

Yolo County Youth Substance Abuse Summit
“Leveraging Our Community for Drug-Free Youth”
September 19/20 2008

FINAL REPORT



Funded by the Sierra Health Foundation



SIERRA HEALTH FOUNDATION
An Endowment for Northern California

Yolo County Youth Substance Abuse Summit
“Leveraging Our Community for Drug-Free Youth”
September 19/20 2008

“Problems that Keep Us Stuck”

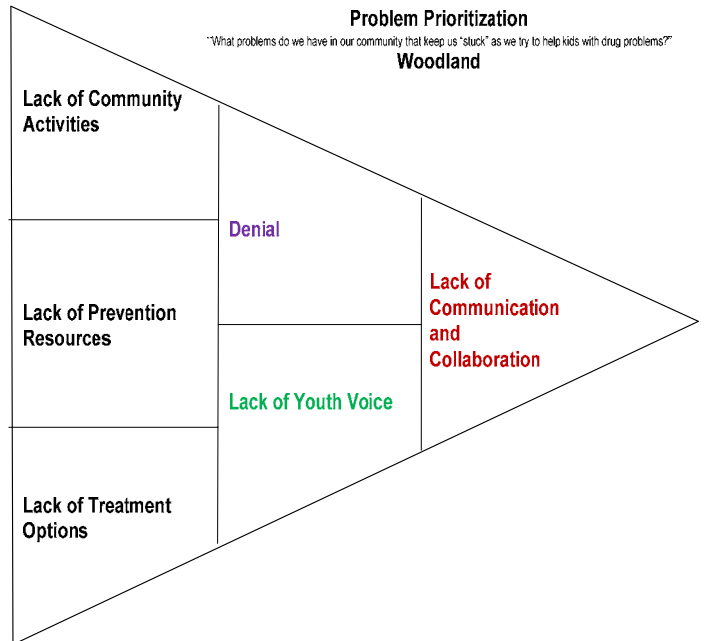
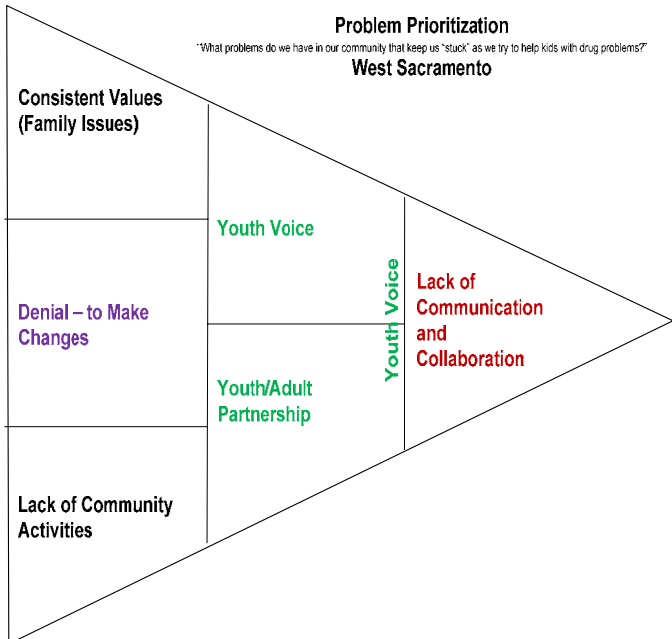
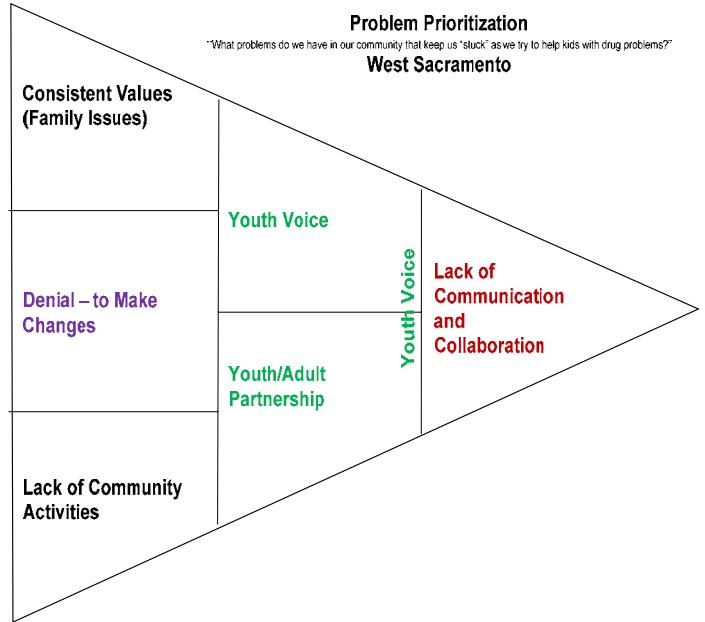
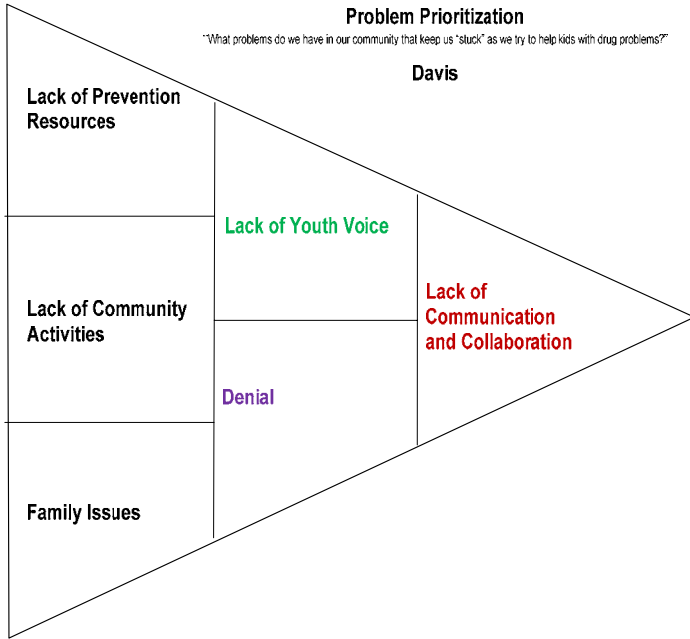


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EXECUTIVE SUMMARY

Substance abuse has been endemic in the American population for a generation and touches every aspect of life. There is no more tragic face of this epidemic than the wave of alcohol and drug use by adolescents. In 2008 in Yolo County, a team of community leaders from medicine, human services, law enforcement, education and local government, convened to raise awareness and understanding of the issue and to create a unified community-based response to the problem.

With funding from the Sierra Health Foundation, this team of leaders planned and implemented a three day event to educate people and stimulate action.

The event began with a half-day training for medical providers to impart the skills and knowledge they need to diagnose and treat adolescent patients who are involved with substances.

That session was followed by a day and half workshop for other community leaders to develop specific plans in each community to reverse the alarming trend we now see in our communities.

More than 90 leaders from diverse fields and from the communities of Davis, Woodland, West Sacramento and Winters were invited to *Yolo County Youth Substance Abuse Summit- "Leveraging Our Community for Drug-Free Youth"* on September 19 and 20 2008 where they heard presentations and worked in cross-disciplinary community teams to identify the key problems in their communities and action plans for addressing them. There was a parallel session for county agency leaders to develop plans in support of community efforts.

The four communities identified several key problems that are responsible for keeping youth substance in place in Yolo County. Foremost among these problems are:

1. Lack of Coordination and Collaboration;
2. Denial; and,
3. Lack of Youth Voice and Participation

Having identified the three key issues, each community developed specific action plans for crafting unique solutions and set follow-up agendas to begin implementing those solutions.

In a parallel process, county level leaders including member of the Yolo County Board of Supervisors and county department heads established plans for supporting community level action. Summit participants established measures to ensure continued follow-up in their communities and government leaders agreed to track and report on progress.

This report contains a full description of the two events each group's findings and plans which are now being implemented in each community.

BACKGROUND

Adolescent alcohol and other drug abuse impacts every aspect our community including education, health, public safety, and development of healthy adults. A sizeable body of research and a generation of practical experience have shown that effective responses to adolescent substance abuse must be multi-disciplinary and community based. In recognition of this fact, a Yolo County planning team formed in early 2008 to design a summit where Yolo County's leaders could learn about adolescent substance abuse issues confronting their community and plan ways to address those problems.

With a \$20,000 grant from the Sierra Health Foundation, the planning team, including local government, health care, education, law enforcement and substance abuse treatment and prevention planned and produced the summit described in this report.

The planning team's preparations included developing a list of key invitees from the Yolo County communities of Davis, Woodland, West Sacramento and Winters; assembling a collection of written materials that highlight key themes and basic information; and designing a workshop to inform participants about the problems and give them a framework to plan community-based activities targeted to each community's unique needs.

PROGRAM SUMMARY

The summit was actually two events. On Thursday September 18, Dr. Michael Wilkes, Vice Dean of Medical Education, at UC Davis Medical School and Dr Martin Anderson, Director of Adolescent Medicine at UCLA Department of Pediatrics, convened a workshop to train primary care providers (physicians, nurse practitioners, and social workers) in methods to identify and treat substance abuse including issues related to confidentiality, denial, and family conflict.

A survey by the National Center on Addiction and Substance Abuse found that 94% of primary care physicians may be missing or misdiagnosing alcohol-abusing patients. The study found that less than 20% of physicians felt that they were "very prepared" to deal with alcoholism or illegal drug use and only 3.6% thought that medical treatment was effective for alcohol dependence and 2.1% for substance misuse. Despite these beliefs, other research indicates that physicians can play a positive role in influencing patients' health decisions about substance abuse.

The provider's workshop had the dual purpose of teaching the knowledge and skills necessary to present a diagnosis and develop an initial management plan for teens with substance abuse problems and to help participants develop strategies for addressing parental concerns about drug use.

Participants were given pertinent reading material prior to the session. Once the session convened, the instructors used a combination of didactic presentation, role plays and small group discussion to achieve the course objectives. A total of 22 primary care providers participated in the four and one-half hour session. The complete course curriculum is in Appendix 1.

The second event was a cross-disciplinary meeting of community leaders from throughout Yolo County. A total of 94 people attended one or both days of the program. They had been selected by the planning committee and represented the five largest cities in the county and a variety of disciplines including health, education, law enforcement and local government. In addition there was also a team of high level county government officials including two county supervisors and county department heads and deputies. The participant roster is in Appendix 2

The meeting convened in the evening of Friday September 19. Each participant was given a resource binder including key data about youth substance abuse and resource materials concerning the topic. A summary of the data is in Appendix 3.

The plenary meeting room, a junior high school multi-purpose room was arranged with dining tables and participants were asked to sit with members of their same community for all meals and plenary meetings. Participant's name tags were color coded by community and as an initial ice-breaker each participant was invited to meet someone from their community and to review and discuss data about youth substance abuse that was on posters scattered around the room.

Keynote speaker, Randy Snowden, Director of Napa County Health and Human services who inspired participants with stories illustrating how other communities have made real differences in addressing substance abuse. The full text of Mr. Snowden's remarks is in Appendix 5. Participants were moved by an essay written by a young man in recovery. On Day 2 actors read two additional essays as well. All three essays are in Appendix 4.

The day-long program on Saturday September 20 was a mix of large group presentations and discussion interspersed with community break out sessions. The day began with a second speaker, Dr. Martin Anderson who talked about adolescent development and the impact of substance abuse. A summary of Dr. Anderson's remarks and his slides are also in Appendix 5.

Following Dr. Anderson's presentation, participants moved into community meetings where each team prioritized the problems facing their community and summarized currently available assets to help address the problems (see Appendix 7).

The groups described their findings from the morning session to one another in a plenary session which was followed by lunch. During lunch Dr. Michael Wilkes, an adolescent medicine specialist facilitated a group discussion of several realistic vignettes describing youth substance abuse issues. The large group discussed each issue offering suggestions on how they might be addressed. A multi-disciplinary expert panel responded to the suggestions. All of the vignettes are in Appendix 5.

In the afternoon participants again moved into their community teams to develop action plans to address the highest priority problems during the next year. The day concluded with large group presentations of each plan and comments by a panel of community leaders and expressions of commitment to support the community plans.

The specific sessions in each day are described in the following section and the complete summit agenda is in Appendix 6.

COMMUNITY PLANNING SESSIONS

Introduction

The planning sessions followed a four step process:

1. **Build Community Teams:** The entire summit was built around the idea of creating multi-disciplinary teams in each community. Team building began with the invitation process which carefully selected leaders from targeted fields that have direct roles in addressing substance abuse. On the first evening participants were seated by community where they worked as teams to respond to the question. *"What problems do we have in our community that keep us 'stuck' as we try to help kids with drug problems?"* The data they generated in this exercise was used in the second step.
2. **Identify and Prioritize Problems:** While the many faces of adolescent substance abuse are easily recognized (e.g. school failure, teen pregnancy, violence, family dysfunction, criminal involvement) underlying issues which inhibit effective action are complex and often obscure. To help participants get to the root issues, the summit used a structured process to identify and prioritize the most critical problems. The process began on the first evening with each community team generating data. The brainstorm yielded more than 80 ideas which the

facilitators clustered into 12 categories. In the first breakout session on Day Two each community group prioritized the top six problem areas for their community. Groups were instructed to give priority to the problems which, if addressed, would give the most leverage in trying to address adolescent substance abuse.

3. List Existing Resources: The first step in solving a problem is to understand the resources available. To help create that understanding facilitators led each team through a summary brainstorm of community resources in the categories: Individuals (e.g. youths, parents, elders); Associations (e.g. coalitions, PTAs); Government Institutions (e.g. city or school programs); Places (e.g. parks, teen centers); Organizations (e.g. counseling agencies, faith based communities); and, Other.
4. Create Action Plans and Commit To Achieving Results: The final step was a session where teams identified 6-12 month goals that directly addresses the highest priority problems in the community. The teams also listed action steps, timelines and persons responsible to achieve those goals. Following the planning session, teams reconvened in a plenary session to report their plans. A panel of community leaders reviewed the plans and offered advice and commitments to support the groups in achieving their goals. The panel included:
 - Helen Thomson Yolo County board of Supervisors
 - Mike McGowan, Yolo County Board of Supervisors
 - Dr. Bette Hinton, Yolo County Health Officer
 - Chief Landy Black, Davis Police Department
 - Steven Lawrence, Superintendent, Washington Unified School District
 - Don Meyer, Chief, Yolo County Probation Department
 - Mark Bryan, Deputy Director, Yolo Co. Department of Alcohol, Drug&Mental Health
 - Jonathan Raven, Deputy Chief Assistant Deputy District Attorney, Yolo County
 - Barry Melton, Public Defender, Yolo County
 - Robin Affrime, CEO, Communicare Health Centers

In the final step, individual participants, agency representatives and panel members made specific declarations of support for the plans.

Findings

Identify and Prioritize Problems: The initial brainstorm at dinner of the first night yielded 85 ideas that were ultimately combined into 12 problem categories (See Appendix 7 for full list of all brainstorm items).

1. Lack of Prevention
2. Resources
3. Lack of Treatment Options
4. Gangs
5. Lack of Resources and Money
6. Lack of Communication and Collaboration
7. Denial
8. Family Issues
9. Lack of Youth Voice
10. Lack of Community
11. Activities
12. Society-wide Conflicts

Each of the four community teams prioritized these twelve using a wedge-shaped graphic that had each group place the problem whose solution would give the greatest leverage at the tip of the wedge, the next two highest priority problems in the second tier and the next three priority

problems in the third tier. (See pages following for the four graphics). Lack of Communication and Collaboration was ranked as the highest leverage problem by the Davis, Woodland and West Sacramento groups and was divided into two problems and ranked in the second tier by the combined Yolo County and Winters group. Denial was listed by all three groups and was ranked as highest priority by the Yolo County and Winters groups. The importance of having a Youth Voice in community affairs was also prioritized by three of the four groups.

List Existing Resources: The groups from Davis, Woodland and West Sacramento brainstormed lists of assets in their communities in the categories: Individuals (e.g. youths, parents, elders), Associations (e.g. coalitions, PTAs), Government Institutions (e.g. city or school programs), Places (e.g. parks, teen centers), Organizations (e.g. counseling agencies, faith based communities), and Other. The County and Winters groups did not have time to perform this exercise.

Create Action Plans and Commit To Achieving Results

All five groups met in the afternoon of Day 2 to set goals that address the highest leverage problems identified in the morning sessions. For each goal, the groups identified action steps, deadlines for achieving those steps and persons responsible to ensure that each action step is completed. The goals for each community were:

Yolo County

Goal: Create a coalition

Goal: Data in public domain

Winters

Goal: Create a Youth Health Coalition.

Davis

Goal: Mobilize effective resources to address youth needs.

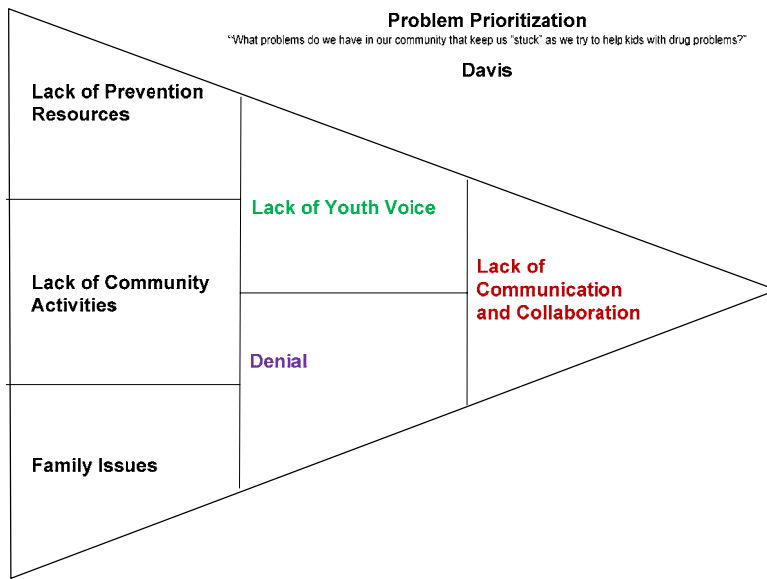
West Sacramento

Goal: Hold a Parents Summit (to pull in the parents and educate them).

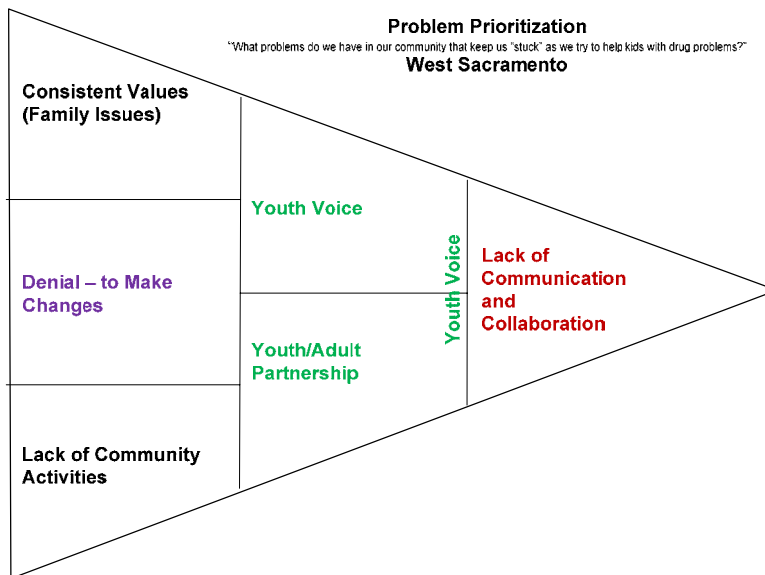
Woodland

Goal: Establish a committee to develop a communication and collaboration plan to address youth substance abuse (focus on underage drinking, strengthen partnerships).

