From Assessment Reactivity to Aftercare for Adolescent Substance Abuse: Are We There Yet?

Yifrah Kaminer, MD, MBA[a,*], Mark Godley, PhD[b]

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• Adolescent substance abuse • Assessment reactivity
• Aftercare • Continued care • Adaptive treatment

Significant progress has been made in the development of evidence-based practice treatment protocols for youth with alcohol and substance use disorders (AOSUD) in the last 20 years.[1] Most interventions have been provided in outpatient settings where more than 80% of youth are being treated.[2] The focus has been on several therapeutic approaches and modalities including family/community therapies, cognitive behavioral therapy (CBT), motivational interviewing (MI), and 12-step/fellowship meetings as reviewed in recent meta-analyses,[3,4] as well as integrated interventions reported in the benchmark Cannabis Youth Treatment (CYT) study.[5]

The purpose of this article is to address less developed areas of clinical research that are of great importance for better understanding the therapeutic process along the continuum of care in youth with AOSUD. These include the rationale, design, mechanisms of behavior change (MBCs), implementation, monitoring, and outcome-based modification of treatment continuum for youth with AOSUD. The specific objectives are: (1) present current knowledge pertaining to the pretreatment phase including the effect of baseline assessment on treatment outcome; (2) address potential MBCs in treatment; (3) discuss the importance of aftercare, also known as continued care, to prevent postintervention relapse; (4) consider how reconceptualization of therapeutic paradigms might advance the field, in particular treatment algorithm or adaptive treatment (AT) strategies addressing poor response to treatment.

[a] Department of Psychiatry, Alcohol Research Center, University of Connecticut Health Center, 263 Farmington Avenue, Farmington, CT 06030-2103, USA
[b] Chestnut Health Systems, 448 Wylie Drive, Normal, IL 61761, USA
* Corresponding author.
E-mail address: Kaminer@uchc.edu

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YOUTH VERSUS ADULTS

Treated teens differ from their adult counterparts in length and severity of substance use, typical patterns and context of use, type of substance-related problems most often experienced, and source of referral to treatment.[6,7] Adolescent substance use and abuse should be evaluated in a developmental perspective. There are subgroups of adolescents who have not yet started drinking, or who have not yet reached the peak of the trajectory characterizing their drinking pattern. Therefore, any effort to reduce or eliminate drinking amounts to ''swimming against the tide or current.'' Furthermore, youth are less motivated to change substance use, and often enter treatment because of external pressures.[8] This happens either as a suggested referral by a concerned parent, mental health clinician, school staff, or as a mandate initiated by the legal system.

An important question is ''when does treatment begin and when does it end for adolescents''? Most clinicians who are not versed in the developmental perspective of youth treatment are likely to cut and paste from their experience with adult patients. That is, focus on a single or repeated treatment episode and determine that the goal is no less than abstinence. Only a limited proportion of adolescents, however, will achieve sobriety from alcohol or abstinence from substance abuse following a single episode of treatment. Some outpatient teens might be more appropriately considered continuing users, who did not have the opportunity for relapse because they either achieved only partial response (ie, harm reduction in terms of frequency, dosage, or transition from heavier to lighter drugs) or did not accomplish complete abstinence from use while in treatment.[6] (Relapse is referred to sometimes as an event; in that case it is more appropriate to define it as a lapse. Relapse is more commonly perceived as a process.) Even those who achieved abstinence are likely to relapse 3 to 6 months later[5,9] and will get in and out of abstinence repeatedly thereafter.[10]

Treatment of youth is not an event but a continued process. The extent of an optimal intervention continuum should include an assessment,[11] treatment, and continued care, which take into consideration the specific needs such as psychiatric comorbidity[12] and the response of the adolescent AOSUD and associated psychiatric comorbidity to treatment.[13]

PRETREATMENT FACTORS AND BASELINE ASSESSMENT REACTIVITY

Therapeutic changes may commence before treatment has begun. The contribution of pretreatment events, baseline assessment, and even an advice to change harmful behaviors, have been underestimated or mostly ignored in clinical practice regardless of empiric findings to the contrary.[14]

Sobell and colleagues[15] reported that some adults with problematic drinking stopped using alcohol by simply being exposed to an advertisement of a clinical trial. Others responded to advice by a clinician to stop smoking[16] or drinking[17] because it might be harmful to their health. More participants quit smoking in the month immediately preceding the research interview than had quit in the month following brief intervention.[16] According to the classic study by Edwards and colleagues[17] 2 groups of alcoholics received either 1 counseling session or several months of in- and outpatient treatment. One year later there was no significant differences in outcome between the 2 groups.

Although youth are not highly motivated for treatment, advice may be an effective brief intervention with older adolescent cannabis users in its own right.[18] Moreover, when fidelity of MI treatment provided to those randomized to the experimental condition was not high, it was not more effective than advice. Given the scarcity of resources for treatment and because only 10% to 15% of youth who need some