Adolescent Substance Use: Engagement and Treatment Approaches

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This presentation is supported by a federal grant under the State Opioid Response program, with funding provided by the California Department of Health Care Services.

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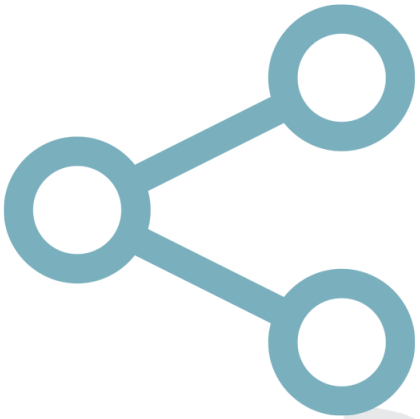

Supporting materials will be shared

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ADOLESCENT SUBSTANCE USE WITH A FOCUS ON STIMULANTS AND OPIOIDS: ENGAGEMENT AND TREATMENT APPROACHES

James A. Peck, Psy.D.

UCLA Integrated Substance Abuse Programs
Pacific Southwest Addiction Technology Transfer Center

December 7, 2021

Start Code

- Start Code: XXXX

- You will be asked to enter the start and end codes in the CE Evaluation to document your full attendance.

LEARNING OBJECTIVES

- After this webinar, participants will be able to:

- Recognize recent prevalence rates of at least three types of illicit and prescription stimulants and opioids used by youth.
- Apply at least two strategies to help engage and retain youth in treatment for substance use disorders and mental health conditions.
- Identify at least two evidence-based SUD treatment approaches that can be implemented with youth who are using stimulants and/or opioids.

WHAT IS THE PREVALENCE OF STIMULANT AND OPIOID USE AMONG ADOLESCENTS?

Monitoring the Future is an annual survey of 8th, 10th, and 12th graders conducted by researchers at the Institute for Social Research at the University of Michigan, Ann Arbor, under a grant from the National Institute on Drug Abuse, part of the National Institutes of Health. Since 1975, the survey has measured how teens report their drug, alcohol, and cigarette use and related attitudes in 12th graders nationwide; 8th and 10th graders were added to the survey in 1991.

42,531 STUDENTS FROM 396 PUBLIC AND PRIVATE SCHOOLS PARTICIPATED IN THE 2019 SURVEY.

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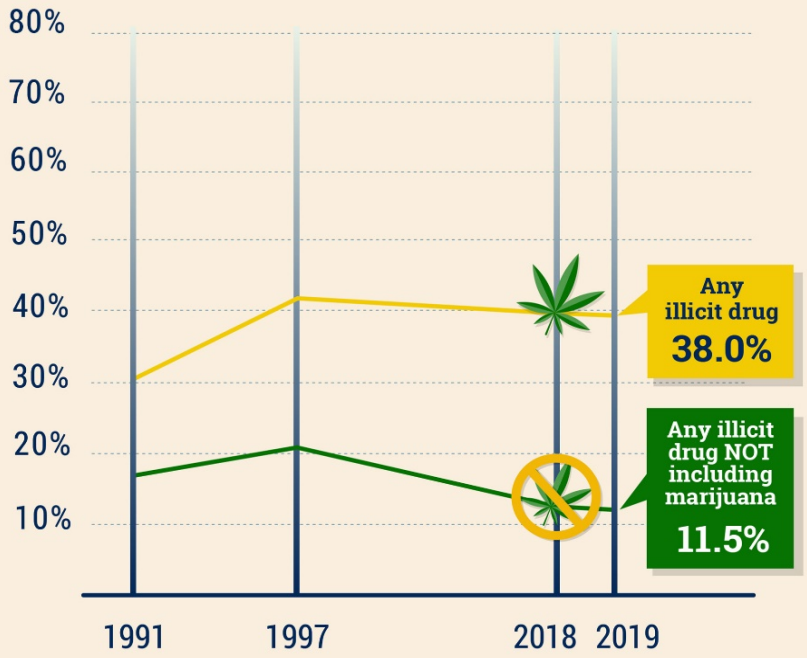
ILLICIT DRUG USE

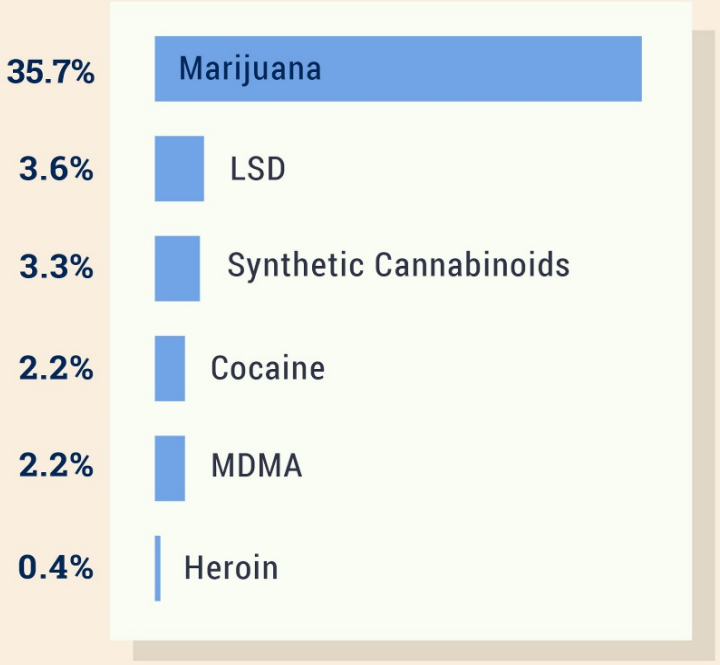
ILLICIT DRUG USE STEADY

Past year use among 12th graders



PAST YEAR ILLICIT DRUG USE

Past year use among 12th graders



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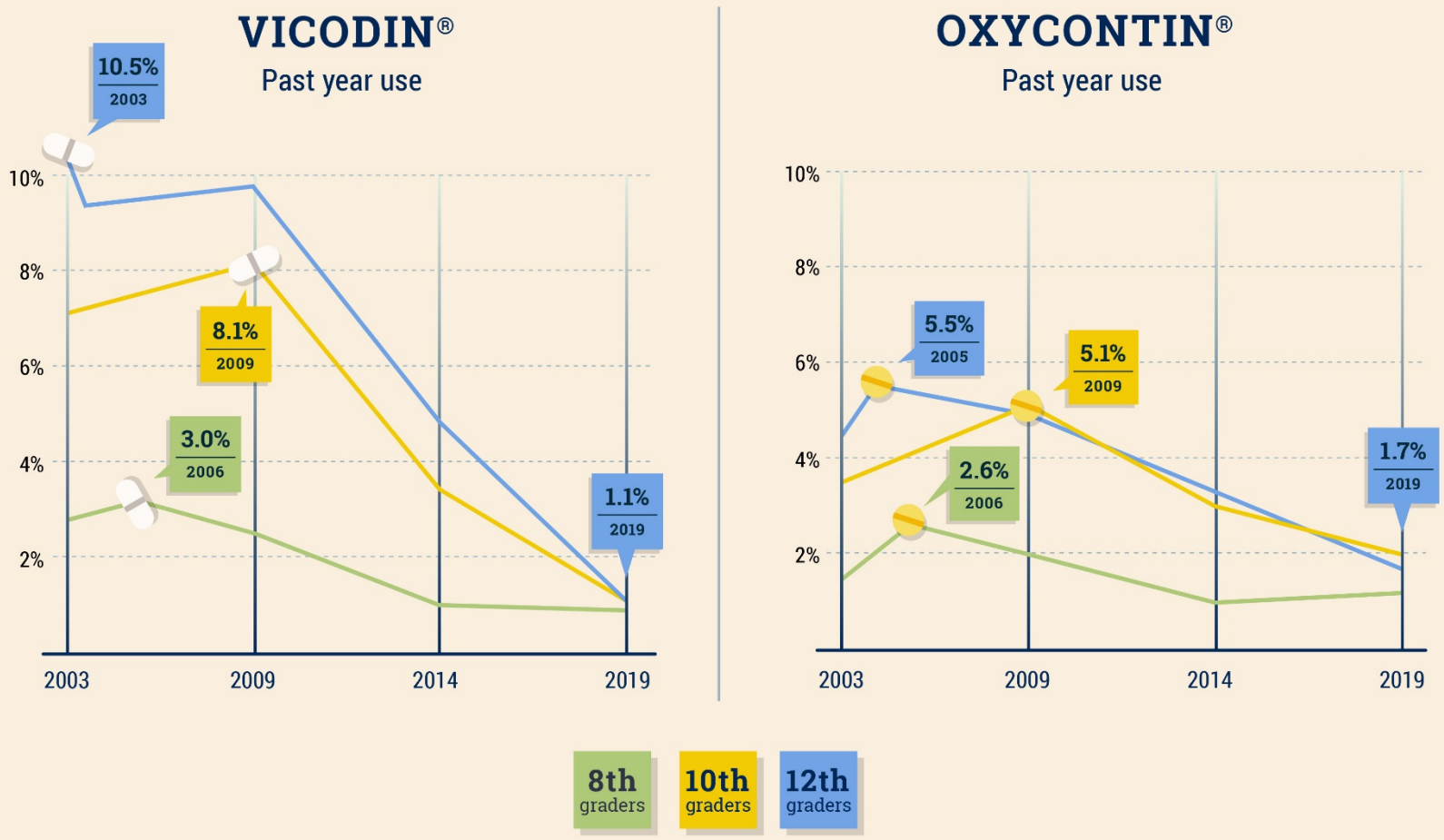
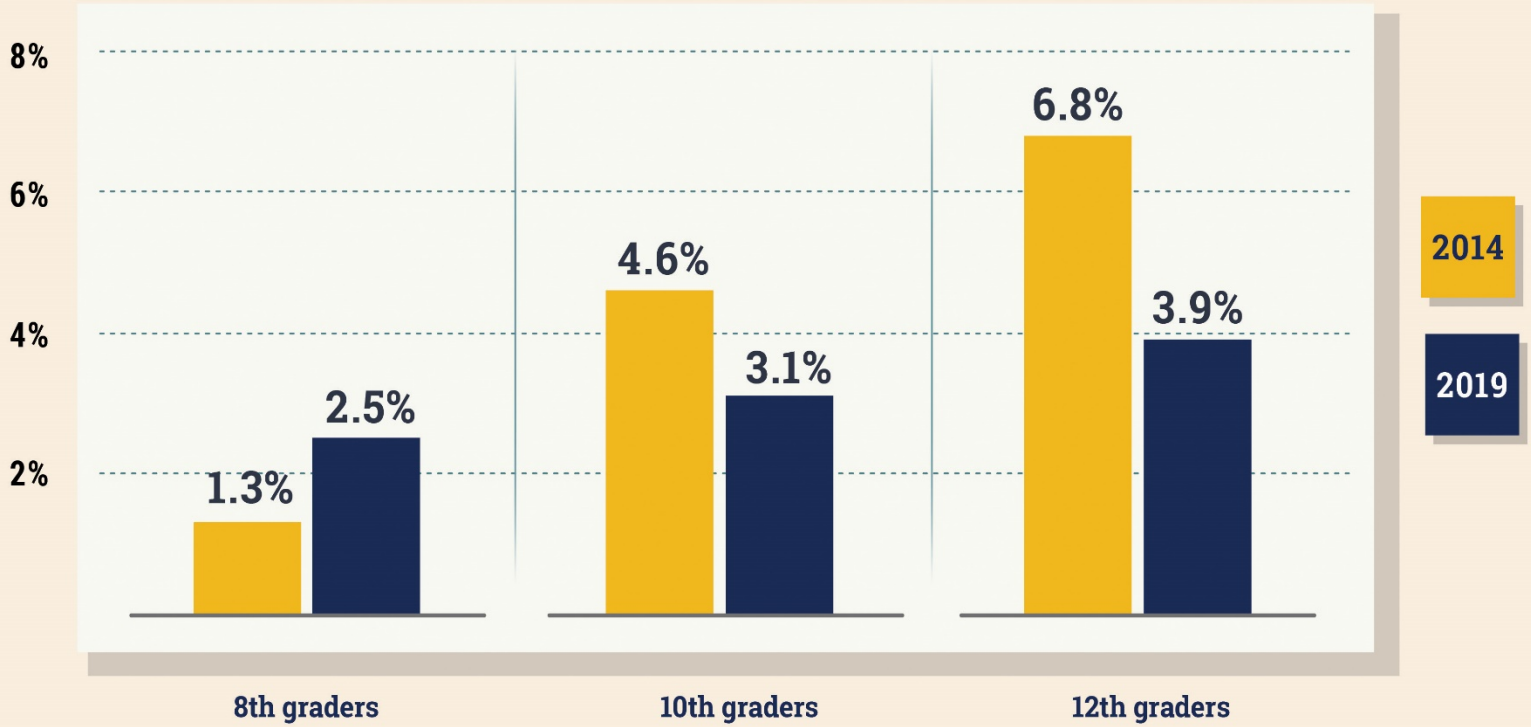
PRESCRIPTION DRUG MISUSE CONTINUES DECLINE FROM PEAK YEARS



