Webinar: Substance Use Among Unaccompanied Minor Youth

February 8, 2022

Transcript

Introduction

Tigest Coleman: Alright, let's go ahead and get started. Hello, welcome and thank you so much for joining today's training on; Substance Use Among Unaccompanied Minor Youth: Cultural and Clinical Considerations and Providing Strength-based and Trauma-informed Integrated Services. My name is Tigest Coleman, and I'm a Switchboard training officer. This training is presented to you by Switchboard, a one-stop resource hub for refugee service providers in the United States.

I'd like to mention that today's session will run for one hour and 15 minutes and that it's being recorded. You will be receiving an email with the recording slides and recommended resources shortly after. We know we have a wide range of providers joining us today with different roles, therefore, we would like to make a note of the general term you will hear us today as "unaccompanied minor youth," to refer to both unaccompanied refugee minors, mostly known as URM, and unaccompanied children, also known as UC, which in this training context is not to reference to the immigration status of the youth.

Zoom Orientation

TC: Alright, let's take a look at some of our settings in Zoom, I know we've all mastered this, but just an overview. All attendees are currently muted and are joined in listen-only mode. You may switch your audio between your computer and phone at any time under "audio settings" in the lower left corner of your screen.

We welcome your comments throughout today's session, and to do so, click the chat bubble icon located on the bottom center of your screen to open the chat window. I see a lot of you are already using it, so great. So make sure you send your messages to all panelists and attendees so fellow participants can read and respond to your comments. We will monitor the chat and drop links for you all as we go along, so we'll try our best to ensure that your voices are heard and that points are also made.

We'll have plenty of Q&A at the end of today's session, but we do also want to love your questions throughout, please type your questions in the Q&A box, and you can also click thumbs up to vote for another participant's question. We've also reviewed the questions you submitted during the pre-registration and we hope to cover many of them during the training.

Finally, you have the option to turn on automated close captioning on today's webinar, and to do so, you can click the CC or live transcript. You may choose subtitles or the full transcript. You also have options to change font size and other parameters. You may turn the close captioning on and off at any time, but please keep in mind that the closed captioning for today's webinar is automated and may not be completely accurate.

Today's Speakers

TC: Again, my name is Tigest Coleman and I am a licensed clinical social worker. Before I turn it over to today's speaker, I want to highlight my connection to the unique field of unaccompanied minors. Before joining Switchboard, I spent the majority of my career working with unaccompanied refugee minors in various settings, including direct service, supervisory and management positions.

So I was thrilled when we received this request and I was even more excited to be collaborating with our amazing speaker to bring this training to you. I also recognize that I have a lot of colleagues from all over who are joining us today, so hello to you all.

With that, I'm honored to be introducing you to our main speaker, Rosalind Rogers. Rosalind holds a PhD in International Psychology, with a concentration in Trauma Services and Refugee Trauma. She currently is a subject matter expert and mental health consultant for the US Committee for Refugees and Immigrants, also known as USCRI.

Dr. Rogers is a licensed mental health counselor with extensive experience working in direct service, supervisory and management positions with adults, adolescents and adolescents suffering from addiction and co-occurring disorder. Dr. Rogers has over 10 years of clinical experience providing individual, group and family therapy in various treatment settings, including psychiatric hospital, private practice, partialized hospitalization programs, and intensive outpatient program. With that, I'll turn it over to you, Rosalind.

Rosalind Rogers: Thank you so much for the introduction, Tigest. I just wanted to add that as a consultant for USCRI, I have had the privilege of working with unaccompanied minors in Chicago as well as in Michigan, which is where I am right now, and we've been providing behavioral health support directly to youth, and providing linguistically appropriate and culturally responsive programming, as well as support to shelters caring for the youth. So I have a much greater understanding and appreciation of the work that all of you do, so I thank you for all of your dedication and your work in working with this vulnerable population.

Learning Objectives

RR: So welcome, all of you. By the end of today's webinar, we hope that you will be able to describe substance dependency and cannabis use disorder and the links to traumatic stress among unaccompanied minors and youth, identify strengths-based, trauma-informed and culturally responsive integrated treatment models for trauma and co-occurring substance cannabis use, and name strategies to overcome challenges to substance use and unaccompanied minor care, including in states where recreational use is legalized.

1. How prevalent is substance abuse among unaccompanied minor youth?

RR: So just to give you an idea of prevalence rates for youth in general, here are some statistics and trends for U.S. youth. So there are about 2.08 million or 8.33% 12 to 17-year-olds in the United States reporting using drugs in the last month, and of them, 83.88% report using marijuana in the last month. 46.6% of teens in the U.S. have tried to illicit drugs by the 12th grade, and 31 million or approximately one in eight of 12-to-17-year-olds used marijuana in the past year. 14% of 8th and 44% of 12th graders have used marijuana in their lifetime, and 6%, which is about one in 16 of 12th graders use marijuana daily.

So some statistics and trends for unaccompanied minors. Although there is research that indicates unaccompanied minors are more prone to substance and alcohol use than accompanied youth or U.S.-born youth, and that untreated mental health problems, stressful living conditions and lack of support and control put unaccompanied minors in general at risk for substance use. There's an overall lack of research on issues related to substance use among this population, particularly in the United States.

In research of unaccompanied minors, substance use may be included as a dimension or one dimension on a scale measuring the occurrence of mental health problems, or is something that is mentioned in passing, in a more general sense, when discussing the experiences and challenges of minors' daily lives. So this may be a consequence of the fact that substance use is not quite a substantial problem within this population. However, I think that greater research is definitely needed, particularly in the United States.

As an indication of this, in a recent study on outcomes for youth served by URM foster care program in the United States, there were no reports of drug and alcohol rehabilitation or other high-risk behaviors among the sample in that study. And to provide you some additional statistics from research that was done in other countries, one in 10 male unaccompanied refugee minors in Germany reported consumption of alcohol and/or cannabis, 50% of refugee youth in Serbia consume energy drinks, 28% tobacco, 13% alcohol, 4.6% marijuana and 1.7% LSD, amphetamines, tranquilizers or cocaine, 15% of Venezuelan immigrant youth in the U.S. with past month alcohol use and 52% with lifetime alcohol use.

