We are in a crisis which calls for a paradigm shift

Teen and young adult drug use is a growing epidemic and the way we have thought about teen drug use and when to refer to treatment certainly needs to be rethought. The view from many professionals working in law enforcement, school systems, health systems, mental health systems and even parents is flawed and outdated with regard to understanding the illness of teen drug use and when to refer to treatment. Many of these systems have views that are overly minimizing and hold prejudice about the severity of consequences which occur from one drug to the next. In addition, the magnitude and intensity of drug use that must be exceeded before these systems makes a referral to counseling is held far too high to allow for a more effective intervention; a paradigm shift has to occur.

I remember when my friend, one of my mentors and colleagues talked about educating therapists in the 80’s that teen drug users needed to be drug tested. He was scorned by the industry yet had the courage to push on with his clinical truth. He was shifting their paradigm. What David Gust was offering in his talks was not the norm and certainly felt uncomfortable for all too even think about getting on board with it. His argument was that teen drug users lie, it is their way to keep the relationship to intoxication undetected and ongoing. Clinicians thought that drug testing would create an injury to the therapeutic relationship and the parent/ child relationship. David’s implicit point was that when a teen is actively using then their primary relationship is to intoxication and not to therapists and parents. Further, people with a relationship to intoxication lie, con and manipulate to protect and cover up their relationship to intoxication as it just goes with the illness. However, drug testing does not lie when drug testing protocol is done properly. Today, drug testing is the norm, however, the practice and implementation of this tool started as an uncomfortable leap in the mindset of many.

In the mid 90’s when I was working at a psychiatric hospital, a colleague and I spent 2 years talking to the staff about why drug testing should be a mandatory part of the
process when a teen was admitted to the hospital. After two years of discussion it is an automatic practice there to this day, but it started with many false starts and hasty retreats by the doctors and administration.

In the early 90’s and prior, it was thought that drug users could not be helped unless they “hit bottom” and wanted to be helped. Many families when they would call a therapist to get help for their drug using teen would be told that “unless your teenager wants help, I can help him.” Today, it is widely recognized that it goes against the diagnosis for drug users, let alone teen drug users, to see their problem and that again in, David Gust’s words, “it is the role of the clinician working with the family to lift the bottom for the drug user…” Today, for most this is recognized as common practice, though sadly many parents and professionals still subscribe to the old belief. And sadly, despite treatments there are many drug users who will have to hit bottom on their own if treatment doesn’t work at that time. Though treatment certainly helps the drug user who continues on in their drug use to see it as a problem sooner than those who never got treatment because they become more aware and connected to the reality that when new consequences from their drug use occur it is because of their drug use... It is simply harder for them to deny when compared to their point of view pre-treatment.

So many paradigm shifts have occurred by persistent leaders in the industry, yet we are still seeing a growing epidemic of teen drug use.

**Today more paradigm shifts are needed.**

While many shifts are still needed at the macro levels of understanding this issue, educating clinicians and other systems about this issue, here are 2 which can occur and need to occur now by anyone working with teens:

**Paradigm Shift 1** we have to see the illness as a “pathological relationship to intoxication” and realize that teens are not hooked on marijuana or alcohol or heroin.

We are more effective when we understand that the name of the drug teens are using is irrelevant because teens are not at all hooked on “marijuana”, “alcohol” and “heroin.” Teens are hooked on intoxication and our own bias that one drug is worse than the other significantly gets in the way of anyone being effective when it comes to identifying and helping teens and slowing or reversing the epidemic of teen drug use (which just goes on to be adult drug use).

To illustrate the point that teens are not hooked on “marijuana,” “alcohol,” “heroin,” and that the real issue is that they are hooked on a “pathological relationship to intoxication,” please help me with the following by helping me to understand which
drug my new client is using (think to yourself which drug it is as you read the following):

Yesterday, I met with a young lady named Lisa. Since Lisa started using she has lied to her family about her use. She has taken money from her family to pay for her use. Her siblings have expressed concern to her about her use. Her family has talked to her about it and has set limits in the home by implementing restrictions. Lisa has also had girlfriends and boyfriends express concern to her about her using by explaining to her how her use has affected their relationship and how they see it effecting her directly.

With regard to school, Lisa has increasingly started to not focus on homework as much, has skipped classes and her grades have been declining. Finally, she is getting a reputation on campus as being a person who uses.

She has had close calls with the law and doesn’t care about sports or music instruction anymore.

My question to use reading the reader is “which substance is Lisa using?” Is it marijuana, alcohol, “molly”, opiates, meth, stimulants, cocaine, 2CB, 2Cl, “wax,” “dabs,” ”budder”, LSD, mushrooms, etc?