PRESCRIPTION DRUG MISUSE CONTINUES DECLINE FROM PEAK YEARS

ADDERALL MISUSE SEES SIGNIFICANT CHANGES IN PAST 5 YEARS

a decrease in 10th and 12th grades, but an increase in 8th grade



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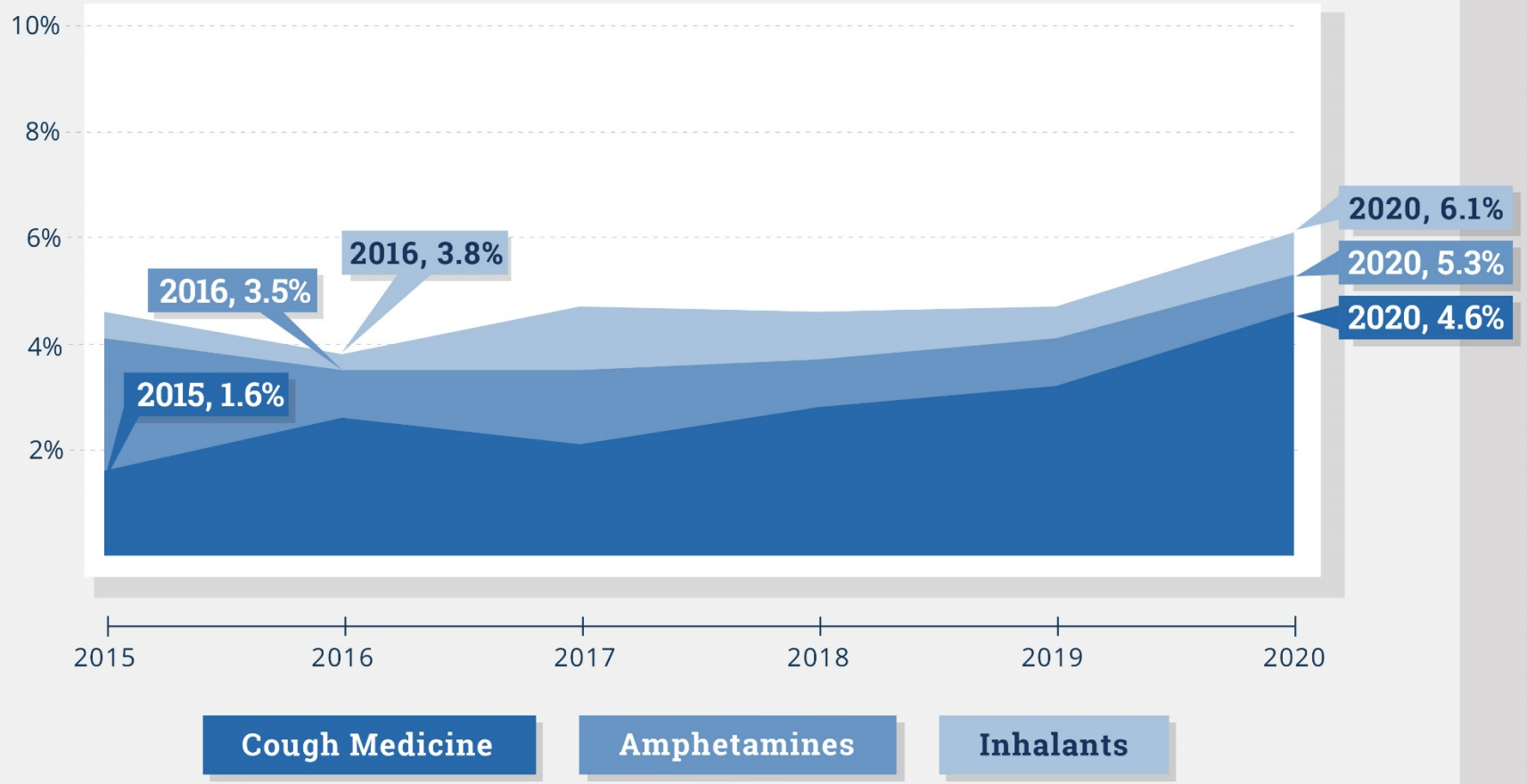
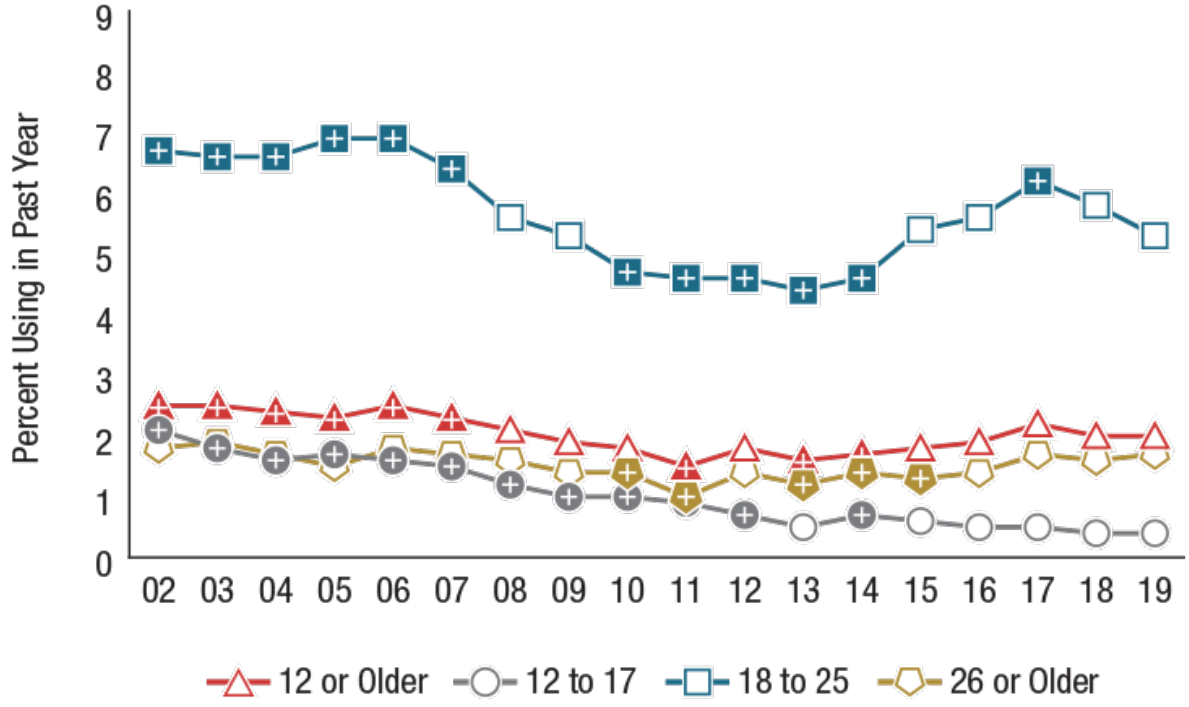
Amphetamine, Inhalant & Cough Medicine Misuse Trending Upward Among Eighth Graders