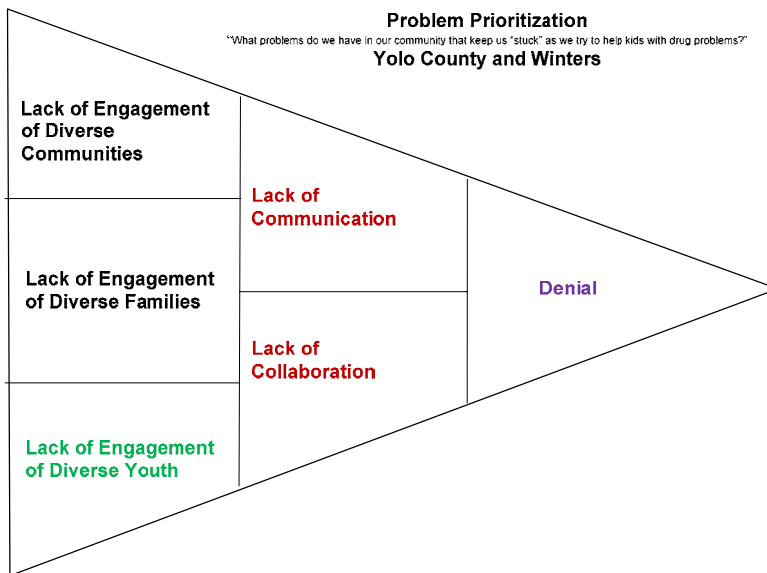
In addition to setting the goals, each group identified specific action steps, timelines and responsibilities and set dates for next meetings. Those specific action plans are shown below.



Leveraging Our Community Implementation Plan				
Community DAVIS		Accomplishment <u>Mobilize Effective Resources To Address Needs Of Youth</u>		
Step	Date	Responsible	Resources	Success Measure
1. Fund and design school resource officer	01/09	Police Department	Youth, Charlotte Campus supervisor, Brian, Finance Dept AP liaison	Resource officer on every campus.
2. Inventory and assess current resources, prevention, treatment, pro-social activities for youth team	09/09	Pam Mari	Providers, youth developers, federal resources include Yolo Link	Creation of a resource guide and training session w/ staff. Make ongoing.
3. Augment task force with business, Yolo link, and service providers and youth organizations	11/09	Elvia	Everyone in room Chamber of commerce Health providers	Representatives of all agencies
4. Conduct need assessment of youth and family		Task force directions resources Steve, Robert	Meeting of school principals, school climate committee	

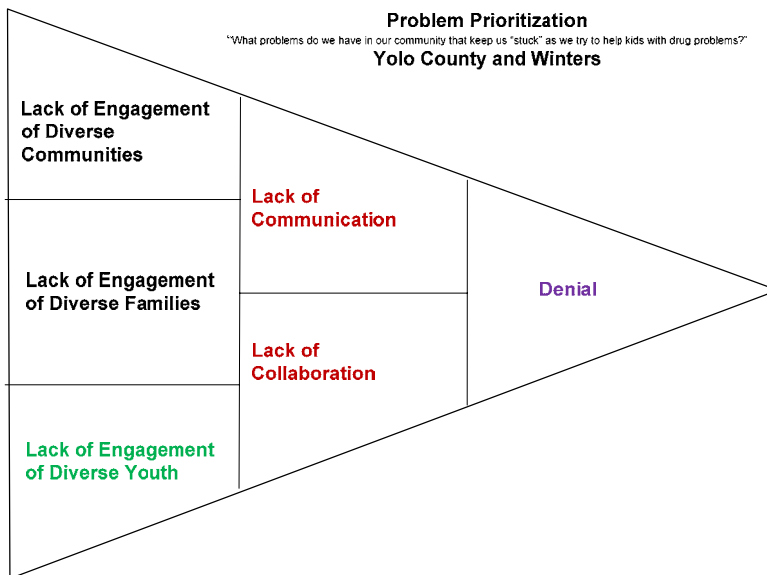


Leveraging Our Community Implementation Plan				
Community WEST SACRAMENTO		Accomplishment: <u>Parent Summit</u>		
Step	Date	Responsible	Resources	Success Measure
1. Create committee meeting	End of Oct	Brandi	Rooms at Park and Rec	Actual meeting is attended
2. Determine relationship with WSYRC	End of Oct	Committee	Place for committee to meet	Figured out relationship
3. Pick place, time and date for Summit	End of Oct	Committee	Asset Community list	
4. Recruit and inform parents	2 mos prior to date of summit	Committee	Asset Community list	
5. Decide content of summit				

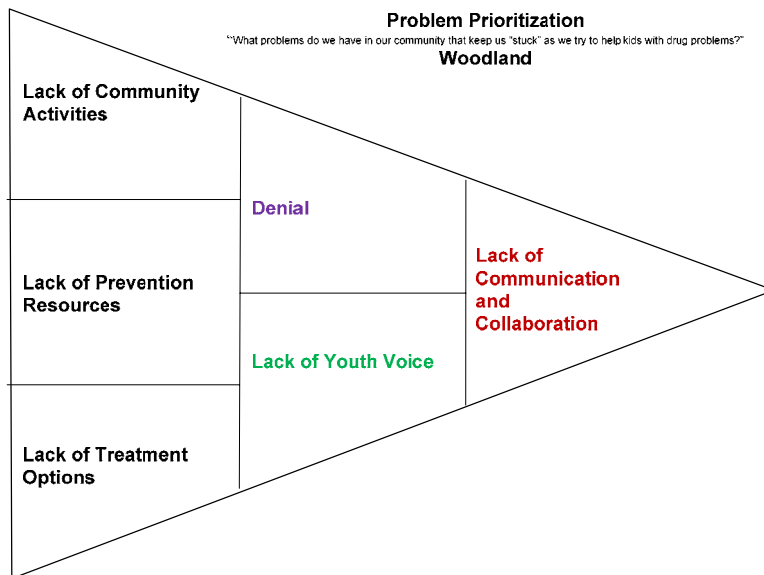


Leveraging Our Community Implementation Plan				
Community YOLO COUNTY		Accomplishment: <u>Data In The Public Domain</u>		
Step	Date	Responsible	Resources	Success Measure
1. Gather relevant available data	08/09	County everybody	Existing Data	Written document/report on data gathered.
2. Assess and synthesize information	11/09	County leads, Mark and Marjorie	Input from partners editing collected data	*Problem statement
3. Identify available resources	08/09	County leads	Input from partners editing collected data	Nov 09 resource guide
4. Public dissemination (Huge public roll-out)	02/10	Boards, city councils, CBOs, Advisory boards, youth groups, other political subdivisions schools churches, health department other		Public engagement

Leveraging Our Community Implementation Plan				
Community YOLO COUNTY		Accomplishment: <u>Creating A Coalition</u>		
Step	Date	Responsible	Resources	Success Measure
1. Define purpose	02/09	Marjorie, Karen	Facilitator, room, snacks	Written purpose statement
2. Identify Partners	Ongoing	All of us	Existing relationships	Engaging and sustaining partners
3. Define information needed	05/09	All of us	Existing relationships	Engaging and sustaining partners
4. Share information with one another.	Ongoing	All of us	Existing relationships	Engaging and sustaining partners



Leveraging Our Community Implementation Plan				
Community WINTERS		Accomplishment: <u>Create A Youth Health Coalition</u>		
Step	Date	Responsible	Resources	Success Measure
1. Expand membership to at least 10 people.	11/1/08			
2. Gather data on youth substance abuse in Winters.	1/15/09			
3. Disseminate data.	4/30/09			



Leveraging Our Community Implementation Plan				
Community <u>Woodland</u>		Accomplishment: <u>Establish a committee to develop a communication plan to address youth substance abuse</u>		
Step	Date	Responsible	Resources	Success Measure
4. Set next meeting date & place	9/20	Linda	Calendars, motivation	Agree to a date <i>Met on 10/13/08</i>
5. Create an agenda	9/23	Linda	Secretary, e-mail input from core group	Typed agenda
6. Invite other community members from summit	9/26	Linda & Jenny	List in binder with e-mails <i>Completed through Collaborative Meeting</i>	E-mail & follow up <i>Core group has been identified</i>
7. Gather/Receive summit notes	9/20	Evelia & Linda	Who & When	Packet of summit outcomes
8. Finding out if there is funding for continuing this effort	9/20	Evelia & Linda	If there is funding from summit	When we get an answer

COMMITMENTS AND FOLLOW-UP

In the final segment of the day, participants spontaneously made commitments to support the action plans that had been developed including the following:

Don Saylor, Mayor Pro Tem, Davis	Will present outcomes from the summit to the other city councils in Yolo County and urge their support.
Marjorie Rist (Probation)	Attend the action plan meetings. Work in every jurisdiction and share those resources. Have a presence with task forces to the extent they are invited.
James Hammond, Superintendent, Davis Joint Unified School District and Landy Black, Davis Chief of Police	Work to make the resource officer vision a reality.
Don Meyer, Chief Probation Officer	Commits to evidence based programs.
Barry Melton, Public Defender	Commit to collaborate and offer resources.
Helen Thomson and Mike McGowan, Yolo County Board of Supervisors	Yolo County Board of Supervisors wants to drive movement, find the problems, come up with solutions, find and fill the gaps and collaborate.
Jonathan Raven, Assistant District Attorney and Don Meyer, Chief Probation Officer	Law enforcement involved in community, move away from the us vs. them image; youth, parent, and schools.

The summit concluded with consensus agreement to follow-up on the implement plans. Each community group identified a coordinator with the responsibility of bringing the group back together at a specified date. The groups will finalize their plans and implement them. Political leaders agreed to monitor the groups and to request reports on progress in order to publicize the efforts and assist with resources and support. The first reports will be made to the Yolo County Health Council and the Davis City Council this fall. In addition Davis Mayor *Pro Tem*, Don Saylor committed to presenting the Summit's findings at each of the other city councils and to solicit their support in monitoring and supporting the planning processes.

With this combination of multi-disciplinary teams and high level support, we are confident that Yolo County will see steady progress to overcome the obstacles we identified at this summit and move the county toward our vision of drug-free youth.

APPENDICES AND RESOURCES

- 1) Provider Curriculum
- 2) Participant Roster
- 3) Key Data
- 4) Teen Essays
- 5) Plenary Presentations
- 6) Summit Agenda
- 7) Summit Findings-Supplemental
 - a) Substance Abuse Problems Brainstorm-With Detail
 - b) Community Assets

Appendix 1
Provider Training Curriculum

FACULTY DEVELOPMENT

And teaching others to care for

**A course to assist primary care providers in caring for ^ teens
and parents around issues of substance abuse**

Developed by :

Michael Wilkes

Martin Anderson

Martin Leamon

Margaret Rea

Sept 2008

Support provided by the Sierra Health Foundation, Yolo Country Health Council and the UC
Davis School of Medicine

Purpose, Goals and Objectives

1. Participants will have the knowledge and skills necessary to present the diagnosis and develop an initial management plan for teens with substance abuse problems.
2. Participants will develop strategies for addressing parental concerns about drug use.

OBJECTIVES

After this workshop, participants will be better able to identify and intervene on behalf of adolescents who are engaged in problematic use of drugs or alcohol, and should be better prepared to:

1. Discuss the epidemiology of adolescent substance use, including trends in the extent of use and common drugs of abuse
2. Recognize the potential consequences of the misuse of alcohol and drugs
3. Describe techniques for interviewing adolescents about their use of alcohol and drugs
4. Discuss screening tests that may be employed in the office setting to identify adolescents at risk
5. Explain the role of laboratory testing in the detection of adolescent substance use
6. Employ brief intervention techniques for teens who are using drugs or alcohol and support continued abstinence for those who are not
7. Recognize and counsel adolescents who require referral
8. Manage parent/child conflicts concerning substance abuse, including requests by parents to have their adolescents' urine tested
9. Understand the six components of a model of intervention.
10. Understand the six stages of a model of change as developed by Prochaska and DiClemente.
11. Understand the role of depression and anxiety as confounders in assessing substance abuse in teens.
12. Understand issues related to confidentiality and the emancipated teen with regard to the family unit
13. Understand the role for motivational interviewing in interacting with teens
14. Use interviewing techniques in a simulated clinical encounter to assess a patient's perception of their problem, stage their readiness to change, and develop a mutually agreed upon plan.
15. Recognize patient defensiveness as an expression of ambivalence and discomfort.
16. Use interviewing skills which will minimize patient defensiveness and promote patient awareness of their substance abuse problem and acceptance of treatment.

METHODS

1. Participants will read pertinent material prior to the session.
2. Participants will review core material in didactic sessions
3. Participants will engage in role plays as both reviewers/observers and players

Prerequisites

- 1) Pre conference worksheet
- 2) **Readings:** Tompson, McNeil, Rea, Asarnow: *Identifying and Testing Adolescent Depression*, West J Med, March 2000;172:172–176 <http://www.ewjm.com/cgj/reprint/172/3/172.pdf>

Course Agenda

4:00 - 4:45 Introductions, overview of evening, group exercise identification of common problems in caring for teens with substance abuse (Wilkes)

4:45 to 5:15 Substance abuse, prevalence and teens (Anderson)

5:15 – 5:30 Review of confidentiality, the emancipated teen, and social change (Wilkes)

5:30 – 6:00 Co-morbidity (depression) Rea

6:00 - 6:45 Dinner and talk on motivational interviewing (Leamon or Anderson)

BREAK UP INTO THREE SMALL GROUPS

7:00 – 7:45 case one

7:45- 8:30 case two

8:30 review of workshop, teaching this material to others, and conclusions.

Course Material

Dealing with Teens (regardless of their problem)

We suggest the following steps when beginning to work with a teen:

Step 1 Set the stage for the encounter

- Welcome the patient.
- Use the patient's name.
- Introduce self and identify specific role.
- Ensure patient readiness and privacy.
- Remove barriers to communication.
- Ensure comfort and put the patient at ease

Step 2 Elicit chief concern and set agenda

- Indicate time available. (e.g. "We've got about 20 minutes together today...")
- Indicate own needs. (e.g. "...and I see that we need to review the blood tests you had done yesterday...")
- Obtain list of all issues patient wants to discuss; specific symptoms, requests, expectations, understanding. (e.g. "...but before we do that, let's get a list of the things you want to discuss today.")
- Summarize and finalize the agenda; negotiate specifics if too many agenda items.

Step 3 Begin the interview with non-focusing skills that help the patient to express her/ himself

- Start with open-ended request/question ("Tell me about your headache.")
- Use nonfocusing open-ended skills (attentive listening): silence, neutral utterances, nonverbal encouragement
- Obtain additional data from nonverbal sources: nonverbal cues, physical characteristics, accoutrements, environment, Self

Step 4 Use focusing skills to learn more about symptoms and their impact on the patient's personal experience and emotions

- Elicit Physical Symptom Story
 - *Obtain a description of symptoms, using open-ended questions*
 - *Echoes (repeat the patient's words, e.g. "Excruciating pain?")*
 - *Summarize ("First you smoked a joint, then two days later your knee began to hurt, and yesterday you began to limp.")*

- *Requests* ("Say more about that.")

- **Elicit Personal Story**

Broader personal/psychosocial context of symptoms, patient beliefs/attributions, again using focusing open-ended skills. (E.g. "How has this affected you?" "What did you think might be going on?")

- **Elicit Emotional Story**

- Ask emotion-seeking questions

direct: "How are you doing with this?" "How does this make you feel?"

indirect: "What has this knee pain been like for your family?" or, "What do think is causing it?"

- Respond with words that empathically address the emotional domain (**NURS**)

Name: "You say being disabled by this knee pain makes you angry."

Understand: "I can understand your feeling this way."

Respect: "This has been a difficult time for you. You show a lot of courage."

Support: "I want to help you to get better."

- Expand the Story

Repeat cycle for each major concern/problem

Remember you are not alone: Extend the system

There will be many occasions when you will want to scream 'Help!' Dealing with complex social and substance abuse problems are as much a reason for seeking help as are technical problems. Help can be obtained by referral but can also be obtained by co assistance. If you see a teen with serious substance abuse problems the help you might seek will include health care colleagues (mental health, social work, etc.) external resources (accommodation, financial assistance), legal advice (what legal obligations are you under to report?), support/advocacy (support groups, legal aid) and more.

The one caveat is to ensure that the patient does not think you're trying to get rid of him or her. Conversely, if you are indeed referring to another doctor or agency for complete management, make sure the patient understands why.

With regard to substance abuse you can significantly reduce problems with substance abuse by conducting brief interventions. We will discuss an approach in detail but it can be summarized in four steps:

Step 1: Ask about substances

Step 2: Acknowledge problem and assess for severity and appropriate action

- Be aware of clues and cues (something is wrong! I wish I wasn't here!),
- Assess for other problems
 - Pause to clarify thoughts – don't just do something – stand there!
 - Use YOUR feelings as diagnostic tool

Step 3: Advise and assist by providing brief intervention to take appropriate action (cut down or quit) and by helping to set goals and obtain further treatment

- Accept the challenge
 - Are you willing to work with this teen?
 - If no, what are your options?
 - If yes, commit orally to working with teen
- Act to build partnership
 - Acknowledge your difficulty and the patient's difficult
- Encourage problem solving
 - *"I'd like to work with you, even though we see some things differently"*
 - *"Can we plan some next steps together?"*

Step 4: Arrange follow up and extended the system:

- What help is needed? (Influence, trust, medications, support, advocacy, expertise (knowledge))
- What are the sources of help? (family, friends, other health care professionals, support groups, teachers, etc.)
- How to extend and get help
 - Inform patient
 - What your responsibilities to patient, to other clinicians, to police, to teachers
 - MAINTAIN CONFIDENTIALITY
 - Referral or collaboration
 - Any reporting requirements (e.g., abuse, neglect, etc.)

Denial and Addiction

The goal of identifying patients with alcohol and drug related problems is to be able to intervene and promote positive changes in the patient's behavior. The issue is more complex with teens where parents play an important role in the patient's life. The process of change is facilitated by the creation of a safe and supportive atmosphere where patients can explore their experiences and problems openly and identify solutions to their problems. In the medical encounter, the physician can create a safe, therapeutic environment by using the techniques of patient-centered medical interviewing and motivational interviewing. These techniques will promote patient self-awareness, an improved sense of self- efficacy and ability to change, and the process of developing successful strategies for change.

