CHILDRENS HOSPITAL LOS ANGELES

Trauma and Co-Occurring Disorders among Youth

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Executive Summary

Children exposed to complex trauma can suffer a lifetime. They can grow into to adolescents and young adults with severe emotional and mental problems. They can begin using drugs and alcohol at early ages and the combination of trauma symptoms and substance use can complicate assessment and treatment. We may or may not label these young people with co-occurring disorders, but we are certain that they are difficult to manage. They are defiant, angry, explosive, withdrawn, overly compliant, reactive, provocative, impulsive, demanding, attention seeking, and they are manipulative. These youth run away from home or are kicked out, are suspended or expelled from school, are placed in foster care or group homes, put on probation and sent to juvenile hall. We often place them in residential settings staffed with the least trained or clinically educated personnel, command a myriad of rules, insist that they take medication, mandate abstinence and drug testing, demand that they attend groups, and plead with them to open up. We become frustrated, label them as resistant, give them write-ups, take away privileges, confront them, and give them ultimatums. We become angry, exit them from programs, and consider them ineligible for our services - yet offer them referrals. Many of them become homeless, continue to engage in high-risk behaviors, or engage in survival sex or criminal activity that leads to arrest. Now, too old for foster care or juvenile hall, they end up in jail, or if they are obviously mentally ill they may end up in a county hospital for a few days, only to be released to the streets or adult residential facilities staffed with the least trained or clinically educated personnel, command a myriad of rules, insist that they take medication, mandate abstinence and drug testing, demand that they attend groups, and plead with them to open up...

Trauma is a major contributing factor to the development of co-occurring disorders in young people. In addition, young people who use drugs and alcohol put themselves at risk for further trauma and complicate assessment and treatment. As administrators, policy makers, and treatment providers we must educate ourselves and the public about the critical issue of trauma in youth with co-occurring disorders. We must build our capacity for developing trauma informed systems of care for young people that not only integrate both substance abuse and mental health services, but offer a range of innovative and comprehensive services. To be successful, we must employ skilled clinicians that are capable of self-reflection and self-care and we must demonstrate that we value these qualities as core competencies and promote professional development. In order to engage and retain these youth in our services we must stop using adult models to treat them, offer developmentally appropriate services, and be open to harm reduction and alternative strategies that have been proven effective. In order to achieve more lasting results, we need to involve young people in their own recovery by offering them choices in order to build their skills while celebrating their strengths. We can increase the protective factors in the lives of children exposed to trauma and we can effectively treat youth with co-occurring disorders.

Overview

This paper will define key terms and provide a description of the impact of trauma exposure on children and youth with co-occurring disorders. A brief and general overview of adolescent development will provide a context for the effect of trauma, mental illness, and substance use on youth development. Emphasis will be placed on the impact of traumatic stress on children and adolescents to support the need for trauma informed systems of care.

Information on the unique aspects of substance use among young people will also be highlighted to provide the framework for alternative interventions and strategies that improve engagement, retention, and overall outcomes with this population. Special populations including gender differences will be noted areas of distinctive need and addressed as they relate to cultural competency. Recommendations for service delivery will focus on integration of services within a harm reduction framework. Resources and information will be provided on screening and assessment tools and several evidenced based interventions will be outlined briefly followed by a short vignette exemplifying daily provider stress and the critical need for self-care. This paper will conclude with a summary that will review the key implications for necessary program standards and policy recommendations.

Definitions

*Adolescent*s, for the purposes of this paper, are broadly defined in the age range from 12 to 24. Further distinction is made between youth ages 12 to17 and "transitional age youth" ages 18 to 24.

Complex Trauma describes exposure to multiple traumatic events and the impact of that exposure on immediate and long-term outcomes. Typically, complex trauma exposure occurs when a child is repeatedly abused or neglected, but it can also be caused by combinations of events such as witnessing domestic violence and living in a community with high crime and violence. Complex trauma is more pervasive than Post Traumatic Stress Disorder (PTSD), which is typically the response to a single traumatic event (National Child Traumatic Stress Network [NTCSN], 2008.)

Co-Occurring Disorders (COD) refers to at least one substance use disorder (abuse or dependence) and at least one other mental disorder; at least one disorder of each type can be established independently and are not just symptoms resulting from one or the other. There are individuals that may not meet the full criteria for either disorder, but who may be at risk of developing further symptoms. These individuals must be included in COD assessment for the purposes of program planning and implementation. Other terms for co-occurring disorders include dual diagnosis and co-morbidity (Center for Substance Abuse Treatment [CSAT], 2006).

Substance Use Disorders as defined by the DSM IV TR include substance abuse and substance dependence. *Substance Abuse* is considered a pattern of use leading to significant impairment or distress, as indicated by one (or more) of the following, occurring within a 12-month period: (1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., substance-related absences, suspensions, or expulsions from school); (2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile); (3) recurrent substance-related legal problems (e.g., arrests for substance-related conduct); (4) continued use despite having persistent or recurrent social or interpersonal problems caused or made worse by the effects of the substance (e.g., arguments with family, physical fights) (American Psychiatric Association [APA], 2000).

*Substance Dependence***:** A pattern of substance use, leading to significant impairment or distress, as indicated by three (or more) of the following, occurring at any time in the same 12-month period: (1) tolerance; (2) withdrawal ; (3) the substance is often taken in larger amounts or over a longer period than was intended; (4) there is a persistent desire or unsuccessful efforts to cut down or control substance use; (5) a great deal of time is spent in activities necessary to

obtain the substance, use the substance, or recover from its effects; (6) important social, occupational, or recreational activities are given up or reduced because of substance use; (7) the substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or made worse by the substance .

Prevalence of Trauma and Co-Occurring Disorders among Youth

Co-occurring disorders among young people are not uncommon. One study revealed that nearly 43 percent of youth receiving mental health services in the United States have been diagnosed with a co-occurring disorder (Center for Substance Abuse Prevention, 2001). Another study suggests that one out of every eight adolescents with a mental illness has a co-occurring substance abuse problem (King et al., 2000). We also have some data of the extent of trauma among young people. Studies indicate that one in four children and adolescents in the United States experience at least one potentially traumatic event before the age of 16 (NTCSN, 2008). Numerous studies report a strong connection between substance abuse and trauma among young people. In one study, teens that had experienced physical or sexual abuse or assault were three times more likely to report past or current substance abuse than those without a history of trauma (Kilpatrick, et.al. 2003). Surveys of adolescents receiving treatment for substance abuse have shown that more than 70% had a history of trauma exposure (Funk, et.al. 2003; Deykin and Buka, 1997). Other studies indicate that up to 59% of young people with PTSD subsequently develop substance abuse problems (NTCSN, 2008).