Past-Year Substance Misuse Among Eighth Graders



Past Year Cocaine Use among People Aged 12 or Older: 2002-2019



Age	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
12 or Older	2.5+	2.5+	2.4+	2.3+	2.5+	2.3+	2.1	1.9	1.8	1.5+	1.8	1.6+	1.7+	1.8	1.9	2.2	2.0	2.0
12 to 17	2.1+	1.8+	1.6+	1.7+	1.6+	1.5+	1.2+	1.0+	1.0+	0.9+	0.7+	0.5	0.7+	0.6	0.5	0.5	0.4	0.4
18 to 25	6.7+	6.6+	6.6+	6.9+	6.9+	6.4+	5.6	5.3	4.7+	4.6+	4.6+	4.4+	4.6+	5.4	5.6	6.2+	5.8	5.3
26 or Older	1.8	1.9	1.7	1.5	1.8	1.7	1.6	1.4	1.4+	1.0+	1.4	1.2+	1.4+	1.3+	1.4	1.7	1.6	1.7

+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

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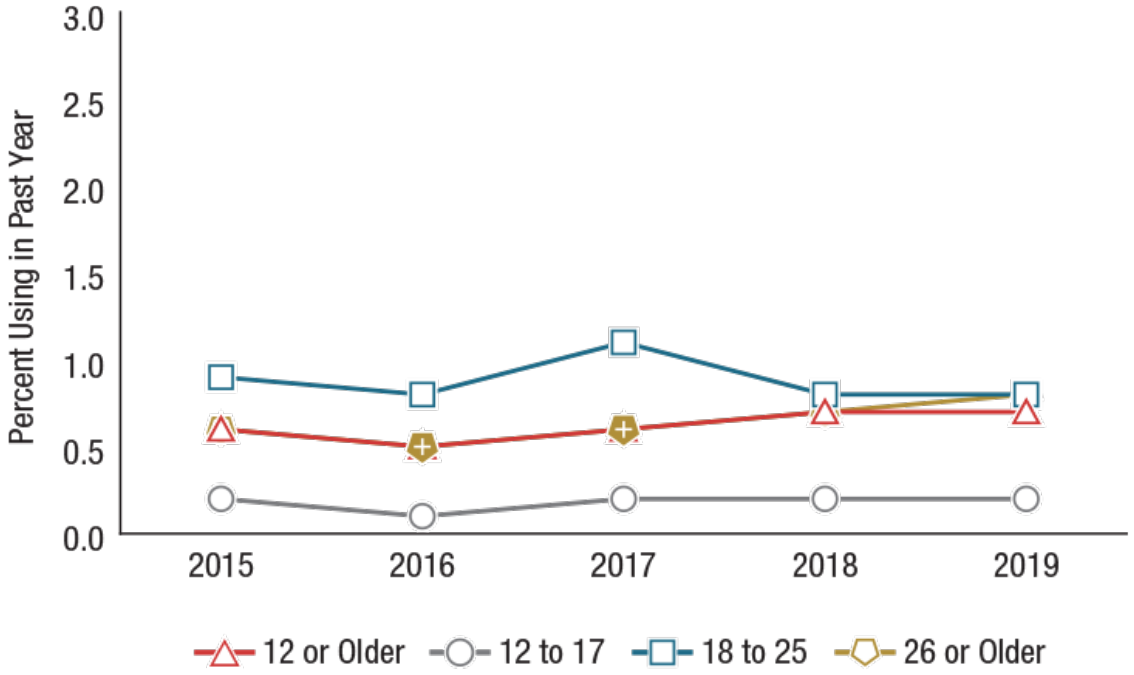
Past Year Methamphetamine Use among People Aged 12 or Older: 2015-2019



Age	2015	2016	2017	2018	2019
12 or Older	0.6	0.5+	0.6+	0.7	0.7
12 to 17	0.2	0.1	0.2	0.2	0.2
18 to 25	0.9	0.8	1.1	0.8	0.8
26 or Older	0.6	0.5+	0.6+	0.7	0.8

+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

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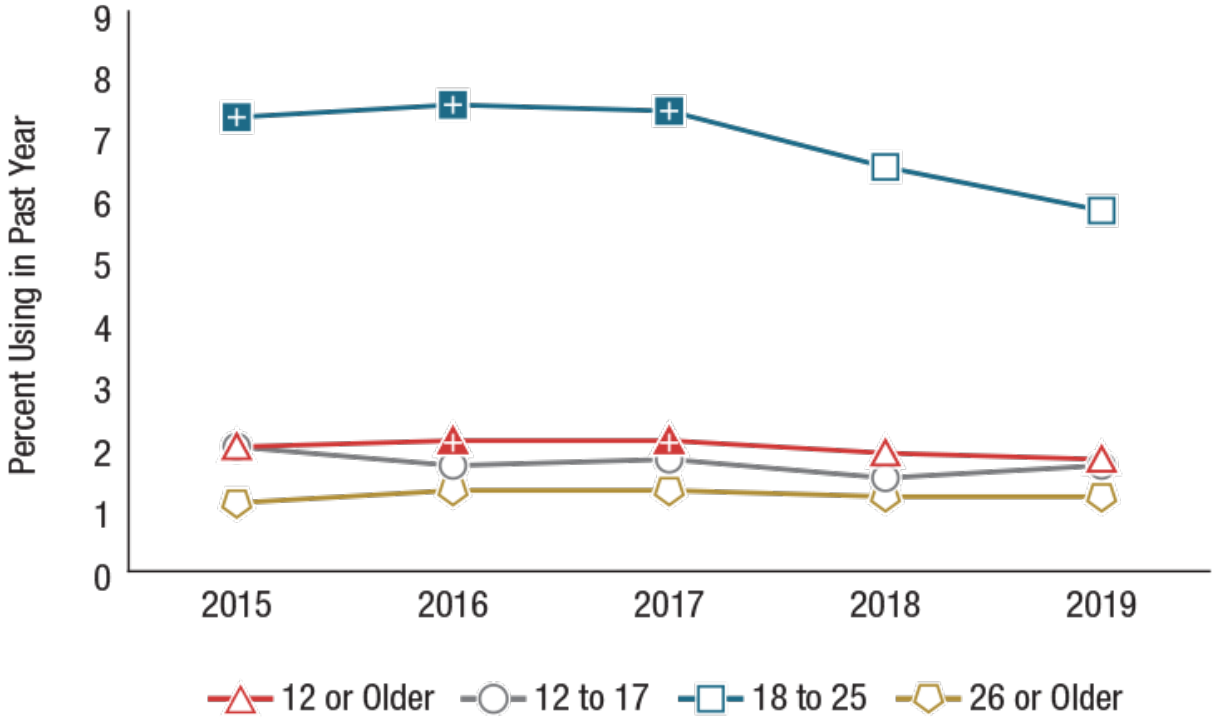
Past Year Prescription Stimulant Misuse among People Aged 12 or Older: 2015-2019



Age	2015	2016	2017	2018	2019
12 or Older	2.0	2.1+	2.1+	1.9	1.8
12 to 17	2.0	1.7	1.8	1.5	1.7
18 to 25	7.3+	7.5+	7.4+	6.5	5.8
26 or Older	1.1	1.3	1.3	1.2	1.2

