be enhanced by memorization of the tools and practice of the conversation skills required to put the adolescent at ease. So we're going to walk through with some couple of those things right now, and I'm going to ask you, what have you found to be effective for you in your practice?

Diana:

So introducing a conversation about substance use and screening is a good skill for any practitioner to practice and in order to naturally transition into administering a screening tool and so when I do a lot of work around expert in instructing and on how to do it and we provide practice skills opportunities, and that type of thing, it really makes sense to practice before you actually do it with the adolescent and so that's why we do skills practice here in trainings, and we have an opportunity here, we'll try to do that. What is really important is to understand that there are certain things that, the atmosphere and pushback might be a little different with adolescent than would normally be with an adult and so you want to be at least prepared for that and prepared as much as you can be. The literature suggests that self-administered computer screening is valid and time-efficient for adolescence and that some adolescents may prefer this method. That's not surprising.

Diana:

A lot of folks are more comfortable and particularly young folks are more comfortable using technology. So there are benefits to using self report devices. So let me show you something. So when we have devices, say we have an environment they're coming in to see the nurse, they're coming in to see the guidance counselor, they're going in to see a doctor, they're going in to see some practitioner of that they're working with and maybe the safe space that you want to have in place prepared already for when you are expecting a young person to come in and do a self report, you want to consider the environment where they would do that.

Diana:

So here are two students, essentially doing two selfless reports. Give me your opinion on this. Does this look like a safe space for them to provide your answers to a screening, to a substance use screener? Here is the space and you have these two students filling out these forms. These are two screens. These they're filling out a screen, a self-report screening tool for substance use. Does that look like a safe space?

Speaker 8:

No, they're sitting right next to each other. They're going to be sharing answers and judging what the other person is or isn't putting. They're not going to take it seriously sitting right next to somebody else completing it.

Diana:

Okay.

Speaker 9:

I just think it's a lack of privacy.

Diana:

There you go. So we're always bound by the confidentiality laws. So having that, it's a great space to have to set something up but to have them together is not a good idea or maybe not at the same time, depending on the space. Okay, so let me show you another picture. That's good. So this is the hallway of the school and this is a principal with another staff member and this is where they often talk to the kids and have them show out things. What do you think about that?

Meredith:

It also lacks the privacy and that safe space requirement for intimacy to really be fostered to talk about something personal.

Diana:

Yeah, and so if this is just, even if they're filling out the self report and then in this hallway, it's so... The change of classes and people walking by at any given time, so how much privacy is there and think about it, I'm also young, also a lot of distractions, other the kids walking by. The other thing is, think about this, also, if it's that important, is it really that important because if they are filling out something just, is it set up to, for them to be accurate or forthcoming in that assessment tool? If they're just out there in this space. It has is a way of possibly being interpreted by an adolescent as it's not that big of a deal. So why do I have to even be honest, I can make up the answers if I want to. It really doesn't seem to be that important.

Diana:

So it actually conveys different messages. So you're safe space, and when we talk about confidentiality, and especially when we're talking about adolescent self report, according to research has been one of the most effective ways to get folks, to get adolescents, to actually provide as accurate information as possible and I get very leery about using the word honest, because I don't want to judge, but for them to be as forthcoming as possible about their answers, you want to create a safe environment, an environment that's conducive for them that is private for them but it also shows that this is important enough because you have it created for them and so it shouldn't be a fly by night type of idea. It's really something to be thought out very concretely and it's really important to say you going through adolescence it's important for you to fill this out and if you're going to do it, do it in a place where it's safe and everybody else doesn't have to know what you do.

Diana:

So let me go back to my slides. So confidentiality, safe spaces is really important not to share with you something else about confidentiality. So the use of confidentiality for setting an atmosphere. So even before you ask an adolescent to self report, the screening tools that we're going to go over is the CRAFT and they're often there can be paper, there can be done on an iPad or computer or it can be done person to person in an interview.

Diana:

So, but even before all that, what we want to consider and the importance of the benefits of explaining confidentiality for adolescents are more likely to discuss high risk behaviors if they believe the case is confidential and so we know that from research and explain what confidentiality is and so a lot of times in my past career moves, when I was doing direct services explaining confidentiality, when I first got into the field, we were told, explain it, have them sign and kind of move on with the rest of what you had to do in the 45 minutes and [inaudible 00:48:22] and so what has happened over time is that we realized, I started to realize that she explained confidentiality. Confidentiality was explained very differently, in different settings, from different social service opportunities and so what we started to do, what we were encouraged to do in the field is to be able to explain it and then ask the person, what do you understand about what I just said to you just to ensure clarity and transparency.

Diana:

Ethically that was my responsibility and so it is our responsibility, no matter what discipline, when you work in to do the same thing, to make sure that they understand. When you take the extra step or the extra few seconds that it takes to kind of just how I list it from your adolescents, what they understand about what you just explained to them. It helps you understand whether they are clear on the information also helps you maybe redress, some confusion that might come up and so adolescents answer confidential screenings more accurately, are more forthcoming, when their answers are not necessarily going to go back to their parents and so state and national laws do allow minors to receive confidential care related to sexual health, mental health, and substance use disorder treatment, right?

Diana:

Also, substance use intervention and I should include that as well. So the research has shown that those who are aware are more willing to seek healthcare, are more willing to seek care or seek support for issues, if they know they have confidentiality, so helping them understand what their rights are and what parameters allows them these opportunities is very important for them to be able to make healthy decisions for themselves. You should explain the full confidentiality policy regarding the disclosure of sensitive issues directly to the adolescent at the very beginning of the screen, even before you do the screen, because what you want to do is set an atmosphere and say, and that's not just physical, that's that cognitive atmosphere that you start to initiate that rapport with your adolescent and there are state laws that govern minor patient rights when it has to do with confidentiality and even though the different states have different variations they all have to do with 45CFR just be mindful or be aware what that is in your state.