2. What are some key risk factors for substance abuse?

RR: Some key points from the research literature that I wanted to highlight, is the burden of migration increases proneness to substance use as a consequence of scarce coping resources, as well as adjustment stress. Sothe most significant risk factors for substance use include being male, unaccompanied, lack of education, emotional abuse, using substances prior to the age of 12, traumatic experiences, greater length in the host country, influence of the country of origin in their lives, exposure to high-risk environments, stressful living conditions, lack of social support and control, and a mental health diagnosis.

Unaccompanied minors have lower levels of externalizing behaviors than native or unaccompanied children, the research has shown. And appropriate interventions targeting PTSD and related internalizing symptoms might also prevent the development of substance use disorder.

3. How do we define substance use disorder?

RR: So what is substance use disorder? So the DSM-5 recognizes substance-related disorders resulting from the use of 10 separate classes of drugs, including alcohol, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics or anxiolytics, and stimulants. The DSM recognizes that people are not all automatically or equally vulnerable to developing substance-related disorders, and that some people have lower levels of self-control that predispose them to develop problems if they are exposed to substances.

So substance dependence, although not officially recognized by the DSM-5, I believe that it was recognizing previous revisions of the DSM, generally means that withdrawal symptoms are present if the person abruptly stopped taking the substance. So to be diagnosed with a substance use disorder, one must use a substance for at least a one year period with the presence of at least two symptoms in the DSM. There are four groups of the DSM-5 diagnostic criteria for substance use disorders, totaling 11 criteria to get a diagnosis.

When assessing and diagnosing, you can specify how severe or how much of a problem the substance use disorder is, depending on how many symptoms are identified. So the presence, as I said, of two to three symptoms would be diagnosed as a mild substance use disorder. So let's take a look at the specific criteria. Next slide. So there are 11 criteria for substance use disorder that are categorized into four diagnostic groups. So under impaired control, there is the criteria of using larger amounts for a longer period of time.

So typically when youth have started to use larger amounts or use a substance, obviously, for a longer amount of time. Repeated attempts to control their use of substances or to quit. So they've typically tried to quit or control their use or moderate their use, but have been unsuccessful. They spend a lot of time on using the substance and they experience cravings for the substance, this could also be psychological as well as physical.

Social impairment is the next category. So neglected major roles because of use, so typically they have failed to meet their responsibilities at work, school or home because of the substance use. Social interpersonal problems related to the use typically result, that cause relationship problems or conflict with others. Typically, activities that they used to enjoy are given up, so they maybe skipped a sport that they really enjoyed and quit the team, for example, because of their substance use.

The next category are risky use of substances. Hazardous use is when they have used a substance in ways that are dangerous to themselves or others. So for example, overdoses, driving under the influence or blacking out, are some examples. There are physical or psychological problems related to the use. This is when substance use has led to physical health problems, such as liver change or lung cancer, or psychological issues such as depression or anxiety.

And the last category is pharmacological criteria which involves withdrawal. So when they stop using the substance, they experience withdrawal symptoms, and those withdrawal symptoms typically across the different categories of substances vary quite a bit. They also develop a tolerance to the substance, so that they have to use more to get the same effect as they did previously.

4. How about defining cannabis use disorder?

RR: So what is Cannabis Use Disorder? So the same 11 criteria for substance use disorder are used to diagnose Cannabis Use Disorder as well, as well as the same severity levels that I mentioned previously, based on the number of symptoms identified. So the use of cannabis for at least a one-year period, with the presence of at least two of the following symptoms, accompanied by significant impairment of functioning and distress.

So difficulty containing the use of substance, so using larger amounts or for a longer period of time than intended; repeated failed efforts to discontinue or reduce the amount of cannabis that is used; an inordinate amount of time is occupied acquiring, using or recovering from the effects of cannabis.

Cravings or desires to use cannabis, and this can include intrusive thoughts and images, dreams about using, the smell of cannabis due to preoccupation with cannabis. Also includes recurrent cannabis use results in a failure to fulfill major role obligations. And continued use of cannabis despite adverse consequences from its use, such as criminal charges, ultimatums of abandonment from parents, friends, and poor productivity. Important activities in life such as work, school, hygiene and responsibility to the family and friends are superseded by the desire to use.

Cannabis is often using contexts that are potentially dangerous, as I mentioned before, such as operating a motor vehicle. And the use of cannabis continues despite awareness of physical or psychological problems attributed to the use, whether it be like a chronic cough, for example, or just general inertia and inability to get things done.

A tolerance to cannabis is built up, which is defined by progressively larger amounts of cannabis that are needed to obtain the psychoactive effect experienced when the use first started. Withdrawal, defined as the typical withdrawal syndrome associated with cannabis, or similar substances used to prevent withdrawal symptoms from cannabis.

5. What are the symptoms of cannabis intoxication?

RR: So symptoms of cannabis intoxication. Cannabis intoxication refers to the side effects seen as a result of the active ingredient found in cannabis, which is known THC. I'm not gonna even try to pronounce the scientific name, so just THC.

There are three forms of cannabis, which are the flower, the resin, and the hash oil. The most widely consumed form of cannabis is marijuana, which contains the most amount of concentrated THC. Marijuana is mostly smoked, though it can also be eaten or drank in a tea. Today, marijuana can also be ingested in the form of edibles, like candy, brownies, cookies or other digestible forms.

Intoxication typically occurs in a matter of minutes when smoking cannabis, but it can also take longer, up to a few hours if cannabis is consumed by the mouth. The effects of cannabis intoxication, they remain ongoing for about three to four hours when they're smoked, but intoxication can be longer when consumed orally.

Poll Questions

RR: So we would definitely like to hear from you. What are some of the symptoms of cannabis intoxication you were aware of? And you can... Participants can join at slido.com or scan the picture on your... I'm sorry. Scan the bar code on your screen.

TC: You can also type it in your chat and I'll try to field that if it's easier for you all, but we'd love to see what you guys are... Some of the things that you guys may have been aware of in terms of the intoxication.

RR: Great. So, "Impaired cognition, redness of eyes, eyes glazed over. Redness of eyes, impaired cognition." Yes. "Munchies, slow thinking." "Sleeping in class." Absolutely. "Dry mouth." Absolutely. "Anxiousness. Slurred speech. Difficulty concentrating. Rapid heart rate." "Lethargy." Absolutely. "Delayed reaction, slow movements."