+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

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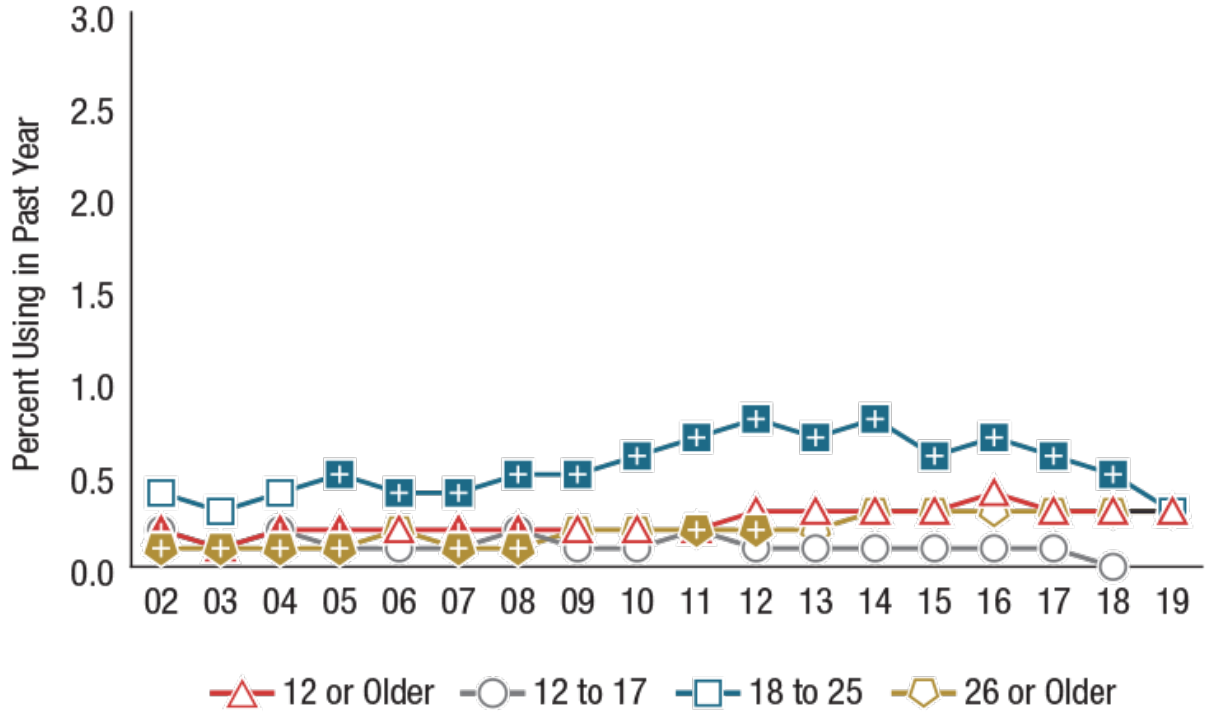
Past Year Heroin Use among People Aged 12 or Older: 2002-2019



Age	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
12 or Older	0.2+	0.1+	0.2+	0.2+	0.2	0.2+	0.2+	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.4	0.3	0.3	0.3
12 to 17	0.2	0.1	0.2	0.1	0.1	0.1	0.2	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.0	*
18 to 25	0.4	0.3	0.4	0.5+	0.4+	0.4+	0.5+	0.5+	0.6+	0.7+	0.8+	0.7+	0.8+	0.6+	0.7+	0.6+	0.5+	0.3
26 or Older	0.1+	0.1+	0.1+	0.1+	0.2	0.1+	0.1+	0.2	0.2	0.2+	0.2+	0.2	0.3	0.3	0.3	0.3	0.3	0.3

* Low precision; no estimate reported.

Note: Estimates of less than 0.05 percent round to 0.0 percent when shown to the nearest tenth of a percent.

+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

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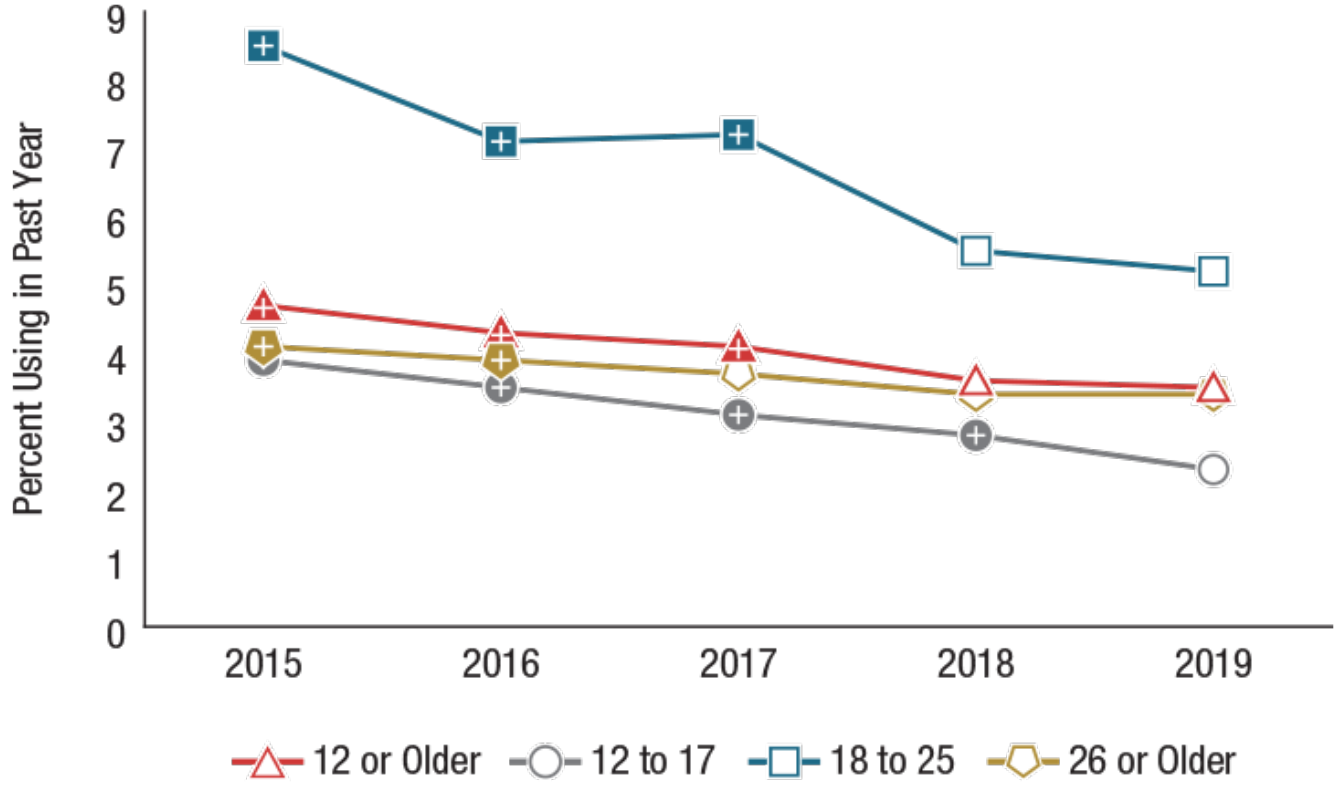
Past Year Prescription Pain Reliever Misuse among People Aged 12 or Older: 2015-2019



Age	2015	2016	2017	2018	2019
12 or Older	4.7+	4.3+	4.1+	3.6	3.5
12 to 17	3.9+	3.5+	3.1+	2.8+	2.3
18 to 25	8.5+	7.1+	7.2+	5.5	5.2
26 or Older	4.1+	3.9+	3.7	3.4	3.4

+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

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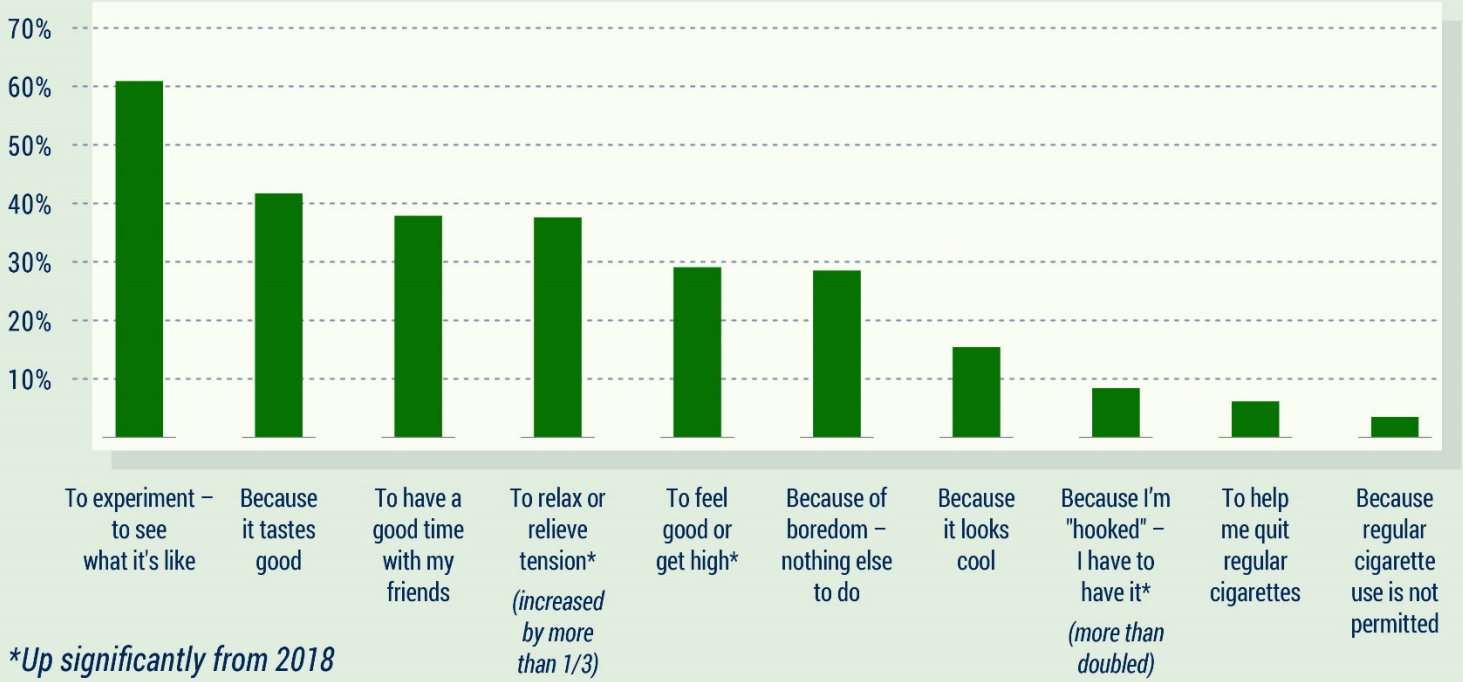
TEEN VAPING CLIMBS SIGNIFICANTLY*

TEENS REPORT REASONS FOR VAPING



*Up significantly from 2018

To view information on other drugs from the 2019 Survey visit:
www.drugabuse.gov/related-topics/trends-statistics/infographics/monitoring-future-2019-survey-results-overall-findings

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Changes During COVID

- Adolescent marijuana use and binge drinking did *not* significantly change, despite perception that availability had decreased
- Marijuana perceived availability (very or fairly available) decreased from 76% to 59% (2019-2020)
- Alcohol perceived availability (very or fairly available) decreased from 86% to 62% (2019-2020)
- Largest year-to-year decreases in perceived availability of alcohol & marijuana since 1975

Source: Miech et al., 2021

Implications of COVID Findings

- Despite decreases in perceived availability, use did not change
- “These findings suggest that reducing adolescent substance use through attempts to restrict supply alone would be a difficult undertaking. The best strategy is likely to be one that combines approaches to limit the supply of these substances with efforts to decrease demand, through educational and public health campaigns.”