Diana:

And so before the screen, and here I want to ask you folks a question. So what might you need to create... What do you need to consider to create an affirming, culturally appropriate, trauma informed environment prior to screening an adolescent? So let me ask it again. What would you need to create an affirming, culturally informed, culturally appropriate, trauma informed environment? I'm asking a question but before you answer that one, why am I even asking that? Why would I even bother asking that question? This is before the screen.

Angela:

I think that it opens up a space for vulnerability. If I don't feel safe, I won't be honest and for me that means putting them in a space where no one can hear our conversation, making sure that we're the same level so that there's no like height differences, making sure I'm not considered like an authority figure, but just I'm a provider I'm here to help. Being very mindful of how I present and how I enter the space and down to like my clothing, because I know I cause a reaction in people just by who I am sometimes and just being mindful of what that means to different people from different backgrounds and their own life experiences and just making sure that the environment is conducive for, I might not match the experience you've had with other white women, but here I am, and I'm not this box I'm here to help.

Diana:

And you want to convey that and thank you for that, Angela. That's really great. And so sometimes we can do it with our physical environment can help, right? But in our physical environment, if we're working in communities, we tend to work in communities with a lot of diversity. So think about what you can put in your environment. So even before you say a word, your environment might be making an impression. So if they come in, they're going to check you out, it's kind of normal. I would check out anybody I'd never met before myself. I'm not an adolescent, I don't know if you can see that, but so I want you to see, I want you to kind of consider that young folks who often are spoken to and not spoken with, want to see you first, want to see what you're about before you even open your mouth.

Diana:

So a lot of times the environment needs to be conducive and unlike all that stuff, everything that Angela added, because it makes us think about do I want a rainbow flag up? Do I want to have pictures and posters that show diverse communities. She spoke about how she dresses, how she presents herself, well, her demeanor in how you create that atmosphere also has to do with how you greet someone and we spoke about that earlier and when Jill had mentioned that earlier about pronouns, those types of things are very helpful. So when you're trying to engage the youth community, some of these things can be very specific. What else do you do? Okay, Meredith.

Meredith:

I was also going to say, and it doesn't have to only be for adolescence, but I like to remember not to walk like in front of somebody as I'm walking back to the office or wherever I'm taking them, kind of walking beside them to just make them feel more comfortable and I noticed with younger patients that, that has been helpful, it kind of puts their guard down a little bit. Like they're not in trouble.

Diana:

That's nice. Very good point. I like that. Sometimes what we do when we don't do, they always kind of speak volume don't they? And that might be very sensitive more for some adolescents than others and we never know what someone is going through. So most folks here understand what trauma inform care is. Right. That was a closed-end question, because I'm expecting nods yes. So then the idea is and I keep framing out the pandemic because it makes it more obvious, but even before the pandemic, we never know who is going through what.

Diana:

Adolescents do not all automatically act out cause something is going on in their family or in their environment. That's not how it works. That's not, just the human element. That's not how it is, but what we do know, and that's already confusing, just being an adolescent, dealing with things for the first time, having a boyfriend or girlfriend for the first time, having a partner of some kind, try understanding your body for the first time and having the information instead of the experience first, and then the information later, there's so many other challenges that adolescents are going through.

Diana:

So when they come in and they are from diverse backgrounds themselves, how you greet them, how you initiate a report, how you speak to them and with them and at them makes a big difference. So I really appreciate what you said Meredith about walking beside them. We can do that cognitively as well. When we are having a conversation, we can do that as well and that's what the screening is about because this is really founded.

PART 2 OF 4 ENDS [00:56:04]

Diana:

As well and that's what the screening is about because this is founded in screening brief intervention referral treatment. We're using the dynamics of effective and work there to talk about screening here. Thank you so much.

Robin:

I have a question. I'm not that familiar with the expert, but inherently itself, is it a biased instrument?

Diana:

A biased instrument?

Robin:

Is there a racial slant within the instrument itself in terms of the questions?

Diana:

No. The screening tools themselves are validated. They're all different. They were developed specifically for either the community and substance use. The reason we included here the question about affirming culturally informed and trauma-sensitive is because those factories need to be included going in. It's not specifically in the tool.

Diana:

When you do ask the questions in the tool, we have to do it verbatim. Otherwise, you can't compromise the fidelity. From that perspective, since we can't do that, and a lot of these tools are pretty old. The CRAFFT II I like it because it's one of the most recently updated tools for adolescents, but it's been [inaudible 00:57:23] for a little while.

Diana:

None of them include cultural aspects and with the health disparities that we have seen, especially during the COVID pandemic, this era that we're surviving through, it's become so important. That's why we talk about framing this out first the conversation, the initial rapport, the environment.

Diana:

If we frame it, we don't have to compromise the fidelity of the practice itself, but it becomes culturally informed from that way. Excuse me. The other thing is the dialogue that you have with the adolescent is really based on some very core skills and motivational interviewing, which is also culturally informed.

Diana:

It comes together really nicely. Thank you for that. I always stressed in importance of not compromising the fidelity of instruments, because otherwise, it won't be the instruments or it's really more based on how we facilitate as opposed to when we don't follow the instruments the way they were designed to work.

Diana:

Let me show you a little bit more about what I need. Good question. Thank you, Robin. The other thing, so what we do is we talk about we create this atmosphere, we engage them, and we walk side by side with them, and we ask them either maybe we going to do a person to person interview.

Diana:

"I'd like to ask you some questions I ask all my patients. These questions will help me to provide you with the best care possible. As with all information, your responses are going to be kept confidential. If you need to, we can stop at any time and come back when you're ready."

Diana:

This is more of an example of how you may want to start and let them know. "I would like to ask you some questions that's substance use is related and it has to do with drugs sometimes somebody smokes a joint at different times. Sometimes some folks, you take a drink other times when they're stressed.

Diana:

I already explained the confidentiality with you. This is just something I need to do. I do with all my students and if it's okay, I can start. Can I ask you these questions? Go from there. The screening process is they're self-administered tools, but they're computer-based, rather verbal interview by the clinician can also be done.