Individual physicians will vary in their interest and abilities to work with patients with substance abuse problems. For some, the main goal of intervening will be to promote patient self-awareness and acceptance of a problem, and then to refer the patient to a substance abuse specialist or self-help group. Others may want to gain the skills needed to develop, implement, and monitor treatment strategies with patients. In addition to physician interest, certain patient characteristics will also influence the choice of whether to make early referrals to specialty treatment. Patients with more severe dependency problems, or those who have had several attempts at treatment with continued relapses, are likely to best be served by early referral to specialty care. Patients with mild or moderate problems may be appropriately treated and monitored in primary care settings with or without referral to self- help groups such as Alcoholics Anonymous or Rational Recovery. Patients with mild or moderate problems may not need referral to specialty care. Determine the patient's response to the primary care physician's treatment interventions before referring. In any case, the primary care physician plays an important role in the early identification of all patients with substance problems and in presenting the diagnosis to patients.

The following model can be used to create a positive atmosphere for change and to promote patient self awareness and acceptance of treatment for substance abuse problems.

A SIX COMPONENT INTERVENTION MODEL:

1. Develop a therapeutic relationship.
2. Relate to the patient's primary concern.
3. Focus on the evidence.
4. Avoid negative labels.
5. Assess patient's perception of the problem.
6. Develop a mutually agreed upon plan.

1. Developing a Therapeutic Relationship

The development of a positive and supportive relationship between a physician and patient is an essential foundation which will facilitate the process of patients making ~ important and often difficult changes in their lives. Certain skills have been described which can be used in the medical encounter to facilitate the development

of therapeutic relationships with patients. Statements of empathy, reflection, support, partnership, respect, and optimism not only promote a therapeutic relationship, but have been shown to have a positive effect on recovery from addictive behaviors. The following are examples of such statements:

"It sounds like it has been hard for you to control your drinking at times."
(reflection)

"I want to help you in any way that I can with this problem." (support)

"This seems difficult for you to talk about." (empathy)

"I am confident that with help you can begin to solve the problems you have been experiencing from using alcohol." (optimism)

"Let's work together to develop a plan." (partnership)

"You deserve a lot of credit for trying to sort through your problems"; "I can see that you really care about your family." (respect)

2. Relate to the Patient's Primary Concern

Responding to the patient's chief concern is central to any therapeutic encounter. Fortunately, many of the concerns that patients bring to the physician's office are clues to an underlying alcohol or substance abuse problem. The physician needs to recognize the symptoms commonly encountered in patients with alcohol problems (anxiety, insomnia, impotence, dyspepsia, fatigue), as well as the common early signs of alcohol problems (hypertension, epigastric tenderness, depression). The ability to link the patient's health or medical concern to problematic drinking allows the physician to promote awareness of the problem in the patient while minimizing the possibility of the patient becoming defensive or guarded.

3. Focus on the Evidence

The presentation to a patient of an alcohol or substance abuse problem is often met with resistance and ambivalence. Evidence collected during the history, physical and laboratory examination should be presented to the patient in a direct, yet sensitive manner. If the patient becomes defensive at this point or begins to express strong negative emotions, it is appropriate to acknowledge those emotions. Using reflective and empathic statements may help to decrease patient defensiveness.

"You seem to become upset when we talk about your drinking."

"It seems like it is hard for you to talk about your use of drugs."

It may also be helpful to follow empathic statements with open ended questions to challenge the patient to think about why she is becoming upset or defensive: "You seem to become upset when we talk about your drinking. Why do you think that is?"

It is important to remember that arguments are not productive. Attempting to coerce the patient into accepting your diagnosis is rarely beneficial.

4. Avoid Negative Labels

Many of the terms associated with substance abuse are emotionally loaded and thus are counter-productive. Calling a patient an "alcoholic", "drug addict" etc. rarely leads to a therapeutic alliance, especially early in the course of disease identification. In addition, there is evidence to suggest that a patient's acceptance of the label "alcoholic" or drug "addicted" is not necessary for positive treatment outcomes. It is important to talk about the patient's problem in a nonjudgmental manner:

"The problems you are having can be explained by your use of alcohol."

"I'm concerned that your use of alcohol is unhealthy."

5. Assess the Patient's Perception of the Problem

It is important to realize that while a patient's substance abuse problem may be clear in your mind, before you can develop a treatment strategy you must understand the patient's perception of the problem. Simply asking for the patient's reaction to your presentation of the evidence is often useful. The use of reflective comments followed by open-ended questions will encourage patients to talk more openly about their problems:

"So it sounds like the only time you have the stomach pain is when you have been drinking. What are your thoughts?"

"It sounds like your wife has been getting upset with your drinking. Why do you think that might be?"

The physician can learn a great deal about a patient's perception of a problem and their readiness to change by encouraging them to talk openly.

Prochaska and DiClemente have developed an important model which can be used to facilitate the process of change in patients. They studied individuals who had made significant behavior changes, both on their own or with the assistance of a therapist, to understand how the process of change occurred. They noted that change rarely occurred as a sudden event. Rather, individuals appeared to pass through a series of stages. In addition, individuals would often move back and forth through these stages. The model of change they created provides a useful framework for identifying where a patient is in his process of change and for developing an appropriate treatment plan.

Communication Skills :

Questions to Ask Concerning Use of Alcohol and Other Drugs *

1. Do you drink alcohol, including wine, wine coolers, beer, or distilled spirits?
If so, on average: days per week, drinks per day, maximum number at one time?
2. Do you use any drugs other than those prescribed by a physician?
If so: what is the frequency of use?
3. Do you use nicotine in any form: cigarettes, cigars, smokeless tobacco?
Do you use physician-prescribed mood-altering drugs?
If so, what, why, frequency of use, used only as directed?
4. Have you ever felt you should cut down on your drinking or drug use? **
5. Have people annoyed you by being critical of your alcohol or drug use? **
6. Have you ever felt bad or guilty about drinking or drug use? **
7. Have you ever had an eye-opener—a drink, a cigarette or a drug early in the morning to steady your nerves? **
8. Has a physician ever told you to cut down on your drinking, smoking, or drug use?
9. Has your drinking, smoking, or drug use caused family problems?
10. When drinking or using drugs, have you ever had a blackout or loss of memory?

* Adapted from the National Institute on Alcohol Abuse and Alcoholism and the American Society of Addiction Medicine ** From the CAGE questionnaire to identify drug use C = cut down; A = annoyed; G = guilty; E = eye-opener

Summary :

It is common for physicians to feel frustration when working with patients with substance abuse problems. It is important to remember that change occurs slowly. In this section we have identified intervention skills which will help primary care physicians promote patient self-awareness, increase patient self-efficacy, and hopefully promote patient change-

MODELS OF CHANGE

PRECONTEMPLATION

CONTEMPLATION

DETERMINATION

ACTION

MAINTENANCE

RELAPSE

Patients in precontemplation neither acknowledge a problem or the need for any behavioral change. When resending the diagnosis to a precontemplator, the response will likely be one of surprise. The presentation of detailed treatment plans to a precontemplator will hold little meaning and will likely not result in adherence to the plan. Rather, the physician's role is to raise the patient's awareness of a problem. This is best done by presenting the "evidence" in a sensitive fashion and then asking for the patient's response. Do not expect the patient in a precontemplative stage to necessarily agree with your diagnosis by the end of a single office visit. It is appropriate to allow the patient go home to think about your concerns and to return to discuss their thoughts at a return visit. The goal is to eventually increase the patient's awareness that his drug or alcohol use is causing problems. As noted above, the physician should avoid actively trying to coerce the patient into acceptance of a problem, as this will likely create a great deal of defensiveness in the patient and limit the therapeutic effectiveness.

Patients in the contemplation phase can usually be identified by their expressions of ambivalence. If encouraged to speak freely, these patients will often be heard to fluctuate between the belief that they have a problem on the one hand, and the belief that their behavior is really a variation of normal. A characteristic expression of individuals in the contemplation phase is "yes, but". On the one hand the patient recognizes the need to change, and yet another part of him does not want to change. A patient who is feeling ambivalent might be heard to make one of the following statements:

"I know that at times I might drink too much, but its not really that often and most of the people I go out with drink more than me."

"I'm sure that I am not an alcoholic because I can stop drinking when I want to. But it does worry my that at times I can't remember what I did the night before."

"There are times when I think I should just quit drinking all together, but I like

having a drink every now and then." .

An important strategy for working with patients in the contemplation phase is to help them become aware of their ambivalence. Reflective statements such as "It sounds like on the one hand you are concerned about your drinking, yet at the same time you feel that you are drinking no more than your friends" are very useful. It is also helpful to encourage the patient to expand on the concerns that they have expressed about their substance use by using reflective comments followed by open-ended comments.

"You said at times that you feel that you drink too much. Tell me more about that."

"You said at times you think that you should just quit drinking. Tell me why you feel that way."

The physician's role is to help the patient identify as many reasons as possible to justify altering his substance use. In addition to presenting evidence, it is also important to help patients build their sense of self-efficacy and ability to change by using statements of respect, optimism, and partnership.

At some point enough evidence or awareness will hopefully accumulate to tip the patient's ambivalence to the side of change. The patient will then move into the determination stage. Determination is characterized by a readiness to attempt treatment. This stage has been described as a "window of opportunity". The physician must be ready to provide a variety of treatment options to the patient and to help the patient choose among them. These may include trials of abstinence or controlled drinking under the primary care physician's observation, referral to self help groups such as Alcoholics Anonymous or Rational Recovery meetings, or referral to inpatient or outpatient specialty treatment. A common mistake is for the physician to insist on a particular treatment that may not be acceptable to the patient at the particular time. Treatment appears to be most effective when patients perceive that they have made their own choice to enter treatment and when patients are allowed to choose among alternative treatment options.

If the patient has enough sense of self -efficacy and ability to change, he will then move into the next stage with a trial of action. Hopefully, the patient will be able to gain a positive experience from initial treatment. If this occurs, then the patient will have entered the maintenance stage.

Maintenance requires the development of skills to maintain sobriety. This, of course, is a major challenge for patients with substance abuse disorders. If patients become discouraged and believe that change is not possible, they may experience a relapse and slip back into contemplation, or even precontemplation. Relapse is a common problem (Marlatt & Gordon, 1985) and the possibility of relapse occurring should be openly discussed and planned for with patients. Patients who experience a difficult time with maintenance and continue to relapse would most likely benefit from referral to specialized treatment centers.

6. Develop a Mutually Agreed Upon Plan

Once the physician has assessed the patient's perception of his problem and staged his readiness to change, the physician should then attempt to negotiate an initial plan. As already mentioned, the goal is not necessarily to get the patient to agree with your optimal treatment recommendations. In fact, when the physician attempts to force the patient to accept her treatment plan without negotiation, the encounter often ends in frustration. The physician needs to consider what stage the patient is in and develop strategies to move the patient forward through the model of change. For example, a patient in the pre-contemplative phase may be appropriate for a drinking diary or other self-monitoring strategy which may increase her awareness of a problem. The process may also be facilitated by bringing in additional family members for interview. Patients in the contemplative phase may be ready for a trial of abstinence or controlled drinking. Controlled drinking trials should be very explicit in terms of the agreed upon quantity of alcohol (beer or wine) and the duration. Follow-up is essential when implementing such a trial. Patients in the determination or action phases should be offered a range of treatment options, as described above. In all cases it is important to schedule follow-up appointments, even if the patient is referred to a specialty care center. As a primary care physician, you have the opportunity to maintain a supportive relationship with the patient and continue to encourage him to maintain sobriety. You may also be an important person to identify early relapse.

Recognizing and Working with Patient Defensiveness and Denial.

The term "denial" has been used by individuals working in the field of addiction to refer to describe how patients with substance abuse problems often misrepresent and distort the extent of their use or dependence. When this occurs, patients have been labeled as being "in denial." However, most often "denial" does not relate to the fact that the patient has no awareness of a problem, but more likely results from the discomfort that patients often feel when confronted about their substance use. It can become emotionally uncomfortable for a patient when a physician, loved one, or work colleague suggests to her that she has a problem and needs to alter her substance use. This discomfort is often manifested through various defense mechanisms such as rationalization, minimization, projection, conscious lying, and others.

Denial is not unique to patients with substance abuse problems. In fact, defensiveness may be expressed in other conditions (hyperlipidemia, diabetes) in which patients are asked to make behavioral changes. Studies have found that denial is present to no greater degree in alcoholics than nonalcoholics. In fact, there is an increasing body of evidence to suggest that the expression of defensiveness can be influenced by the style of the intervening physician or therapist. Patient defensiveness can be decreased by using skills to develop a therapeutic alliance,

making sure the patient's perception of problem is understood, and allowing the patient choice in the treatment options.

Summary thoughts:

It is common for physicians to feel frustration when working with patients with substance abuse problems. It is important to remember that change occurs slowly. In this section we have identified intervention skills which will help primary care physicians promote patient self-awareness, increase patient self-efficacy, and hopefully promote patient change-

Useful Definitions

- 1. Sensible drinking (non-problem use); very low risk to develop problems.
 - a. very safe quantity (safe maximum of 2 drinks (NOT average 2 drinks), 6 drinks in 1 day less often than every 3 months
 - b. consistent limits
 - c. social (drinking in groups)
 - d. heeds warnings (both internal--hangover, drunkenness effects, and external--like friends or spouse worry)
- 2. Hazardous drinking. High quantity and/or frequency. Suggest use of more than 5 drinks per occasion for men (more than 4 for women), or more than 25 drinks per week for men (more than 20 for women) as cut-off region.

a. Additional stratification suggests:

<u>RELATIVE RISK</u>	<u>MEN</u>	<u>WOMEN</u>
Low	< 14	< 10 standard drinks/wk
Intermediate	15-25	11-20
High	>26	>21

- 3. Harmful drinking (or drug use)
 - a. Few, small problems.
 - b. No sustained problems.
 - c. Mostly controlled use.
- 4. Risky Drinking (or drug use)
 - a. Drinking (or using drugs) in a way which puts the user at increased risk for an acute negative event (examples -driving while impaired, getting high in situations where risk of unsafe sex is great, using illicit drugs when professional risk if apprehended is great). (The above are applicable only with no substance abuse or dependence)

5. Clinical criteria for diagnosis of the illness.

- a. Periodic inability to control use.

- b. Use in spite of serious problems.
- c. Significant time, repeated problems.
- d. Denial system in place; consistent use of rationalization, projection, minimization.

Rationale for Prevention

Physicians who do not screen all patients for alcohol and drug abuse (HEADSSS assessment) will probably wish to focus their energy on such screening first. As their skills and success improve, they may wish to add screening for high-risk use, as we describe here, when patients do not have current abuse.

The U.S. Preventive Services Task Force has articulated 4 criteria for evaluating possible preventive services

- (the illness to be prevented must be reasonably common and
- cause significant mortality or morbidity,
- the detection method must be reasonably good,
- there must be an effective treatment for the condition if found early that is more effective than
later treatment,
- and there must be evidence that the detection method and treatment reduce, morbidity or mortality in actual use).

Screening

High-risk drinkers should be identified among all patients who are not already identifiable as problem drinkers. But for this to happen regularly in practice, the screening must be brief and follow logically the screening for alcohol problems. The logic of the suggested algorithm, which has not been formally tested, initially differentiates drinkers from non-drinkers. Non-drinkers are asked for personal or family history of drinking problems - if present, these findings may place the patient at higher risk. Current drinkers are asked the CAGE. This is not as useful for teens as it is for older people (eye opener??). Finally, questions about risky use (driving and sexual activity while high) are asked. -

The CRAFFT questions:

- C** Have you ever ridden in a **CAR** driven by someone (including yourself) who was 'high' or had been using alcohol or drugs?
- R** Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?
- A** Do you ever use alcohol or drugs while you are by yourself, **ALONE**?
- F** Do you ever **FORGET** things you did while using alcohol or drugs?
- F** Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
- T** Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

A. Typical impediments produced by stigma, which may surface during any discussion of alcohol/ drug issues with patients.

1. Shame and humiliation, feelings of judgment and criticism.

- a. produces anxiety, fear, confusion and guilt.
- b. inhibits speaking; promotes unclear, mixed responses.
- c. promotes anger, hostility.
- d. produces skepticism of physicians; inhibits trust.
- e. impedes rational discussion and information transfer.

2. Some high-risk patients may be especially sensitive to shame and humiliation (e.g. if family history is positive).

- a. substance abuse or other dysfunction in families which produce high-risk patients, also produces or exaggerates "sensitivity" to shaming
- b. peer feedback for high-risk or problem behavior tends to be shaming or ridiculing.

B. Specific Behaviors and Skills

- a. empathy, respect, unconditional positive regard, support and partnership.
- b. active listening (with verbal and nonverbal responses which indicate attentiveness).
- c. optimism, attribution, new explanatory model (these are repeated in the content set).
- d. uncertainty, tentativeness, exploratory attitude (e.g., "I'm not certain exactly of the correct next step, but let's talk more; or let's develop a plan together; or I've been thinking xyz in my mind, how does that suit you, etc").

Issues regarding Drug Abuse Prevention

There are at least two perspectives on the prevention of drug abuse. Since they are rather different, we will discuss both, so that participants can adopt the approach most compatible with their own beliefs. Unless physicians are quite comfortable with the underlying assumptions of a prevention program, they are unlikely to carry it out effectively, or at all.

One perspective views drug abuse as analogous with alcohol abuse. Drug use is defined by DSM as when it is causing problems. In this perspective, patients who use drugs without evidence of abuse or hazardous use are counseled to avoid increasing use and hazardous use. This approach is quite analogous to what has been described for prevention of alcohol abuse. A difficulty is that while all drugs may cause serious harm in some situations, sensible limits are not defined. Indeed, the point can be made that any use of an illicit drug is potentially hazardous legally, (and for some, hazardous to job security, professional status or health). On the other hand, this perspective is more compatible with the disease model of drug abuse, and may facilitate more open communication with drug users.

An alternate perspective views all drug use as harmful, and efforts are focused on preventing all drug use. This perspective avoids the difficulties of defining safe levels of use in the absence of adequate data. The difficult task of determining current drug use

level is not as important, and this perspective is more consistent with the prevailing public policy. On the other hand, there is little evidence that it might be effective, and this approach would be unlikely to facilitate patient discussion of their drug use in the future. It is less compatible with the disease model of drug abuse. (For physicians dealing with young adolescents, a version of this perspective which aims to delay onset of use in developing teens is more widely acceptable).

Prevention efforts by physicians are more likely to be effective when based on genuine beliefs, and we suggest that participants base their practice efforts to prevent substance abuse on a perspective which is consistent with their beliefs.

Risk Factors

Relatively little prospective work to identify risk factors for alcohol abuse and drug abuse has been done. Vaillant's long prospective cohort observational study did not find dramatic psychological or social risk factors, although antisocial personality disorder and certain cultural groups seemed to have increased risk for alcohol abuse. Other data show increased risk in males. **Family history of alcohol or drug abuse is certainly an important risk factor.** History of abuse of any substance is an important risk factor for abuse of other substances.