Source: Miech et al., 2021

SBHC Providers' Attitudes, Beliefs, Perceptions, and Practice Regarding Opioid Misuse

- Only 8% of adolescents who need Substance Use Disorder (SUD) treatment ever receive it
- Only 1% of the 38,000 physicians waivered to prescribe buprenorphine are pediatricians
- Youth in adult SUD programs typically experience poor outcomes because adolescent-specific needs are not addressed
- Many adolescents engage in at-risk alcohol and marijuana use, which almost always precedes initiation of opioid use

Source: Harris & Rich, 2021

SBHC Providers' Attitudes, Beliefs, Perceptions, and Practice Regarding Opioid Misuse (2)

- Study conducted with SBHC providers in NY state
- Attitudes/perceptions re: opioid crisis:
  - Opioid overdose is a major health-related crisis for adolescents in this country: 77%
  - My SBHC has a role in preventing opioid misuse and overdose: 82%
  - I have the skills to prevent opioid misuse and overdose among my students: 49.2%
  - I am confident in my ability to prevent opioid misuse and overdose among my students: 34.4%

Source: Harris & Rich, 2021

SBHC Providers' Attitudes, Beliefs, Perceptions, and Practice Regarding Opioid Misuse (3)

- Perceived barriers to implementing opioid misuse and overdose prevention services:
  - Adolescents in my SBHC face other more pressing health concerns: 37%
  - SUD treatment providers are better suited for this role than providers in my SBHC: 34%
  - I don't feel confident in my ability to prevent opioid misuse and overdose: 26%
  - I'm not trained to deliver services that prevent opioid misuse and overdose: 24%

Source: Harris & Rich, 2021

SBHC Providers' Attitudes, Beliefs, Perceptions, and Practice Regarding Opioid Misuse (4)

- Greatest influence of specific messages on the adoption and implementation of SBIRT:
  - SBIRT can prevent adolescent opioid misuse by reducing alcohol and marijuana use
  - Standardized screening tools provide a simple way for assessing risk and determining an appropriate level of intervention
  - SBIRT model can incorporate other behavioral health concerns such as depression and anxiety

Source: Harris & Rich, 2021

Why Screen for Youth *Opioid* Use in Particular?

- A recent study of over 3,000 high school students in Los Angeles County found that teens who use prescription opioids when they are younger are more likely to start using heroin by high school graduation
  - Study enrolled freshmen, followed them thru senior year
  - Racially/ethnically diverse (48% Latinx, 17% Asian, 5% African-American)
  - 54% female/46% male
  - 35% reported depressive symptoms
  - 22% reported anxiety symptoms
  - 70% reported family history of substance use
  - Almost 600 reported prescription opioid use

Kelley-Quon et al. (2019). Association of non-medical prescription opioid use with subsequent heroin use initiation in adolescents. JAMA Pediatrics 173(9).

Engaging and Retaining Youth in Treatment

- Whether for substance use or mental health issues, adolescents often:
  - Do not believe they need help
  - Are apprehensive about the process
  - Are not aware of available services
  - Are concerned about stigma around substance use and/or mental health services
  - Are hesitant to ask an adult for assistance

Source: National Child Traumatic Stress Network

Engaging and Retaining Youth in Treatment (2)

- To identify youth in schools who may need help with substance use or mental health issues:
  - Use standardized screening instruments (i.e. CRAFFT or S2BI, PHQ-2 or -9, GAD-7)
  - Utilize peer networks – student leaders who have been trained to provide assistance to at-risk teens
  - Use Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) to identify traumatic stress, which often accompanies substance use

Source: National Child Traumatic Stress Network

Engaging Youth

- Frequent high rates of no-shows at first appointments
- Strategies:
  - Make reminder calls
  - Be especially welcoming at first session – praise them for just making it to the appointment
  - Be culturally aware and sensitive – beliefs & attitudes toward mental health and substance use vary from culture to culture

Source: National Child Traumatic Stress Network

Intersectionality

- Need to recognize intersection of mental health conditions and homelessness among youth
- Risk factors:
  - Disrupted support networks
  - Fragile family relationships
  - Foster care involvement
  - Substance use
  - Traumatic events

Source: Narendorf, 2017

Engaging Homeless Youth

- Higher rates of substance use and mental health issues among homeless youth than among youth in school
- Strategies:
  - Stay “at their level” during first contact; if possible demonstrate that you are familiar with their culture and the many challenges of being homeless
  - Avoid blaming – reframe current situations i.e. drug use, living in a shelter, in non-judgmental, matter-of-fact terms rather than as personal failures
  - Convey hope and empowerment – change is possible
  - Respect his/her concerns i.e. confidentiality, contacting parents/caregivers, etc.

Source: National Child Traumatic Stress Network

Involve Families to the Extent Possible

- Adolescents with caregivers involved in treatment process tend to have better outcomes than those whose caregivers do not believe treatment will help and/or are unwilling to work with treatment providers

- There are some specific strategies for involving families in treatment

Source: National Child Traumatic Stress Network

Involving Family Members

- Foster family motivation – determine what changes the family member would like to see and try to incorporate them into treatment goals
- Validate parents/caregivers – acknowledge their sense of stress & their own struggles
- Provide education about the nature of mental health/substance use issues, i.e. behavioral/emotional problems may not just disappear if adolescent stops using drugs/alcohol

Source: National Child Traumatic Stress Network

Build an Alliance

- Establish rapport – find out what the adolescent would like to talk about, so they don't feel like an intervention is being imposed upon them
- Show genuine interest in, and respect for, his or her unique interests, concerns, and worldview
- If possible, demonstrate understanding of his/her culture

Source: National Child Traumatic Stress Network

Discuss Limits of Confidentiality

- Discuss limits of confidentiality at beginning of treatment
- Plan with adolescent how information will be communicated to parents and other authority figures
- Reassure adolescent that if you must disclose information, you will make every effort to talk with him/her before you do it

Source: National Child Traumatic Stress Network

TREATMENT APPROACHES ADAPTABLE FOR USE WITH ADOLESCENTS

TREATMENT FOR OPIOID USE DISORDERS INCLUDES MEDICATIONS, BUT TREATMENT FOR STIMULANT USE DISORDERS IS BEHAVIORAL

MEDICATIONS FOR OPIOID USE DISORDER
MOTIVATIONAL INTERVIEWING
COGNITIVE-BEHAVIORAL THERAPY

SBIRT for Youth

- American Academy of Pediatrics recommends use of SBIRT (Screening, Brief Intervention, and Referral to Treatment) by pediatricians during routine health visits
- Important to use validated screening instruments such as the CRAFFT or S2BI because pediatricians' clinical impressions often not accurate
- However, due to lack of evidence from clinical trials with youth, the U.S. Preventive Services Task Force does *not* currently recommend routine screening by pediatricians

Source: Robinson & Wilson, 2020

Treating Youth OUD in the Pediatric Primary Care Setting

- Youth OUD can be treated in pediatric primary care settings with medications and behavioral interventions
- Pediatricians should engage families of youth in treatment as much as possible, as this has demonstrated improved rates of treatment adherence and completion, longer duration of abstinence, and fewer relapses for youth
- Harm reduction strategies/education about opioids also important to implement, as youth misusing opioids tend to have riskier use practices than adults

Sources: Robinson & Wilson, 2020; Cedarbaum & Banta-Green, 2016

Youth Overdose Risk

- Youth using opioids, just like adults, are at risk of overdose, especially with recent increases in adulteration of illicit opioids with fentanyl (50 times more potent than heroin)
- Overdose education is crucial and should include counseling on strategies for reducing opioid overdose risk, recognizing signs of overdose, and responding to an overdose, including use of naloxone (i.e. Narcan)
- Naloxone can be used by non-healthcare professionals to reverse overdose, although multiple doses may be required if fentanyl was ingested