Despite growing interest in the area, the research is still limited and it is difficult to determine the full extent of trauma in youth with co-occurring disorders. The data is limited by multiple factors. Systems of care remain uncoordinated, screening and assessment tools are

limited in scope, and many service providers are untrained in integrated treatment approaches and often misdiagnose these complex problems. There is general agreement, however, that mental illness often develops in childhood, sometimes in response to trauma and that substance abuse in these youth is common. Therefore, co-occurring disorders, particularly in children with histories of trauma should be the expectation rather than considered an exception and is especially prevalent in our child welfare systems, juvenile justice systems, and community based organizations serving at risk youth.

Adolescent Development

Every young person is unique and extraordinary when we look for their distinctive qualities. Interacting with youth can be rewarding and fun, but there are developmental themes that also make working with adolescents a challenge. In early adolescence, around the ages of 12 to 15, a young person's body and mind are growing at rapid speed, often exceeding emotional development and leaving young people struggling with things like their self image. They are usually focused on appearances. Their sexual feelings are often overwhelming, and sexual identity and gender role confusion compound their feelings of awkwardness and uncertainty. Parents are often distressed by their frequent mood swings, their new levels of defiance, and the general sense that a stranger now lives among them. During middle adolescence, somewhere between ages 15 and 18, a young person is challenged to think critically, to show more impulse control, to be more self-directed, and more independent from their parents or caregivers. They still need limits and supervision, even though they may object. Common conflicts occur over money, curfews, chores, appearance, and activities with peers. It is not uncommon that they experiment with drugs and alcohol during this phase of their development. By late adolescence, between 18 and their early 20s, young people are preparing for adult roles. They are often

focused on the future, are discovering longer-term intimate relationships, and negotiating relationships in general. Given a safe environment to test their new skills, a chance to take risks and even make a few mistakes, young people develop a healthy sense of self and grow to become well-adjusted adults. However, many young people are not inoculated against poverty, racism, homophobia, violence, familial addiction or mental illness, physical disability and disease, childhood abuse and neglect, or acute and complex trauma. Adding any of these risk factors to the life of a budding young person makes achieving a healthy well-adjusted adulthood monumental.

Traumatic Stress in Children and Adolescents

The *Diagnostic and Statistical Manual* (DSM-IV) defines a "traumatic event" as one in which a person experiences, witnesses, or is confronted with actual or threatened death or serious injury, or threat to the physical integrity of oneself or others. A person's response to trauma often includes intense fear, helplessness, or horror (APA, 2000). However, for many children and adolescents, this definition is not inclusive of their experiences. Many youth are exposed to more than one traumatic event, often within the care giving system, and exposure is simultaneous or sequential, occurs over time and is chronic. The National Child Traumatic Stress Network Complex Trauma Task Force outlined seven primary domains of impairment in children exposed to complex trauma (NTCSN, 2003). These domains include: attachment; biology; affect regulation; dissociation; behavior control; cognition and self-concept. A brief description of the impairment in each domain is outlined below.

One of the worst sources of trauma for an infant or child is an unpredictable environment with an unreliable caregiver. All infants need a primary caregiver who is consistent, sensitive, who makes sense of and responds to their needs. These are basic requirements in order for that

child to have a secure enough base from which to explore the world, become resilient to stress, and form meaningful relationships with themselves and others. For example, when a child cries, a caring and attuned caregiver feels concern and acts in a way that communicates concern and provides nurturing to soothe the child. If a child is smiling and wants to play, the caregiver acknowledges this desire and responds in a positive manner. Through this interaction, the infant learns to regulate his or her mind, emotions, and physical self. It is important to note that a caregiver doesn't have to respond perfectly all the time in order for a child to develop a secure attachment. However, if a caregiver is consistently unavailable, unpredictable, or too overwhelmed themselves, children develop insecure attachments. Insecure attachment patterns have been consistently documented in over 80% of maltreated children (NTCSN, 2003). Children with insecure attachment patterns may be classified as avoidant, ambivalent, or disorganized. When a caregiver is unavailable or rejecting, a child may adapt and cope by avoiding closeness and emotional connection. Another child who experiences a caregiver's communication as inconsistent or intrusive may feel ambivalent about the attachment, which results in a chronic sense of anxiety and feelings of insecurity. Disorganized attachment occurs when the child's' need for emotional closeness remains unseen or ignored, and the caregiver's behavior is a source of disorientation or terror. When children have experiences with a caregiver that leaves them overwhelmed, traumatized, and frightened, the young person becomes internally disorganized and chaotic. Disorganized attachment leads to difficulties in the regulation of emotions, social communication, and academic reasoning as well as to more severe emotional problems.

Research on the biology of the brain suggests that lack of responsive care giving caused by constant maltreatment, neglect, or caregiver dysfunction can lead to lifelong difficulties

managing stress. It is not uncommon to see traumatized children (and adolescents) react to stress with uncontrolled helplessness and rage. Biologically compromised children are at risk for disorders in reality orientation (e.g., autism), learning (e.g., dyslexia), and cognitive and behavioral self-management (e.g., ADHD). In middle childhood and adolescence chronic stress can lead to disruptions in self-regulation (e.g., eating disorders), interpersonal problems (e.g., borderline personality disorder), reality orientation (e.g., thought disorders), and substance abuse and addiction.

Affect regulation is another domain that is significantly impacted by complex trauma. A young person may have a hard time identifying how he or she feels, knowing how to safely express those feelings, or how to manage those feelings. When a child grows up with mixed messages from a caregiver, such as smiling while berating or rejecting the child or becoming angry with a child who is distressed or crying, he or she doesn't learn to accurately interpret their experiences or the feelings of others. A child may not know when, where, or even how to express feelings safely. His or her feelings may become severely restricted, labile, or explosive, causing significant consequences. As a result of failed attempts to self-soothe or self-regulate their emotions, children and adolescents exposed to complex trauma often develop alternative ways of coping which in turn lead to significant impairment in mood and affect such as dissociation, (chronic numbing of emotions), and mood disorders like major depression.

Dissociation is a key feature seen in children and adolescents exposed to complex trauma. It is a survival technique that allows individuals enduring overwhelming feelings and horrific circumstances to preserve some areas of healthy functioning and a sense of self. Everyone dissociates to one degree or another. We can "space out" in meetings, in sessions, in traffic, sometimes to our detriment, but most of the time it is temporary and a way of shutting down in

response to the assault of daily stressors. It's important to note that it is an automatic central nervous system response to stress. However, a person who has been chronically stressed, and dissociates much of the time, is more likely to do things like cutting or using drugs and alcohol *to feel something*, anything which brings relief or release from this constant state of nothingness. Dissociation can be a barrier to treatment if a provider isn't aware of this phenomenon and pushes a youth to talk about things he or she is not ready to talk about. If the youth does not yet have skills to deal with the traumatic events, these dissociative states may result in self-harming behaviors in order to cope with the feelings that arise.

