Webinar Summary

This presentation examined the value of evidence based screening, assessment and evidence based practices for adolescents with substance use disorders and provided an extensive list of recent references. Dr. Michael Dennis a) reviewed multiple large demonstrations of the feasibility, replicability, effectiveness and cost effectiveness of several approaches to screening, assessment, treatment and recovery support services; b) demonstrated why comprehensive assessment is important because most present with multiple co-occurring problem; and c) examined recent meta analyses and research demonstrating that a wide range of evidence based treatment, recovery support and other practices are associated with better outcomes than treatment as usual.

Participant Questions & Presenter Responses

Q 1	***Where can we get information about the GAIN Short Screener and Full GAIN Assessment, including age range, ASAM placement, costs and training required?***
Response 1	Copies of the instruments, manuals, reports, norms, psychometrics, and publications, as well as information on training, certification, software and scoring are publicly available at www.gaincc.org . You can also just email any questions to GAINinfo@chestnut.org for an individualized response.
Q2	***If we use the GAIN Short Screener, does the full GAIN have to be used, or can other assessments be used? What do you recommend for a follow-up assessment?***
Response 2	It can be the full GAIN or other assessments. The 5-minute GAIN Short Screener (GSS) can be used to track change itself (e.g., Ratterman 2014 evaluation of recovery schools), as a placement or triage tool related to the need for behavioral health and risk of recidivism, and/or to figure out whether to do a more detailed assessment. The latter can be but certainly does not need to be a 25 minute GAIN-Quick version or the full 1-2 hours GAIN-I. In Washington State where the GAIN SS has been mandated across all systems of care for adolescents and adults, the full range of existing assessments were left in place. In some counties/systems of care in Washington (e.g., King County adolescent treatment), the GAIN SS is followed by the GAIN Quick or full GAIN-

	Initial. In others counties/systems the GAIN SS is followed by whatever else they were already using. For follow-up, I do use and would recommend using a GAIN instrument for follow-up: repeating the GAIN SS or Quick if that is what is done at baseline, or using the GAIN Monitoring 90 day (GAIN M90) if following a GAIN-I. If there were well established records to gauge administrative outcomes (e.g., treatment initiation, engagement, urine test results, recidivism), I would not hesitate to use that initially or in addition to any GAIN measure. While the GAIN includes outcome measures that I frequently use, in my own research I also frequently add other measures focusing on those that are reliable, valid, short and inexpensive (e.g., the EQ5D, LCSF, REALM). A great source for these other measures is NIH's common measures tool box at www.phenx.org .
Q3	***Is there any data around using particular screening tools with American Indian/Alaskan Native youth?***
Response 3	Yes, the 2012 GAIN data set is one of the largest clinical sets with information on AI/AN youth and adults. There have been several publications focused on AI/AN youth (e.g., Haring et al., 2012a&b; Stewart et al., 2003, 2012) as well as presentations to the Bureau of Indian Affairs (BIA), Indian Health Service (IHS), and Office of Indian Alcohol and Substance Abuse (OIASA). In collaboration with BIA, we have also created versions of the GAIN SS and Q3 for use in Indian Country that include additional items on cultural identity/consideration, use AI/AN norms in the reports, and predict the risk of recidivism for diversion programs. You can get more information from www.gaincc.org or by contacting GAINinfo@chestnut.org .
Q4	***Do you know of any research on the effectiveness of SBIRT within schools?***
Response 4	The adaptation to using SBIRT with youth in general and specifically in schools is relatively recent. At the end of this document are some citations that report on some early and non-experimental efforts (e.g., Alayan & Shell, 2016; Curtis, McLellan & Gabellini, 2014; Gonzales et al., 2012; Harris et al., 2015; Mitchell et al., 2013, 2014; Winters .,2016). King County, WA and the state of KY are also using the GAIN SS for SBIRT including in several school based settings.