Source: Robinson & Wilson, 2020

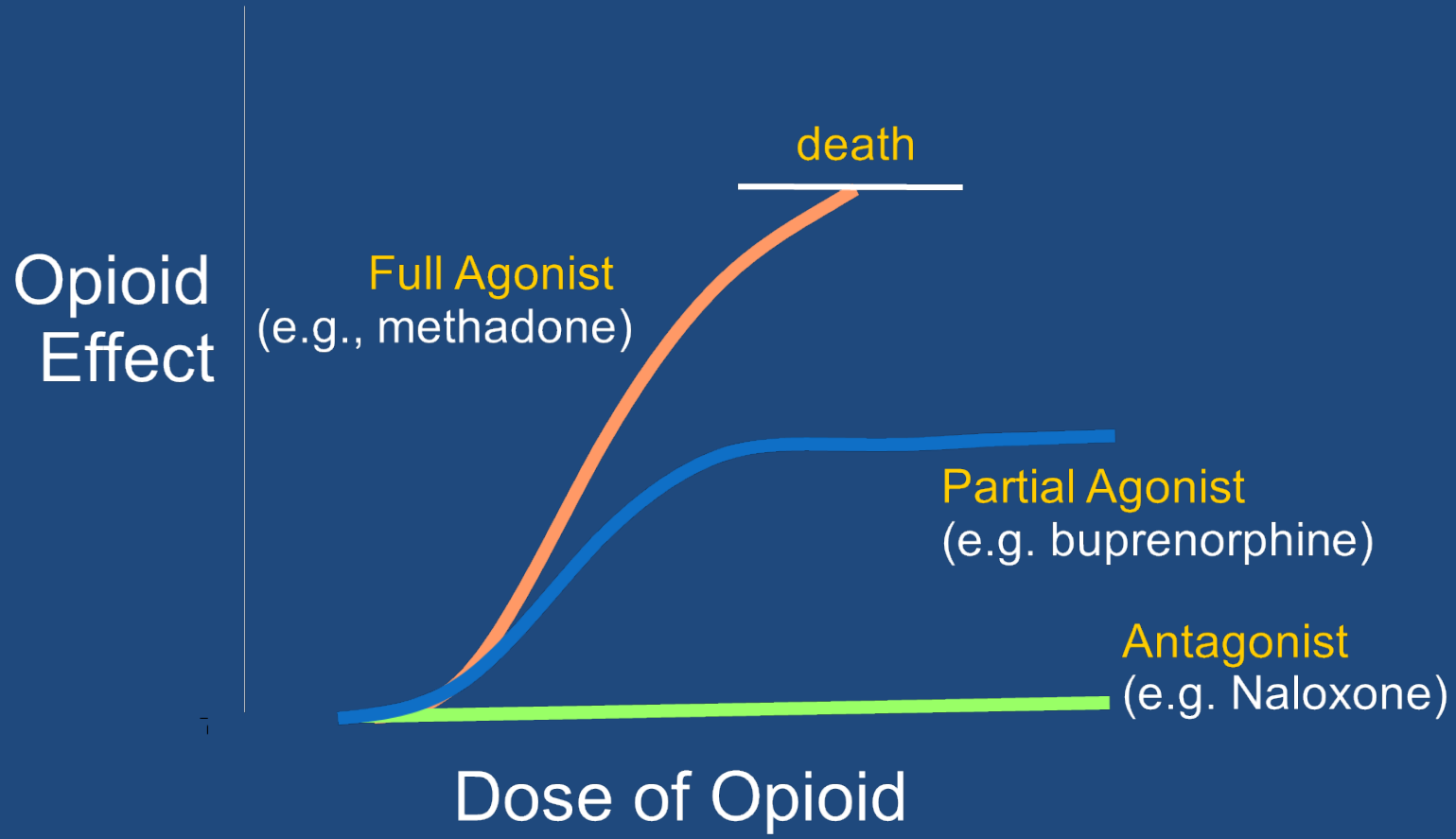
MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

MOUD for Youth/Young Adults

- In 2016, the American Academy of Pediatrics Committee on Substance Use and Prevention issued a policy statement recommending that Medication-Assisted Treatment (MAT) be made available to youth and young adults over the age of 16 in primary care and pediatric settings

Source: AAP, 2016

Partial vs. Full Opioid Agonists



Methadone Maintenance Therapy

- Methadone is a full opioid agonist, meaning if you take too much of it, you can overdose
- Used to treat severe pain
- Also used to treat opioid use disorder
- Suppresses opioid withdrawal symptoms and reduces/prevents cravings
- However, typically requires daily dosing at federally-licensed clinic
- Historical stigma

Source: Mattick et al., 2009

Methadone Maintenance Therapy

- Advantages:
  - Suppresses opioid withdrawal and reduces craving
  - Reduced participation in crime
  - Reduced transmission of blood borne viruses
  - Few long-term side-effects
- Disadvantages:
  - Opioid dependence is maintained
  - Withdrawal/tapering can be challenging
  - Requires daily time/travel commitment
  - Potential for diversion

Source: Salsitz & Wiegand, 2016

Buprenorphine and Buprenorphine/Naloxone

- Buprenorphine is a partial opioid agonist
  - Provides opioid agonist effects up to a limit
  - Has a ceiling effect at higher doses
  - Like methadone, it reduces/eliminates withdrawal symptoms and cravings
  - When naloxone is added (Suboxone ®), it becomes very difficult to dilute and inject, reducing diversion and allowing for take-home doses
  - Usually prescribed at a doctor's office, unlike methadone
  - Less stigma than methadone

Source: Zoorob et al., 2018.

Buprenorphine/Naloxone (Suboxone®)

- Naloxone blocks any opioid agonist effect if the suboxone is illicitly injected, but passes through the GI tract without being absorbed if medication is taken as instructed

- Dosage typically starts at 4-8mg/day, going up to 16-24mg for maintenance (although some providers induct on 24 mg, then gradually reduce dose based on response)

Source: Zoorob et al., 2018

Naltrexone

- Opioid antagonist, so it blocks opioid effects
- Must be inducted after patient has gone through detox, otherwise it will induce withdrawal symptoms
- Can be taken orally or as extended-release injection (Vivitrol ®)
- Vivitrol injections only required monthly, so increases medication adherence
- Increases opioid abstinence & retention in treatment, and reduces cravings & relapses
- Blocks opioid and alcohol effects, so opioid pain meds will not be effective if taken while on naltrexone

Source: Cousins et al., 2016

Naloxone

- Full opioid antagonist; rapidly displaces opioid agonist molecules i.e. heroin, which is why it is used in the event of overdose
- Reverses the CNS and respiratory depression caused by opioids
- Takes effect in 2-5 minutes
- Available as nasal spray (Narcan) or auto-injector (Evzio)
- Distributed to first responders around the country

Source: Ryan & Dunne, 2018

MOUD May Not Be Enough

- It may not be enough to increase access to MAT in communities of color
- Opioids may be coping mechanism for members of communities traumatized by decades of poverty, violence, and neglect
- Need to recognize value of community-led needs assessments and routine check-ins with the community that address the social determinants of health

Source: SAMHSA, 2020

MOTIVATIONAL INTERVIEWING

Motivational Interviewing: Definition

Motivational interviewing is a client-centered style of interaction aimed at helping people explore their ambivalence about their substance use and begin to make positive behavioral and psychological changes.

What is Motivational Interviewing?

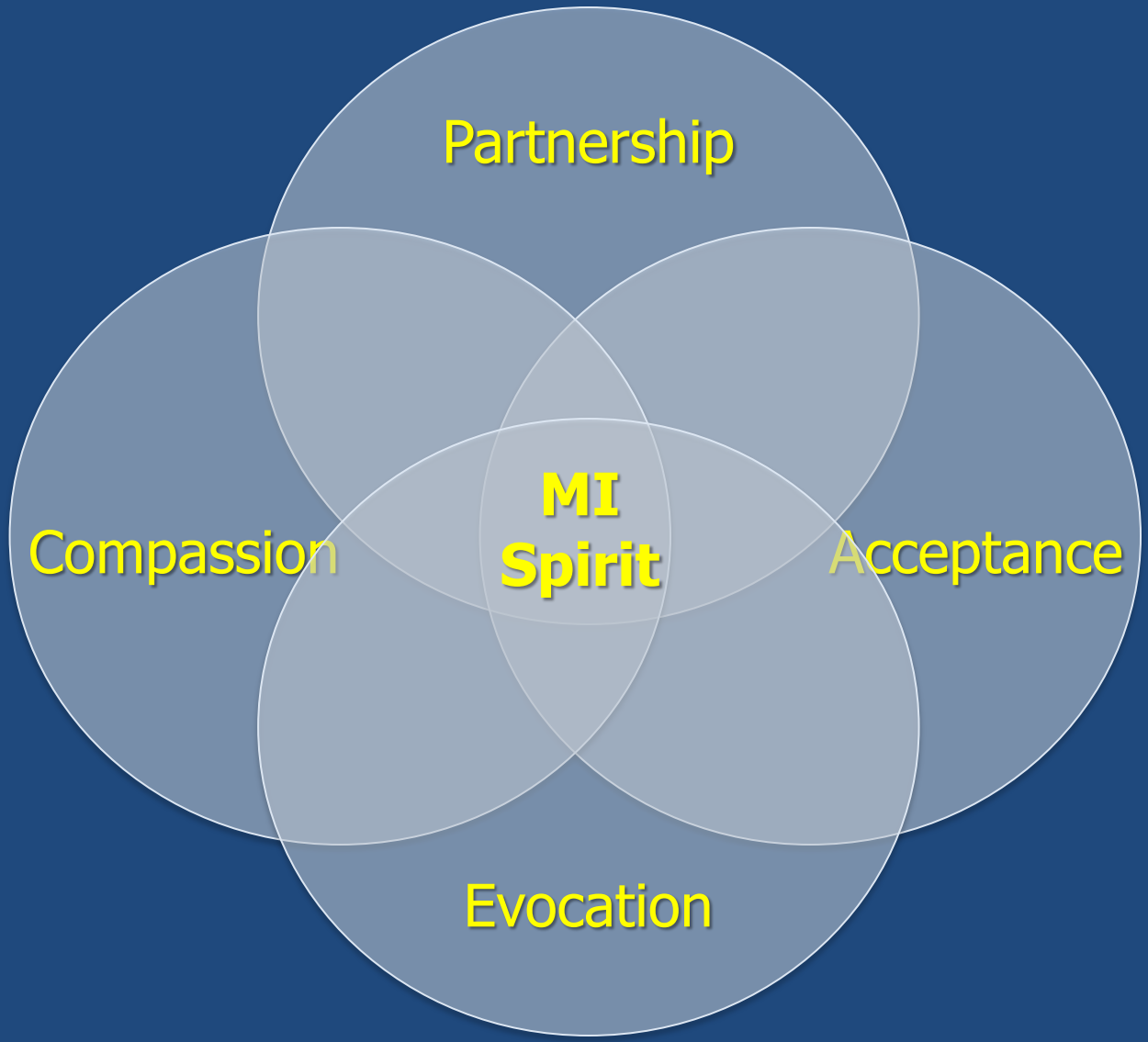
Developed by William Miller (U New Mexico), Stephen Rollnick (Cardiff University School of Medicine), and colleagues over the past three decades. Miller and Rollnick (2012, p. 29) define MI as:

"MI is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion."