Some individuals, such as those who report the flushing response to alcohol, or who clearly have always had other unpleasant physical symptoms from small amounts of alcohol, are at reduced risk.

PARENT/CHILD CONFLICTS

One of the most challenging situations in a primary care office is deciding what to do when a parent demands a drug test against the will of an adolescent. The physician must acknowledge and evaluate the concerns of the parents while maintaining the patient's trust. Speak briefly with the parent about why he or she would like a drug test. It may be best to have this conversation without the teen present. After clarifying the parents' specific questions, first validate their concerns.

Explain the limits of laboratory testing and the possibility that it may compromise what is now a trusting physician/patient relationship. Advise that the information they have provided, coupled with a thorough, confidential history and physical, is the most sensitive and specific means of assessing drug use. One of the most challenging situations in a primary care office is deciding what to do when a parent demands a drug test against the will of an adolescent. The physician must acknowledge and evaluate the concerns of the parents while maintaining the patient's trust. Speak briefly with the parent about why he or she would like a drug test. It may be best to have this conversation without the teen present. After clarifying the parents' specific questions, first validate their concerns. Explain the limits of laboratory testing and the possibility that it may compromise what is now a trusting physician/patient relationship.

Advise that the information they have provided, coupled with a thorough, confidential history and physical, is the most sensitive and specific means of assessing drug use. Specify that information provided by the teen will be kept confidential unless there are concerns for the teen's safety. The next step is to interview the adolescent privately, beginning with an explanation of confidentiality and its limits. A useful way to open further discussion is simply to ask "Why did your parents feel you needed to see me today? Why do you think they want you to have a drug test?" When there is a discrepancy between history obtained from a teen and that obtained from the parent, or when a parent remains suspicious despite a teen's denial of drug use, the physician may decide to give the teen the option to take a drug test. From a teen's perspective, the test can be done to support his or her denial of use.

Both teen and parent should understand the reason for performing a test and the limits of testing. The physician should emphasize that a negative test indicates only that none of the substances in the test panel were detected in the urine. Since the half-life of most drugs is brief, a negative drug test generally indicates no use within the past 24 to 48 hours. Marijuana is a notable exception; urine tests can remain positive for weeks in chronic users. A single positive urine test for cannabis indicates that a teen has used marijuana; it does not confirm a diagnosis of a substance use disorder. Passive inhalation of marijuana will cause positive drug tests only when exposure has been significant. This may occur if a teen intentionally remains in a small, poorly ventilated space (such as a car) with many smokers; and should be considered a true positive.

In some instances an adolescent will refuse to give a urine sample despite staunch denial of substance use. Although this raises concern that the adolescent may be using substances, *the American Academy of Pediatrics clearly states that testing against the will of a competent adolescent is not recommended*. In these cases we recommend close follow-up with child and parent. The true history will almost certainly become apparent with time. Home drug testing kits have been on the market since 1995, and now parents can easily obtain them from the Internet. Given the complexity of drug testing and the difficulty of interpreting the results, we do not believe that home testing kits provide enough support for parents to get meaningful information from of a substance use disorder.

Passive inhalation of marijuana will cause positive drug tests only when exposure has been significant. This may occur if a teen intentionally remains in a small, poorly ventilated space (such as a car) with many smokers; and should be considered a true positive. In some instances an adolescent will refuse to give a urine sample despite staunch denial of substance use. Although this raises concern that the adolescent may be using substances, *the American Academy of Pediatrics clearly states that testing against the will of a competent adolescent is not recommended*. In these cases we recommend close follow-up with child and parent.

A second common dilemma that occurs in the pediatric office regarding substance use is the issue of when to breach confidentiality. It is helpful to set confidentiality rules prior to taking the history from an adolescent. We recommend telling the patient that confidentiality will be maintained unless acute safety concerns arise. Determining when

a patient's safety is at risk is a matter of clinical judgment. The box at left provides a set of guidelines to help physicians determine whether confidentiality should be breached.

CONFIDENTIALITY

- As a general rule, the older the patient, the more confidentiality can be afforded.
- Physicians cannot maintain complete confidentiality for patients who need acute hospitalization or residential treatment.
- Confidentiality should be breached if a patient is at risk of harming him/ herself or others.
- When confidentiality must be breached, the specific reasons and the information to be revealed should be discussed with the teen prior to the discussion with parents. The physician should limit revealing details and focus on the need for treatment.
- If parents request a copy of the written medical record, they should be discouraged and told that such a breach of confidentiality may damage the physician patient relationship and limit the potential for further therapeutic intervention. (Laws regulating such demands vary by state.)
- Physicians should include relevant information only in the chart (ie, only that information used to make the diagnosis or treatment plan). Specific details, such as who supplies drugs, who uses drugs with the patient, etc need not be recorded in the chart.
- Certain information (substance abuse treatment) in clinic records may be protected under special federal confidentiality rules (42 CFR, Part 2) and can only be released with specific signed consent; a general medical release form is not adequate for this purpose. These pages should be signaled in the chart, by placing a header on top of the note or by using a different color paper.

Assessment of Communication Skills

General

Patient Education

- Answered patient's questions
- Used language appropriate to patient's level of understanding
- Seemed comfortable discussing drug use
- Explained problems in a non-judgmental manner
- Asked patient if she/he had further questions

Patient Management

- Able to determine priorities of management
- Clearly counseled patient to avoid inappropriate drug use
- Patient left knowing problems and management plan

Alcohol Use

- Asked appropriate questions to elicit answers to CAGE questionnaire
 - Comfortable in discussing anxiety and depression in relation to drinking
 - Ended session stressing need to discontinue use of all mood-altering drugs, including cigarettes.
 - Developed a clear plan with follow-up visits
-

Decision Balance

- Identifies benefits of drinking or drug use: relieves stress, feels good, relieves boredom
- Identifies concerns about drinking or drug use: harmful to health, causing problems in interpersonal relationships with wife, with friends, at work, etc.
- Identifies concerns about cutting down or stopping drinking or drug use: unable to do so; fear of what will replace this activity; not convinced a real problem exists
- Identifies benefits of cutting down or stopping drinking or drug use: decrease in physical symptoms, if present; better feeling of self; improved interpersonal relationships

Counseling

- Provides non-judgmental feedback about assessment results of CAGE and ADEPT scores, presence of dependency
- Engages patient in discussion of decision balance
- Helps patient explore feelings about changing behavior

Management

- Asks patient to specifically decrease use towards abstaining
- Asks patient to consider AA or NA meetings
- Suggests patient keep diary, recording feelings during trial of diminishing drinking or inappropriate drug use
- Requests return to see physician in a month or sooner to report results of trial

Providing Advice for Change

- Use an empathetic, non-confrontational style
- Provide a decision balance to patient, reviewing the benefits or reasons for continuing this behavior as well as the existing concerns and reasons to change
- Offer choices as to how to affect change
- Emphasize personal responsibility
- Convey confidence in person's ability to change
- Provide referral source, if needed

Examples of Decision Balance

Motivational Balance	Reasons to Continue	Reasons to Change
Currently Using	Benefits: <ul style="list-style-type: none">• Enjoyable• Relieves anxiety• Helps to make it	Concerns: <ul style="list-style-type: none">• Disturbs interpersonal relationships• Expensive

	through the day	<ul style="list-style-type: none"> • Illegal • Occupies too much time • Poses danger of job loss • Creates adverse physical effects
Low-Risk Use or Abstinence	Concerns: <ul style="list-style-type: none"> • Not able to function • Withdrawal symptoms • Have to face reality 	Benefits: <ul style="list-style-type: none"> • Improved interpersonal relationships • Better ability to keep job • Sense of better physical well-being • Ability to derive satisfaction of making it on one's own

MOTIVATING THE SUBSTANCE ABUSER TOWARD TREATMENT

SUMMARY OF MOTIVATIONAL INTERVIEWING WITH PROBLEM DRINKERS *

Therapeutic failures have been attributed to denial in the problem drinker, whereas responsibility for success is often claimed by the treatment program. As a result, the patient is in a no-win situation.

According to the traditional view, denial of alcoholism is a personality defect in the patient. However, there is an alternative view. Denial is elicited by interactions between patient and other. According to this view denial is not inherent in the alcoholic individual, but rather is the product of the way in which people (doctors and counselors and family) have chosen to interact with problem drinkers.

Development or non-development of motivation in an interview is conditioned by the principle that "I learn what I believe as I hear myself talk." Thus, effective Interview strategies involve eliciting an appropriate response from the patient rather than confronting him or her with painful truths.

Every individual coming to talk about substance abuse feels two ways about drinking -- one side favors doing something about the problem, the other side favors avoidance." The physician's task is to place weights on the positive change-seeking side of the balance.

PREMISE: "Denial is not inherent in the alcoholic individual, but rather is the product of the way in which the medical community has chosen to interact with problem drinkers," i.e., confrontationally:

PREMISE:
"I learn what I believe as I hear myself talk."

"The confrontational (usual) method may have ... the effect of motivating the client to become more committed to 'not abstinent' positions."

PREMISE:

Direct argument is dreadfully ineffective in changing attitudes.

Result of direct argument (1) "I am not an alcoholic"

Corollary Result (2) "I do not have to abstain ..."

The opposite of adversarial argumentation is "counter attitudinal role play."
To make statements and take action on behalf of a new position, even under role play conditions, begins to move the person's attitude in the direction of the new position.

"The physician's job is to help the individual in this motivational struggle.-"

Motivational Interviewing with Problem Drinkers, William Miller, Behavioral Psychotherapy 11, 147-172, 1983.

Four Key Principles of Motivation:

1. De-emphasis on labeling:

- "Labeling is not essential."
- "Rather what matters is this: what problems-is the person having in relation to alcohol and will needs to be done about them?"

2. Individual Responsibility:

- "Motivational interviewing places responsibility on (the patient) to decide for himself/herself how much of a problem there is and what needs to be done about it."
- "The physician presents reality to the patient in a clear fashion but leaves it up to the patient to decide what to do about it." The decision not to change is seen as a viable, though perhaps unwise choice."
- "Motivational interviewing attempts to provide "... sufficient support and an atmosphere in which the difficult decision for change can be made more easily,"

3. Internal Attribution:

- Placing responsibility on circumstances, people, or things beyond the patient's control is called "external attribution."
- Changes that are attributed to the patient's own choices tend to be more long lasting."
- "The third precept is highly related to the second, because the individual is thus seen as not helpless."
- "The decision to (take the first) drink is made by the individual and he or she is responsible for it,"
- "The decision to begin drinking is often confused with continuing to drink once started. The loss of control assumption refers to the latter, not the former."

4. Cognitive Dissonance: This is the simultaneous holding of conflicting beliefs.

- When a person "perceives his or her behavior is seriously discrepant with his or her beliefs, attitudes or feelings a motivational condition is created and brings about change ... so that consistency is restored.

- "Recognition of inconsistency within the individual necessitates a change."
- **PREMISE:** Understanding this principle provides us with two general tasks: "the first. to increase the amount of cognitive dissonance experienced by the patient; the second. to direct the dissonance so that the result is changed behavior rather than modified beliefs (denial), a lowering of self esteem or a drop in self-efficacy."

STRATEGIC GOALS

The direction of motivation toward behavior change requires the following strategic goals:

1. Increase In self esteem:

- a. "The motivational interviewing approach expresses overt as well as implicit respect for the individual, and seeks attributions which elevate self esteem."

Example: Physician: "Although this may be hard for you, I can see that you are making a serious attempt to be honest with yourself and with me."

2. Increase self efficacy:

- a. A belief in their ability to change is communicated to the patient.
- b. "The person is not seen as helpless over alcohol or dependent on others for judgment and direction, but as capable of redirection and responsible choice."

Example: Physician: "You are not responsible for your disease but you are responsible for your recovery."

3. Increase dissonance:

- a. "In the presence of an affirmative atmosphere that encourages self esteem and self efficacy ... the creation of dissonance is therapeutic." ...
- b. "It should be noted that this (creation of dissonance) is fruitless if at the same time self esteem and self efficacy are damaged."

Example: How do you plan to avoid a repetition of your arrest for DWI? How do you see that working for you?

4. Direct dissonance reduction toward behavior change:

- a. "The creation of motivational dissonance without providing an accessible and effective means for behavior change may be unhelpful or even harmful."

Examples:

Patient: "My doctor told me I must stop drinking because of my liver problem ... but he didn't tell me how to do that." (Unhelpful)

Patient: "My doctor told me I must stop drinking because of my liver problem and immediately put me in touch with Paul who took me to my first AA meeting that same day." (Helpful)

Strategies of Motivational Interviewing:

1. Affirmation: reflective listening, accurate empathy.

Rather than give advice, warning, threatening, labeling, moralizing, etc. the physician listens empathically to what the client has to say and attempts to reflect it back.

- a) Reflection as reinforcement: the physician reinforces the patient's statements of self perceived problems related to alcohol.

Example: Physician;- "You say your wife reports that the children are frightened of you when you've been drinking." (Reflection) "Have you any idea of why she feels this way?"

2. Increasing dissonance (Awareness)

Reflection as restructuring: to restructure content slightly, to place it in a different light.

Example: "I can't be an alcoholic because ... " may be reflected with, Physician: "I imagine that's confusing to you, etc."

3. Awareness:

A person is more likely to integrate and accept that which is reached by his or her own reasoning process. Information is not simply offered up on a plate, to be passively received.

4. Eliciting self motivational statements.

Using the notion that "I learn what I believe as I hear myself talk" the goal here is to elicit statements that include:

- recognition of alcohol related problems
- concern regarding the problem (affect)
- recognition of the need to change drinking pattern (behavior)
- One approach for evoking these statements is to ask for them.

Example: Physician: "What things have you noticed about your drinking that concern you or that you think might become problems?"

Patient's views of such concerns are then reinforced by reflection, nonverbal listening clues (head nods, eye contact, etc.) and occasional affirmations ("I can see how that might concern you").

5. Extend the list: Ask

"What else have you noticed?"

"What other things concern you?"

6. Paradoxical approach: By asking,

"Is that all?"

"What else?", the physician paradoxically encourages the patient to provide further evidence of the problem and to own it.

Example: "this treatment program is one that requires a lot of motivation, and frankly one concern I have in talking to you is that I am not sure whether you really have enough motivation."

7. Summarizing: The goal here is to accurately summarize the physician/patient interactional process thus far, with heavy emphasis on the patient's positive self motivational statements.

Evaluation

TITLE: Faculty Development Seminar: A course to assist primary care providers in caring for teens and parents around issues of substance abuse

Date: Sept 18 2008

1. How would you rate today's seminar?

	Well Below Average	Average	Average	Above Average	Superior
a. Content.....	1	2	3	4	5 6 7
b. Presentation style.....	1	2	3	4	5 6 7
c. Sufficient time for questions/discussion.....	1	2	3	4	5 6 7
d. Overall quality.....	1	2	3	4	5 6 7

2. How would you describe your experience in today's seminar?

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
a. Satisfying.....	1	2	3	4	5 6 7
b. Stimulating.....	1	2	3	4	5 6 7
c. Frustrating.....	1	2	3	4	5 6 7
d. Enjoyable.....	1	2	3	4	5 6 7
e. Relevant.....	1	2	3	4	5 6 7
f. Boring.....	1	2	3	4	5 6 7
g. Good use of time.....	1	2	3	4	5 6 7
h. Educational.....	1	2	3	4	5 6 7

3. Overall, how well did this seminar help to refine your skills around caring for teens with substance abuse?

Did not Help at All	Helped Moderately	Helped A Lot
1 2 3	4 5	6 7

4. Please list the most important thing you learned:

5. Please list one thing that is still confusing or a question unanswered:

6. Other comments and/or suggestions for future seminars:

7. I will apply knowledge/skills from the course to my clinical practice:

Agree						Disagree
1	2	3	4	5	6	7

8. This presentation was free from commercial bias.

Agree						Disagree
1	2	3	4	5	6	7

If conflict of interest was noted, please specify:

9. Issues in cultural/linguistic competency were adequately addressed in this activity (prevalence, diagnosis, treatment, etc.)

Agree						Disagree
1	2	3	4	5	6	7

9. Overall, please rate the following faculty members in how effective they were:

	Not Effective		Moderately Effective			Very Effective	
Martin Anderson	1	2	3	4	5	6	7
Martin Leamon	1	2	3	4	5	6	7
Margaret Rea	1	2	3	4	5	6	7
Michael Wilkes	1	2	3	4	5	6	7

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PRECONFERENCE WORKSHEET

- 1) All of us experience occasional frustration related to caring for teens. These frustrations may interfere with our satisfaction in practicing medicine or our ability to properly care for teens.

In the space below please describe in short phrases some of the situations you find frustrating in caring for teens. It may help to think of specific patients and specific situations

- 2) In the next few spaces please list specific difficulties you have managing or dealing with teens who have substance abuse problems

- 3) If there was one thing you wanted could learn from this workshop what would it be?