Diana:

Have these things over here. The validated data screening tools to use are these. You have CRAFFT, CRAFFT II, you are encouraged to use adolescent-specific tools. Back in the day, there was a time when we used to use dumb down versions of adult screening tools and adult assessments for youth.

Diana:

Of course, we had very ineffective outcomes. These are very specific. Just know which ones they are and become familiar with how they work. I want to show you a quick video. Let's see if I can do this correctly. I'm going to show you a quick video.

Doctor 1:

When you told me earlier, was that you got into a car with someone you knew had smoked marijuana earlier. What were you thinking?

Student 1:

Well, it was raining. I didn't want my science fair project to get wet. I knew my parents weren't-

Doctor 1:

Science fair project or not, don't you know what happens when someone drives under the influence of marijuana or alcohol? It's bad. They can wreck the car. You can lose your life. I thought you were smart. You're taking AP classes. You want to get into an Ivy League school. This is not the way you do that.

Student 1:

It really wasn't that big of a deal.

Doctor 1:

It's a big deal. You can't drink either, you're 16. The drinking age is 21. I think you know that. You could get into an auto crash. I just want you to hear this. I don't tolerate as a doctor drinking or driving with somebody who's under the influence. If you do it again, I'm going to tell your parents.

Student 1:

Okay.

Diana:

Comments?

Robin:

Not the best approach.

Diana:

I like what Robin did not the best approach.

Participant 4:

A lecture.

Diana:

A lecture, that was part of it.

Participant 5:

He's very judgmental.

Diana:

Tamara, go ahead.

Tamara:

He was badgering her like he was her father or parent. He failed in a big way, that's all I have to say.

Participant 3:

He didn't pay attention to confidentiality.

Diana:

That's the thing that struck me when I saw that video was he threatened to tell her parents. I said, "That's not what we were supposed to do." We explained confidentiality for a different reason not to coerce. That was tough. That's such a big out. Anything else you want to say about that one?

Tamara:

Why were they leaning up against a bed? Does he not have a desk? That's not appropriate.

Diana:

They had that gurney thing there in the doctor's office. They wanted to make it authentic. What I thought was interesting also if you noticed, and let me remind you, she just starts to talk, she seemed comfortable at first. She did start to talk and instead of him capitalizing on that opportunity, he actually pushed her away.

Diana:

It's like, "Darn, she was getting comfortable." She seemed very calm at first when she responded. Knowing that, sometimes we speak with adolescent, particularly if it's the first time speaking to adolescent that can be a challenge. When you have an opportunity, you want to capitalize on that. He certainly didn't do that.

Tamara:

He was raising his voice and scolding her.

Diana:

Yes, he was. It was very similar to what Tamara was saying by badgering her more of a parent. Imagine what if she has family issues and she has some trauma going on in her house? She was comfortable at first talking to this individual. He starts to speak to her the same way.

Diana:

Adolescents can get reclusive and go inside, and they can get quiet. They can start to just keep whatever they're going through inside. That's so unhealthy and it's not just for substance use, but for other mental illnesses. There was so much about this as well. Let's talk about what a screening process should be like.

Diana:

When we talk about administering the screen, the screen can be written on or as we've been saying, in self-administered screening, it's important to inform the adolescent about them completing the form on their own and to be it as forthcoming as possible.

Diana:

We can do that with a nice tone of voice and not in any directive type of approach. Then what you do as the provider, as the clinician is review and verify the self-administered responses during the visit. The CRAFFT questionnaire, which is just one of several different screening tools, as I had shown you before.

Diana:

What I like about the CRAFFT tool it uses a different approach as opposed to how many times do you use or how much substances do you use. It looks at related situations, it's easy to understand for self-reporting. It has the same basic question as the original version of it, but it has the sensitivity and specificity.

Diana:

I'm going to show you what it is now. I put the form there because as our communities are become more and more diverse, you may want to use different versions or very language specific versions of that tool. The CRAFFT II is here. I want to show you on the right.

Diana:

It has these questions, during the past 12 months how many days did you and when the last year drink more than a few sips of beer, wine, or any drink containing alcohol? You're not precisely measuring exactly how much, it's just giving a good idea.

Diana:

The second one is use any marijuana, for example, weed oil, or hash by smoking vaping or in food, or in synthetic marijuana, for example like K2 and spice. Then, the third question uses prescription medication or pill that was not prescribed to you, or you use more than what was prescribed to you.

Diana:

For example, prescription pain pills or ADHD medications. Using anything else to get high like illegal drugs over the counter medications, things such alcohol or vape. After the first four questions you have one more question is have you ever ridden in car driven by someone, including yourself who was high or had been using alcohol or drugs?

Diana:

When you look at the questions, one of the things I also suggest when you ask, if you can introduce this screening and just have a couple of things to add is what we are talking about different substances that people use, that folks use, I might get specific about it.

Diana:

You prepare the person. You prepare the adolescent before you start asking questions. That way, they're not necessarily surprised because this can get very specific. That's what I appreciate about it because that way it's minimal room for not including a substance that they may be using.

Diana:

What you want to do is introduce the screening, just reiterate their confidentiality. Define what the substances are. There are certainly in your area, in your community, the students, or the adolescent that you work with, they might be a prevalence of certain substances use more in your community than other areas.

Diana:

I present here on vaping, I present on alcohol, but maybe methamphetamine is the biggest or more common challenge within the youth community within your area than these other substances I presented. Understand and be aware of what it is that's more commonly presenting in your area with your student body or with your youth cohort.

Diana:

The references should be more relatable that way. Ask permission, ask the questions, and always use exact wording. The way it works, if any yes responses for the questions, if there are any yeses for these questions here, if there's any affirmative answer at all, you want to ask the other ones.

Diana:

If all of them, if one through four is zero and you put zero, if there's a no answer, but they have ridden in a car driven by someone, you want to ask the following questions. The other questions and that's where the acronym comes from. Do you ever use alcohol or drugs to relax or feel better by yourself or fit in?