Q 5	***Is there any research on the effectiveness of spiritual based prevention programs/activities in schools?***
Response 5	I have not seen much research on this topic with adolescents to date. I know that there have been some American Indian/Alaskan Native programs that use it as a key component. From cross-sectional data, I do know that self-reported days of spirituality and measures of religiosity are in general related to more days of abstinence. But the topic is in need of further study.
Q6	***There were several questions about the effectiveness of other treatments, such as the 12-step approach, MATRIX for adolescents, and TruThought?***
Response 6	There have been some longitudinal studies of 12-step based treatment (Kelly et al., 2016; Winters et al., 2007) that show good pre-post change scores similar to what has been seen in the Tanner Smith et al., 2012 meta-analysis of other evidence based programs. But I am unaware of any experimental tests of their effectiveness with adolescents. I know that Christine Grella <cegrella@chestnut.org> evaluated the use of the Matrix model with adolescents; but I am unaware of any publications that came out of it. I am not familiar with Truthought, and do not see it listed in the two main peer reviewed forums I use (www.nrepp.samhsa.gov , www.crimesolutions.com), do not see any publications on their website (https://www.truthought.com/), and do not see any published experiments or quasi-experiments using it with youth in Google scholar. But you might also want to try contacting them directly to see if they have articles with outcome data that they can send you.
Q7	***Our state is reviewing an EBP for juveniles and we have reviewed A-CRA, and CYT Volume 1, 2, and 3. Which one would you recommend for the juvenile justice involved youth?***
Response 7	It depends a little bit on how much time you will have them. The 5 interventions examined in CYT were similar in outcomes, but A-CRA (aka volume 4) and MET/CBT5 (aka volume 1) were more cost-effective and MET/CBT was the most cost-beneficial in 12 months (Dennis et al., 2004;

	French et al., 2003). Taken out to 30 months, A-CRA and MDFT (aka volume 5) did slightly better on sustaining their outcomes and benefit-costs. If you are looking for a brief (5 fixed sessions over 6 week) easy to implement protocol, I would probably go with MET/CBT5. If you have more time with the youth (in sessions or duration) – I would go to A-CRA as it is more flexible, can be individualized, provided for longer durations and/or delivered in several modalities (e.g., outpatient, residential, continuing care) and involves parents/caregivers. If you have a labor supply of family therapists and/or can afford them, you might also want to take a look at MDFT. Whatever you do, remember that half the effect is coming from whether the therapists get (post training) coaching on and help with reliably implementing the protocol. You can get information on the cost and who is providing training on each of these interventions at www.nrepp.samhsa.gov .
Q8	***There were several questions about school-based treatment, including how are parent permissions handled, logistically how does school-based treatment work (e.g., pulled from classrooms, after school, other location), how are school-based programs funded, and what are the most effective school-based treatments?***
Response 8	It has varied by study and system to date. Some require active parental consent, others passive consent, others follow state rules allowing youth age 15 or older to consent on their own to treatment. Logistically they varied as well, including a community based program contracted to be on-site, a student assistance program, a school based health center, and in one case a school system (in Olympia, WA) that got licensed by the state to provide substance use treatment directly. Funding comes from multiple sources including state block grants, state treatment agency, the Children's Health Insurance Program (CHIP), Medicaid expansion, and/or private insurance. HRSA and SAMHSA are currently working with several states interested in starting a new series of Federally Qualified Behavioral Health Centers in the coming year as well.

	I do not know of any meta analyses focused on treatment in school based settings, but the Belur et al., 2014 study of MET/CBT and Hunter et al., 2014 study of A-CRA were replicated in 8 school systems each and showed that each evidence-based practice worked as well or better than they did in community based treatment. The 2 other studies I mentioned, Ratterman, 2014 evaluating recovery high schools and Wagner et al., 2014 evaluating self-guided change, also demonstrated considerable promise in individual school based settings. Thus those are where I would probably start.
Q9	***I work in juvenile justice and supervise youth on parole who are also getting medical marijuana cards. Does the benefit of using marijuana outweigh the cognitive effects to IQ?***
Response 9	To the best of my knowledge this question has not been directly evaluated to date.
Q10	***What is the optimal length of time to offer aftercare services?***
Response 10	NIDA's (2014) Principles of Substance Use Disorder Treatment for Adolescents (see https://www.drugabuse.gov/sites/default/files/podata_1_17_14.pdf) suggests that a period of 3 months or more based on a variety of factors including reduced likelihood of relapse, reduced total costs to society, and the half-life of the brain regaining its functioning. The Godley et al., 2014 paper reports on one of the larger randomly controlled trials of 3 types of continuing care and shows that type (not just duration) also matters. In addition, more complex cases involving OUD and co-occurring problems may require longer continuing care duration than less complex cases.
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