TC: We see in the chat some, "Slow movements," as well, "Slow speech, slurred speech, giggles, paranoia, drowsiness, complex tasks redness of eyes." So lots of what we're seeing in the Slido. Great. Thank you all for your participation. There is a question mark under "throw up" here. Rosalind, I don't know if you saw it? I think it's...

[overlapping conversation]

RR: Yeah, I did. Yeah, I did.

[laughter]

RR: Yeah.

TC: Alright.

RR: Okay. So taking cannabis can result in, obviously in a range of physical and mental symptoms, stemming from increased hunger to psychosis, even hallucinations. And THC binds to the cannabinoid brain receptors, and once these receptors are activated, it interferes with the normal sequence of brain functioning, producing the effects that you all have mentioned.

So one of the main features of cannabis intoxication is that any behavioral or psychological changes should take place while using or right after using cannabis. And just to name some of the symptoms, including some that you've already mentioned are, euphoria, obviously impaired judgment, motor skills which have taken place since the cannabis use.

Also there is typically about two of the following which occur within two hours of cannabis use, so as a lot of you mentioned, red eyes, dry mouth, increased appetite, like munchies, tachycardia, issues with short-term memory, being unable to accomplish mental tasks, so I think I saw laziness, lethargy was on there, and excessive drowsiness. And in some cases, as was also mentioned, severe anxiety and social withdrawal can also be present.

6. What about the symptoms of cannabis withdrawal?

RR: In terms of cannabis withdrawal, according to the DSM-5, the most salient symptoms of cannabis withdrawal would present themselves in individuals who use marijuana daily or nearly daily for at least a few months. The symptoms appear within one week after the individual stops smoking marijuana. The symptoms peak typically within about 10 days after an individual has discontinued the use. Following the peak of symptoms, they may begin steadily declining in severity over a period of about 10 to 20 days.

So marijuana withdrawal symptoms may include, feelings of anger, irritability or aggressiveness, sensations of extreme nervousness or anxiety, disturbances with sleep that can include insomnia, very disturbing dreams and even nightmares, a decrease in appetite that may or may not be associated with a significant loss of weight. Feelings of restlessness, the onset of feelings of depression, and physical symptoms that cause a significant distress such as abdominal pain, fever, chills, sweating, headaches, more like cold-like symptoms.

The withdrawal process for marijuana is not considered to be life-treating, however, in some individuals, there's always the potential for someone to except it poor judgment or be more prone to accidents, and even develop suicidal thoughts as a result of the distress and depression that can occur during withdrawal. Next slide.

7. How can we understand cannabis use disorder’s comorbidities?

RR: Comorbidity or dual diagnosis. So when we talk about substance or cannabis use among unaccompanied minors, it's important to consider them in the context of trauma, which is so prevalent in many of their lives. Therefore, one clinical term that is important to know is comorbidity or dual diagnosis when it comes to mental health and substance use disorder.

Comorbidity is defined as the existence of more than one clinical condition at the same time, or one after another. So two conditions could overlap for several reasons. The same genetic or environmental factors could increase the risk of developing multiple disorders.

There's also evidence that development of some mental disorders can render an individual more vulnerable to substance use, as well as vice versa. So about half of people who experience a mental illness will also experience a substance use disorder at some point in their lives. And vice versa. Few studies have been done on comorbidity in children, but those that have been conducted suggest that youth with substance use disorders also have high rates of co-occurring mental illness, particularly depression and anxiety.

Although substance use disorders commonly occur with other mental illnesses, this does not mean that one caused the other, even if one appeared first, so in fact establishing which came first or why can be quite difficult. However, research suggests three possible possibilities for this common co-occurrence. So common risk factors can contribute to both mental illness and substance use disorders. Research has suggested that there are many genes that can contribute to the risk of developing both.

For example, some people have a specific gene that can make them at an increased risk of mental illness as an adult, if they frequently use marijuana as a child. A gene can also influence how a person responds to a drug, whether or not using the drug makes them feel good.

Environmental factors such as stress, abuse or trauma can cause genetic changes that are passed down through the generations, and may contribute to the development of either a substance use disorder or a mental illness. So the second. Mental illnesses can contribute to drug use and substance use disorders. Some mental health conditions have been identified as risk factors for developing a substance use disorder.

So for example, some research suggests that people with mental illness may use drugs or alcohol as a form of self-medication or coping. Also, some drugs may help with mental illness symptoms, sometimes this can also make symptoms worse.

Additionally what a person develops a mental illness, there are brain changes that may enhance the rewarding effects of substances, predisposing that person to using the substance.

And third, substance use and addiction can contribute to the development of mental illness. Substance use may change the brain, again, as I said, in ways that make a person more likely develop a mental illness.

And so for example, the use of marijuana, as I mentioned earlier, prior to the age of 12, they are twice as likely to develop a mental illness compared to those who use marijuana at age 18 or older. Research shows that girls between the ages of 14 and 15 who use marijuana daily were five times more likely to suffer from depression at age 21.

So regardless of the causal relationship, it is understood that each condition assists in maintaining or exacerbating the other, and that addressing both conditions is definitely critical.

Poll Questions

RR: A discussion question. As we all know, unaccompanied minors are extremely vulnerable population, due to their heightened risk of a myriad of pre-migration, migration and post-migration factors that taken together, put

them at an increased risk for developing mental health problems. So what are the risk factors for developing PTSD? So please have your answers in the chat. We'll give you a few minutes to do that.

TC: And reminder, please type your answers in the chat and send it to all panelists and attendees, so that your fellow participants can view them.

RR: So, "So sexual abuse. Trauma. Exposure to violence. Trauma homelessness. Complex trauma. Physical abuse. Abandonment. No support. Child trauma. Insomnia. Verbal abuse. Economically depressed environments that contribute to extreme hunger. Neglect. Victims of trafficking. Unemployment persecution." "Intergenerational trauma." Absolutely. “Warzone areas. Toxic relationships. Particularly in the family. Genocide." "World events such as war or natural disasters." Absolutely. "Poverty. Racial trauma" Yes. Great, yes, thank you.