Chronic childhood trauma is also associated with behavioral patterns that range from impulsive and out of control to rigid and inflexible. These behaviors can be seen as an attempt to cope with overwhelming feelings of stress and a young person's efforts to gain control and mastery over their feelings and the environment. Chronic experiences of helplessness and lack of power can lead to being overly compliant with adult requests, or extremely resistant and reactive to any changes in routine. This is often observed in nonflexible bathroom rituals and eating problems with rigid control of food intake. Other young people may not develop the impulse control needed to plan, organize, or delay their responses. These young people display impulsive and often aggressive behaviors. Frequently, young people re-enact behavioral aspects of their trauma (e.g., aggression, self-injurious behaviors, sexualized behaviors, and controlling relationship dynamics) as habitual responses to trauma triggers. As might be expected, these behaviors put youth at risk for further complications such as teen pregnancy, substance abuse, suicide and self-harm, criminal activity, and re-victimization.

Children who have been abused and neglected early in life often do not develop basic cognitive functions needed for language proficiency and overall academic performance. They

have problems paying attention, completing tasks, being curious, and processing new information. By early elementary school, maltreated children are more frequently referred for special education services (Shonk & Cicchetti, 2001). By middle school and high school, maltreated children are more likely to be rated as working and learning below average, and they show higher incidence of disciplinary actions and suspensions (Eckenrode, Laird, & Doris, 1993). It isn't difficult to see how poor cognitive development can impact self-concept and can lead to later educational and occupational challenges.

Responsive, nurturing caretaking and positive early life experiences foster a sense of self as worthy and competent. A child's self-concept is significantly impaired by repeated experiences of abuse and neglect. These children grow with a sense of being unlovable, incapable, and helpless to affect change. Young people who have been abused are more likely to expect rejection and blame themselves for bad things that happen. Dissociation compounds the problem by disrupting healthy identity development. Over time, for a child who has been repeatedly physically and sexually assaulted, dissociation becomes reinforced and conditioned. Because the dissociative is such effective means of escaping one's feelings, children who are very skilled at it use it whenever they feel threatened or anxious -- even if the anxiety-producing situation isn't abusive. Often, even after the traumatic circumstances are long past, the leftover pattern of defensive dissociation remains. Repeated dissociation may result in a series of separate entities, or mental states, which may eventually take on identities of their own. These entities may become the internal "personality states," of a system. Children with severe abuse, often sexual, can develop what used to be called Multiple Personality Disorder, which is now called Dissociative Disorder (APA, 2000).

Substance Use among Youth

Why do young people use? The simplest answer is they use because they can and because drugs and alcohol are easily accessible. Many young people use because they are curious, they want to have fun and they want to fit in. Other young people use because they are suffering from mental and emotional problems and want to feel better. It is important to note the differences between these groups of young people because our national prevention efforts are currently designed for the first group. Youth suffering from the effects of trauma that have co-occurring disorders are less likely to respond to warnings to delay use, change the peers they hang out with, or have the internal resources to find other ways to have fun and relieve stress.

Results from the 2008 Monitoring the Future Survey on adolescent substance use indicate that almost half (47.4%) of 12th graders surveyed used illicit drugs over their lifetime and close to three quarters (71.9 %) had used alcohol (NIDA, 2009). On any given day, approximately 9% of American adolescents between the ages of 12 and 17 meet the American Psychiatric Association's diagnostic criteria for substance abuse or dependence (SAMSHA, 2008). It can be helpful to look at adolescent drinking and using on a continuum. There are those who do not use, contrary to many youth's perceptions. There are those youth who experiment and then stop. Experimentation can be indicative of healthy curiosity and a certain amount of risk taking can be seen as a normal part of adolescence. Other youth will continue to drink and use on a more social and recreational basis without negative consequences. However, it is when a youth begins to misuse, or use to alter feelings and thoughts, that problems begin to surface. Some youth attempt to self-medicate psychiatric symptoms, and others misuse to relieve feelings of boredom and peer-pressure, which can also lead to habitual use. The

diagnostic categories of abuse and dependence are at the far end of the continuum of use and indicate a need for more intensive interventions.

The earlier a young person engages in regular drug and alcohol use the more likely he or she is to have problems later in life. We know that the brain is not fully developed until the early to mid twenties and that drugs and alcohol have a significant impact on brain development. Substance use can impact brain development in the areas of critical thinking, planning, impulse control and emotional regulation. Substance use can also impact social development, identity development and learning. A young person may attach to a social subculture that reinforces regular use and antisocial behaviors. Chronic use allows little opportunity to develop skills that are necessary for healthy relationships such as conflict resolution and negotiation. Youth may also form their identity around drug using behavior and an associated peer group, which can prevent exploration of new ideas, new behaviors, and new activities, all critical processes in adolescent identity development.

Historically, substance abuse treatment programs have been designed for adults, and adult models of treatment are not effective with youth (Chapman & Rokutani, 2009). Many of our current treatment programs for youth are still based on adult models. However, there are important differences between adolescent and adult patterns of drinking. Adolescents tend to binge drink or drink a lot at one time in social situations. Many appear to meet the criteria for tolerance, which is one criterion for substance dependence, but it can be argued that they are just learning how to drink (or use). Adolescents haven't used as long as most adult addicts or alcoholics; they don't have the same medical, occupational, or interpersonal problems or consequences seen in adults, making it harder for them to see their use as problematic. In addition, adolescents often use a greater number or different types of substances, making

assessment complicated and withdrawal more difficult (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2005). In addition, adolescent developmental issues are very different than adults, and include moving toward more self-directed behaviors, being more independent and separate from parents and most adults. Mandating a 16 year old to an AA meeting, where most participants are older adults who have war stories of being "beaten down" by drugs and alcohol, does not match the young person's identity, need for independent decision-making, and often highlights and reinforces the differences in patterns and consequences use. These mandates do little to motivate action toward sustained change. This is not to say that 12-step and abstinence only programs don't work for adolescents, some do - for some adolescents.

It is also important to note that our current policies for zero tolerance and drug testing are generally ineffective for reducing substance abuse. South Park's Counselor Mackey says simply, "Drugs are bad, don't do drugs okay". Nancy Regan's "Just Say No" campaign during the 80's was similarly straightforward and uncomplicated. However, we now know that scare tactics and prohibition are not the best strategies to prevent use among youth, yet our schools and juvenile courts still promote these policies and practices. The first large-scale national study on student drug testing found virtually no difference in rates of drug use between schools that have drug testing programs and those that do not, (NIDA, 2003). Follow up studies confirm these results. The only formal study to report a reduction in drug use was suspended by the government because it lacked sound methodology (Kern, et.al. 2006). Drug testing and zero tolerance policies also marginalize at-risk youth by suspending or expelling students and preventing them from accessing afterschool programs and activities that promote positive youth development and may in fact reduce substance use. Prominent national organizations representing experts on adolescent health that oppose student drug testing include the American Academy of Pediatrics,

the Association for Addiction Professionals, the National Education Association, the American Public Health Association, the National Association of Social Workers and the National Council on Alcoholism and Drug Dependence.