Appendix 2

Community Summit Participant Roster

DAVIS

1. Robin Affrime
2. Dori Anderson
3. Landy Black
4. Robert Byrd
5. Mike Cawley
6. Sharla Cheney
7. Bridget Egan
8. Bill Emlen
9. Elvia Garcia
10. James Hammond
11. Chris Helweg
12. Lamar Heystek
13. Leslie Hunter
14. Charlotte Krovoza
15. Cara Leppington
16. Brian Liou
17. Pam Mari
18. Steve Nowicki
19. Trease Petersen
20. Margaret Rea
21. Tim Taylor
22. Frank Tenedora
23. Hannah Trost
24. Michael Wilkes

WOODLAND

1. Susan Cassady
2. Crystal Gasca
3. Evelia Genera
4. Kathy Green
5. Linda Gutierrez
6. Amy Kline
7. Gabriel Kogan
8. Bill Marble
9. Adrienne Monroe
10. Jeff Monroe
11. Olga Nevarez
12. Izabelle Ponce
13. Art Ramirez
14. Veronica Robbins
15. Naomi Roudman
16. Debi Sterling
17. Rogelio Villagrana

WINTERS

1. Lisa Baker
2. Kathy Blankenship
3. Debbie Clifford
4. Beth Curry
5. Amy Morgan
6. Bruce Murimoto
7. Susan Slover

WEST SACRAMENTO

1. Staci Anderson
2. Jennifer Blackburn
3. Estella De La Torre
4. Brandi Dionne
5. Ken Fellows
6. Raven Hoops
7. Steven Lawrence
8. Mary Leland
9. Bruce Maier
10. Michael Minnick
11. Juan Oquendo
12. Bradley Palmer
13. Steve Palmer
14. Paul Preston
15. Anna Ramirez
16. Peter Simpson
17. Matthew Stegman
18. Oscar Villegas
19. Sheri Wright

YOLO COUNTY

1. Angela Angel
2. Jan Babb
3. Pat Billingsley
4. Mark Bryan
5. Maryfrances Collins
6. Gina Daleiden
7. Stuart Greenfeld
8. Jackie Hausman
9. Bette Hinton
10. Heather Hopkins
11. Elena Jaime
12. Carrie Jones
13. Karen Larsen
14. Catherine Masek
15. Mike McGowan
16. Barry Melton
17. Don Meyer
18. Dorothy Montgomery
19. Bill Olson

20. Andrea Pelochino
21. Jonathan Raven
22. Marjorie Rist
23. Jennifer Sanow
24. Don Saylor
25. Anna Sutton
26. Helen Thomson

FACILITATORS AND SPEAKERS

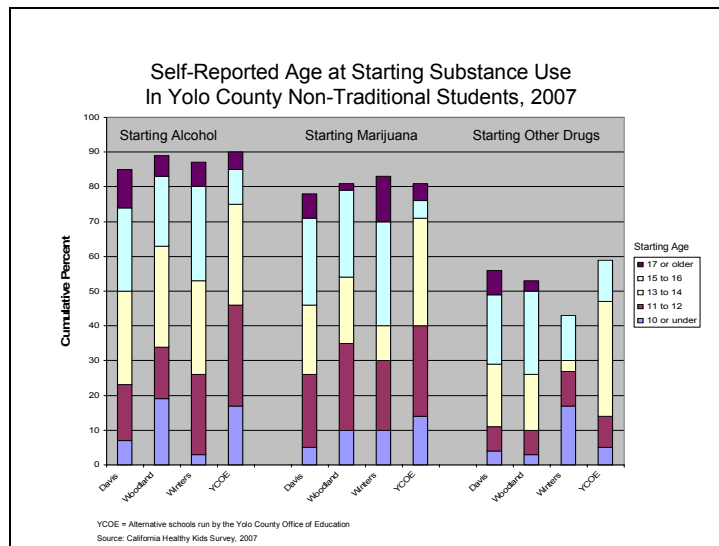
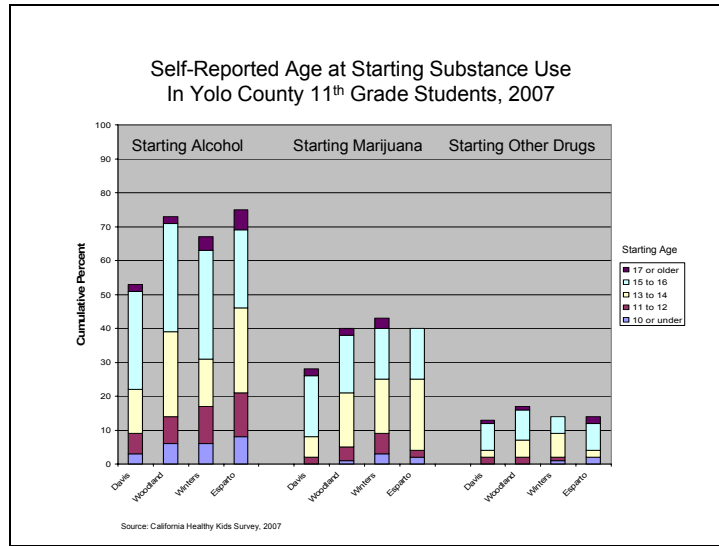
1. Vanessa Avila-Pons
2. Linda Ryan
3. Judy Thornhill
4. Karleen Watson
5. Chris Webster
6. Dave Stoebel
7. Martin Anderson
8. Randy Snowden

OTHERS

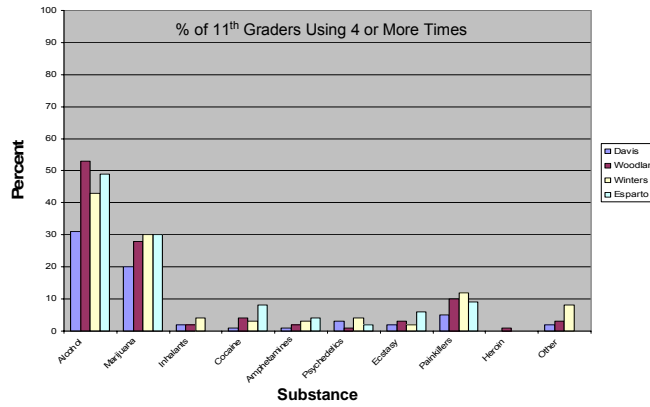
1. Donna Lagarias

Appendix 3 Key Substance Abuse Data-Yolo County

Key Data Presented at Yolo County Drug Summit September 19-20, 2008

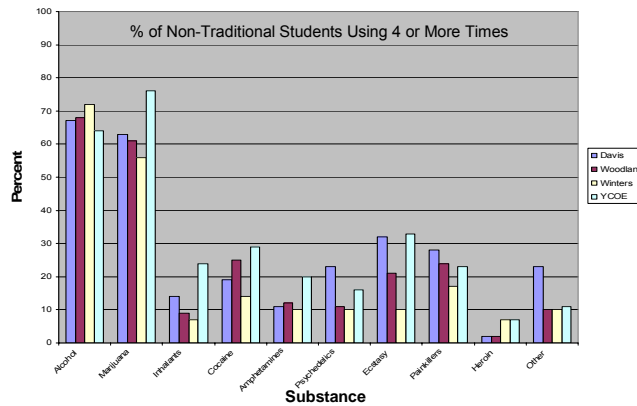


Self-Reported Substance Use in Yolo County 11th Graders, Listed by Type of Substance, 2007



Source: California Healthy Kids Survey, 2007

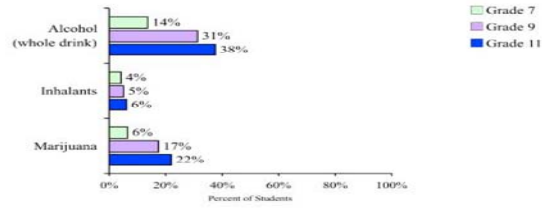
Self-Reported Substance Use in Yolo County Non-Traditional Students, Listed by Type of Substance, 2007



YCOE = Alternative Schools run by the Yolo County Office of Education
Source: California Healthy Kids Survey, 2007

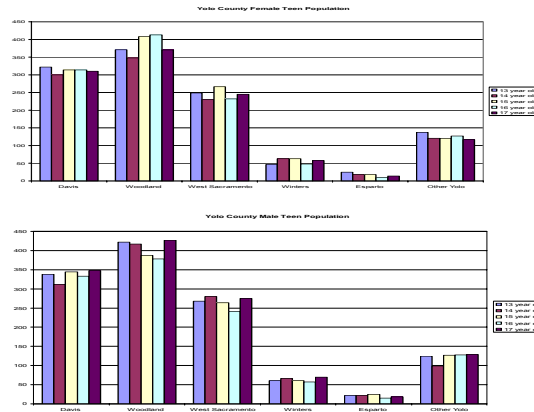
Self-Reported Drug Use In West Sacramento, 2004

Percent of Students Who Used Alcohol or Other Drugs
During the Past 30 Days

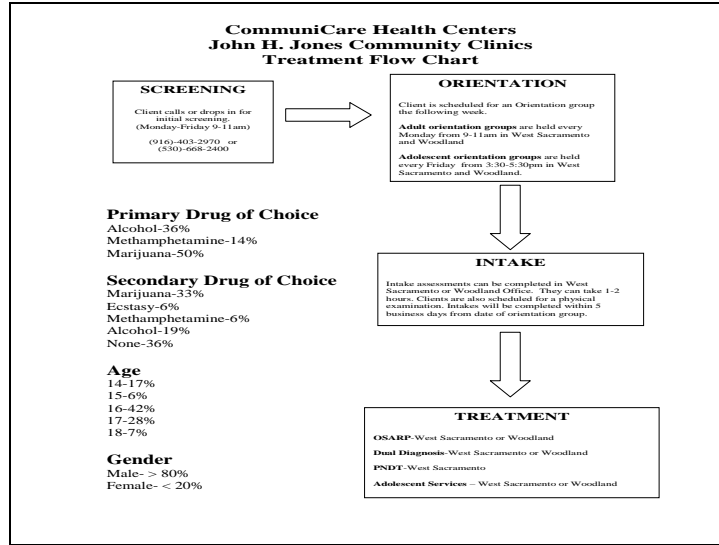


Source: California Healthy Kids Survey, 2004, Washington Unified School District

Yolo County Teen Population



Source: 2000 United States Census



Yolo County Youth Substance Treatment

Annual Treatment Statistics

CommuniCare Health Centers
John H. Jones Community Clinics

	2005-2006	2006-2007	2007-2008
Clients served	757	503	199
# of assessments	106	143	159
# of discharges	106	115	123
Race/Ethnicity		1166(49Grad)	1228(82Grads)
Caucasian	60	82	67
Latino	59	92	98
Native Amer.	6	8	10
Asian/Pac. Is.	2	5	7
African Amer.	4	14	20
Other	3	2	2
Group			
West Sac	38	25	38
Woodland	41	53	42
Davis	30	26	17
Day Is.	27	50	38
Winters			
Anger Man.	43	41	120
Camp Interv.			
Washington Unified	13	25	62
Merkley			
River City	7	0	23
Yolo HS			
Lee Middle School			18
Referral Source			
Drug Court	62	72	73
Violence Court	13	39	36
YCCP	5	12	7
Probation	27	30	44
School	11	29	40
Parent	16	14	2
YCMH			0
BCC		1	1
CPS		1	3
David PD		4	0
Group Home			2
WSac Diversion			2
Funding Source			
AB1913	57	66	38
EPDET	42	95	115
PacificCare	5	5	5
Self Pay	18	11	18
CPS	0	1	0
Grant	15(12 Yolo)	8(6 Yolo)	7(WUSD)
AOC	37	0	0

SCREENING

Client calls or drops in for initial screening (Monday-Friday 9-11am)
(916)-403-2970 or (530)-608-2408

→

ORIENTATION

Client is scheduled for an Orientation group the following week.

Adult orientation groups are held every Monday from 9-11am in West Sacramento and Woodland.

Adolescent orientation groups are held every Friday from 3:30-5:30pm in West Sacramento and Woodland.

↓

INTAKE

Intake assessments can be completed in West Sacramento or Woodland Office. They can take 1-2 hours. Clients are also scheduled for a physical examination. Intakes will be completed within 3 business days from date of orientation group.

↓

TREATMENT

OSARP-West Sacramento or Woodland
Dual Diagnosis-West Sacramento or Woodland
PNDF-West Sacramento
Adolescent Services - West Sacramento or Woodland

Average Treatment Statistics

Primary Drug of Choice
Alcohol-36%
Methamphetamine-14%
Marijuana-50%

Secondary Drug of Choice
Marijuana-33%
Ecstasy-6%
Methamphetamine-6%
Alcohol-19%
None-36%

Age
14-17%
15-6%
16-42%
17-28%
18-7%

Gender
Male- > 80%
Female- < 20%

Yolo County Juvenile Probation Statistics

Data from the Detention Risk Assessment Instrument

Assessments.com - Yolo County Juvenile Probation Page 1 of 1

DRAI 2.0

Presenting Offense (check one)

257 - Total Participants
257 - Total Participants Who Responded
100% - Percentage Who Responded

Answer	Responses	Visual Percentage	Percentage
NO/NO WVC offense - 18 years or older (SEE 3 WVC)	20	<div style="width: 7.8%;"></div>	7.8%
Patrol crime of violence	20	<div style="width: 7.8%;"></div>	7.8%
Patrol sexual offense	15	<div style="width: 5.8%;"></div>	5.8%
Patrol 2 or more separate felony crimes	15	<div style="width: 5.8%;"></div>	5.8%
Patrol high-speed chase	10	<div style="width: 3.9%;"></div>	3.9%
Other felony offense, except drugs	104	<div style="width: 40.5%;"></div>	40.5%
Arrest or possession for sale of drugs	3	<div style="width: 1.2%;"></div>	1.2%
Possession of child or underage	3	<div style="width: 1.2%;"></div>	1.2%
Possession of child	29	<div style="width: 11.3%;"></div>	11.3%
Other misdemeanor offense	13	<div style="width: 5.1%;"></div>	5.1%
Detention statistics	17	<div style="width: 6.6%;"></div>	6.6%
PTA Warrant			

Aggravating Factors (check all that apply)

257 - Total Participants
211 - Total Participants Who Responded
82.1% - Percentage Who Responded

Answer	Responses	Visual Percentage	Percentage
Possession of firearm and ammunition	10	<div style="width: 4.8%;"></div>	4.8%
Possession of weapon or imitation weapon	14	<div style="width: 6.6%;"></div>	6.6%
Has alcohol, or arrested for underage (DUI or similar)	84	<div style="width: 39.8%;"></div>	39.8%
Has suspended and/or expired (has G.E.D./ diploma and/or is G.E.D. / A.S. Student)	9	<div style="width: 4.3%;"></div>	4.3%
History of runaway behavior from home (last 18 months)	74	<div style="width: 35.1%;"></div>	35.1%
History of educational non-compliance (last 18 months)	15	<div style="width: 7.1%;"></div>	7.1%
Violations from court	86	<div style="width: 40.8%;"></div>	40.8%
History of substantiated abuse	156	<div style="width: 74.0%;"></div>	74.0%
Report parent/guardian concern	61	<div style="width: 28.9%;"></div>	28.9%

Assessments.com Marjorie Rist 9/11/2008

Yolo County Police and School Statistics

Number of Drug and Alcohol Related Yolo County Juvenile (<18) Arrests and Citations in 2007

Police Department	Drug or Alcohol	Drug Related	Alcohol Related
Davis	35	17	18
Woodland	73	not available	not available
West Sacramento	89	50	39
Winters	12	4	8
Yolo County Sheriff	21	13	8

Number of Drug and Alcohol Related Suspensions and Expulsions

School District	2006-2007 School Year		2007-2008 School Year	
	Suspensions	Expulsions	Suspensions	Expulsions
Davis	75	2	62	2
Woodland	50	2	77	7
West Sac.	57	7	89	2

Davis = Davis Joint Unified School District
Woodland = Woodland Joint Unified School District
West Sac. = Washington Unified School District

Appendix 4

Teen Essays

Youths in Yolo County were invited to submit essays about how drugs and/or alcohol have affected their lives. All members of the Planning Committee were given a flyer to distribute within their communities. The flyers were also distributed via the listservs for the West Sacramento and Woodland Youth Coalitions and CommuniCare Health Centers distributed flyers to all youth enrolled in their outpatient substance abuse treatment. Additionally the Yolo County Department of Alcohol, Drugs and mental Health distributed flyers to their clients in treatment and in the Juvenile Detention Facility.

The planning Committee judged the contest and selected the top three essays to be read at the Summit. Each of the three winners received a \$100 prize.

Due to confidentiality concerns no information can be given about the three youths who wrote the essays.

Essay 1

An addiction is an easy way to escape, to run and hide. Or so the addict thinks. The reality is it just throws you into the middle of everything that your soul is crying to be free from. Even as a young girl sitting at my computer, I've seen things that would curdle a softer person's blood, and I've done things that nauseate me to this day. My past is a whirlwind of almost every drug you can name, eating disorders, self-mutilation and self-deprivation, overdoses, molestation, rape, running away from home, instability, and so much more. There's so much of my life that I can't even remember, and some that I can't stop remembering. This is my story of my many addictions.

My living situations have always been relatively unstable; I don't think I've ever lived in one place for more than two years. From birth until I was about four or five I was with mother in multiple houses and apartments in different cities in the American River area. My mom was born deaf, and quite a bit crazy. My first memory is of her watching her take a braided leather belt, and tie off to shoot up. That's pretty much the best way to describe what she was like. She hung out with bikers, and threw parties all the time. The people she kept around molested and raped me, which I'm still not completely over.

This is hard to admit, even to my keyboard, but I can remember sometimes I would run into a room and hide under a table or in a corner and urinate myself out of fear, I think, of the parties and the people. Everyone was so loud and obnoxious, and there was never an escape. I was so young. I also have memories of being about three four years old, and being so enraged with her that I would commit acts of self-infliction. I can remember taking my arm and just biting into it... as hard as I could until it bled, not even feeling the pain. Only feeling the release, some sort of twisted emotional gratification that comes from hurting myself when I'm overwhelmed.

I later returned to this habit of self-mutilation at about twelve, using methods of cutting, burning, searing, asphyxiation, and anything else creative I came up with. I'm covered in scars everywhere, but they're around to remind me of what not to do now and in the future. Jump forward, I'm about twelve or thirteen, and living in Oregon with my maternal grandparents. I've lived with almost every family member I have. At that time, I was really messed up in the head, and I'd already tried to kill myself over a dozen times in about a dozen different ways. I'd spent the last two or three years drinking absurdly heavily, smoking weed, selling and experimenting with acid, and that's when I find heroin.

Now, both of my parents have been to prison and used needles, and I'm deathly afraid of diseases. So my best friend at the time and I 'rail' it, which means put it up our noses. After a few months of that, I get sent to a rehab for teens in Nevada. After rehab, I come back to Oregon, and all of my belongings were taken out of my room during the sixty days I was gone. The bed that was built into the wall, the pictures and posters on my walls, everything was gone. I spent the next three days curled in the fetal position, crying hysterically, and having black outs in the middle of the floor of my empty room.

Once I leave my room for food, I see two half gallons of my poison at the time – Potters vodka. I leave it alone; I don't want to go back to what I was. A few days later, my grandfather tries to rape me, and my sobriety goes out the window as the first handle goes down my throat. I woke up in my own vomit, one of many times I've awoken that way. Anyways, after a few days my grandmother decides to choose him over me, so she buys me a plane ticket to Sacramento and tells me to pack my stuff. I have no place to go, I'm not sure what's going to happen, but I'm really not that scared. It's just another move.

I get to the airport, and I find my dad's phone number, who has just gotten out of prison on parole for good behavior. So he saves my skin and lets me stay, and I end up moving in. After a

while, that doesn't work out, he's too violent. I go to the police, but they won't help me, after all, they never really had before. Getting the police involved just ended up in a bunch of conflict, but I ended up moving out. Eventually after moving around, I was back to smoking weed, drinking, doing ecstasy pills, and had developed a fondness for cocaine at fourteen years old. After another suicide attempt I got too tired of it all, and left home. Intending to leave for good, and officially dedicating my life to doing drugs and evading the authorities, is where I lost what miniscule control over myself I ever had.

Living out on the streets I thought I was fine, because I was never raped, molested, abused, or victimized. I had it covered. I never got in a fight I didn't win, and I never went without a weapon in case of emergency. Always going into my situations carefully, money wasn't an issue. I ate what and when I wanted, I did what drugs I wanted, I went where I wanted, and I partied whenever and wherever I wanted. I had control over everything in my life. Cocaine was introduced to me before meth, and has always been better to me. Cocaine gave me an egotistical feeling and high that I just adored with every part of my mind, and I already had a habit of putting stuff in my nose.

After quite a while, I finally got arrested and taken to C.R.H. in Sacramento, which is the Child's Receiving Home. It's the first group home you get booked into when you don't have anywhere to go. When the cops picked me up I was tripping on acid, seeing colors and shapes and just having a grand old time in the waiting room. Once I got to my room I stayed up all night and waited for a day or two to figure out the staff's shift changes, went out the window, over a ten foot fence like it was nothing and was gone.