8. What are the risk factors for PTSD?

RR: So as we work with people, we explore the stressors that lead to, exacerbate, and become potential catalysts for mental health symptoms and conditions. So what are the risk factors for developing PTSD?

So unaccompanied minors by the very nature of their status are a particularly vulnerable group, with regard to mental health problems such as PTSD, depression and anxiety. And research has found that these problems are still present years after resettlement.

So childhood and adolescence are both the obviously vulnerable life stages, both characterized by continued brain development, a time when important developmental tasks must be completed, and a time when physiological and emotional regulation is dependent on the presence of a safe, consistent and caring relationship with the caregiver.

Trauma has been shown to adversely affect many of the neurobiological systems responsible for cognitive development and the regulation of emotions and behavior. So trauma can delay developmental processes responsible for realistic appraisals of danger and safety and abstract thinking for problem solving.

Exposure to war and armed conflict, which was mentioned, are associated with a high conditional risk of PTSD in children. There is a meta-analysis of children affected by war, which reported that a pool PTSD prevalence rate of 47%. So there are high rates of PTSD have been reported in children who are displaced in living as refugees.

PTSD is particularly common among child soldiers who are forced to commit violence, and PTSD rates have been estimated at 35% to 97% among child soldiers.

Children who experience events involving interpersonal violence, including rape, sexual assault and physical abuse by caregivers, have the highest rate of PTSD onset. In studies, between 30% to 70% of children who experienced physical or sexual abuse will develop PTSD.

Children with a history of having other mental disorders are also more to develop PTSD following trauma exposure, than children who have never had a mental disorder.

Youth with less social support are more likely to experience trauma and develop PTSD. The lack of emotional, physical, even, I think there was a couple of people who mentioned financial parental support, both during the migration process as well as post-migration, have been demonstrated to significantly increase the risk of developing PTSD as well as other mental health conditions.

And research has repeatedly shown that higher levels of traumatic stress symptoms in unaccompanied minors compared to refugee children accompanied by their parents.

So repeated trauma, I think we saw complex trauma, regardless of type, heightens the probability of PTSD symptoms and diagnosis among children as well as adolescents, and the number of traumatic events experienced is one of the most predominant factors influencing the level of emotional problems among unaccompanied minors.

Research has shown that unaccompanied refugee minors are typically exposed to multiple and repeated traumatic events during pre-migration, migration and post. Additionally, studies suggests that experiencing different traumatic events might have a cumulative effect, and therefore an even stronger negative influence on the adolescent's emotional well-being.

Unaccompanied minors are mostly confronted with Type 2 traumas that result from multiple prolonged and sustained exposure to repeated stressors. Chronic stress and cumulative adversity experienced by unaccompanied minors is associated with the increased risk for PTSD and other mental health issues extending into adulthood.

Then there's non-trauma-related factors that may determine the risk of developing trauma, such as age, gender, and typically with gender it's female adolescents that are at the highest risk, as well as country of origin.

In particular, the situation of the country of origin before the occurrence of individual stress from trauma, seems to influence the subsequent coping options after flight from the country.

So the longer substantial instabilities in the country of origin are associated with social stress factors and less full education, it seems to affect individual resilience.

Then there are cognitive and emotional responses to traumatic events that have been associated with risk factors for PTSD in children. So higher levels of anger and shame about the traumatic events they experienced, rumination; so constantly thinking about the traumatic event, and catastrophizing and more negative appraisals about the event, have all been associated with a greater risk of developing PTSD.

Elevated levels of avoidance and suppression of trauma-related thoughts, which are symptoms of PTSD in and of themselves, and greater disassociation during and after the traumatic event, are also associated with a higher risk of PTSD. As well as coping strategies following the trauma, as I mentioned, avoidant coping, as well as distracting and blaming.

9. What are the risk factors for substance use disorders?

RR: So now let's take a look at the risk factors for the development of substance use disorders. In your opinion, what are some of the risk factors for the development of substance use disorder? You can type your answers in the chat and we'll give you a few minutes to go ahead and do that.

"Gender. Exposure at a young age. Exposure to trauma. Mental illness. Family history. Unstable housing." Yes. "Exposure to domestic violence. Sexuality. Lack of support. Socioeconomic status. Hereditary abuse. Social reinforcement by older community members. Grief and loss. Cultural norms. Self-medicating. Peer pressure." Great, yes. Thank you.

Substance use disorder risk factors. So as some of you have noted, there are quite a few risk factors for the development of substance use disorder. Research has demonstrated that being an unaccompanied minor and separated from family is a significant risk factor for substance use. If children are raised in a family with a history of alcohol, drug addiction, it increases the likelihood that children will also have alcohol or other drug problems.

Pre-existing or untreated behavioral problems and/or mental health conditions increase the risk for the development of problematic substance use, including impulse control, high sensation seeking, low harm avoidance, lack of behavioral self-regulation, aggressiveness, anxiety, depression, PTSD, ADHD, as well as an anti-social behavioral and/or conduct problems. So exposure to traumatic events, including war, community violence or child abuse and neglect. And even normal school transitions predict increases in problem behaviors, for example, from elementary to middle school.

And it could even be from... And obviously from moving, moving around is obviously another huge transition that can cause a lot of problems. So displacement as well as frequent moves in placement, so for example, from shelter to shelter, or residential facility or foster placements, place children at a higher risk of substance use. Research with refugee youth have found that those who resided in a greater number of refugee camps, for example, have experienced greater loss and higher post-migration stress, are a greater risk of substance use. Less social support, which includes lack of or limited adult supervision and monitoring, severe inconsistent discipline, high family conflict and low caregiver warmth.

The earlier the use of substances, as we have mentioned, before the age of 12, the greater the risk that these behaviors will continue later in life. I know someone mentioned something related to culture, so loss of cultural identity. Minority children may experience higher levels of psychological and social stress due in part to discrimination, loss of contact with their culture and their language, and imposed cultural change in the host country and perceive negative context of reception by the host country as well.

Academic failure and low commitment to school, particularly in the late elementary grades, increases the risk of substance use. And for this it's the experience of failure, not necessarily the lack of ability, appears to increase the risk of problematic behaviors. Association with peers, as someone mentioned, who use substances, is one of the most consistent predictors that research has identified, that places children at higher risk of substance use. So favorable attitudes about substance use is a very strong predictor among peers of substance use involvement. So as you can see, there is considerable overlap between risk factors for PTSD, as well as substance use.