Making the Connection between Substance Abuse and Trauma

It is critically important, though not easy, to address co-occurring substance abuse and traumatic stress concurrently. Providers often believe that before they can address underlying issues relating to trauma they must first treat substance abuse problems in order to limit the potential harm and threat to the individual. Other providers believe that unless the individual learns ways to manage distress associated with trauma, the likelihood of substance abuse relapse is almost inevitable. Both are views are valid, therefore increased communication and coordination among substance abuse professionals and mental health providers is imperative. All professionals need to remain aware of the connection between trauma and substance use. Trauma assessment should be an integral part of the services provided by agencies and individuals working with adolescents, particularly those at high risk of trauma exposure.

Trauma and Substance Abuse: Myth and Facts

Myth: Attributing drug or alcohol use to stress just prevents adolescents from taking responsibility for their actions. **Fact**: Defining the relationship between a youth's trauma history and his or her substance use can actually enhance his or her ability to take responsibility for his or her actions, particularly in adolescents who are reluctant to acknowledge that their substance use is a problem. In addition, the self-medication hypothesis can be extremely helpful in understanding both the origins of a youth's substance abuse and the factors that may lead to continued use or relapse. (NTCSN, 2008)

Special Populations and Cultural Competency

Gender

Effective treatment of youth includes acknowledging the importance of gender differences. We live in a male dominated society and gender roles and expectations are shaped accordingly. Girls often learn to internalize their experiences; boys often learn to externalize them. Male teenage substance abusers tend to have more disruptive disorders such as conduct and oppositional defiant disorders whereas females tend to have higher rates of mood and anxiety disorders (Latimer, 2002). Compared to boys, girls experience more sexual victimization overall, including sexual assaults, rapes, and sexual harassment. However, all types of maltreatment (sexual, physical, and neglect) can increase the risk of delinquency for both sexes. Depression and anxiety disorders have been associated with delinquency. Girls receive these diagnoses more frequently than boys (NIDA Notes, 2003).

Homeless Youth

It is estimated that 2 million youth in the United States experience at least one night of homelessness each year, with over 100,000 youth sleeping long-term on the streets (The National Alliance to End Homelessness, 2009). Homeless youth have significant mental health problems, including depression, anxiety disorders, posttraumatic stress disorder, suicidal ideation, and substance use disorders (Cochran, et.al. 2002). Most of these youth experienced traumatic events before they left home, and many of them are retraumatized once they arrive on the street (Stewart, et.al. 2004). Homeless adolescents who abuse substances engage in more high-risk behaviors, are more resistant to treatment, and have higher rates of psychopathology and family problems than substance-using adolescents who are not homeless (NTCSN, 2008).

Providers must offer low barrier access to services in order to be effective with homeless and runaway youth, especially those with co-occurring disorders. Often, it is more effective in the long run to address the immediate needs of the youth such as the need for food, a shower, or clean clothes than to insist on clinical services. Homeless youth are much more likely to engage in treatment once they have established a trusting relationship with a service provider. Establishing this relationship may take a long time and require a lot of patience and loving tolerance. In an excellent brief on *Trauma and Homeless Youth*, Schneir and associates state, "engaging and retaining [homeless] youth in treatment is challenging, even for the most skilled clinicians" (Schneir, et al., 2007).

LGBTQ Youth

Lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) are at significant risk for trauma and substance abuse. They face rejection from family, friends, and peers. They are kicked out of their homes, verbally and physically harassed, and even murdered because of their sexual orientation. In a survey of LGBT youth in secondary schools across the nation, name-calling, harassment, and violence were common experiences of these youth (Kosciw & Diaz, 2005). In this survey, based on their sexual orientation nearly two-thirds (64.3%) of the students reported feeling unsafe at school; nearly two-thirds (64.1%) reported that they had been verbally harassed at least some of the time in school in the past year; over a third (37.8%) experienced physical harassment at school; and nearly a fifth (17.6%) of students had been physically assaulted. Multiple research studies indicate that a conservative estimate is that one in five homeless youth self-identify LGBTQ and experience higher rates of physical assaults, sexual exploitation, and mental health deterioration than their heterosexual homeless peers (The

National Alliance to End Homelessness, National Advisory Council on LGBTQ Homeless Youth, 2009).

Many LGBTQ youth never self-identify or disclose their orientation. It is imperative that providers not expect or pressure youth to "come out." Whatever the reason a young person decides for not disclosing his or her sexual orientation needs to be respected as a process over which the youth maintains the control. The following treatment recommendations provided by the National Child Traumatic Stress Network can be used as a framework for cultural sensitivity surrounding LGBTQ youth (Killen-Harvey and Stern-Ellis, 2006).

Use inclusive language. Most of our language assumes heterosexuality. How many providers wouldn't think twice about asking a new adolescent male client, "Do you have a girlfriend?" This question will create a significant dilemma for any LGBTQ youth. The question assumes a heterosexual orientation. A more inclusive LGBTQ question would be: "Is there anyone special in your life or anyone you feel attracted to?" This allows for a wider range of responses. *Recognize that there is a difference between "same sex sexual encounters" and being gay or lesbian.* The former describes a behavior that may or may not describe sexual orientation. It is not uncommon for many individuals to have same sex sexual interactions and not develop a gay or lesbian identity. *Connect youth with support groups or student organizations that allow them to interact with other LGBTQ youth.* This will go a long way towards diminishing feelings of alienation and isolation. The Internet should be used cautiously but, with a well-informed provider, can be an important part of providing opportunities for safe connection. *Learn about the stages of sexual identity development for LGBTQ individuals.* When providers take the time to educate themselves, they are more likely to understand and respect wherever the youth may be in this process. Counselors can explore safeguards with youth and help them lessen their

personal risk factors through each of these stages. *Remember that a counseling intervention has been successful whenever an adolescent is willing to be vulnerable and process challenging material.* If a provider has succeeded in providing a safe space for LGBTQ youth, this may very well be a lifeline and a vehicle to reducing risk of future traumas. (Adapted from *Trauma Among Lesbian, Gay, Bisexual, Transgender, or Questioning Youth,* Trauma Brief by NTCSN, v1 n2, 2006).

Juvenile Offenders

The prevalence of youth exposed to trauma is believed to be much higher in juvenile offenders than youth in the general population. One study found that over 90% of the juvenile detainees reported experiencing at least one traumatic event in their lifetime (Arroyo, 2001). Nearly two-thirds of incarcerated youth with substance use disorders have at least one other mental health disorder (Marsteller, et al., 1997). Mood disorders, such as depression, appear to co-occur with substance abuse problems more frequently among the juvenile justice population than among youth generally (Edens & Otto, 1997). Youth exposed to traumatic events exhibit a wide range of symptoms such as anxiety and depression and may self-sooth with drugs and alcohol, but many other youth externalize their experience and cope by resorting to indifference, defiance, or aggression. Risk taking behaviors, breaking rules, fighting back, and hurting others, often characterized as conduct and oppositional defiant disorders, are means of self preservation that often lead to encounters with the juvenile justice system. These encounters in and of themselves can be retraumatizing to youth (Ford et al., 2007). Given the high rates of trauma in this population, screening for trauma should be routinely performed on youth at the initial point of contact with the juvenile justice system and all personnel should be trauma informed.