Diana:

This sounds very much what a lot of the teenagers have told us over the years. Do you ever use alcohol or drugs while you are by yourself or alone? That's something the research has shown that lot of kids do not necessarily use with other peers, but they do use by themselves. Do you forget things while using alcohol or drugs?

Diana:

Do your family or friends ever tell you that you should cut down on your drinking or drug use? Have you ever gotten into trouble while you were using alcohol or drugs? All of these type of questions come from the different research over the years that have presented these to be main concerns and main issues that have come up with adolescents during their at risk substance use.

Diana:

A score from zero to one can indicate that there are no problems, a score two or more can indicate that more significant problem may exist, and a brief intervention be warranted. Two plus is a cut up score, but it's not a hard and fast rule. You want to understand that they're using prescription medications, what they're using, and more specifically based on the screening tool.

Diana:

When you do a brief intervention, you have to have a reason to do it. The score for a screening tool is what justifies it. This is from Michigan. This is not as clear as I thought it would be. They have the whole screening tool on the left hand side, it walks you through the steps.

Diana:

It gives you an idea of what the brief intervention should look like. Then breaks down the processes, what the different parts of it are, and what question you want to ask. Let me see, I'm going to stop sharing. I need two volunteers to read, two.

Diana:

Great. Thank you, Meredith and Savannah. If you ever go to a training with me in person, one of the things that I do is that everybody who sits in the back, you know how a class everybody feels in the back first, I don't usually pick on people in the front. I go all the way to the back and I pick them.

Diana:

Conceptually, what that means is that if you raise your hand here, I can call your name out here. I probably should have told you that in the beginning. I have two case studies. Meredith, I want you please read the first one and then Savannah, you can do the second. Then we'll figure out what we going to do. Thanks. There you go.

Meredith:

Elaine is a 14-year-old girl presented for an annual physical examination required for participation in her school's fall sports program. She completed the paper CRAFFT screening questionnaire. She answered "No" to all three opening questions and no to the car question. Next steps?

Diana:

The CRAFFT tool that I just showed you, remember, he said the first four questions, if there's zero that's great. The last question you ask about the car, if they say positive, we keep asking questions. She said no to everything. What do you do? What might you say to her? What's your next step?

Tamara:

You said if you don't continue that would be it, for one of them anyway.

Diana:

You want to tell her something though. She just took the screener, you want to acknowledge her. You want to say something. What might you do? It's great that she didn't respond affirmatively. That's a good thing. You said about saying certain things and acknowledge certain things. Go ahead, Jill.

Jill:

I might say, "Well, based on the screening, it doesn't look like alcohol or drugs have had much of an impact on your life, but is there anything that you want to share with me that isn't one of these question?"

Diana:

That's great. At least you acknowledge that she's not using any substances, which is really important. That can be very validating. That's great. Thank you, Jill. I had something very similar. "It's great that you're avoiding tobacco, alcohol, and drugs. It's one of the best ways to protect your health. I would kind of followed it up with a reason for you to continue that behavior."

Diana:

Especially, it had to do with her fall sports. She was doing this to make sure that she can participate in the Phys-Ed program. That was helpful. Thank you for that one. Acknowledge and recognize opportunities of strengths. Here's the next one.

Savannah:

Matthew, a 16-year-old boy presented to the nurse office with a minor leg injury resulting from a fall in school. The nurse dressed the cuts and took the opportunity to ask the four CRAFFT II opening questions. Matthew replied yes to the question about drinking alcohol.

Savannah:

The nurse then asked Matthew the six CRAFFT II questions and Matthew answered yes to one question. He had gotten into trouble once while drinking with his friends, trouble. Matthew's total screening score was two. What are the next steps?

Diana:

Here we go. He responded affirmative to two of those questions. Remember what I said about what next steps would be for two or more. What would you do at this point if the screener gives you a positive outcome? One more clue.

Diana:

What are we justified in doing that because the screener has a positive outcome?

Meredith:

A brief intervention.

Diana:

There you go. It was in the course description. Thank you. Ask more information regarding intervention. Very good, that's exactly right. I want to show you a video on how that gets done. The intervention that the other individual did is not the ideal intervention. That's a great example not to follow.

Diana:

I like it because it's brief and it reminds me of what I should you. If I continue to maintain an awareness of myself and how I practice, how to interact with other individuals, I am more likely to see myself coming, especially with an adolescent if I think I want to be directive. If I think I want to be the adult have to be careful about that. Let me come back here.

Narrator:

Is a 16-year-old student who completed a physical checkup at her school-based health center. After the exam, the nurse addressed Natasha's answers on the CRAFFT screening tool.

Nurse:

Is it okay if we go over the form you had filled up? We give this up to everybody who comes in. Here, it looks like you wrote that you drank alcohol on a few occasions in the last year. You had used marijuana more often, 30 days in last year?

Natasha:

Something like that.

Nurse:

When students and I talk about their substance use, the first thing I always say, I don't like to tell anyone what to do, that's not my job. Instead, I like to see if there's anything they would like to do, if anything, about their use. What can you tell me about your marijuana use?

Natasha:

I vape. I have a pen, but I don't smoke it though.

Nurse:

How often?

Natasha:

A few times a month.

Nurse:

Do you vape anything else besides marijuana?

Natasha:

I did a peppermint oil once, someone shared it with me.

Nurse:

Is it okay if I share some information with you?

Natasha:

Mm-hmm (affirmative).

Nurse:

We know marijuana has effects on the developing brain. For example, it can make it harder for you to concentrate. It can make it harder for you to remember things. Vaping can seriously hurt your lungs.

Nurse:

About one in six people who begin using marijuana as a teenager later on become addicted. What do you think about all this information that I've shared?

Natasha:

Well, I don't think it's going to hurt me.

Nurse:

How do you think it affects you?

Natasha:

I don't know. It makes me relax and it's fun to have it with my friend.

Nurse:

Is there anything about marijuana that worries you? Any things that you don't like?

Natasha:

Well, I don't want to get in trouble at school.

Nurse:

How could you get in trouble at school?