The Concept of Motivation

- Motivation as state rather than trait
- Motivation is influenced by the clinician's style
- Motivation can be modified
- The clinician's task is to elicit and enhance motivation
- *"Lack of motivation" is a challenge for the clinician's therapeutic skills, not a fault for which to blame our clients/patients*

The Underlying Spirit of MI



Four Processes of MI

What's the Best Way to Facilitate Change?

- Constructive behavior change comes from connecting with something valued, cherished and important

- Intrinsic motivation for change comes out of an accepting, empowering, safe atmosphere where people can be honest with themselves

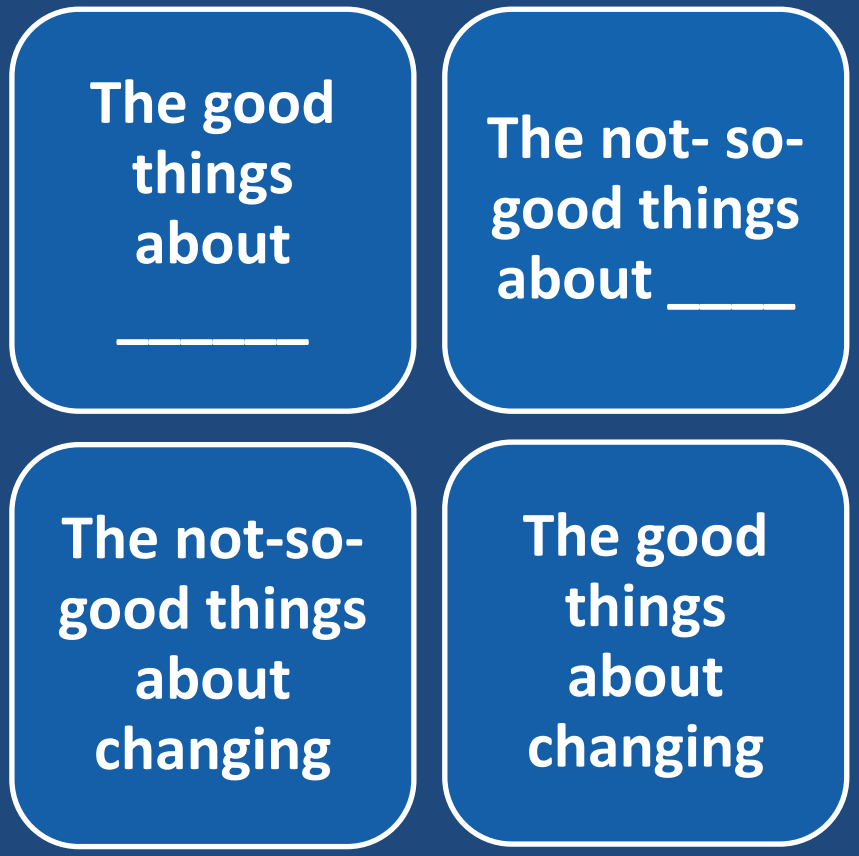
Provider Interaction Style

- Nonjudgmental and collaborative
- Based on student and clinician/provider partnership
- “Gently persuasive”
- More supportive than argumentative
- More listening than telling
- Communicates respect for and acceptance of students’ feelings and worldview

MI: Principles

- Motivational interviewing is founded on 4 basic principles:
  - Express Empathy
  - Develop Discrepancy
  - Roll with Resistance
  - Support Self-efficacy

The Decisional Balance



- Open-ended questions
- Affirmations
- Reflective listening
- Summarizing

Avoid questions that inspire a yes/no answer.

Core Skills ("Microskills")

- **O** pen-Ended Questions
- **A** ffirmations
- **R** eflective Listening
- **S** ummarizing

Establishing Empathy through Reflective Listening

Reflective listening is used to:

- Check out whether you really understood the student
- Highlight the student's own motivation for change
- Guide the student towards a greater recognition of her or his problems and concerns, and
- Reinforce statements indicating that the student is thinking about change

MI: Conclusion

- The interaction style and microskills of Motivational Interviewing are designed to engage a student in a structured, constructive, supportive conversation about making significant changes like reducing/stopping their substance use

- It communicates acceptance and respect for the student while gradually helping to move them toward the choice to make changes that are in their own best interest

Cognitive Behavioral Therapy

Why is CBT useful?

- CBT is a counseling-teaching approach well-suited to the resource capabilities of most programs/clinics
- CBT has been extensively evaluated in rigorous clinical trials and has solid empirical support, both for mental health conditions and substance use
- CBT is collaborative, structured, goal-oriented, and focused on the immediate problems faced by individuals using substances
- CBT is a flexible, individualized approach that can be adapted to a wide range of students as well as a variety of settings and formats (group, individual)

Conceptualizing Behavior

- Classical conditioning
- Operant conditioning
  - Positive reinforcement
  - Negative reinforcement
- Social learning theory

Important concepts in CBT
Classical Conditioning

- Repeated pairings of particular events, emotional states, or cues with substance use can produce craving for the substance

- Over time, substance use is paired with cues such as money, drug paraphernalia, particular places, people, times of day, days of the week, and emotions. This is the development of "triggers".

- Eventually, exposure to the cues/triggers *alone* produces drug/alcohol cravings

Important concepts in CBT

Operant Conditioning

Drug use is reinforced by the positive reinforcement that occurs from the pharmacological properties of the drug, i.e. the “high”

Important concepts in CBT

Operant Conditioning

- Drug use is reinforced by the negative reinforcement of removing or avoiding painful withdrawal symptoms or other unpleasant experiences like depression or anxiety.

Important concepts in CBT

CBT attempts to help students:

- Follow a planned schedule of low-risk activities
- Recognize drug-using (high-risk) situations and avoid those situations
- Cope more effectively with a range of problems and problematic behaviors associated with substance use

Principles of CBT

- CBT is used to teach, encourage, and support individuals about how to reduce / stop their harmful drug use.
- CBT provides skills that are valuable in assisting people to achieve initial abstinence from drugs (or to reduce their drug use).
- CBT also provides skills to help people sustain abstinence (relapse prevention).

Behavioral CBT Concepts

In the early stages of CBT treatment, strategies emphasize behavior change, and include:

- Setting a schedule to promote engagement in behaviors inconsistent with substance use
- Recognizing and avoiding “high risk” situations, people, places, etc.
- Facilitating positive coping skills

Cognitive CBT Concepts

As CBT treatment continues, more emphasis is given to the "cognitive" aspects of CBT. This includes:

- Psychoeducation on effects of substances in the brain
- Teaching students about triggers and cravings
- Teaching students cognitive skills (e.g., "thought stopping" and "urge surfing")
- Identifying "red flag thoughts"

CBT Summary

- Behavioral strategies: scheduling and avoidance of high-risk situations
- Cognitive strategies: recognizing triggers and cravings, thought-stopping, recognizing “red flag thoughts,” and analysis of the chain of events that result in a “slip” or “lapse” vs. “relapse”
- Optimally, CBT strategies can be used while using style of interaction consistent with MI
- CBT effects are robust across alcohol and many types of drugs

Final Note On Treatment

- Involve parents/caregivers when possible
- Adolescent substance use often reflects underlying problems/dynamics at home
- Parents are often part of the problem and should be part of the solution when possible
- Brief Strategic Family Therapy is an evidence-based approach that can be helpful in changing patterns of family interactions that help maintain adolescent substance use

Thanks for Joining Us!

Jim Peck, Psy.D.