Another problem related to juvenile offenders is that their victimization has often gone unreported and therefore more likely to go untreated. Contributing factors for not reporting may include adolescent concerns about personal autonomy, fears of being blamed or not taken seriously, fears of retaliation, fears of being punished, and the perception of both youth and adults that offenses against youth are not real crimes (NTCSN, 2004). In order to increase youth reporting, the justice system needs to remove the disincentives to reporting and become leaders in changing the way people think about crimes against juveniles. Communities need to provide incentives to report, including information to help youth protect themselves from future victimization or from retaliation. Given the high rates of trauma in this population, screening for trauma should be routinely performed on youth at the initial point of contact with the juvenile justice system. Targeted interventions and trauma informed services must be applied and made available to this highly vulnerable population, particularly those youth with histories of witnessing violence or who have been victims of violence.

Comprehensive Care

Youth Focused

As we attempt to build capacity and develop comprehensive programming for youth with co-occurring disorders impacted by trauma, the first step is to ensure that our efforts are youth focused. Can we look at our services through the lens of a youth? If so, what do we see? Are we actively involving youth not only in their treatment plans but in our program planning as well? Successful service coordination is grounded in the core values of working with youth. A useful model was adapted from the Core Values for Supportive Education in the California Mental Health Directors Association's *Transition Age Youth Subcommittee's Resource Guide.*

These values were outlined in the COD E- Circular published by the California State Department of Alcohol and Drug Programs in February 2009. They are as follows*:*

1. Flexibility: Services are evaluated on an ongoing basis.
2. Dignity: Services are provided in a manner and in an environment that protects privacy, enhances personal dignity and respects cultural diversity.
3. Coordination: The resources are brought together to work for the benefit of the participants.
4. Individualization: Services are tailored to meet the unique and changing needs of each youth. Services build on the individual strengths of participants.
5. Self-determination: Youth set the goals and fully participate.
6. Active involvement: Youth participate in all aspects of the program from planning to implementation to evaluation.
7. Strengths: Services are built on the unique strengths of each individual youth.
8. Hope: Youth are treated as developing persons, capable of growth and change.
9. Advocacy: Youth are given support to advocate on their behalf.

Integrating Harm Reduction and Abstinence Only

Harm reduction is a relatively new approach to treating substance related disorders. It has been applied to mental health and medical problems as well. It is imperative that administrators, policy makers, and service providers understand this fundamental approach and endorse it as a viable frame when working with anyone struggling with addiction as the literature supporting its effectiveness is substantial. Harm reduction is practical, humanistic, low barrier, and focused on immediate goals. A harm reduction philosophy can serve as an umbrella under which youth are allowed to address their immediate issues, gain stability, and reduce

harms associated with their substance use. However, in spite of the evidence to support it, harm reduction is controversial and often resisted as a sound approach or philosophy in addressing addiction.

The current, dominant position at federal, state, and local levels in response to drug abuse and addiction is to abolish illicit drugs, condemn, criminalize, and punish those who use. Harm reduction is often seen as an adversary of these dominant views, a liberal position that supports drug use and even encourages it. Harm reduction neither supports nor encourages drug use. Implicit in the term harm reduction is the fundamental recognition that all drugs, including alcohol have associated harm. There is no universal or concise definition of the term. One common description is that it is "a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users where they're at, addressing conditions of use along with the use itself" (Harm Reduction Coalition, 2009).

Some of the strongest opposition within the field comes from substance abuse providers. There is a false notion that harm reduction is the opposite of abstinence-based treatment and 12-step programs. Harm reduction and abstinence-based substance abuse treatment cannot only be integrated, but their integration is more powerful than either separately (Futterman et. al. 2004). Traditional abstinence-based substance abuse treatment programs require abstinence for admission and as the goal of treatment. An individual must identify as an "addict" or "alcoholic" to show treatment readiness, if unable or unwilling to do so, he or she is typically told to come back for services when ready to achieve sobriety. However, early drop out in these programs is a common problem and can lead to further deterioration. A program philosophy of total abstinence

reasons that ‘tough love’, ‘hitting bottom’, ‘confronting denial’ using techniques to ‘deflate the ego’ are necessary for recovery and many treatment providers view harm reduction as “soft”, enabling, and not strong enough to confront the power of addiction. This simply isn’t so.

Integrating harm reduction and abstinence models begins with accepting youth into programs at various levels of substance use and not discharging them because of continued use. Abstinence can still be the long-term goal. There can be firm structure without harsh rules and punitive application of consequences. Emphasis is placed on engagement and retention. Respect, understanding the stages of change, aiming for abstinence but making room for ambivalence is cornerstone for this integration. Providers must build trust over time and work with what the youth are willing and able to do. Though it is an adult model, a successful application of the integration of harm reduction and abstinence only treatment modalities can be found at the Growth and Recovery Program, an outpatient substance abuse program at North Central Bronx Hospital and Jacobi Medical Center in the Bronx in New York City (Futterman et.al. 2004 and 2005).

Integration of Substance Abuse and Mental Health Programming

Integrating substance abuse and mental health services in the treatment of co-occurring disorders is a standard recommendation. Training clinicians in assessment and treatment of both disorders is necessary. Ensuring a multidisciplinary team approach is good practice and offering a continuum of services that include a benefits specialist, case management, vocational training, and access to housing is fundamental. So why are there so few truly integrated programs and coordinated services available? In a statement by The County Alcohol and Drug Program Administrators of California, three primary reasons were identified: first we don’t have the cross

training or tools to effectively identify or treat persons with co-occurring disorders; second, we don't have the funding; and third, our systems of care are not skilled in the unique aspects of different populations (CADPAC, 2005).

There is another, perhaps more fundamental problem that contributes to the difficulty of integrating and coordinating substance abuse and mental health services. Historically, we've separated substance abuse services from mental health services and while there is a call to bring them together, there is a lack of understanding how to do it effectively. What are the implications of sending a youth to see a substance abuse counselor *and* a psychotherapist? Is the substance abuse counselor only to discuss drug and alcohol use? How can a psychotherapist only talk about mental health issues without discussing substance use? The good news is that we see the need to address both issues when we make efforts to coordinate services, but are we duplicating efforts and confusing the youth? The professional disciplines associated with substance abuse and mental health are often very differently trained and often somewhat contentious. If we are calling for true integration, then we must address the differences that have us segregated in the first place. It can be helpful to explore the following questions: What do clinicians who are trained as social workers, marriage and family therapists, and psychologists believe about substance abuse and addiction? What do they believe about 12-step approaches? What do counselors trained in substance abuse and addiction believe about therapy? How do they feel about psychotropic medications? These are fundamental questions that must be addressed in a safe environment where honest discussion can take place and efforts made toward greater understanding and appreciation can develop. Without addressing these issues, we can integrate substance abuse and mental health services but not do so effectively and ultimately do more damage to the youth we are trying to serve by confusing them and fragmenting their care.