Natasha:

Well, I can get suspended and I would get kicked off the basketball team.

Nurse:

Staying in school and playing on the basketball team is important to you?

Natasha:

Right.

Nurse:

When you think about these things, are there any things you would like to change about your marijuana use?

Natasha:

Well, I was thinking to not use when basketball season start.

Nurse:

What would be the benefits of that?

Natasha:

Well, I play better when I'm not high.

Nurse:

A marijuana affects how well you play. What would be the benefits for you?

Natasha:

Well, I wouldn't get caught with using a pen so I wouldn't get kicked off the basketball team.

Nurse:

It sounds like you have a goal of not using marijuana once basketball starts. How long do you think you could not use?

Natasha:

For about a month.

Nurse:

If I asked you to pick a number zero through 10, zero meaning you're not very confident at all meeting at your goal or 10 meaning you're very confident, what number would you pick?

Natasha:

Seven.

Nurse:

A seven. Why do you think you pick that instead of a lower number like five?

Natasha:

Well, I'm pretty sure I can stop using for a month. I want to play well.

Nurse:

What steps could you take to help you stop using for a month?

Natasha:

I don't know.

Nurse:

How about this question, what might happen within a month that might make you want to vape?

Natasha:

Well, if I'm stressed or unhappy, that's when I usually want to vape.

Nurse:

What else could you do instead of vaping when you feel that way?

Natasha:

I like to play video games.

Nurse:

Anything else?

Natasha:

I can play basketball with my friends here.

Nurse:

Playing basketball and playing video games are a way to feel better. Well, I'm glad to hear that you have a goal of quitting for a month, and you are confident of reaching that goal. If you're willing to come back in a month or so, I would be curious to hear how your plan works out.

Nurse:

Well, good luck with basketball practice. If you want anything or need to talk about something before our next appointment, I'm here Monday through Thursday. It's always good to see you.

Diana:

What do we think about this video, in this interaction?

Tamara:

She was very positive.

Diana:

She was positive. Are you familiar with some of the skills that she used?

Participant 6:

Motivational interviewing.

Diana:

Motivational interviewing. More specific, let's break it down. What did you see?

Robin:

Reflecting on the question.

Diana:

She reflected, that's right. What else did you see? What did you hear about it?

Meredith:

I like the fact that she asked, can I ask you a question and can I ask you how long? Everything was, "Can I ask you a question? Can I ask you that?" I thought that was a very good approach.

Tamara:

Open-ended questions also.

Diana:

The am I approach of asking permission is such an essential part of inviting the other person in a conversation as opposed to what a lot of people used to being talked to, and providers be more directive. What is especially helpful with adolescences when you're asking permission is it's very rare when anyone asks them permission for anything.

Diana:

Most times if it's adults around their life, they're probably telling them something or directing them somewhere. Imagine just how essential, how effective that can be, once you've already initiated rapport, to continue to build on that report. Then I heard someone say open-ended questions. What else did we hear?

Meredith:

I liked how she shared power and said, "I'm here if you want to talk some more. Here are some resources and whatever you want, I'm here to be your ally." Instead of saying, "I'm here as a provider for you as part of the school system." I thought that was really inviting.

Diana:

I like that, that's true. She was trying to make sure that she was available and it was up to the student to connect with her. Anything else?

Participant 6:

I like how she rephrased the question about she asked her what was the problem. Helping her reach her goal at basketball, and she didn't have an answer. Then she rephrased it. I forgot what she said. What would help you with the season or something? It was almost what would cause you to use on a basketball season?

Diana:

What might make you go back to vaping?

Participant 6:

That was skill how she did that.

Diana:

I agree. That's one of my favorite things about this video of her skills, how she changed that around. That's not surprising when you ask someone, "What do you think you can do?" I'm not sure. I don't know. That could be for anybody.

Diana:

Especially for the tool, an adolescent. Changing it around was really well done. Meredith, what were you going to add?

Tamara:

I was just going to say, I like how she elicited how likely are you to reach your goal? She said, "You're a seven, which is great." She acknowledged that, but how could she do that? What will that look like. How she could bring that up. She was getting an idea of really where she was at. I like that.

Diana:

She was using the readiness rule of this. Here's the thing about the readiness rule, a lot of folks, and I think it comes back from being taught the first version of MI. We used to think let's ask someone right away, how ready are you to do this?

Diana:

That can be very off-putting. She was very skillful saying, "How confident do you feel in doing so?" Erica, you have your hand up. What would you like to add? What did you like?

Erica:

Excuse me. I really liked her tone and the way she was able to have a conversation, but I'm not a direct provider and I'm a parent. I really struggle with the balance of how is it not just accepting.

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Speaker 10:

How is it not just accepting that she'll use again in a month? Is there a way to convey... Accept where the teen is at, but still make sure you convey a clear message that any use is harmful?

Diana:

Yes. In the brief intervention dialogue, this information giving that you can, that can help them understand that using has its harmful effects. I will daresay as a parent, right, that using motivational interviewing is being about being present with the other individual, not necessarily directing them to not use. It is an approach that we use in our practices to meet the person where they're at, and to help them think of reasons for their own reasons, their own reasons for why they may want to do something different, address their behavior differently. It doesn't necessarily have a goal that says stop using, but we have opportunities in the dialogue, and that's what the brief interventions mean. I've always instructed it to be more of a conversation than to be an actual clinical intervention the way we typically use the lens that we use in our disciplines is it's a clinical process, it is.

Diana:

But to put it in people terms, it's actually just a conversation, and really what it is, is the goal is not necessarily for abstinence, but how you engage someone, is more likely to motivate them to not necessarily do this again, or not to start to reduce that behavior. That's the idea, we want to reduce consumption. With adolescents, we have the opportunity to let them know, Hey, this is what happens. So we don't encourage anyone to use or anything, but this is part of the reason why, what do you think you could do? What do you think about that information? So, there's different ways of being able to convey that, but it's more of a person-centered process, where it's up to the individual.