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YOUTH SUBSTANCE USE & SCHOOL DISCIPLINE POLICIES

I'm going to cover…

- **Why**, as school-based providers, it's important to consider clinical practices in conjunction with school policies...
- **What** we know about youth substance use and educational outcomes…
- **How** important it is to re-think school discipline policies… and how you can advocate…

Relationships between students & adults

School practices & policies

School climate practices

Discipline policies

SBHC/ health providers

STUDENTS AND SUBSTANCE USE

Substance use is linked to lower grades, student absenteeism, and higher rates for high school dropout[1]

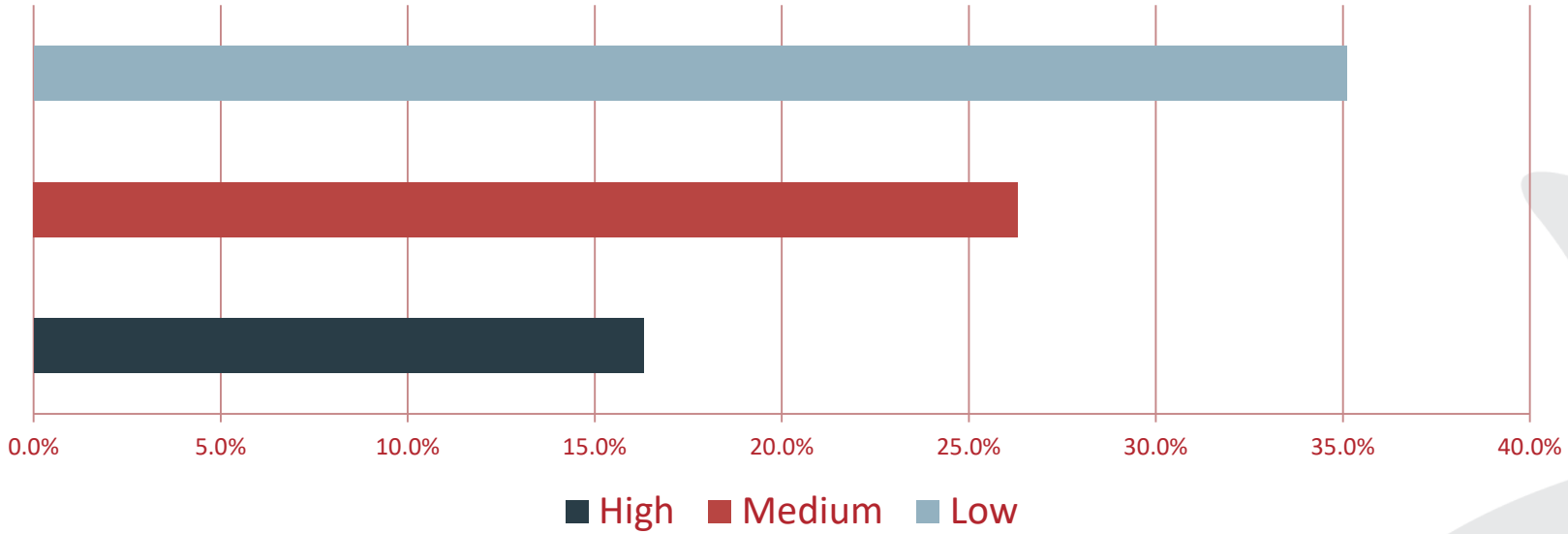
In California, **20%** of 9th graders and **29%** of 11th graders used alcohol or drugs at least once in the last month[2]

ADDRESS student substance use,
DON'T punish it

(1) D'Amico, E.J., et al. (2016). Alcohol and Marijuana Use Trajectories in a Diverse Longitudinal Sample of Adolescents: Examining Use Patterns from Age 11 to 17. Addiction, 111(10), 1825–1835; Engberg J., Morral A.R. (2006). Reducing substance use improves adolescents' school attendance. Addiction, 101(12), 1741-1751.
(2) California Healthy Kids Survey. (2017). Alcohol/drug use in past month, by grade level [data file]. Retrieved from www.kidsdata.org.

SCHOOL CONNECTEDNESS HELPS

Percentage of students who used alcohol or drugs in the past month, by level of school connectedness, 2013-2015



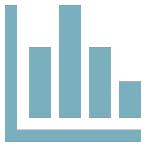
School connectedness = a measure based on student responses to five questions on the California Healthy Kids Survey about feeling safe, close to people, and a part of school, being happy at school, and about teachers treating students fairly

As cited on kidsdata.org, WestEd, California Health Kids Survey (CHKS) and Biennial State CHKS. California Dept. of Education (March 2019).

RE-THINKING SCHOOL DISCIPLINE

In California during the 2017-18 school year[3]:

Nearly one in seven out-of-school suspensions and 29% of expulsions were drug-related



Nearly 70 percent of drug-related suspensions involve Latinx or Black students

A student who was suspended or expelled is **twice** as likely to repeat their grade and nearly **three times** as likely to be in contact with the juvenile justice system the following year[4]

(3) California Department of Education. Suspension Data 2017-18. Available here: https://www.cde.ca.gov/ds/ad/filessd.asp.
(4) Council of State Governments Justice Center. (2011). Breaking Schools' Rules: A Statewide Study on How School Discipline Relates to Students' Success and Juvenile Justice Involvement. New York, NY: Tony Fabelo, Michael Thompson, and Martha Plotkin.

CALIFORNIA ED CODE

Greatest school discretion
A student *may* be suspended or recommended for expulsion if they: • Unlawfully possessed, used, furnished, or been under the influence of a controlled substance, alcoholic beverage, or intoxicant (48900(c)) • Unlawfully offered, arranged, or negotiated to sell a controlled substance, alcoholic beverage, or intoxicant (48900(d)) • Possessed or used tobacco or tobacco products (48900(h)) • Unlawfully possessed, offered, arranged, or negotiated to sell drug paraphernalia (48900(j)) For discipline cited above, a superintendent or principal may use their discretion to provide alternatives to suspension or expulsion that are designed to address the student's specific behavior (48900(v)).
Some school discretion
A student *must* be recommended for expulsion for the following act, *unless* an alternative means of correction would address the conduct: • Unlawful **possession** of any controlled substance, except for the first offense of less than an ounce of marijuana (48915(a)(1)(C))
No school discretion
A student *must* be immediately suspended and recommended for expulsion for the following act: • Unlawfully **selling** a controlled substance (48915(c)(3))

"May" vs. "Must"

"Unless an alternative means of correction would address the conduct"

"Suspensions should be imposed only when other interventions fail"

Resource Available: School Discipline & Student Substance Use: A guide for school-based health providers, https://bit.ly/SUDdiscipline

RE-THINKING SCHOOL DISCIPLINE

Instead of…

… Do These:

- ✓ Change school discipline policies
- ✓ Refer to SBHCs or other health providers
- ✓ Provide mental health services
- ✓ Incorporate comprehensive substance use info in health education

IN PRACTICE: SAN FERNANDO HS

- Students with an on-campus minor substance use violation
- Can attend four sessions of substance use counseling in lieu of suspension
- Counseling provided by on site SBHC

64% decrease in suspensions in first year

Northeast Valley Health Corporation
a california health+ center

MAKING THE CASE

CA state law is clear that **other means of correction** that address the student's conduct should be implemented instead of suspension or expulsion (Education Code 48900.5).

Punitive school policies **do not address the underlying issues** contributing to substance use.

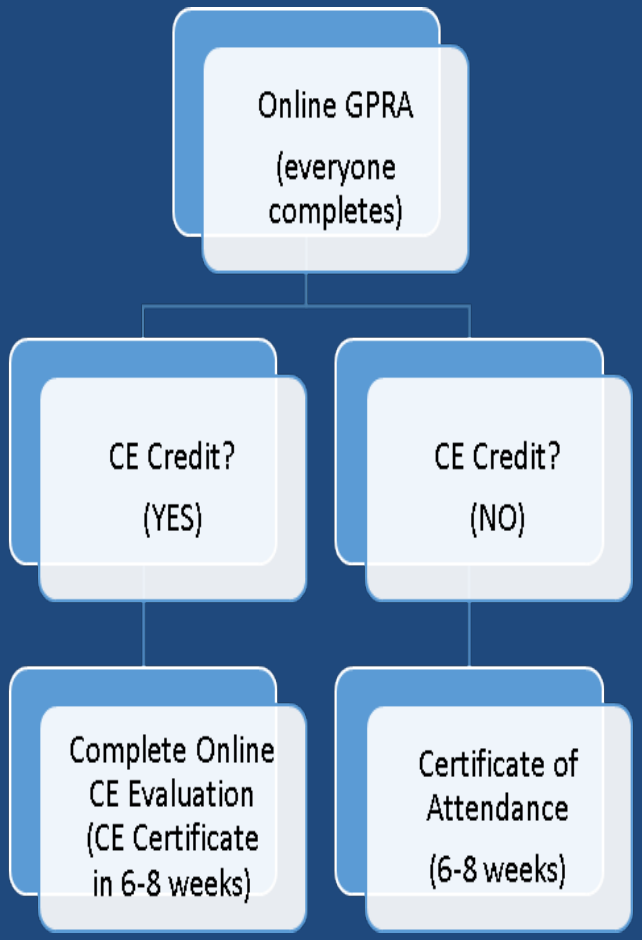
The **most effective approaches** to helping youth reduce tobacco use are through counseling and education.

School connectedness can have a positive impact on whether a student uses tobacco or other substances. Exclusionary discipline responses decrease a student's school connectedness.

Resource Available: Alternatives to Suspension: Student Tobacco and Substance Use, https://bit.ly/TobaccoDiscipline

Evaluation and CE Process

Please note: We recommend filling out the GPRA and CE evaluation immediately following the training. All surveys will close within one week of the training.



Post-Training Evaluation (GPRA)

- Please fill out an evaluation!
- We will post the link in the chat and send it via email.
- You can also use your phone to fill out the evaluation using this QR code:

- If you are willing to complete a follow-up survey 30 days from now, please include your email.
  - If you complete the follow-up survey, you will be entered into a drawing for a $10 gift card.
  - More information on our training evaluation can be found at: http://uclaisap.org/gpra-survey-disclaimer.html

Continuing Education (CE) Credit

- After completing the post-training GPRA evaluation, you will find the link an **online CE course evaluation.** Please chose the link the corresponds with the type of credit you need.
- Once the CE course evaluation is submitted, you will receive your CE certificate via email in 6-8 weeks.
- We will also send you an email with all of these details and links.

End Code

- End code is: XXXX

- You will be asked to enter the start and end codes in the CE Evaluation.

STAY CONNECTED

schoolhealthcenters.org

info@schoolhealthcenters.org

schoolhealthcenters

sbh4ca

sbh4ca

CALIFORNIA SCHOOL-BASED HEALTH ALLIANCE
Putting Health Care Where Kids Are

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