Trauma Informed Systems of Care and Trauma Specific Services

The term *Trauma Informed System of Care* is based on a thorough understanding of the vulnerabilities of trauma survivors. Often, traditional service delivery approaches do not recognize trauma triggers and re-traumatize youth. To ensure that our programs are trauma informed, we must provide trauma training to *everyone* who may come in contact with youth, including receptionists and facilities personnel. The goal is to make the entire environment safe and welcoming. Services must be designed so that all of our actions are thoughtful and aim to empower youth and optimize recovery. *Trauma Specific Interventions* are those services that directly address individual's traumatic experience and aim specifically at effective recovery. These interventions aim to improve attachment, self-regulation, and self-competency.

If we understand impact of trauma on youth, we realize that providing youth with choices enhances their growth and development. Having choices is what helps the young person develop a sense of empowerment. We must be genuine in our efforts to help but we must also remember that healing takes time. If one has ever been rear-ended you know it takes months to stop looking in your car's rearview mirror. It takes time for a young person with a history of trauma to trust that your efforts will not ultimately hurt them. If a young person's behavior does not make sense or looks like "acting out", it doesn't necessarily mean that it doesn't make sense for that youth. We need to remember that trauma leaves a young person feeling unsafe and powerless and easily triggered, inducing similar feelings, resulting in efforts to gain control. Often, those efforts are made impulsively, if not reflexively. Knowing how to respond without reacting to our own need to control, providing limits and structure with care and concern, and implementing trauma

informed consequences without punishment is our challenge as trauma informed service providers.

Screening and Assessment

Ideally, careful assessment of traumatic stress and co-occurring disorders would be an integral part of the services provided by all agencies working with adolescents. In reality, although much progress has been made in the treatment of both substance abuse and traumatic stress, these fields remain primarily independent of each other and few service providers are skilled in assessing the multiple needs of youth with trauma and co-occurring disorders. Screening and assessment instruments for identifying trauma, mental health, and substance related problems of adolescents differ considerably in the kinds of psychological and behavioral characteristics that they evaluate. Most instruments focus on deficits and impairment, looking at symptoms and behavioral problems. An essential part of a complete assessment includes attention to strengths of youth and the family or systems from which they have been referred. Differences in age, gender, ethnicity, setting, cognitive abilities and language skills of the youth, and the level of expertise in staff available to do the screening and assessments make it impossible to find one tool that fits all. Selecting reliable and valid tools requires several considerations.

Both screening and assessment instruments should require low levels of reading ability and use relatively simple response formats such as paper and pencil. Instruments should be responsive to youth of different ages, gender, sexual orientation, and ethnic and cultural backgrounds. Instruments should always assess psychological or behavioral conditions that may indicate a need for immediate intervention (e.g., suicide potential, severe depression, aggression, substance dependence and potential withdrawal). Instruments that can be accessed through the

public domain or are low per-case cost and low publisher fees can be as effective as those requiring higher costs . Optimally, tools are brief and simple to administer, require little or no specialized expertise, and offer easy scoring that produces uncomplicated results. Appendix A lists several instruments that meet most of these requirements.

Evidenced-Based Strategies and Theoretical Frames

SAMHSA's National Registry of Evidenced-Based Programs and Practices (NREPP); The National Center for Mental Health and Juvenile Justice's Models for Change initiative; and the National Child Traumatic Stress Network's Evidence-Based Programs and Promising Practices offer a multitude of strategies to address the needs of youth impacted by trauma and that also address co-occurring disorders. Below are a few models that are particularly trauma informed and address the needs of youth.

A**ttachment, Self-Regulation, and Competency (ARC)**

ARC is a guideline for individuals working with traumatized youth in the community. Interventions focus on building secure attachments, enhancing self-regulation, and increasing competencies across multiple domains. Each area of focus (attachment, regulation, and competency) is grounded in trauma-informed interventions, techniques, and auxiliary treatment methods. Based upon the youth's needs and strengths, the clinician chooses appropriate interventions from a menu. Therapeutic procedures include psychoeducation, relationship strengthening, social skills, and parent-education training as well as psychodynamic, cognitive, behavioral, relaxation, art/expressive, and movement techniques. The number of sessions, frequency, and duration all vary depending on youth's needs. ARC can be used in clinic, school, or community settings (e.g. transitional housing for homeless clients who have experienced

domestic violence). By using ARC as a therapeutic framework, we engage youth differently by looking for opportunities to increase attachment, emotional regulation, and competence. ARC targets both male and female participants, ranging from early childhood through school age and late adolescence. Participants have represented all race/ethnicity categories including American Indian and Alaskan Native. Evaluation results have revealed a 50% reduction in PTSD symptoms as measured by the Clinician Administered PTSD Scale-Child Version (NTCSN, 2009).

Brief Strategic Family Therapy (BSFT)

Youth with co-occurring disorders frequently report high levels of family conflict, including parental abuse, criminality, and substance abuse. In addition, their families often have histories of unstable housing situations and often are characterized as emotionally unavailable and lacking effective parenting skills (Bass, 1992; Whitbeck et al., 1999). BSFT is a time-limited intervention used to treat adolescent drug use that occurs with other problem behaviors. BSFT is a family systems approach; it identifies the patterns of interaction in the family that influence the behavior of each member; interventions target and provide practical ways to change those patterns of interaction. BSFT can be implemented in approximately 8 to 24 sessions. However, the number of sessions can depend on the severity of the problem, the availability of the family, the youth's willingness to engage with the family, and the clinical appropriateness of such involvement. BSFT has shown decreases in substance use, reduction in negative attitudes and behaviors, and improvements in positive attitudes and behaviors. Specifically, BSFT has shown 75% reduction in marijuana use, 42% improvement in conduct disorders, and improvements in self-concept and family functioning (NIDA, 2002).

Cognitive Behavioral Therapy (CBT)

CBT is a psychotherapeutic approach that focuses on the relationship between an individual's beliefs, emotions, and behaviors. Cognitive-behavioral therapy is based on the idea that our *thoughts* cause our feelings and behaviors. The benefit of this notion is that we can change the way we think in order to feel and therefore act better, even if the situation does not change. Clinicians focus on teaching rational self-counseling skills. CBT is based on the scientifically supported assumption that most emotional and behavioral reactions are learned. Therefore, the goal is to help youth *unlearn* their unwanted reactions and to learn new ways of reacting. Irrational beliefs can contribute to painful emotions, such as anxiety and depression. These same beliefs can also contribute to a variety of other mental health difficulties, including substance abuse problems. CBT is a collaborative process involving the clinician and the youth working together to identify current problems and solutions. CBT is a fundamental component in many interventions because it challenges many beliefs of youth that lead to high-risk behaviors.