Speaker 10:

Okay, so [crosstalk 01:26:09]. So there's no risk of a student leaving a brief intervention or motivational interview feeling like, oh, the school nurse thinks it's great if I stop using during basketball and then I can start using again in the spring, because that's my goal. And she didn't share any concern about that plan?

Diana:

Well, you know what the thing is, is that successes are in increments, when it comes to MI, and it's an opportunity. And remember what she did at the end, she wanted to see her again. And so what she has the opportunity to do is, build on this rapport and this dialogue that she already have, she's already succeeded in meeting her where she's at, and the student already decided that she's going to stop using for a little while. That is a success. When she comes back to see her again, she could also come back and also she can also include information about the benefits to help motivate her, to keep not using again. So it's done from a different trajectory, with a different process in mind. It does not necessarily have the end goal of being abstinent, but that's definitely what in schools that we're supposed to be doing with, especially with people, kids under 18, but it's all in the [inaudible 01:27:32] how we give the information.

Diana:

So, if we tell someone... and I, Angela, I see your hand up, I'll call you in a second. Here's the thing, if we tell an adolescent, right, "Don't use, it's not good for you. We need you to stop using." If we give them a conclusive... Give all the information that supports why we are saying you shouldn't use, it's not as effective as when we use motivational interviewing to help reduce their concern, help them consider their own reasons for them stop. They may want to slow down. They may want to stop. But what we want to do in motivational interviewing, to use a screener, to use that dialogue, what we want to do is meet them where they're at. Cause we have a better chance of building that rapport and continuing the conversation. And that might end up with that, them actually not using at all. I hope that helps a little bit.

Speaker 10:

Yeah. It does help, I guess from the nonclinical perspective, because in prevention, clear messages are what's effective. So I'm still a little torn, a potential mixed message, if you're not. So you don't have to tell the adolescent not to use, but I would think it would be important for them to understand that that's what the clear goal is for their optimal health, and not perceive a mixed acceptance of their use. You still accept them, but you want to be clear that you're not... That any substance use is harmful for their health.

Diana:

You can include that in the information. You can include that in the dialogue, but you still want to meet the person where they're at, because you don't want to be directive in terms of saying you should not use, right? Once you get to be directive like that, you can lose the rapport that you have and the opportunity to continue the conversation, to help them to get to that point. So that's the thing about the screening and the intervention. The intervention is for reducing. Now, if there's someone who is using at a point where the screener shows that they are likely to have a disorder, then that's another conversation that gets more specific, right. And that has other details. I understand what you're saying. And I know it seems contradictive, but actually what the provider was doing, what the... I think she was a nurse, what she was doing, was giving her the information so she can come up with her own reasons to stop. And she did. She stopped. She decided she committed to stop using for a month. More can be built upon that, on the next visit. Yeah. Angela?

Angela:

And I want to add, because I am a big fan of motivational interviewing, I come from a domestic violence intervention background, so it's just as precarious. And I, for me, have always looked at it as every time I interact someone, I plant the seed, but I can never force someone to be who they aren't. But if I nurture that repertoire and I become a resource of support, I'll be there to keep building on that, to make those healthy changes. And it's in that relationship building that I'm able to find the motives that this person is using the substance to... What they're using the substance for, without having to necessarily have that direct connection, but being able to see, so this is the need that's not being met. And look here, let me provide you with alternatives, so that eventually the person for themselves decides, I don't want to use, because I believe it, versus, well, my experience has been with some of these other approaches where, because I'm the grownup, that's the reason, because I said so.

Angela:

And I think that, for me, was a learning process and it has continued to evolve. I feel that people don't really get honest about their use and their relationships, when you first meet them. But if you build that relationship over time, they will tell you anything, because they believe that you are really on their side and that we're complex people and different power dynamics really impact our willingness to look at ourselves and be willing to want change something about ourselves. So I really just wanted to throw my two cents in because I think that that interview in the nurse's office really is just a very small point of the stages of change model that it seemed to me that the nurse was working towards. And that was just the first intervention, and not the only one. And I feel like I wanted to highlight that this is all part of that, the stages of change modality of intervention.

Diana:

That's why MIS stages of changes connects so well. And they were developed very coherently. So thank you for that, Angela. And just to be clear, in the video, at no point did she acknowledge and agree with any kind of use of students. She never said it was a good thing. She did come up with reasons and acknowledged her strengths, in her own, and the student's own ideas of wanting to change her behavior, which at no point did the adult do that. So, Lori, go ahead. Thank you. Thanks, Angela.

Laura:

Oh, thank you. What we're discussing about?

Diana:

Okay. Go ahead, Laura.

Laura:

Did I skip over someone?

Diana:

No, it's okay.

Laura:

Okay. Well, what we're discussing about the nurse possibly thinking in the back of her mind, that she would love for the student to abstain altogether, but meets her where she's at, with the agreeing to stop for a month. And the nurse's attitude is, I'll take that and build on it later, as you say. It's not that far removed from the approach in the 12-step programs where they talk about don't drink or use just for today, or one day at a time.

Laura:

What they call a newcomer, who's new to the 12-step program comes in, somebody who's possibly been drinking or using for of decades every day, is not going to relate to the veteran who's sitting next to them, who has like 15 years of sobriety. They're going to relate to the person who has been able to put together five days of sobriety, and they can handle the advice to try not to drink for today, because to them, that's doable, maybe I can do that. Can I stop drinking for a year? I doubt it right now, but I could try to not drink for today. So I just see that parallel bit.

Speaker 10:

Yeah. I disagree with that though, 'cause the 12-step is very clear that you're going to a 12-step meeting. The ultimate goal is sobriety. You take it one day at a time, and you may relapse, and you're going to be around other people, but you know what the goal is when you show up. My concern with this interaction was, to me, it was not a clear goal of no use during adolescence, with brain development and all the harms and risks that are involved.