Links to traumatic stress. Research has clearly established these links and the pathways connecting them are quite complex, but as the previous slide hopefully made clear, is that trauma can increase the risk of developing substance use disorders, and substance use could increase the likelihood that children will

experience trauma. Unaccompanied minors may turn to substances to manage the intense flood of emotions and traumatic reminders associated with traumatic stress or PTSD, or to numb themselves from the experiences of an intense emotion, positive or negative. On the other hand, research has also shown a direct link between substance use and engagement and risky behaviors that may result in trauma, and youth with substance use disorders are more likely to develop PTSD following trauma exposure due to functional impairments that are caused by substance use.

So whatever the temporal relationship may be between trauma and the development of substance use, it's clear that the negative effects and consequences of one disorder definitely compound the problems of the other. So youth who have been exposed to trauma, they spend an enormous amount of energy, emotional and mental energy, responding to as well as coping with and trying to come to terms with the trauma. And this can reduce the capacity, obviously, to master other age-related appropriate developmental tasks. All individuals with substance use disorder, as I mentioned before, are at a risk of experiencing intense cravings of further substances abuse when they're exposed to stimuli that are associated with the use.

And in substance abusing youth with a history of trauma, those cravings can also be triggered by people, situations, places or things that evoke past traumatic experiences. Recent research in this area suggests that traumatic stress or PTSD make it more difficult for adolescents to stop using, as exposure to reminders of the past trauma have been shown to increase drug cravings in people with co-occurring trauma and substance use disorder. So this creates this very vicious cycle in which exposure to traumatic events produces increased substance use and so forth. So integrated models of treatment. Strength-based, trauma-informed and culturally responsive.

10. How do we address co-occurring disorders?

RR: Unaccompanied minor services for co-occurring disorders. So in order to address co-occuring disorders among unaccompanied minors, the approach should be comprehensive, using a four-pronged approach. Which would include prevention efforts, addressing barriers to treatment and access to services.

Proper assessment is critical in order to identify unaccompanied minors who need help, and to provide adequate care and the use of integrated treatment models that address both trauma and substance use problems.

Although prevention strategies are beyond the scope of this webinar, prevention strategies must be aimed at minimizing the risk factors and building and strengthening protective factors of unaccompanied minors.

So prevention strategies should be aimed at addressing individual, peer, family, school and community factors that protect, put unaccompanied minors at risk. So prevention strategies will only be effective if the relevant factors at each level are addressed.

In terms of barriers to treatment, accessing services must be addressed, as I mentioned, including the fragmented structure of services related to the divide of mental health and substance use services, as well as between mainstream services and services specific to unaccompanied minors.

Such as like the structure of services for unaccompanied minors is set up in such a way that the co-occurring mental health and behavioral issues will be, for example, might be denied placement. So if they have mental

health, they may be denied placement in a behavioral health facility and vice versa. And that also applies in the overall health system, mental health system in the United States as well.

So the lack of knowledge and benefits of services available to unaccompanied minors and limited help-seeking behaviors of unaccompanied minors, which is pretty common among this population.

The stigma and lack of cultural competency and language barriers must be addressed in order for services to be used, as well as to be effective. So for example, activities that promote mental health awareness and knowledge of services in culturally appropriate ways, the use of bicultural interpreters, bilingual materials, culturally adapted treatment models and so forth. And UM's fear and mistrust of services must also be addressed, in terms of confidentiality, or fear of affecting immigration status.

Because the signs and symptoms of trauma and substance use can be hard to spot, because the signs of both trauma and substance use are so similar to problem behaviors that are part of the natural developmental course of adolescence, it may be hard to recognize these problems early on.

So therefore, proper culturally validated and regular assessment of trauma and substance use is critical for early detection, and in order to provide adequate care. So a multi-faceted approach to assessment is also important.

Although the research on integrated approaches to treatment with unaccompanied minors is very limited, experts in the field have recommended using integrated treatment models that, as I mentioned before, simultaneously treat trauma and other mental health conditions and substance use.

Some recommendations that support integrated treatment models include early emphasis on the management and reduction of both substance use and PTSD symptoms to start psycho-education and relapse prevention, targeting both substance use and trauma-related reminders and cues early in treatment.

And so that might include building problem-solving skills, drug refusal and safety skills, and desensitization to trauma reminders, and to provide psycho-education for youth and families or foster families about trauma and substance use problems and encourage caregiver involvement in the treatment, with the goal of increasing caregiving skills, communication and conflict resolution.

Establishing a therapeutic relationship that is consistent, trusting and collaborative, focusing on stress management such as relaxation skills and positive self-talk, focusing on developing emotion regulation skills, such as identification, expression and modulating their negative affect.

Incorporating cognitive restructuring techniques and providing social skills training, and considering referral to child and adolescent friendly self-help groups as needed, and making use of school-based treatment programs to reach at risk youth, is very important.

So five principles for working with unaccompanied minors with co-occurring disorders. An integrated model of treatment for co-occurring disorders is characterized by a well-coordinated stage-specific treatment of mental health and substance use disorders, with an emphasis on dual recovery or co-occurring disorders, having goals as well as the use of effective treatment strategies for the mental health and the substance use disorder treatment fields.

So first, use a recovery perspective, which has two main features to it. So it acknowledges that recovery is a long-term process of internal change, and it recognizes that these internal changes go through various stages. And the stages are engagement, stabilization or persuasion, active treatment and continuing care or relapse prevention.

In terms of practice, this means that treatment may occur in different settings over time, and that much of the recovery process typically occurs outside of or following treatment.

And that could be through participation in mutual self-help groups or through family, peer and community support, and so therefore, it's important to reinforce that long-term participation in these continuous care settings.

This also includes devising treatment interventions that are specific to the tasks and challenges faced at each stage of the recovery process. So in other words, all services should be consistent with and determined by each youth's stage of treatment.

The phases of treatment correspond to the stages identified in the recovery perspective, which is also... I'm sure many of you have heard of the stages of change model.