Girls Circle and Boys Council

The Girls Circle Association is a nonprofit organization based out of Northern California that provides gender informed comprehensive training and materials. Their groups are research based and considered a promising practice approach within the Office of Juvenile Justice and Delinquency Prevention. In a study specifically testing the efficacy of Girls Circle, participants reported an improvement in four long-term outcomes: a decrease in self-harming behavior; a decrease in rates of alcohol use; an increase in attachment to school; and an increase in self-efficacy (Roa, et.al. 2007).

The Girls Circle model is a structured support group for girls from 9-18 years old. It integrates relational theory, resiliency practices, and skills training in a specific format designed

to increase positive connection, personal and collective strengths, and competence in girls. It aims to counteract social and interpersonal forces that impede girls' growth and development by promoting an emotionally safe setting and structures within which girls can develop caring relationships and use authentic voices.

Boys Council is a strengths-based group approach to promote boys' and young men's safe, strong and healthy passage through pre-teen and adolescent years. Boys Council meets a core developmental need in boys for strong, positive relationships. The groups are structured and recognize boys' strengths and capacities, challenge stereotypes, question unsafe attitudes about masculinity, and encourage solidarity through personal and collective responsibility. Boys Council incorporates a relational-cultural framework and masculinity research practices, building on boys' abilities and creating opportunities for resilient actions and relationships in boys and young men's lives.

Motivational Interviewing (MI)

MI is a style and approach that involves using specific discussion techniques to enhance an individual's motivation to change problematic behavior. MI pertains to both a style of relating to the client as well as therapeutic techniques that facilitate the process. Its main tenets include: 1) taking an empathic, nonjudgmental stance while listening reflectively, 2) developing discrepancy, rolling with the client's resistance, and avoiding argumentation, and 3) supporting self-efficacy for change. The conceptual background for MI relies on brief interventions and understanding the stages of change. The model relies on the influence of the clinician and is based in conflict theory. Individual and group MI interventions are consistent with each youth's stage of recovery and readiness to change and incorporated into his or her treatment plan. A systematic literature search produced 72 randomized controlled studies assessing the

effectiveness of motivational interviewing in client counseling to date (Rubak et al, 2005). MI has been found to increase retention, adherence, and staff-perceived motivation (Hettema et al, 2005). It is particularly effective with youth because it meets them where they are, puts them in the "driver seat", and demonstrates respect for their efforts at independent decision making.

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

SPARCS is a group intervention that was specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress and are experiencing problems in several areas of functioning. These areas include difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life as well as worldviews that make it difficult for them to see a future for themselves. Overall goals of the program are to help teens cope more effectively in the moment, enhance self-efficacy, connect with others and establish supportive relationships, cultivate awareness, and create meaning. SPARCS is predominantly cognitive-behavioral. Its components include mindfulness, interpersonal, and emotional regulation skills derived from Dialectical Behavior Therapy (DBT) for Adolescents (DBT is an evidenced-based practice listed on SAMHSA's National Registry of Evidence-based Programs and Practices); problem-solving skills from Trauma Adaptive Recovery Group Education and Therapy (TARGET- also listed on SAMHSA's NREPP); and social support enhancement and skills regarding planning for the future from the School Based Trauma/Grief Group Psychotherapy.

Managing Professional Stress and Self Care

5:00 a.m. "*God, do for me what I cannot do for myself*." I drag myself out of bed, scuffle to the bathroom, and become more alert as I dress in the dark. Out the door on my morning walk, (s*elf-care tip #1 – exercise*); I am able to breathe in fresh air as I allow thoughts to wander in and out of my brain without destination. I make a point not to judge or control the myriad of reflections (*self-care tip #2 – don't try to control everything*), rather note with interest that 95% of these thoughts are about work. 6:45 a.m. I have taken a shower, made breakfast, and kiss my partner goodbye.

7:00 a.m. "It's my music day!" I argue with my five year old in order avoid hearing Dolly Parton sing Walter Henry for the millionth time. He concedes and we drive to school trying on new music and wondering who is more a heroic, Wonder Woman or Hawk Girl (*self-care tip #3 – play*). 7:30 a.m. Tommy doesn't show up for his appointment. I'm relieved because I have an hour to prepare for my staff meeting this afternoon. "*I'm sure he's fine. I don't need to call, do I? I'll call later.*" I am able to work on a tracking system for referrals. Looking at systems issues to ensure integrated services is not easy to do. 8:30 a.m. I attend the fifth of nine meetings scheduled this week. 9:50 a.m. I get an important phone call from a judge regarding our newest referrals. 10:10 a.m. I am late for Sally's appointment but she appears diffident and obediently takes her seat in my office. She is 20 years old and originally from Guatemala. She is homeless but living with a friend at the moment. I've known her for over a year and she has only recently agreed to see me for therapy. Sally has a long history of poly substance dependence, preceded by horrific trauma. She has talked of being spit on by her alcoholic mother, beaten with a broom handle, left bleeding in a closet. Today, she is 21 days

free of all substances. She is adamant that she is only sober because she doesn't want her boyfriend to leave her. She is angry and depressed. In the middle of our session I hear my name being paged overhead. I ignore it. My phone rings. I ignore it. Then someone knocks on my door, "the state monitor is here for a surprise visit". *Great*, "he'll have to wait until I'm done here." 11:00 a.m. I greet the monitor, let him know I have a meeting downtown at 11:30, introduce him to staff, pull some charts and personnel files, try to make him comfortable at my desk and encourage him to ask for whatever he needs (*self-care tip #4 - remember to breathe*).

11:30 a.m. I meet with my friend at Homeboy Industries in downtown Los Angeles. We eat and she tells me about all the wonderful services being offered for ex-offenders and gives me a tour. I walk pass lighted candles and flowers on a table. In the middle of the table is a picture of one of the staff that died after he was shot 13 times last week at a reunion. 12:45 p.m. (*self-care tip #5 – forgiveness is hard*). I look through a multitude of new emails and see an urgent request to prepare a document for a meeting scheduled tomorrow. 2:00 p.m. The staff meeting seems upbeat as we work on systems issues. I treat them with the cookies I brought downtown, trying hard not to beat myself up for having eaten way more of them than I should have.