Diana:

With this one, the idea was to meet her where she was at, using this strategy. And with that, that can revolve that much more. And the idea is, yeah... So what the research has shown, is when you are directive with an adolescent, with an adult who uses or misuses, or at that level of at-risk use, not even at a disorder, at an at-risk at risk level, where a lot of consequences have yet to happen. Not many things have happened to make you want to need to acknowledge that you have a problem or anything, as what the research has shown is that meeting a person where they're at, is more effective than them committing to change, as opposed to a provider directing them. And that's where we've seen the research being more effective, and that's why the strategy has been supported for the last many years.

Diana:

We've been talking about this and, and instructing on this because of that, because you will have more people who will be able to at least stop for now, and may consider benefits while the experience of stopping, what that does for them and how you can build on that, as opposed to telling them, "You got to stop right now. This is not good for you, cause it's going to be a problem. You might end up with disorder later." And a lot of times, especially with this community, with this youth cohort, we kind of tend to think like, oh, that's not ever going to happen. You know? So it's really about what the approaches are the most effective for these folks. And that's what the research have been showing so far. Thank you, Laura. Lori?

Lori:

Okay. So my concern was, basketball season lasts more than a month and I think the nurse is the one that suggested a month and not the... She asked the kid if that's possible for her. But I think if she would've said, during the basketball season, because that was her biggest issue, she didn't want to be kicked off the team or anything like that. So during that basketball season, would've been a better, to me, a better timeframe for her abstinence.

Diana:

That's true. She could have said the season instead, she could have suggested the season and then asked her, and said, "What do you think you can do?" That's true. Just the same way like, and again, I'm still hearing Erica, and it's just the same way, like we could say... When we say what we know that it impacts your memory and it's hard to remember things, and you know what? We always encourage folks to not use at all. What do you think you can do? And you can do that. You can do that, but it's still always about bringing it back to the person, and so that was just an idea of how it can go as opposed to what we first heard and what the directive approach does. When you can consider this approach and the first video that you saw, it's kind of obvious that the one you might want to consider is the second one. Cause then you have someone who is committed to doing something different from their own relationship, from their own reasoning. And not because you told them. How important is that with an adolescent?Go ahead, Joan.

Joan:

So I would do this with one of my students. And the reason is that the student chose the month timeframe. And so I would, like she said, check in, actually I would check in to support them during the month, but after the month I would say, "Wow, you made it a month. And basketball season is still going. What are the positive effects that you've gained in that month? What do you think about extending it another month?" Or asking, "Do you think you can go longer? How much longer?" I mean, I think that's where she's going with this. Yeah.

Diana:

That's exactly what she was going with that. That's what I meant by building on this opportunity. Remember what she said at the end, she says, "And hopefully I, if you don't mind, maybe I can see you again." And the girl was nodding yes. So if we worked that out to consider this a real situation, and when she started, she says, "I don't tell, I don't tell adolescents, I don't tell my students what to do." That was the first point that she made. And as she continued, she was working with what she, what the student would say. And at the end she says, "Listen, that sounds great. It sounds like you're committed to doing certain things. It'd be great if we could talk about this, if I could check in with you within a month." Girl nodded yes.

Diana:

There's more opportunity. Change doesn't happen overnight. Nobody is a light switch, but over time, I bet you that experience for that young woman can be that she has more reasons to come back and talk about it and say, "It was really good doing it this way. No, I really like how I'm feeling." And maybe she found, and the clinician also had a way of helping her understand how to cope with stressors in a healthy manner. There are other things, it's not just substance use, it's learning coping skills, healthy coping skills, right? So there's a couple of different things here that when we look at it really closely there's opportunities. If you were to use this dialogue, if you were to facilitate the dialogue, you might have certain specific words or certain messages you want to convey, but you can still use this process and be person centered, meet the student at a lesson where they're at, still convey your message and give a... And the information was given in very simple, simple dialogue.

Diana:

It was easily understood, even when she gave her that statistic. And it was very relevant to the youth cohort. So all of that has so much potential. This is really a matter of being mindful. And this is where we encourage you go to a complete SBIRT training or take the MI training with SBIRT. We take our time to actually practice this and just using your own style, using these words, and these sentences, and the open ended questions and the core skills of open ended questions around affirmation, reflective listening, and summarizing, the way this lady did, in the video, to use that more naturally and more comfortably.

Diana:

I tend to encourage participants, and before I even come back and check in with them, when I'm working with organizations, I ask them, use these core skills with your family members. They don't have to know that you're practicing anything, but try it, have conversations this way. And so see how it can mitigate certain barriers that might come up, certain... Maybe sometimes... I don't like to use the word resistant, but sometimes folks are reluctant to consider change, when you tell them. But when you put it within the context of what benefits them, and they're the ones who are coming up with the reasons, then we see the efficacy of MI coming together. Go ahead, Mary-Beth.

Mary-Beth:

I was going to say too, I think it's just important to remember that our adolescents and on all patients or people that we work with, they're really the SBIRTs on themselves, right. And, we're sort of, we have some SBIRT as well, and we're trying to guide, but they're they're the SBIRTs. They're going to give us information and we're going to sort of collect it and help them get through that barrier to the change. I just think that, coming from that strength base, we want the change to come from them, not be forced upon, just like you were saying.

Diana:

Yeah, there's a lot more, you get more successful outcomes when the commitment is self.... it comes from the individual, and that's what MI does. And I agree with you, Erica. And that's why I was saying, it's like, yes, when you give information, you can say, "The ultimate best situation is if not to use at all, so you don't get impacted at all. What do you think you can do to help yourself?" You can still include that in the message, you can try it out and see how that works for you. As long as you are using an approach that is meeting the person where they're at, and they're coming up with their own reasons, and the strategies that you use, and the listening information is working and building on the comments that they're telling you, that's the key. That's the key.

Diana:

So let me go to my slides. This has been a great discussion, wish this was a full SBIRT training. This is a slightly blurry, but I am going to give you something in the chat box before we close out, so you can consider just for reference. The brief intervention, the dialogue is, review whatever the screening tools and ask the score, and ask them to tell you a little bit more about the substance use. Very similar to what the video showed. There are a ton of different videos you can reflect back that might be, and you can choose which one is more conducive for you. Recommend not to use, "As your doctor, my recommendation is not to use any alcohol, marijuana, or other drug use, because they can harm your brain, interfere anything." And what you were saying before, Erica, is included here.