And the phases of treatment are, engagement, as I mentioned, stabilization, persuasion, active treatment, and continuing care, relapse prevention. Which correspond to the stages of change model, which are pre-contemplation, contemplation, preparation, action and maintenance, stages of change.

So very closely related to the stages of change is using motivational interviewing techniques, which will help unaccompanied minors to enhance their intrinsic motivation to change by exploring and resolving their ambivalence and committing to change.

Second, adopt a multi-problem viewpoint. Since unaccompanied minors with co-occurring trauma and substance use will more than likely have an array of mental health substance use, social problems needing treatment, that addresses immediate as well as long-term needs, therefore services should be comprehensive to meet the multi-dimensional problems that typically present with this population.

Third, address specific real life problems early in treatment. Since there's this growing recognition that co-occurring disorders come about in the context of personal and social problems with disruption of personal and social life, it's important to use approaches that address specific life problems very early on, and that can also help with building rapport with youth as well.

So this may involve case management, getting you through the bureaucratic hurdles or handling academic family, legal matters, or vocational goals. Solving those problems really is an important first step.

Fourth, is a plan for youth cognitive and functional impairments. So youth with co-occurring disorders, they may display cognitive and other functional impairments that affect their ability to comprehend information or complete tasks. So the manner in which the interventions are presented must be compatible with their needs and their cognitive functioning and developmental functioning.

Typically, when these impairments are present, it's recommended to have relatively short, highly structured treatment sessions that are focused on practical life problems, and then gradually pacing and using visual aids and repetition are also very helpful.

Fifth, mutual self-help groups, the family or foster family, the faith community, and other resources that exist within the community can play an invaluable role in youths' recovery and long-term recovery. And this can be particularly true for youth with co-occurring disorders, as the majority have not enjoyed a consistently supportive environment.

So mutual self-help groups like AA, which is Alcoholics Anonymous, Narcotics Anonymous, Dual Recovery Anonymous and Double Trouble in Recovery, are recognized as important components in the treatment of co-occurring disorders, particularly since personal responsibility, self-management and helping one another are basic tenets of all those groups. Next slide.

11. What are some recommended therapies for substance use disorders?

RR: Recommended therapies. Treatments for co-occurring disorders among unaccompanied minors may include individual therapy, group therapy, medication management, or a combination of all three.

And the therapies that most often are recommended, an evidence base include the following that are on this slide. Please keep in mind that integrated treatment could include components of these therapies and that they must... Any component of these therapies that are used should be culturally adapted to the population or the youth that you're working with.

So cognitive behavioral therapy or culturally adapted cognitive behavioral therapy can be used to focus on changing negative behaviors, improving emotional regulation, and developing health coping strategies.

Trauma-focused cognitive behavioral therapy or TF-CBT, can be used to address the specific needs of children and adolescents that have PTSD, as well as substance use disorders or other traumatic life events.

And one thing to keep in mind with this therapy is that it was designed to address a single one-time traumatic event, which is simply not the case for many unaccompanied minors. So keep that in mind.

Contingency management, which uses motivational incentives and rewards to reinforce positive behavioral changes. So for example, if random and regular drug screening is part of treatment, contingency management could be used to reinforce those negative drug screens.

Other targeted behaviors could include abstinence, treatment engagement, so showing up for every treatment session, or if there's homework assignments, turning those in, as well as lifestyle improvements.

Dialectical behavioral therapy focuses on emotional and social aspects to help regulate unstable emotions and harmful behaviors, and the core skill components of DBT include mindfulness, emotion regulation, distress tolerance, and interpersonal effectiveness.

As I already mentioned about motivational interviewing as it's tied to the stages of change model, it focuses on resolving ambivalence and insecurities, to find the internal motivation within youth to change negative behaviors.

And then there's acceptance and commitment therapy, which uses acceptance of mindfulness strategies, combined with commitment and behavior change strategies. And it helps unaccompanied minors to reinterpret past painful events, identify avoidant behaviors and identified values to commit to actions in line with their own values. And it's also been, research has also shown that it's an evidence-based therapy.

So to quote a refugee youth, even with counseling or any of those kinds of health services, they're using Western point of view and that is different to what other cultures believe, so it's totally different.

12. What are the barriers to treatment, and how do we overcome them?

RR: Overcoming challenges. Substance use in unaccompanied minors, care in states where recreation use is legalized. So I wanna go over some common barriers to treatment.

Research has consistently reported that individuals with co-occurring disorders typically have poor prognoses, premature mortality, higher rates of suicide, a more severe illness course, greater burden of disability, difficulty obtaining correct diagnoses and greater difficulty accessing effective treatments. And greater use of health services in those with only one disorder.

There are four categories in terms of where barriers are typically encountered. So there are youth and individual barriers, as I had mentioned earlier, distrust and the repercussions of that, cultural beliefs, and the nature of co-occurring disorders.

I think that across the board research has always shown that unaccompanied minors have a huge amount of distrust for authority figures. Many of these youth fail to obtain treatments and often terminate prematurely.

And much like their adult counterparts, youth who abuse substances often have a very hard time making positive changes, and they experience difficulties with emotional regulation, as I had mentioned.

And research has found that traumatic stress or PTSD make it harder for youth to stop using. And substance use is commonly thought of as a chronically relapsing condition, with rates of relapse ranging from 40 to as high as 60%.

So this makes the treatment of co-occurring disorders that much more important, but also there's a lot of barriers to that as well, particularly with relapse rates that are so high.

And studies with youth in treatment indicate that adolescents tend to relapse more often in situations in which there is direct or indirect social pressure to use. When they have urges or temptations, most often when they are also experiencing negative emotions and negative interpersonal situation and while in the presence of others.

And cultural beliefs that reinforce feelings of shame for having a mental health condition or being weak, for seeking help, are also barriers to treatment.

In terms of social barriers, such as stigma and peer pressure, this is a huge barrier for unaccompanied minors. Peer pressure may also stand in the way of entering, engaging or staying in treatment.

Practical barriers such as transportation, insurance coverage and insurance instability, these are just practical problems that need to be addressed very early on in treatment, I would even say be addressed in pre-treatment stages, so that they're taken care of once the youth actually starts engaging into treatment.

Clinical and system barriers. So a lack of linguistically and culturally appropriate providers, lack of access, as well as I had mentioned much earlier, the fragmentation of services, and inappropriate placement.