Once I was back out, I got arrested again, and decided it was time to come home. I moved to my current location in Woodland with my dad, and it was a tearful return. I was thinner than anyone had ever seen me, my collarbones could be seen all the way out to my shoulders, and I must have been about a hundred pounds. To give you an idea, my ideal weight is about 135, which is still slim for my body. My father has changed a lot, too. We still have our problems with each other, but it works. I'm going to graduate a year early, even after all of the schools I failed at and got expelled from. My life today is something I can be and am proud of. September 7th of 2007 is my clean date, with no relapses so far.

The thing with addiction is, it's not just in a person's mind. It kind of is a person's mind. It's in the way I think, the way I speak, the way I act. My addictions distort the way I perceive my world, the way I react to things. All of my urges still come and go. Sometimes I just want to feel that pain. Some times I just want to feel that numb. No matter what, I want my life tomorrow, and that means I have to sacrifice the easy way out today.

Essay 2

My Life Story (Drugs in My Life)

Drugs have affected my family's lives in a bad way and have controlled my family since I was a baby. Growing up I thought it was normal for everybody to get high or do drugs because my family did. My mom has nine kids: seven boys and two girls. She lost custody of four of my brothers and one sister because of her heroin addiction. To this day my uncles still use heroin. And I've lost one uncle to the use of heroin. My mom is still a heroin addict. She is currently in a hospital recovering but it sucks because when she gets better, I know she will begin using heroin again, which in turn, hurts my brother and I. I was addicted to marijuana and I experimented with other drugs as well as alcohol. Today I'm clean and sober. The first time I used drugs I was about eleven years old. The first time I tried alcohol I was ten years old and I went to school the next day with a hangover. I have one brother who was sent to jail at fourteen for drugs and robbery and he was released at twenty-three. Now he's a preacher and he's getting married. Now I live with my brother who was in a lot of trouble as a kid and as an adult. He was addicted to meth for about two years and had to go to rehab to get his life back together for his kids. I lost one of my sisters to crack and AIDS. She died at twenty-seven and it hurt me the most because we were really close. In a way, I considered her my mom because she raised me and taught me a lot of things, some good and some bad. I knew about drugs at an early age. I remember as a kid watching my mom and uncles shoot up heroin in front of me. I remember when I made this drug dealer give my uncle some heroin because he was really sick. I watched a man overdose in my house, and my uncle slap him and tell him to wake up because he was scared that the guy was going to die. That incident was scary and that's why I never did heroin. I remember people coming over just to get high and lay low. I remember them buying me things and then taking it back just to sell it for drugs.

We never had money growing up so we depended on welfare and food banks. All my mom and uncles thought about was heroin. Since my mom was always high she couldn't take care of me, so my grandma raised me the best she could and I love that woman for that. My family has always had trouble with the law and I recently got off probation. My fifty year old uncle is still in and out of prison because of heroin. It's made my family very dysfunctional. All we do is take advantage of each other and treat each other like dirt. The only time my family gets together is when there's a funeral. My brother and I still go visit my mom and family in Stockton when we can. My uncles never really had jobs or places of their own. They just lived off my grandma and took from her so they could get high.

I used to sell drugs as well. I'm not proud of it but I sold to my family, friends, and strangers. It has made my family turn on one another and has made us really distant, which sucks. I have a lot of family that I don't know and might not ever know because of drugs. Drugs made my family really lazy and made them not care about anything but drugs. We lived in a three bedroom house with about ten people living there. My house was always filthy, messy, and infested with roaches and mice. I never had clean clothes so when I did go to school I was dirty and embarrassed. I never really went to school because I thought I was grown up already. I would smoke weed and get drunk before I went to school every morning. We had to lie to cops for my mom and uncles. We were always dumpster diving and looking for cans to trade in for money. I was always around grown ups so I kind of grew up quickly thinking I knew everything, but boy was I wrong. I was doing grown up things at the age of fourteen. I had to learn how to push myself because everybody was too worried about getting high and staying that way. I have seen a lot of violence due to drugs and alcohol. When the schools would ask me how my family was I would always lie and say that everything was okay when really it wasn't. I have an uncle who

comes over to visit my brother and me and he's always drunk. I would wake up every morning looking forward to selling drugs and getting high. I don't think I went a day without getting high. I would walk the streets at three in the morning looking for weed. I would walk the streets with my sister getting rid of crack as she was teaching me about the streets. My drug dealer was my sister's husband and when they would go to Reno he would leave me with the drugs and a phone until they came back. I was becoming known in the streets as a drug dealer. I would have people looking for me because they knew I had what they wanted. There are about six people who know that have died from drug related incidents. Some of those people who passed away would come over every day and get high with my family.

Even though all that has happened, some of my family members are doing okay. Like I said about my brother who got locked up at fourteen, he moved on and got his own place, is getting married and is preaching now. I have a cousin who has changed his life as well, and he lives in Stockton. So when I take trips there, I see him and I can tell he's happy now. I have even changed. I moved away from Stockton and came to Woodland. Then I joined a program called Yolo County Conservation Program (Y.C.C.P) and met a counselor who opened up my eyes to see that just because I grew up the way I did doesn't mean that I couldn't be successful. Then I heard about a program called Friday Night Live (F.N.L), it's a program where kids and teenagers can be themselves without drugs, alcohol, and violence. Because I needed community service hours I signed up for their summer camp to help out with the youth. I ended up loving it because it gave me a chance to be a kid again, meet some really nice people and I ended up getting a job with them. That's when I got off probation and quit smoking marijuana. Now I have a lot of people who I give thanks to everyday for giving me a chance. It doesn't matter if you come from a messed up family or hard life there's always a chance to do good.

Essay 3

When I was younger I thought I would never be an addict. But here I am a couple of years later, the addict I said I would never be.

It all started with my mom and dad. My dad was an alcoholic and my mom was an alcoholic-addict. Ever since I was little I've always been around drugs and alcohol. SO, it seemed very normal for me, to be around drugs and alcohol.

I was in about seventh grade when I had started using drugs and alcohol. I was drinking on a daily basis. Then it slowly progressed to using drugs. I started using drugs on a weekly basis, but, it was only a matter of time before I started using on a daily basis.

Now, it was only a matter of time until my using would go out of control, and it did. My whole life was around drugs and alcohol. Whether it was I who was using, or I was with my family and they were using.

I did not notice that my using was getting out of control, until I was blacking out, and not remembering the things I did the other night. It was only then that I realized I was a young addict. It scared me at first, because I pictured an addict to be old, and gross; somebody that lived on the streets, and used all day long. Then I realized that I was just a young version of that. I know that if I kept it up I would be on that same road along with them.

The people I have hurt the most would be my family. My mom and dad don't look at me the same. But they are coming around slowly. I have put them through so much during my drug use. I remember times I could not even play with my little brother, because I was either too high or not high enough to play with him. All my drug use did was just brought me down. Because of my drug use my older brother does not even want anything to do with me.

So, all drugs did for me is get me so far in the gutter that nobody wanted anything to do with me. I know that I will always be an addict but, it's my choice whether or not I want to live that way. What I've learned today about my addiction is that I don't have to live that way anymore. I can make my own life without drugs and alcohol. I've also learned how to take responsibility for my own drug use and I try not to blame others.

Written by a 17 year old female from Yolo County Juvenile Detention Facility

Appendix 5

Plenary Presentations

Community-Based Youth Substance Abuse Interventions (Randy Snowden)

Introduction

Youth substance abuse is an enormous issue, both for the human suffering and death that's implicit in the problem; and also the cost to the community in public health terms: higher costs of medical care, law enforcement, incarceration, spousal and child abuse and neglect, reduced productivity, and lower educational attainment.

For years, our field was driven by enthusiasm and good intentions. Heavy reliance on adult models, which were in turn heavily based on anecdotal experience and often on very strong personalities. That resulted in a world that included:

- Youth prevention programming consisting of young teenagers being placed in shock groups facilitated by convicted murderers in state prisons.
- School based prevention programs that probably had a very beneficial impact on youth perceptions of police and other authority figures, and probably made police officers more understanding of youth, but which had a neutral or negative impact on youth drug acceptance and use.
- Drug treatment programs that let successful clients go bar-hopping on their graduation nights.
- Programs that wouldn't take clients who weren't motivated to become abstinent.
- Youth treatment programs that provided cigarettes to clients who couldn't afford to buy their own.
- Programs that kicked out clients who relapsed.

In retrospect, this is simply amazing.

Under Coach Bill Walsh, the San Francisco 49ers football team in the early 1980s would distribute before the game a list of their first 15 plays. And they still won. Today in the world of youth substance abuse, the plays have been released – they're called evidence based practices; the winning games are evidence based programs

This is possible because in the past 15 years there's been an avalanche of research; the findings were incorporated into program models; and in some cases the models were outcome tested; so we now have a lot of prevention and treatment models that can be formally designated promising, research informed, or evidence based.

So, it's relatively easy to lay out what a community should consider when crafting an initiative to reduce teen substance abuse.

Evidence based Prevention Principles

- (1) Whatever you do needs to be **ongoing**
- (2) Work toward a comprehensive, **continuum**: universal, selective and indicated interventions
- (3) Your foundation should be a **coalition** of key constituencies: youth, parents, schools, law enforcement, CBOs, faith based organizations, prevention and treatment people, health care people, etc.

- (4) You'll want **Wide community involvement** in needs assessment, planning, program selection, development, oversight, and advocacy
- (5) A strategic goal should be community wide **awareness and education**
- (6) Promote **“normative beliefs”** (self knowledge, personal responsibility, respect for others, anti-drug beliefs, non-use norms) at the individual, family and social group levels
- (7) An important corollary to “normative beliefs:” tackle head on community and parent beliefs regarding underage drinking, binge drinking, gateway drugs, and other illicit drug use
- (8) Promote **positive attachments** to socially normalized groups, like family, school, sports, churches
- (9) Educate and train parents about **early childhood development** and **parenting skills** (organic brain development, self-efficacy, child rearing, social support, setting behavioral expectations, supervision, effective discipline, problem solving)
- (10) Create and enforce **laws restricting access and use – and that increase actual and perceived risks** of substance abuse
- (11) **Responsible beverage** programs
- (12) For at risk groups and individuals, **curriculum based prevention programming** – brief motivational enhancement and cognitive behavioral interventions that promote social and emotional competencies (communication, decision making, avoiding trouble, conflict resolution, aggression replacement, anger management, coping skills, problem solving, resisting peer pressure, and goal setting)
- (13) Your entire initiative should be informed by the **Youth development** model.

Evidence Based Treatment Principles

- (1) **Diagnostic screening**
- (2) Standardized **level of care** assessment
- (3) **Empathic engagement**
- (4) **Comprehensive** multi-domain assessment, treatment planning and **case management**, including co-occurring mental health issues
- (5) **Stages of change**
- (6) **Motivational enhancement and cognitive behavioral therapy**
- (7) **Behavior modification**
- (8) **Diversity**
- (9) **Family** involvement
- (10) **Youth development**
- (11) Ongoing support during the community **reentry** phase

The play book is open. We know what we need to do. So why do so few communities across America have a comprehensive continuum of youth prevention and treatment services?

The common answer is money.

If money is your only problem, it means you're 90% of the way to success. If you're starting from scratch, money is only 10% of your problem, so don't let it hold you back.

So what are the impediments?

1. Barrier #1: We're all in the movie. Research has identified the likely markers for adolescent addiction:

- (1) Genetic predisposition
- (2) Untreated mental health issues
- (3) Trauma, including molestation or physical abuse

- (4) Undetected developmental issues and learning disabilities
- (5) Family use
- (6) Social pressure and peer affiliation

But even if a 13 year old has all six of these, it's still astounding that thousands of children can devolve to daily drug use while they're living in a home where people love them; and attending school, where they interact with dozens of trained adult professionals who have dedicated their lives to children.

Our community and we individuals that make it up – may be a part of the problem, too; we are in the movie. And our unwillingness to face up to that sabotages the chances of successfully addressing it.

Just as the mother's judgment is impaired, ours is, too. We really care too much, so, in desperation, we cling to familiar, but outdated practices within our disciplines. The treatment person who says that drug courts are too harsh, the police officer who says punishment is a necessary intervention for addiction, the therapist who says that 1:1 counseling is an effective intervention for a 16 year old who only happens to be an addict – we are all saboteurs.

We need to take acknowledge that our involvement as parents, community members and professionals is clouding our judgment.

We must join together in a blood oath to follow evidence based practices, even if they feel ... paradoxical.

2. The Nettlesome Little Problem of Values. [“normative beliefs”]

At least in our comfortable, well informed Northern California world, there is a deep seated reluctance to promote values systems.

“Family values” originally gave this issue a bad name. Today, the term “Family Values” has been so perverted by the political process that it seems synonymous with insincerity at best, demagoguery at worst.

It is essential for a community to come to terms with the “values” issue if we're serious about attacking youth substance abuse and addiction.

As I use the term, the issue is less what a family's values *are*, more the question of *whether a child is growing up in a social system where behavior is expected to be guided by an external value system*, rather than considerations based solely on *self gratification or expediency*.

And, do the adults validate this value system by investing time in the process, explaining values *and their important corollary, limits*, and then helping children apply them in their everyday lives?

And, do we adults consistently follow them ourselves?

There are layers to “values.” The first layer is the child herself. Next is the layer of the households where our children are growing up. My personal hunch is that too many of us – and I include myself in this – shy away from our responsibility to establish and consistently observe a framework of ethics and values when we're interacting with youth.

This is because, as soon as our children confront us on this, we realize, values really aren't “cool.” We prioritize the immediate, collegial relationship with children over our long term responsibility as adults. As a result, too often, values aren't expressed, and limits aren't set until a child is in deep trouble and we adults are frightened and mad. That's not a productive time to introduce a values system to a child.

So, that's “values” at the family level.

Another layer for “values” is at the community level, like when we come together like this to address youth addiction. Let's say that I'm right and an important ingredient in creating

resilient successful young adults is to teach them how to shape behaviors by use of an external values system.

This is the moment when “values” can crash on the rock of diversity. Your values aren’t my values.

Don’t let yourselves get derailed. The question is, are there values, not what the values are. It doesn’t matter if they’re militant Black power values, or Buddhist values, or San Francisco Rainbow Coalition values or conservative Christian values. Is there a family values system?

Why am I belaboring this?

A lot of the key evidence based interventions for youth substance abuse, like Motivational Enhancement Therapy, the more generic CBT, the oft misunderstood behavior modification, assume decisions regarding behavior will involve hesitation and objective thought.

Values are the overarching principles that a human being needs to guide that process.

Pursuing the values model, there’s another layer beyond child, family, and community, which comes up as we move out into our institutions. So many children who use drugs end up in the juvenile justice system.

System is largely informed by the adult justice system, where there’s an expectation that punishment – dressed up in terms like “learning the logical consequences of bad choices” – punishment will effect a change in a child’s ability to think logically and alter her behaviors.

You’re with me on this proposition: Post facto punishment teaches a child values?

I’m not aware of any evidence base to this assumption. It’s like discussing a low fat diet when a heart attack victim is being defibrilated. The way we create that ability in a child isn’t through punishment. It’s through proven, evidence based service models delivered at other times in the child’s life – well before the punishment issue arises.

My suggestion is that any successful community initiative is going to have to leave its comfort zone and confront the values issue.

3. Diversity

This is both the simplest issue to describe but often the most difficult to address.

The road to Hell is paved with good intentions, and nowhere is that more true than in the area of diversity.

The difficulty, of course, is that we all think we’re good at understanding diversity – that we live it in our lives. We’re not and we don’t.

When I was at Thunder Road, we were thrilled when the East Bay Recovery Project asked us to partner with them to work with addicted Asian teenagers. The Project was a brand new collaboration of five agencies with different Asian “centricities:” Chinese, Japanese, Korean, Cambodian, Pacific Island – the gold standard for Asian cultural competency in the East Bay Area. We had only been working together for a month or two when the Project asked for a time out. They came back a year later to explain that they had figured out that they were trying to present a monolithic “Asian” façade for what they eventually decided were over 50 Asian-Pacific sub-cultures.

To avoid getting stalled around diversity, embrace a diversity model from the outset.

If you need to, bring in an outside advisor – otherwise, it can be difficult to confront this sensitive issue within your group, even with the best of intentions.

A little more time invested at the front end could save your whole initiative later on.

4. Youth Development.

The other road to Hell is Youth Development. This is an evidence based approach to youth services that emphasizes inclusion of youth in a way that allows them to have a meaningful impact on their world. It’s as tricky as diversity because it also concerns the sharing

of power. Which is especially tricky when you're dealing with a group of children who may be suffering from a values deficit, lack of limit setting, and so on.

The evidence base for youth development is strong. If you have it working in your county already, you're ahead of the game. If not, bring in some experts, like the Youth Leadership Institute from Marin County.

5. Collaboration – Criminal Justice.

There are different verbs to describe the interactions among groups that are trying to work together. They can communicate; or coordinate; or collaborate; or integrate. To successfully mount a community wide initiative to address youth AOD use, I'd suggest that the constituencies – juvenile justice, schools, providers, community groups, and so on – your relationship has to go way beyond integration. You need to get married and have children together. Unless the relationship is that close, you'll probably be unsuccessful.

One constituency that often has difficulty in this area is juvenile justice professionals – law enforcement, parole, courts, district attorneys.

Think about how this all looks from their perspective.

The public expects them to punish offenders; financial support for their supervision and treatment activities have been declining for decades; they're constantly exposed to the most sociopathic people in our community. And, they haven't seen any of the rest of us come up with a plan to effectively address the problems of youth substance abuse, gang affiliation, truancy, pregnancy, or crime.

To top it all off, when a youth finally offends, it's like we've flipped the lights on and who does the public see standing right there next to the offending youth? The criminal justice folks.

We need to recognize the vulnerable political position of the criminal justice players in a community collaborative. They're the ones who will take the first hit in the morning paper when something goes astray.

What do we do about it? First, spend extra time learning about evidence based practices – they exist for youth addicts who have entered the criminal justice phase.

Then, expand your planning focus beyond outcomes involving just substance abuse to include to CJ outcomes, like gang affiliation, violence, recidivism and truancy.

Publicly share the heat – form a high profile coalition, adopt guiding principles, and share in the responsibility for your program design and its consequences.

Proactively educate the public on what you're doing and, when a case goes the wrong way, as they occasionally will, don't leave anybody out on the limb in the public's perceptions.

6. Collaboration: AOD Professionals

As far as potential barriers to a successful collaboration go, criminal justice is the problem child, right? The only constituency that has historically not "got" EBP? We can be confident that, once a child makes it into a professionally designed and operated prevention or treatment program, we're home free, right?

Wrong.

My observation as someone who has been the director of two adolescent prevention and treatment programs is, we alcohol and drug professionals seem to be sublimely comfortable bypassing evidence based technology.

This is ironic, because AOD services are actually better researched than a lot of the other social services – child welfare, poverty, probably all of the human service disciplines except physical medicine.

Let me ask the treatment folks here tonight if you've ever had an experience like this? You're in a treatment planning conference. The 16 year old addict has been stuck in the "contemplation" phase of the stages of change. He has finally told his counselor that he thinks he should go ahead and try to get clean and sober and is ready to work on a plan.