Diana:

That's why I do agree with it. But the opportunity here is to make sure that there's still a recommendation. What do you think you can do? So, riding and driving this counseling motor vehicle crashes are the leading causes. You know, part of this brief intervention dialogue, this conversation is, when you elicit information [inaudible 01:44:32] permission to, if you could give them information. When you're giving them information and you're giving your recommendation, you can say that vehicle crashes are leading causes of death for young people. And so not only to scare you, but there are a lot of times where folks get into cars and even if they're not using their, they get into a car with someone else who's driving and under the influence.

Diana:

And so give them small bits of information for them to consider and ponder, ask them what they think about it, and get it back. So response, reinforce, "I believe you have what it takes to keep alcohol and drugs from getting in the way of achieving your goals." Always connecting it back to what is important to that young person. So react is an acronym for reinforce, educate, anticipate challenges of tomorrow. So this is an approach that is also included in SBIRT Dialogue's three step responses. Students who have not used substance in 12 months. It's the most frequent conversation you'll have in the SBIRT process. It's meant to reinforce healthy decisions to prevent or delay of use. And we talked about the OARS, we saw it in effect. So asking open-ended questions is what it does. It invites the other person to participate in the conversation, which is especially important for adolescents who usually are not speaking too much in conversations. They usually have to hear a lot from the other person.

Diana:

And so questions are phrased to encourage adolescents to explore and share their feelings and their perspectives and support collaboration. And so here are a few examples where I want to come in here, affirming adolescence, focus on their strengths. I've noticed that you're really good at identifying strategies, which help you reduce stress. And so that kind of brings back to what Anthony was saying about acknowledging strengths, encourage the adolescent's persistence, in spite of past problems. Like, "You did a great job dealing with pressure from your friends to drink, when you made a commitment to cut back." Or make encouraging statements and elicit positive responses like, "You're making great progress. Tell me how you feel in comparison to two weeks ago." And so, because behavior change is a process, behavior change has different cases depending on the individual and their motivation and their commitment to their own change for their own benefits.

Diana:

It does not happen overnight. So it's important that you situate yourself as an ally, and so acknowledge the positive. "It seems that to me, that school is getting better for you. You're getting to school on time. You're no longer getting to trouble for being late. That must really feel good." This may be very similar to something that that lady might say to... That clinician might say to that student when she comes back in a month. So celebrates the steps taken so far, "You doing it really great. You have come in three weeks so far." Think about things that you can say. "I know this appears very difficult to overcome, but you've been able to do it before. So celebrate the past successes. Thank you for taking a few minutes to talk to me about your alcohol and marijuana. I appreciate your openness and sharing your experiences and thoughts with me today." And, compliment the willingness.

Diana:

It's always about acknowledging and validating, celebrate the adolescent as a person. "You're a kind and warm person, and I can see how this problem affects you. It's important that an adolescent have not just their peers to go to for information and support. And if they're in that developmental place where the parents are not as... They're not as close to the parents that it used to be, for whatever the reason, it could be 100 different reasons. And peers seem to be the most important people in their life, being the adult, that based on where that at, hears their voice, can be helpful in so many different ways, and not just for substance use. So reflective listening is how you elicit information from the individual, and have them do most of the talking. And so summarizing the team's thoughts, things like you might conclude a summary saying, so what else? Did I miss anything? You're inviting them to elaborate, instead of using like directive or straight comments where you only, or close ended questions where you get a yes or no response.

Diana:

And so that's not what we want to do. We want to have the conversation work, the more of the conversation we can have, the more we are initiating OAR in a relationship with the individual. And that's important because we want to come back. We want to meet with them again, check in on their progress, but also continue the conversation. Everything doesn't have to get done right now. And so reinforce resilience and resources. And at the end of the brief intervention, do that, and... Let's see, and remind the adolescent of the resources they have available on making this change. Not only the things that the young girl had said that she could do, but you know, the clinician could have also added, "If you wanted to, I also have some other things. We have some support groups here that we do sometimes. There are some support systems that you can see, you can access on social media."

Diana:

There are different... Know what your resources are. You can also offer them as well. So they may include further assessment, intensive substance use treatment. So if the person has a high screening score, by that time, most times when a person already is showing they have a high screening score, they're likely to have a probable substance use disorder. We don't tell them that they have a substance use disorder, that they need treatment, but that they will benefit from further assessment. And this is all contingent upon a a positive atmosphere in that dialogue conversation you have. What happens is a lot of folks are already at that level, that severity of substance use, where they meet the criteria. There's a lot of different, negative consequential things that are going on, and they're more likely to be open to, or receptive to getting help.

Diana:

And so, in sense, that might include a referral for further assessment. And we don't say referral to treatment. We say further assessment, because on only a person who's credentialed to do that assessment, which would be a person [inaudible 01:50:32] like in New York city, or a certified credentialed alcohol or addiction professional in any other state would be the ones to be able to do that. So we're very specific with that one. I'm a stickler for the words we use. Cause it's, we want to keep people engaged. And so, as a practitioner become familiar with the type of resources you can discuss and focus on the adolescent's strengths for making the change. How often do they talk about their strengths with an adult?

Diana:

And I have some resources here for you. I have a slide on that, and I have a pocket card, and I'm going to show you very quickly that as we go into the last slide that has the link and the code that you can scan, but this process can work for everyone here on this platform, absolutely everyone. You've just got to practice a little bit. I encourage you, practice just the OARS alone, practice it within your social circle or within your family members. You would be surprised how the conversations will go, if you were to do it that way. And so feel comfortable doing it like that, so you can do that with adolescents too. Any questions?

Diana:

All right, then. So as promised, thank you all for being here, thanks everyone for your participation. And I hope to see you again.

PART 4 OF 4 ENDS [01:51:50]