One of the things... The fragmentation, I just wanted to mention it one more time, that has traditionally existed between mental health and substance use systems, it limits the type of services that youth are able to receive, as well as the coverage that is available for different levels of treatment as well, for both.

Marijuana legalization in the United States. So the most recent monitoring, the Future survey, demonstrated that marijuana use has declined among 8th graders over the past five years to 0.7%, and as of November 2020, 15 states and DC have legalized marijuana for recreational use by adults. And another 22 states have legalized medical marijuana.

So using data from Youth Risk Behavior Surveillance System, which was a survey of health behaviors conducted among youth in high schools nationally, the trend is toward fewer youth reporting marijuana use.

Of six states with post-legalization data, in four, adolescent use reportedly decreased in the years immediately prior to legalization and then returns roughly to the same rates as prior use rates. So the available data show no obvious effect of legalization on youth marijuana use.

Poll Question

RR: So what are some other barriers or challenges that you or your clients have come across? So if you want to scan the bar code or you can join at slido.com.

TC: Takes just a few seconds, I think, for it to populate. Again, think of some of the challenges that you've experienced while supporting your clients and... There we go. "Self-awareness. Availability of therapy. Not acknowledging youth." Yes. "Linguistic access. Acceptance. Pressure from peers to the US. Acceptance. No medical. Availability of therapy."

"Interpretation. Lack of motivation. Ease of use, meaning accessibility. Acceptance." I see some in the chat, "Culturally sensitive therapy. Many clients believing marijuana is not a drug, nor it's addicting, and that they can stop at any time." I think that was something that also came up in a question, but certainly that gateway. Right? "Availability to transport. Language barriers." Thank you all you for sharing this, and I think you'll see in the next slide, that is seen and it's a shared challenge among a lot of providers.

RR: To quote a few providers, "Most people from these communities don't seek help until they are dying. If it's not serious, they don't seek help until it is a crisis." From one provider.

From another, "I think that sometimes when services are funded so specifically, a provider may say, 'Well, no. We are not funded. It is not in our service agreement to work with a client experiencing mental health issues.' And then you have the mental health services that say, 'No, no, we are going to address the drug and alcohol issue. We're only funded to help with mental health.'"

"It's really hard for the young person to understand why their issues have to be broken down, why they have to see so many services. We have to look at problems holistically."

So addressing the barriers. In order to increase initiation engagement, as well as a retention of unaccompanied minors in treatment, obviously all of these barriers have to be addressed. Which I know is a big ask, but we had to do what we can.

Outreach efforts are very important and can assist in engaging minors who are at risk of developing co-occurring disorders. Outreach in schools, I think may be an especially effective way of reaching youth, since schools are a key access point for early identification.

Outreach can also, can use peer networks, standardized screening procedures or a combination. And by using in-school student support resources, providers are more likely to identify minors who would otherwise not have approached an adult for treatment.

And part of outreach could include reminder calls or notifications for upcoming appointments and resolving, as I mentioned, practical barriers early on in treatment.

In addition to integrated treatment with a stepped approach, offer a comprehensive array of services. If this is not possible, then at least have strong partnerships with local agencies that can address those issues. That can go a long way towards meeting the practical needs of youth, when it cannot be met by a civil organization.

And this is very, very important because unaccompanied minors have such a range of needs, and so case management, for example, can respond to these immediate needs and can begin the process of engagement and also increase youth retention.

Linguistically appropriate and culturally competent services are absolutely essential. Be aware of cultural values and expectations that guide social interaction, mental health, substance abuse treatment and salient themes in youth culture as well as in their communities.

If staff are unaware of the cultural backgrounds of the minors that they are there to assist, it is critical that they receive cultural competency training, as this will greatly contribute to successful treatment, engagement and delivery.

Build rapport that is based on respect and trust, and convey hope and empowerment. Meet minors where they're at in terms of treatment readiness and substance use goals, including the issues faced by many of the youth.

So present treatment options in a non-threatening, appealing manner, by emphasizing that other youth similar to them have participated and benefited from treatment or the program and are doing well in their lives.

Communicate that change is possible and that the youth will have control over his or her participation in treatment. Respect their concerns, including about confidentiality and the involvement of third parties, and discuss limits to confidentiality and set down boundaries very early on.

Use motivational interviewing. It's been shown to be effective in youth with an initial low motivation to attend treatment and change. I know that was kind of the main answer that all of you provided.

Take an empathetic, non-judgmental stance and listen reflectively, helping them feel understood so that they could be more open and honest with you, as well as with others.

Work with minors to identify personally meaningful goals and helping evaluate whether what they are doing now will interfere with where they wanna be in the future.

So roll with the resistance that are often presented as a common refrain in motivational interviewing, which means rather than arguing with youth when they hit a roadblock, help them develop their own solutions to their problems. And support self-efficacy for change, by helping them be more helpful and confident about their ability to impact their own future in a positive way.

Education is prevention, so legalization efforts across the US should coincide with prevention efforts to prevent unintended harms, particularly obviously among youth.

Although research overall does not indicate concerning trends in higher marijuana use among young people in states where recreational marijuana is legal, an important question is whether risk factors for youth cannabis use are changing since legalization.

So to get a sense of this, there are five risk factors to focus on when gaging minors. It's perceived harm and risk, perceived access, peer norms, caregiver disapproval and media messaging.

So ask youth what they have heard or what they know about marijuana use, listen carefully and avoid judgment, as I mentioned earlier, so that lines of communication remain open.

Youth should be informed about both the benefits and the potential harms of marijuana products to make better decisions and not to demonize use. Therefore, honesty is extremely important. Honesty and transparency.

Our research shows that talking about substance use does not make youth want to try substances. The earlier minors get the information, the more likely they are to make educated decisions. And it's important that messaging is directly applicable to them, so how things can affect their appearance, their breath, their performance in sports or in school.

But also, it's important to be upfront about the fact that more long-term studies are definitely needed in order to fully understand the effects of marijuana.

But it's also important to emphasize what experts do know, that the teenage brain is vulnerable to substance abuse, that brains are still developing until a person is in their early 20s. Developing brains are more susceptible to negative consequences from substance use, like the effects on coordination and focus.