"So it's time to promote him into the planning phase, right?"

The counselor says, "well, he used over the weekend, so we can't *reward* him with phase change!"

How many youth are held back in treatment because they got fired from their job, or their grades weren't good enough, or they didn't go to school at all, or we were so worried about their safety, we held them back in treatment to protect them?

Where I'm going with this is, if anything, prevention and treatment professionals are more uncomfortable with evidence based practices than people who haven't been trained for the field.

Many of these practices are "paradoxical" when compared to traditional treatment assumptions.

Probably the most conspicuous example, equally offensive to criminal justice and treatment professionals, is that, in the early stages of treatment, abstinence *is not* the goal. Progress in the stages of change is the goal. Going straight to a goal of abstinence is such old technology that it's malpractice – yet, how often do we find it driving the bus?

So, AOD professionals, our job is to realize that our minds have to be just as open as everybody else's.

7. Money.

Alcohol and drug treatment funding started with a trickle for alcoholism because normal, middle class people sometimes caught alcoholism. Then came the Viet Nam war, and we had thousands of soldiers coming back with a little problem of heroin addiction. So the county systems began to receive the Federal Substance Abuse block grant. Adult treatment programs sprang up to soak up all the money.

Then the experts woke up to the need for prevention, so the Federal government created the "prevention set-aside." Counties had to spend at least 15% of their block grant money on prevention.

More recently, they woke up to youth addiction. Or, actually, opened one eye briefly and rolled over. New Federal money was added as the "youth treatment allocation." That came to about 1% of the block grant.

In Napa County, our Alcohol and Drug Division budget is about \$4 million. The Federal block grant is about \$1 million. The Prevention set aside is about \$150. The youth treatment set aside is about \$15,000.

It's estimated that we have about 5,000 children in the county who are detrimentally involved with alcohol or other drugs.

That's \$3 in categorical, dedicated funding per child.

Whatever you decide you want to do, the fact is, normal funding streams will not get you started, let alone run anything.

My rule of thumb for *treatment* programs is, if you can find the money to start one, no matter how well you run it, you'll never be able to wring more than 80% of your cost out of conventional funding streams. The ratio for prevention programs is about 80% worse.

Go in with that understanding and don't waste time whining.

The best way to break through this is to find money in the community. There are fewer strings attached. Often, you can create a parade that you can develop into political influence to bring the government funders on board.

There are also some longer range institutional approaches to money. Ten years ago in Napa County, AOD was buried in two other divisions. Nobody was sure who the Administrator of Alcohol and Drug Programs was. The budget for AOD services was probably around \$2 million, although it was so blended in, nobody was sure.

Total expenditures for prevention were the \$150,000 set aside and there was *no* youth treatment.

Flash forward to today: alcohol and drug is a separate division on the same plane as Public Health, Mental Health, and Child Welfare. The division budget exceeds \$4 million. Youth prevention and treatment is around \$750,000.

I'm not suggesting this is any kind of model – we're not there yet. But it is proof that institutional change is possible if you prosecute a strategy persistently and pragmatically.

8. A Public Health Approach to Youth AOD Involvement.

There are a lot of different people out there making up our communities. Some of them believe that addiction is a disease. Some believe it's a choice. Some believe it's a crime. Some believe it's a sin.

Don't let your efforts run onto this rock of discord. You may find it useful to "sell" your movement on a straight public health platform: you're saving the community money.

The truth is, you're also saving lives, reducing misery, poverty, child abuse, malnourishment, emergency room visits, unemployment, spousal abuse, and homelessness. But, when in doubt, go to the public health model: "research has shown that we can reduce the cost to our community by addressing these problems with these evidence based practices."

Done.

A Few Other Suggestions to Actually Get Something Going


1. Don't let your efforts get subsumed into some other or larger public health initiative; youth AOD will get lost. Sorry, that's just what happens.
2. Create infrastructure – it will help bridge the weak times; create divisions, build budget units, every little program helps build legitimacy.
3. Gather data to support funding.
4. Don't get hung up by the data freaks.
5. If your strategy relies on anything beyond your control, it's worthless. Develop a plan that you can control and stick to it.
6. Rely heavily on the community, which probably means strong role for non-profit sector. They have money options that government doesn't have.
7. Don't dig on over internal control. That will regress to non-collaboration. Every therm burned up in internal friction will equal a disproportionate weakening of your whole effort.
8. Balanced strategies, build a continuum. This isn't rocket science. The technology is there. The thing that's usually missing is execution. Any football team could have taken the 49ers play list.
9. Think about money creatively; if you wait for the conventional funding streams to make it possible, it won't happen; the closer you can come to printing your own money, the better.
10. Leadership – threshold issue is the individuals in this room. We have to accept this as an overarching, unavoidable, priority. We have to acknowledge our responsibility for the problem of children using drugs and unequivocally step up to do something about it.

Substance Use and Adolescent Brain Development

Martin Anderson MD

(Dr. Anderson's presentation was an informal discussion of the information in the following slides. It does not translate well into a verbatim transcription. The notes to the right of each slide capture his key points.)

Adolescents are:



- Age: 10-19
- 40.7 million

There is no consensus about the age range that defines adolescence. A fairly common one is young people ages 10-19. I am using this one just because the 2000 census used this categorization.

According to that last census there are approximately 40.7 million adolescents in the US. The exact number is 40.747.962

Shakespeare

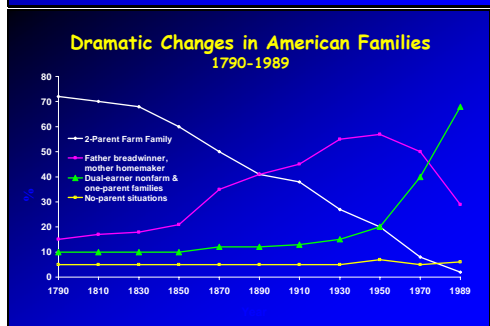
- I would there were no age between ten and three-and-twenty, or that youth would sleep out the rest; for there is nothing in the between but getting wenches with child, wronging the anciently, stealing, fighting.

Even in Shakespeare's day Adolescence was seen as a time of great turmoil

The Primary Challenges of Adolescence

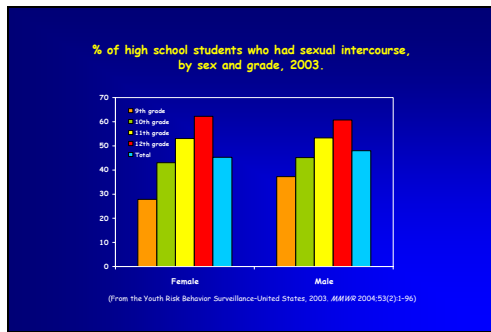
- The achievement of biological and sexual maturation
- The development of personal identity
- The development of intimate sexual relationships with an appropriate peer
- Establishment of independence and autonomy in the context of the sociocultural environment.

Adolescence is a time when each person needs to determine who he or she is and wants to become.



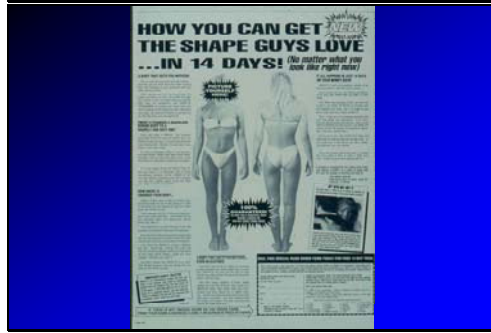
Today this is happening in the face of dramatic changes in how families are structured and the roles they play.

A teens' expected role in the family can vary widely depending on culture.



Teens are influenced by numerous and changing influences and expectation.

Today a majority of adolescents are sexually active.



They are bombarded by images of how they should look, act and be.



There is a particular focus on body image, especially for girls...

Adolescent Weight Control YRBS 2003

	Male		Female	
	9th grade	12th grade	9th grade	12th grade
Risk of overweight	14.3	15.5	14.5	12
Overweight	17.8	13	10.5	6.7
Self-described as overweight	22.6	24.1	33.1	38.7
Trying to lose weight	31.2	28	54.1	61.7
Exercised	50.2	46.4	65.7	63.2
Dieted	28.8	29.8	53	57.9
Fasted	10.7	6.9	18.3	15.7
Used pills	7	8.5	9.2	13
Used laxatives	4.6	3.8	7.9	7.3

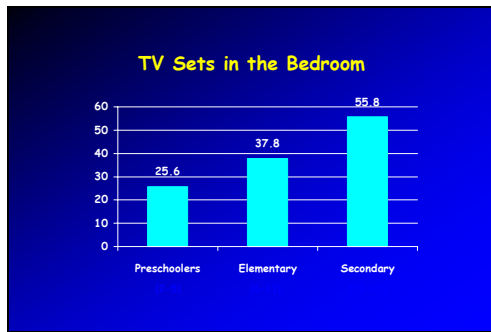
... with a particular emphasis on weight control...

% Physical Activity YRBS 2003

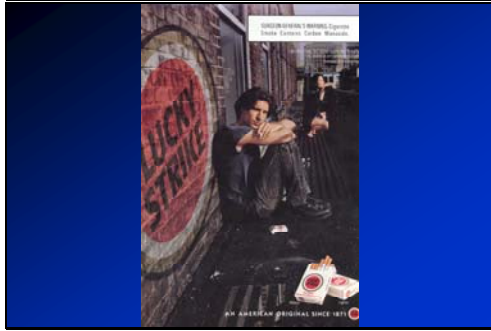
	Male		Female	
	9th grade	12th grade	9th grade	12th grade
No vigorous or moderate physical activity	8.4	10.9	9.7	17.0
Inadequate physical activity	23.8	32.1	32.7	48.5
>3 hours TV watching per day	46.5	29.9	41.2	31.3

... in spite of the fact that in America today, teens are less physically active than ever before.

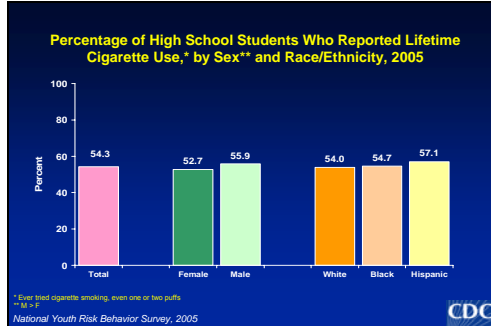
Mass media, in particular, television have a huge impact...



... and present images that promote substance use.

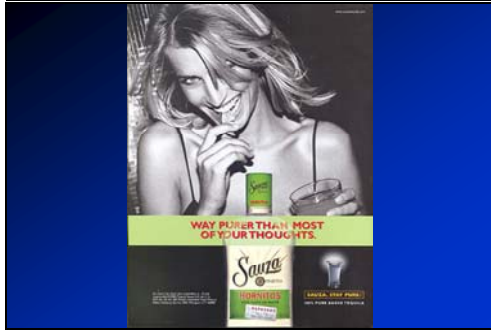


Nationwide in 2005, 54.3% of high school students had ever tried cigarette smoking (even one or two puffs) (i.e., lifetime cigarette use). Overall, the prevalence of lifetime cigarette use was higher among male than female students.

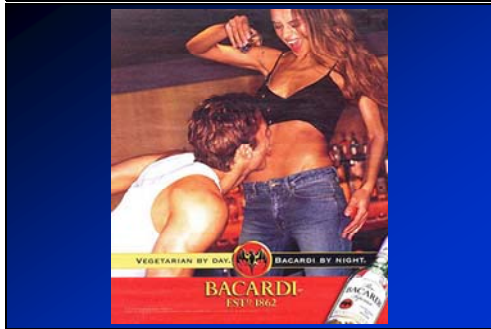


Sophisticated marketing campaigns present alcohol use as glamorous, sexy and something to be done in a variety of settings

...

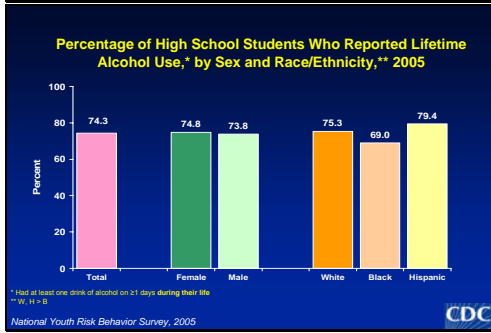


... and in ways that can lead to all kinds...

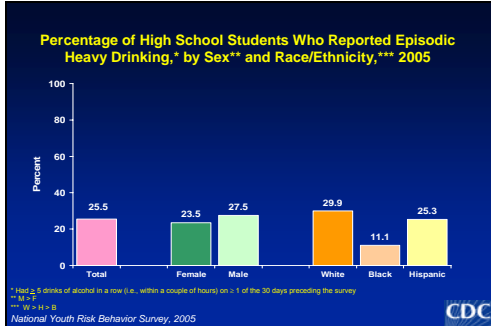




... of risky behaviors.



Nationwide in 2005, 74.3% of high school students had had at least one drink of alcohol on one or more days during their life (i.e., lifetime alcohol use). Overall, the prevalence of lifetime alcohol use was higher among white and Hispanic than black students.



Nationwide in 2005, 25.5% of high school students had had five or more drinks of alcohol in a row (i.e., within a couple of hours) on one or more of the 30 days preceding the survey (i.e., episodic heavy drinking). Overall, the prevalence of episodic heavy drinking was higher among male than female students, higher among white than black and Hispanic students, and higher among Hispanic than black students.

Alcohol Use Trajectory Groups Identified in Longitudinal Research on Adolescents

Trajectory Group	Alcohol Use Pattern	Approximate Representation, %
Abstainers/light drinkers	Stable low use or nonuse of alcohol	~20-65
Stable moderate drinkers	Stable moderate use, limited heavy use	~30
Fling drinkers	Time-limited periods of heavy use	~10
Decreasers	Early onset but declining course of alcohol use	~10
Chronic heavy drinkers	Early onset and stable course of heavy drinking	<10
Late-onset heavy drinkers	Late onset with rapid escalation to heavy drinking	<10

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While by no means are all teens involved in behavior that will "ruin their lives forever" the trends are alarming.

- Risk Factors for Alcohol, Other Drug Use and Risky Behaviors**
- FAMILY FACTORS**
- Positive family history of alcohol or drug abuse, dependence, or both
 - Dysfunctional parenting style
 - Permissiveness or authoritarianism
 - Conflicted families
- PROBLEM BEHAVIORS**
- Antisocial behavior
 - Negative affect, low adaptability, impulsivity
 - Aggressiveness
 - Early sexual experience
 - Attention deficit disorder

Reversing the trends is a major challenge. Fortunately there is sound, research based information identifying the significant risk factors that can predict later substance abuse problems.

Risk Factors for Alcohol, Other Drug Abuse and Risky Behaviors (2)

SCHOOL FACTORS

- Early school failure
- Incomplete homework and truancy
- Lack of commitment to education

COMMUNITY FACTORS

- Ready availability of alcohol and other drugs
- Tolerance for the use of alcohol or illegal drugs
- Overpopulated, disorganized and deteriorating neighborhoods

OTHER FACTORS

- Association with drug using peers
- Early onset of drug use
- History of sexual abuse

The Challenges for Young People

- Challenging authority
- Taking risks
- Experimenting with drugs, alcohol and sex
- Challenging the moral and social structure of society
- Demanding rights
- Taking responsibility for self and others
- Seeking spiritual paths (organized or cult religions)
- Getting a job
- Changing schools and educational environment
- Developing relationships
- Understanding sexuality
- Renegotiating rules at home

Psychosocial Development of Adolescents

Task	Early Adolescence
Independence	<ul style="list-style-type: none"> • Less interest in parental activities • Search for new people to love or admire • Wide mood swings
Body Image	Preoccupation with self and pubertal changes Uncertain about appearance
Peers	Intense relationships Some sex friends
Identity	<ul style="list-style-type: none"> Increased cognition Increased fantasy world Idealistic vocational goals Increased need for privacy Lack of impulse control <ul style="list-style-type: none"> Testing authority Sexual jokes Center stage Unique life

Josh Billings (1815-1885) American humorist and lecturer.

- When I was a boy of fourteen, my father was so ignorant I could hardly stand to have the old man around. But when I got to be twenty-one, I was astonished at how much the old man had learned in seven years.

Psychosocial Development of Adolescents

Task	Middle Adolescence
Independence	Peak of parental conflicts
Body Image	General acceptance of body Concern over making body more attractive
Peers	Peak of peer involvement Conformity with peer values
Identity	Increased sexual activity and experimentation Increased scope of feelings Increased intellectual ability Feeling of omnipotence Risk-taking behavior

Addressing these factors must be done while still recognizing the fact that adolescence is a time of life when teens are changing and growing.

That growth requires a certain level of turmoil and risk.

While stressful for both teen and parent. Millennia of human experience show that outcomes are usually positive.

Major problems arise, however, when teens inject mind-altering drugs into the process of development.

Psychosocial Development of Adolescents

Task	Late Adolescence
Independence	Reacceptance of parental advice and values
Body Image	Acceptance of pubertal changes
Peers	Peer group less important More time spent in sharing intimate relationships
Identity	Practical, realistic and vocational goals Refinement of moral, religious, and sexual values Ability to compromise and to set limits.

Adolescence is a time when a girl or boy creates the foundation of the person she or he will become.

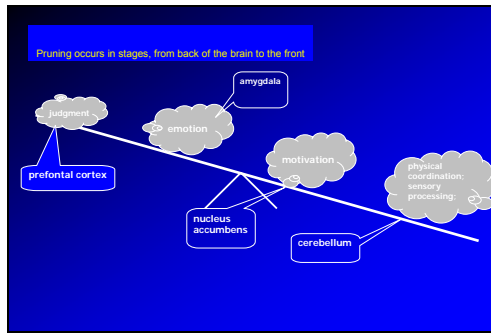
Psychological Effects of Timing of Puberty

	Early Puberty	Late Puberty
Biological	Taller than peers but may end up short	Short stature but later should achieve normal height
Psychological	Psychological effects positive in boys (higher self-esteem) negative in girls (low self-esteem)	Low self-esteem in boys; no major problems in girls
Social	Different from peers: treated as adolescent while still a child	Treated by adults and peers as less mature than real age; difficulty in separating from parents and in getting work.

It is a period marked by critical developmental phases.

- ### Brain Development
- During late childhood, neurons get bushier and increase in the number of connections.
 - At about age 11 in girls and age 12½ in boys, this thickening undergoes pruning.
 - At the same time, the myelin sheaths that encase nerve cells thicken.
 - Myelin sheaths are like insulation on a wire; they make nerve cell transmissions faster and more efficient
 - Net effect when complete is faster, yet fewer, connections in the brain.

... and drugs can alter that developmental process.



The child's brain develops in stages with the critical thinking and judgments maturing later than other functions.