4:00 p.m. I pick my son up from school, sorry to hear that "he forgot his listening ears today". We talk about it on the way home, I express my sympathy, and we make plans for a more compliant evening. 5:00 p.m. I make dinner and prepare my son's bath. Fortunately, his tape recorder is nearby and I am able to tape his rendition of the Pledge of Allegiance his imaginary conversation between Barrack Obama, his wife Michelle, and some mysterious interactions with Joe Biden and the Filipinos. *Where does he get this stuff?* (S*elf-care tip #6 – its good to laugh.*) 6:30 p.m. The state monitor calls telling me he couldn't find specific documents

that I am certain were in the files. I assure him I'll FAX them tomorrow and he assures me I'll receive his report then. I have 30 days to develop some kind of plan I don't understand or care about in the moment, a new requirement from Alcohol and Drug Programs. 8:30 p.m. After reruns of the Simpsons, the New Adventures of Old Christine, and half an episode of Dexter, I am ready for bed. *God, thank you for this day. Thank you for your love and goodness to me. And thank you that I'm still clean and sober.* I kiss my partner, pull the covers up, stroke the cat next to my pillow, push the other one away from my feet, and fall quickly into my dreams (*self-care tip #7 – take it one day at a time).*

This is a typical day for me. I am certain it is not an atypical day for many providers, with variation of course. Working with victims of abuse and neglect is hard work. Combined with pressures of daily reports and increasing accountability, increased case loads and greater expectations to coordinate care in routinely complex clinical situations, administrators and direct service providers become overwhelmed. Some call it compassion fatigue, vicarious traumatization, or just plain burn out. Some individuals respond by distancing themselves from the youth, others become overly involved. Self-care is being aware that we are not God; we cannot fix everything or anyone. Our job is to do the best we can with what we have, remember to laugh, to bathe, to be easy on ourselves and others, and to remember that taking care of ourselves is essential to our ability to continue doing the amazing work we do.

Conclusions

Young people who have been exposed to complex trauma and who develop co-occurring disorders often grow up to be adults who continue to suffer from the impact of trauma and co-occurring disorders. Youth use drugs and alcohol for many reasons and to varying degrees. To

effectively intervene, we need ongoing training to improve our ability to accurately assess and treat these youth. Our approach to treatment must encourage engagement by being youth focused and welcoming and we need to consider harm reduction as the frame for implementing our interventions. Integrating and coordinating services involves challenging our beliefs and encouraging open dialogue about different perspectives and therapeutic approaches across systems. We need to educate ourselves about complex trauma and constantly ensure that all personnel and system structures support and empower the youth we serve, guarding carefully against re victimization. In order to more effectively serve this vulnerable population, we must improve our own practices of self-care. Administrators, policy makers, and service providers must make room for and encourage daily self-reflection and supervision, taking time out and time off to revitalize and recharge in order to be of optimal service to others. The need to address trauma among youth with co-occurring disorders is not likely to decrease, and the stress of providing comprehensive and informed services to this population is not likely to subside. In order to be effective, we must ensure that we are informed, coordinate and integrate our services, and receive the support we need.

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Appendix A

Validated Instruments for Traumatic Stress and Substance Abuse*

Instrument	Description	Source
GAIN Global Appraisal of Individual Need	The GAIN is a series of clinician-administered biopsychosocial assessments designed to provide information useful for screenings, diagnosis, treatment planning, and monitoring progress. Domains measured on the GAIN-Initial (GAIN-I) include substance use, physical health, risk behaviors, mental health, environment, legal and vocational. Several scales are derived from the GAIN-I, including substance problem, traumatic stress, and victimization indices.	Dennis, M., White, M., Titus, J., and Unsicker, J. (2006). *Global Appraisal of Individual Needs* (GAIN): Administration guide for the GAIN and related measures (Version 5.4.0). Bloomington, IL: Chestnut Health Systems. http://www.chestnut.org/LI/gain
TSCC Trauma Symptom Checklist for Children	The Trauma Symptom Checklist for Children is a self-rating measure used to evaluate both acute and chronic posttraumatic stress symptoms.	John Briere, Ph.D. Psychological Assessment Services http://www3.parinc.com/products/product.
UCLA PTSD RI for DSM-IV University of California Los Angeles Posttraumatic Stress Disorder Reaction Index	This scale is used to screen for exposure to traumatic events and DSM-IV PTSD symptoms. Three versions exist: a self-report for school-age children, a self-report for adolescents, and a parent report. An abbreviated version of the UCLA PTSD RI is also available. This nine-item measure provides a quick screen for PTSD symptoms.	UCLA Trauma Psychiatry Service 300 UCLA Medical Plaza, Ste 2232 Los Angeles, CA 90095-6968 rpynoos@mednet.ucla.edu
CRAFFT	The CRAFFT is a six-item measure that assesses adolescent substance use. The measure assesses reasons for drinking or other substance use, risky behavior associated with substance use, peer and family behavior surrounding substance use, as well as whether the adolescent has ever been in trouble as a result of his or her substance use.	The CRAFFT questions were developed by The Center for Adolescent Substance Use Research (CeASAR). To get permission to make copies of the CRAFFT test, email info@CRAFFT.org.

***Listed in NTCSN's *Understanding the Links Between Adolescent Trauma and Substance Abuse*, 2008.**

Screening Instruments (15 Minutes or Less, Paper-Pencil or Structured Interview, No Clinician Training)*

Instrument	Description	Source
Adolescent Substance Abuse Subtle Screening Instrument (Adolescent SASSI)	A self-report screening instrument that examines symptoms and other indicators of alcohol and drug dependence (Miller, 1985). The Adolescent SASSI, using a third-grade reading level, examines both obvious and subtle symptoms related to alcohol and drug dependence (Cooper and Robinson, 1987).	The SASSI Institute 201 Camelot Lane Springville, IN 47462 800–726–0526 www.sassi.com
Massachusetts Youth Screening Instrument-Second Version	A 52-item, self-report instrument that identifies potential mental health and substance use needs of youth at any entry or transitional placement point in the juvenile justice system (Grisso et al., 2001). The MAYSI–2 can be administered to juveniles in probation intake interviews or within 24 to 48 hours after admission into juvenile justice facilities.	National Youth Screening Assistance Project (MAYSI) Department of Psychiatry, WSH–8B University of Massachusetts Medical School Worcester, MA 01655 508–856–8564 www.umassmed.edu/nysap
Reynolds Adolescent Depression Scale	A self-report instrument that can be administered individually and in groups (Reynolds, 1987). The RADS consists of 30 items rated on a four-point scale. Well suited for individual or group assessment in clinical or school situations, the RADS is highly effective for large-scale administration.	Sigma Assessment Systems, Inc. P.O. Box 610984 Port Huron, MI 48061 800–265–1285 inforeq@sigmaassessmentsystems.com www.sigmaassessmentsystems.com
Resiliency Attitude Scale	Provides a brief self-report of resiliency in various domains. The RAS measures persistence in working through difficulties (Biscoe and Harris, 1994).	Belinda Biscoe bbiscoe123@aol.com psyche@okcforum.org

***** As listed *Screening and Assessing Mental Health and Substance Use Disorders Among Youth in the Juvenile Justice System, 2004*