And that not everybody who tries marijuana ends up having an addiction, but that experts say that many adults with an addiction started using a substance as a teenager.

It's also important to convey the laws. It's illegal for them, and young adults might still get in trouble under new laws. Also discuss the potential consequences of use, including driving under the influence or going to school under the influence.

So the greater ease and honesty with which this topic is discussed, the more likely minors will address the questions or concerns and ask for help in the future.

13. Recommended resources and frequently-asked questions.

RR: And here's the reference list that I use that you can access. I think to just... You can let them know how to access that.

TC: All right, as needed. I'll be sending a list of the references, as well as the recommendation resource list along with the recording of the webinar, so you'll be receiving that. Again, the recommended resources, I will also be putting it in the chat right now, so hopefully you all can get it. And last but not least, it's now time for our Q&A session, and I think Rosalind has done a really great job answering a lot of the questions that we received during the pre-registration.

But I'll just kick us off with a few questions we received during the pre-registration, there's also I see that have been answering on the side and some that are remaining. One is, how do you... Or what do you say with someone or when people say marijuana is not addictive? It's a common belief, but it seems to have psychological additive properties.

RR: Absolutely. So yes, there is definitely research indicating otherwise. And I think that, as I mentioned before, because of legalization efforts, I think that that is always something that has to be addressed and that you have to keep in mind when you're speaking to them.

Because you could drive through a state where legalization for recreational use, for example, and there are billboards that you can see. And so youth are getting messaging that unfortunately goes against what we all want for them, obviously.

So I think it's important to, as I said, be upfront and honest with them, about the effects of marijuana. Particularly as a youth. I think that's one of the most important things to remember. That in terms... And you could even go into the biological and brain changes that can go on, I think that's also important.

And I'm sorry, what was the... There was the last part of the question? I'm sorry. Could you repeat it again?

TC: No, I think you answered, it. That's...

RR: Okay. [chuckle]

TC: Yes. And something that goes along with that that I see is how have open conversations with youth regarding substance use? Which also goes with another question of, how do you help a child that has told you that they're using drugs? Right?

RR: Absolutely. So in both cases, I think, as I mentioned, being non-judgmental. And of course, I'm thinking of parents in this, but you all are providers as well as parents, I'm sure. But not catastrophizing the event, but showing concern in non-judgmental way, I think is very important.

Especially for youth that are using, I think it's very important to understand why they started using in the first place, as well as looking at their environmental social factors that may be supporting that youth, so do they have a peer group that are also using or that are very accepting of substance use. So I think those are all important things to be looking at.

TC: Great. One more question, 'cause I know you wanna show us a tool or a really cool tool online, so I'll save a minute for that. What is the cultural difference of the opinions of drugs between the URM's culture and an American culture? Is another one that came up.

RR: Sure. Yeah, great question. So there are obviously a lot of differences, unless you come from maybe like the Netherlands. Research has consistently shown that the longer that youth, refugee youth as well as unaccompanied minors remain in the host country, in the US, the greater the likelihood that they will use an elicit substance at some point in their life. So the research shows that.

So there is definitely a cultural component to this in terms of assimilating into American culture, and that impacting the likelihood that they will use substances. That's something very important to keep in mind, unfortunately.

But that also relates to how important it is that youth also remain connected to their language as well as cultural identity, so that plays into it as well.

TC: Thank you. Let's see. Maybe as I go to the tool that you wanna show us, there's one more question around, how to bring the harm reduction approach in a trauma-informed manner, helping youth understand the linkage between trauma and addiction?

RR: Sure. Great question. So harm reduction, which I have used in the past with a few of my clients, typically in those cases they had relapsed and we had tried various different approaches, and this was what they wanted. And I'm their therapist and so I have to work with them on their goals.

Now for youth, I think that it is definitely a different approach and different factors that need to be kept in mind. Obviously, it's illegal for youth to be using substances, so a harm reduction approach, I think would be very... Ethically, I think it will be a very difficult position to be put in.

However, when you look at the alternative of them potentially not being engaged in treatment or in therapy, and not having the support of a provider or a treatment team, for example, I think not having that the alternative, I think would be potentially sometimes worse.

So I think there's a lot of things to consider. I think there's obviously the substance that they're wanting to use, but also while incorporating a harm reduction approach.

So I think it's important to keep that in mind as well, because again, like I said, you have to think about the alternative of not using a harm reduction approach and then not having them in treatment or in therapy.

TC: Great. And I think you could see, let me know if you can't see it, but there's a...

RR: Yes.

TC: You wanted us to pull the findtreatment.gov website that you say you use a lot, so please walk us through this.

RR: Sure, absolutely. So this is part of SAMHSA and it is an excellent tool. You just put in your zip code, and then you have a huge range of filters, which are very, very helpful.

So what level of care are you looking for for them? Do they have Medicaid? Do they have no insurance, so they need free or sliding scale payment options?

Obviously here it would be for youth that you would be looking for. Languages spoken is excellent. This is a new, I don't know when, but back in the day, about 15 years ago when I was using this, this was not available, so this is very helpful in terms, especially the population that you all are serving. And you can... Then there's a huge number of languages that you could choose from.

TC: All right.

RR: Yup. And then also in terms of if you're looking for medication-assisted treatment as well.

TC: Great.

RR: And you will get a huge range of results. It's very helpful.

Conclusion

Feedback Survey

TC: All right. Now going back to... And we're almost done. Thanks for your patience. All right. I think what we'll do is if we still have a lot of questions that are not answered, please feel free to email us. We hope that you... These are the learning objectives that we hope that you have now achieved. And we'll also be sharing an email with the list of recommended resources, like I said.

I've dropped a link in chat of our survey, and before signing off, I do hope that you'll take a very short moment to complete our feedback survey. It takes a very short time to do it, and it's incredibly helpful for us to improve our trainings going forward.

Depending on how you join this webinar today, the survey itself might also be open in your web, so please click the link in the chat or on the... On your web.

Stay Connected

TC: And finally, here is Switchboard's contact information, and I do hope you'll stay in touch with us and join our future training. Thank you so much again for joining today. And a huge, huge thank you to you, Rosalind, for coming in and bringing in such a great needed expertise that we thank you all for be here.

RR: Thank you.

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