- NA = regulates motivation to seek rewards
- Amygdala = emotional processing center; evaluates relative pleasure vs. aversiveness
- PFC = planning; setting priorities; organizing thoughts; suppressing impulses; weighing consequences of one's actions

Age 24

Brain Development

- Back of brain matures before to the front of the brain...
 - sensory and physical activities favored over complex, cognitive-demanding activities
 - propensity toward risky, impulsive behaviors
 - group setting may promote risk taking
 - poor planning and judgment

Brain Development

- Back of brain matures before to the front of the brain...
 - activities with high excitement and low effort are preferred
 - poor modulation of emotions (hot emotions more common than cold emotions)
 - heightened interest in novel stimuli

Are adolescents more susceptible to alcohol than adults?

- Adult studies suggest that the areas of the adolescent brain that are remodeled are sensitive to the effects of alcohol
- **Four** pieces of evidence

Are adolescents more susceptible to alcohol than adults?

1. Adolescent rats are less sensitive to the sedative and motor impairment effects of intoxication

The developmental process continues into the mid twenties.

Because the teenage brain is still changing and growing, teens who use alcohol or other drugs are at far greater risk of serious consequences.

Supporting Human Studies

1. Reduced sensitivity to intoxication

Are adolescents more susceptible to alcohol than adults?

2. Adolescent rats are more sensitive to the social disinhibition induced by alcohol use

Are adolescents more susceptible to alcohol than adults?

3. Adolescent drunk rats perform worse on memory tasks than adult drunk rats

impairs memory to memory

disrupts the hippocampus

brain damage in the PFC

planned thinking

(Brown, 2002; Wuethrich, 2001)

Supportive Human Studies

- Adolescents with a history of extensive alcohol use, compared to a control group...

Reduced hippocampus volume (10-35%)

Less brain activity during memory tasks

Are adolescents more susceptible to alcohol than adults?

4. Hyperexcitability issue

- Alcohol relieves hyperexcitability state
- Relief is temporary; continued seeking of alcohol is reinforced
- Hyperexcitability is a key characteristic of conduct disorder, ODD and ADHD, which are often co-morbid with alcohol use disorders
- Hyperexcitability...
 - may have its origins in neurological deficits
 - found in non-alcoholic relatives - suggests inheritance of this trait

Are adolescents more susceptible to alcohol than adults?

Increases reinforcing properties

1. Reduced sensitivity to intoxication
2. Increased sensitivity to social disinhibitions
3. Medicates "hyperexcitability"
4. Medicates "hyperexcitability"

Are adolescents more susceptible to alcohol than adults?

Greater deficits

- 3 Greater adverse effects to cognitive functioning

• Neurodevelopment may contribute to....

- > risk taking (particularly in groups)
- > propensity toward low effort - high excitement activities
- > interest in novel stimuli
- < capacity for good judgment & weighing consequences

Shakespeare

• MACDUFF: What three things does drink especially provoke?

PORTER: Marry, sir, nose-painting, sleep and urine. Lechery, sir, it provokes and unprovokes: it provokes the desire but it takes away the performance.

And those consequences have been known throughout human history.

Substance Abuse Vignettes

(The following Vignettes were used to prompt discussion during the noon session on Day 2)

CASE 1:

Roberto is 15 years old and last weekend he was arrested. Saturday night, seven 15 and 16 year old males were arrested for disorderly conduct, breaking and entering a convenience store, and possession of meth. All the arrested teens were Latino and all were members of the Sureño gang.

- What Questions would you want to ask Roberto?
- Who is best suited to interview Roberto and find out what is going on?
- What barriers do you predict in him being honest with you?
- Can you promise confidentiality?

Roberto reports that he uses meth no more than once a week. He would use it more, but he'd rather sell and have the money. He is afraid of telling too much, but here is what he admits:

- All the arrested teens are first generation Mexican Americans;
 - He has been arrested twice before; once for possession of alcohol and once for assault. Both times he was given community service.
 - Roberto says he belongs to the gang because it provides him protection, friendship, and social activities;
 - The gang uses and sells meth at the schools and local malls
 - He rarely goes to school because he says he's not very smart and the teachers don't like him.
 - Roberto comes from a single parent home. His mother speaks only Spanish;
 - His mother works two jobs and is gone from 6 am until 10 pm.
 - His has three younger brothers and sisters who are cared for by a neighbor.
 - Roberto says he uses half of the money he makes from selling meth to help support the family (rent, care for younger siblings)
 - Mom is undocumented and uninsured
-
- What steps should be taken to deal with Roberto? Please note, there are no in-patient treatment facilities in Yolo County.
 - What should the police and justice department do with Roberto?
 - What health care services are needed?
 - What should the schools do with him?
 - What advice should we give his mother? How responsible is she for his behavior?

CASE 2:

1. Robbie is a 15 year-old high school sophomore. He is a good student, although he gets very stressed out by exams and competitions from his classmates. He lives at home with a younger sister and both his parents who are well educated and solidly middle class. One Saturday night Robbie is brought home by police in middle of the night. He snuck out of the house and was found smoking marijuana in a local park.
 - a. At this point, what should be the police's response?
 - b. What should be the parent's response (both right now and the next day)
2. The next morning Robbie says he rarely uses marijuana but does admit to daily use of ecstasy for anxiety and to make him feel better. He agrees that he needs some sort of professional help with his problems.
 - a. What services are available to Robbie and his parents?
 - b. He has health insurance through an HMO which provides very limited mental health and substance abuse treatment.
3. He goes to his family physician who spends 45 minutes talking with Robbie. He reports that he feels Robbie is depressed and prescribes antidepressants.
 - a. You ask the doctor if Robbie is using any additional drugs. The doctor tells you that State law requires that this information is confidential. If Robbie won't tell you himself, then the doctor can not share this information. How do you find out this information? How do you deal with communication?
 - b. Is there any role for drug testing? Can this be required by you?
4. Robbie goes to an outpatient drug program in Yolo County (John H. Jones is the only one) and 12 weeks later is discharged from the program drug free.
 - a. Can he now be managed at home? If so, what specific actions should his parents take?
 - b. How much control and how many restrictions should be placed on Robbie?
 - c. Is there a role of drug testing or do you just need to trust him?
5. Robbie has done well in school and has no disciplinary actions, no unexcused absences. His grades are very good and he has a 3.4 average. One night Robbie reports he is still stressed out by school and he asks for permission to smoke marijuana on weekends to relax. You do not agree to this. Two weeks later Robbie is found at school smoking marijuana on the school property.
 - a. Should he be suspended or expelled from school?
 - b. Should the school report this activity to the police?
 - c. Should he be arrested?
 - d. What is the role of confidentiality (between police and school)?
 - e. What is the role of the school in punishment/treatment?
 - f. What can schools do to be more sensitive to "at risk" kids?
 - g. Is there a role for random drug testing in school?

CASE 3:

Marilyn is a senior at high school where she has a solid B average. She is college bound. She also works 20 hours a week at a restaurant and plays volleyball. Her family is very supportive of her and discussions at home are usually open and frank. Marilyn had a boyfriend whom her parents liked and trusted.

Marilyn came to her mother this past weekend scared she was pregnant. She had unprotected intercourse which surprised her parents. At home they had talked often about sex and had encouraged Marilyn to start on birth control pills. They even bought condoms which they left in her bathroom should she ever need them. It turns out six weeks ago she was at a party and got drunk and had sex with her boyfriend. She says she just “forgot” to use protection.

- Is there reason to worry about Marilyn’s drinking or is this just developmentally appropriate behavior?
- If you are concerned, what would you do at this point?
- It turns out that Marilyn had taken a bottle of rum from her parents’ liquor closet. What issues does this raise?

Marilyn’s volleyball team wants to have an end of season party. Regina, the captain, offers to have it at her home but her parents know that Regina’s parents are rarely home and there is a strong chance there will be no parental supervision. They worry about drinking and drugs. Her parents agree to have the party at their home. Marilyn says that her friends are mostly seniors and they might want to drink. She asks if people can drink some alcohol as long as they sleep over and leave their keys with her parents

- Is this acceptable?
- If not, why? What would you tell Marilyn and what options would you offer her?

Marilyn goes to Regina’s house and promises not to drink. The next week she is picked up by the police. When they pulled over a driver for going through a red light they found Marilyn and her two friends in the back seat drinking beer and intoxicated.

- She is placed on diversion by the courts.
- What should her parents do with her drinking? Is this a problem?
- What services are available / needed?
- Should the school be told about this arrest?
 - If so, why? What should the school do with this information?

CASE 4:

Tuesday night the police picked up Rachel, a 16 year old. She was found downtown wandering around seemingly intoxicated. It turns out she had taken no alcohol, but her behavior was abnormal and she speech fast and slurred.

- What actions can the police take to determine if she was using drugs?
- Do her parents need to be contacted prior to any interviews?
- What rights does she have?

Rachel goes to an alternative high school and is a poor student. She has an amazingly low self esteem. Her school counselor reports she has a mild to moderate learning disorder and has no real interest in graduating from high school. Most nights she hangs out downtown with friends. She has no police record. Her parents both work 3 – 11 pm.

It turns out that she was taking Vicodin which her friend found in her parents' medicine cabinet.

What steps should be taken to help Rachel?

Where she should she be referred?

How do you understand her problem?

What next steps would you take?

CASE 5:

Susan Marino has two children age 15 and 13.

When putting away her son's clean clothes she finds a small bag of marijuana hidden in the back of his underwear drawer.

- How should she approach her "find"?
- Whom else should she tell?
- How does she know how serious a problem her son has?

He tells you the marijuana isn't his, but belongs to his friend and he was just holding it for him.

- Does this change your approach?
- Is there a role for drug testing?
- Would you refer him for help? If so, to whom?

Appendix 6: Summit Agenda

FRIDAY September 19

- 5:30** **Gathering Of Summit Participants**
- 6:00** **Welcome - Dinner Served and Dinner Exercise**
Participants have dinner with other members of their community to meet one another and to begin discussion of community substance abuse problems.
- 6:45** **Overview Of Evening and Charge for the Summit**
- 7:00** **Keynote Address**
Randy Snowden (Director Napa County Health and Human Services Agency)
- 8:30** **Final Evening Activities**
- 8:45** **ADJOURN**

SATURDAY September 20

- 7:30** **Breakfast Served** (Coffee at 7:15)
- 8:00** **Welcome and Introduction of Morning Speaker**
- 8:15** **The Youth Substance Abuse Problem**
Martin Anderson, MD (Director, Adolescent Medicine, UCLA School of Medicine)
- 9:30** **Community Work Teams Session 1: Problem Definition/Community Asset Identification**
Multi disciplinary teams from each Yolo County community will meet to identify the most critical substance abuse problems in their communities and their community's assets to help solve them.
- 11:00** **BREAK**
- 11:15** **Community Work Team Report Out**
Each Work Team reports its conclusions about substance abuse problems in its community.
- 11:45** **LUNCH SERVED**
- 12:00** **Lunch Time Discussion Three Pictures of Substance Abuse**
Large group discussion of possible responses to three realistic vignettes with input from a panel of experts.
- 1:45** **Community Work-Teams Session 2: Action Planning**
Each community Work-Team meets to develop action Plans to help solve problems identified in the morning.
- 3:15** **Work Group Reports and Leadership Panel Response**
Community Work Teams present their plans to entire summit. A panel of elected and other community leaders respond, offering suggestions and, as appropriate support to implement plans.
- 4:45** **Next Steps And Declarations**
Community Work Teams Identify their next steps to implement action plans. Individuals including leadership panel members, make declarations of the specific actions they will take to further the implementation process.
- 5:00** **ADJOURN**

Appendix 7a Problem Brainstorm

What problems do we have in our community that keep us “stuck” as we try to help kids with drug problems?

Lack of Communication & Collaboration	Lack of Resources & Money	Lack of Treatment Options	Family Issues	Society-wide Conflicts	Denial	Lack of Community Activities	Lack of Prevention Resources	Gangs	Lack of Youth Voice
<ul style="list-style-type: none"> • Communication • The Davis City Council never talks about it • We professionals don't seek help in serving youth (from other agencies) • Each professional views the problem too exclusively through the lens of their own training/experience • Inadequate case management, information sharing, systems and ability • Lack of true inter and intra agency collaboration • Poor interagency communication • Lack of networking • Interconnectedness of community while not on the same page • Lack of coordinated care • Identify the population and collect better data • Lack of local church involvement • Communication and networking with the faith community 	<ul style="list-style-type: none"> • Misplaced priorities • Available money • Focus • Energy • Money • Hard to find treatment for those with no money • Free assessments for those who fall through the cracks • Silo-ed funding streams vs. systems of care • Categorical funding restrictions • Lack of money for resources • Support from where? • Poverty • What other resources? • Not everyone has health insurance • Rural access problems • Insufficient resources and clinicians groups 	<ul style="list-style-type: none"> • Treatment facilities • Limited therapeutic resources • Program design is often determined by anecdote with little collaborative design and outcome evaluation • Insufficient screening and assessment at front door. • Lack of treatment options without stigma • Fragmented services • Outcomes not routinely measured • Lack of effective treatment resources • Lack of treatment • Untreated Other Problems 	<ul style="list-style-type: none"> • Lack of trusting adult other than parent for kids to talk to until its too late • Lack of skills within families • Disengaged family • Parents lack of involvement • Entitlement: Kids have money and time and no supervision • Parents unavailability • Broken homes • Lack of family/comm unity support • Parents • Intergeneratio nal drug use x 2 • Split families • Neglect • Parental substance abuse x 2 	<ul style="list-style-type: none"> • Too much violence: not enough compassion for another living being • Permissive society • Racism • Hopelessness • Fear • Split Community • Stigma of drug and alcohol issues within family and community 	<ul style="list-style-type: none"> • Denial x 3 • Head in sand • Not a problem • Minimizing and denial • Parents in denial (lack of awareness) • Denial of community • Outside of Davis people don't think we need the help • Thinking it is someone else's problem 	<ul style="list-style-type: none"> • Lack of teenage activities • Boring town for teens • Lack of things to do • Limited afterschool activities • Lack of skills and places for teens to make drug free friends 	<ul style="list-style-type: none"> • Lack of drug and alcohol education • Teachers' awareness • Lack of drug recognition experts • Lack of prevention programs • Just say no isn't working 	<ul style="list-style-type: none"> • Gangs x 3 • Gangs, sales, use, peer support • Gangs push drugs • Drugs fund gangs • Drug obligations, threats/intimidation to those who try to get out of it 	<ul style="list-style-type: none"> • Thinking we have the solutions without talking to youth • Not including the youth voice • Peer pressure

Appendix 7b Community Assets

(The Yolo County and Winters groups did not do this exercise.)

	Individuals	Associations	Government Institutions	Places	Organizations	Other
Woodland	<ul style="list-style-type: none"> ▪ Don Meyer ▪ Marjorie Rist ▪ Dr Wilkes ▪ Dr. Noweki ▪ Therapists ▪ Principals/Vps ▪ Coaches ▪ Parents ▪ Teachers ▪ Doctors ▪ Debi Sterling 	<ul style="list-style-type: none"> ▪ Rotary/All service clubs ▪ Colors ▪ Boy Scouts/Girl Scouts ▪ FFA ▪ Latino Community council ▪ Chambers of Commerce (2x) ▪ Concilio ▪ Café ▪ PTA/Boosters ▪ Youth sports ▪ AA/NA/Alanon/Atlateen 	<ul style="list-style-type: none"> ▪ Schools ▪ Law Enforcement ▪ PD-CHP ▪ PO ▪ DA ▪ Sheriff ▪ Public Library ▪ YTAC ▪ DARE/AWARE ▪ Parks and Recreation ▪ Woodland CC 	<ul style="list-style-type: none"> ▪ Ferns Park/Parks ▪ Community Center/Sports Park ▪ School-based services ▪ Woodland Opera House ▪ School Facilities ▪ Pools ▪ Fairgrounds ▪ Malls 	<ul style="list-style-type: none"> ▪ YFRC ▪ Health services ▪ Woodland Youth council ▪ SADVC ▪ Safe Schools, Healthy Students Collaborative ▪ ADMH ▪ John H Jones ▪ Food Bank ▪ Wayfarer ▪ Salvation Army ▪ Parenting groups ▪ Friday Night Live ▪ Churches/church youth groups ▪ Youth in focus ▪ YMCA 	<ul style="list-style-type: none"> ▪ EBP/Materials ▪ Bus system/transportation ▪ Community Events ▪ Yolo Link ▪ Cable television
West Sacramento	<ul style="list-style-type: none"> ▪ Families ▪ Pastors ▪ Teachers ▪ Youth ▪ Volunteers 	<ul style="list-style-type: none"> ▪ Chamber of Commerce ▪ Rotary 	<ul style="list-style-type: none"> ▪ School District ▪ Police Departments ▪ The City ▪ Health Department Internships ▪ Parks and Rec. 	<ul style="list-style-type: none"> ▪ Teen Center(s) ▪ Rec. Centers ▪ New High School ▪ Parks ▪ Club West 	<ul style="list-style-type: none"> ▪ Communicare\Collins Youth Center ▪ Churches ▪ PTA ▪ Youth Coalition ▪ FNL ▪ Youth Sports Organizations ▪ ACE Mentoring Program ▪ Character counts ▪ Summer Internship Programs ▪ West Sacramento Youth Resources Coalition ▪ WIA 	<ul style="list-style-type: none"> ▪ Employment ▪ ROP ▪ PIQE ▪ Parent Project-School ▪ Parent Drug Meeting

	Individuals	Associations	Government Institutions	Places	Organizations	Other
Davis	<ul style="list-style-type: none"> ▪ \$ ▪ Cognitive Resources ▪ Doctors ▪ Parents-Caring parents ▪ Treatment professionals ▪ Coaches ▪ School counselors ▪ Teachers ▪ Activists 	<ul style="list-style-type: none"> ▪ Neighborhood associations ▪ AYSO ▪ Other sports organizations ▪ Boy/Girl Scouts ▪ PTAs ▪ YFSA ▪ Davis Bike Club ▪ Soroptomists ▪ Rotary ▪ DPOA ▪ Rowing ▪ DDBA 	<ul style="list-style-type: none"> ▪ Schools <ul style="list-style-type: none"> ▪ Career centers ▪ Sports teams ▪ Strong music program ▪ University ▪ CPS ▪ Probation ▪ YTAC ▪ Davis PD ▪ DA's office ▪ ADMH ▪ Diversion Program-PD ▪ Co Attendance and Welfare ▪ Insight ▪ City Parks and Rec. ▪ Truancy Intervention Program 	<ul style="list-style-type: none"> ▪ Parks ▪ Recreation fields ▪ Small town ▪ Delta Venus ▪ Baskin Robbins ▪ Teen Center ▪ Greenbelts/Bike Paths 	<ul style="list-style-type: none"> ▪ Volunteer organizations ▪ Health Organizations ▪ Youth Organizations ▪ University ▪ Recreation ▪ Local Teams ▪ Davis Special Sports Needs Olympics ▪ Churches ▪ Parent ▪ Sport Organization ▪ Rowing ▪ Biking ▪ Theater groups 	<ul style="list-style-type: none"> ▪ Churches ▪ Religions Affiliation ▪ Small Town ▪ Newsletter/e-mails Strong community