When I ask this question to a large room full of seasoned clinicians, they struggle to answer it correctly. The correct answer, “it could be any of the drugs.” What I have laid out in the case vignette were simply the symptoms of late stage substance abuse and stages within addiction. Yes the symptoms are the same across the board 95% of the time from one drug to the next. We get to caught up in the 5% biological differences. This case and question help people to see that the symptoms of substance abuse/addiction are the same from one drug to the next so the name of the drug is irrelevant and what needs to be understood is that the issue is the pathological relationship to intoxication. It is Intoxications which is driving Lisa to use despite the symptoms of negative consequences occurring in her life.

What is getting in the way for parents and professionals working with young people is their own “drug bias” which also gets in the way of intervening sooner and more effectively when it is discovered that a young person is using. It is actually this bias when trips people up on my question post case vignette you just read above. To further illuminate the bias, I ask this question to many therapists when I am speaking at trainings and conferences “I want you to take a quiet moment and think about your son or daughter… In this very moment I want you to connect to your gut… Now
I want you to hold that connection and connect to what it feels like for you right now when you get a call from the police and they say your child has just been busted at the park with alcohol… What does that feel like? (I invite you to do this while you read as well). How driven do you feel in the moment to mobilize and take action? Stay connected. Alright, now you get the same call but the officer says your child has been busted with “Molly” or ecstasy. What is the reaction now? Again, your child has been busted with heroin. What is your reaction now? You see the visceral difference don’t you? That is the “drug bias” that has to be removed. A huge paradigm shift is that we have got to lose this bias and see all drugs as harmful. Once a person forms a pathological relationship to intoxication the symptoms and progression will all play out the same. Certainly, there are differences, but not enough to know which drug my client was using in the vignette given a moment ago.

Finally on the note that teens are not hooked on a particular drug, they are hooked on intoxication, what happens when the addict’s drug of choice is removed? Do they stop using? Are they sober? When a marijuana user is now being drug tested by parents or the legal system, do they stop seeking intoxication? Of course not because they were never hooked on marijuana, they were hooked on intoxication it is just that marijuana was their favorite flavor. You know, and they will admit, they will just shift to a different source of intoxication like K2-Spice, Alcohol, opiate pills, etc. This is the reality. We have to lose the bias, recognize this issue at a deeper more serious way and then we will help them sooner and more effectively.

One caveat that goes with my point hitherto is that drug users don’t hit bottom until the system around them hits bottom. The system are the parents, teachers, coaches, friends, employers, MD’s and therapists. When the system freaks out and says this is not okay, no more of this, this is painful to know where this could be headed, then the system acts and puts the floor in under the user going further downhill and progressing in their use. Sadly, today’s systems are still holding drug of choice biases and making statements like “it is only alcohol,” “it is only marijuana,” “it is the teenage years, a phase… “Certainly this fails to recognize that kids are using 73+% THC compared to 5% in the 80’s, 10-20% in the 90’s, and that most teen related deaths are related to alcohol. This ignorance supports addiction and allows it to progress. This is a system which has not hit bottom. This is a system that might hold the car keys while a group of teens gets drunk at their house after a Friday night football game. However, systems react when teens use Oxycontin which has now shifted to heroin. Now we have a system that recognizes a problem and is more motivated to do something about it which in turn makes it so the user has to face the issue of their drug use. Personally, I get frustrated that communities and politicians are freaking out today about the heroin epidemic we are in today with
teens and young adults. Why didn’t they freak out on the growing drug problem which has been unfolding for a long time with alcohol and marijuana? They are subscribing to the idea that heroin is the problem, and missing the other drugs and the illness as a whole. This all plays into the next paradigm shift I am hoping for that I think will really help.

Paradigm Shift 2: Referrals to outpatient programs needs to happen the very first time it is discovered that a teen has used.

“It is easier to prevent symptoms than reverse them”

When I lecture and train MD’s, I am usually asked, “When should I refer a drug using teen to outpatient treatment?” My response is “the very first time it is discovered they have tried alcohol or other drugs.” When I say this, the crowd usually thinks I am being intellectually tricky because this is a huge paradigm shift for most of them. I tell them that it is easier to prevent symptoms from progressing than it is to reverse them, wouldn’t you agree?”

Then I pose the following (I invite you to consider this too), but first I preface with the fact that 9 times out of 10 when a teen shows up for outpatient treatment they have already been using 2 years longer than the parents knew. And those moments where the school finds that a teen has drugs on them and makes the referral to treatment and the kid insists to the school and parents that it was their first use, well that is just too statistically unlikely.

So I pose the MD’s and other clinicians, wouldn’t you want the following for your child? Your child has just been busted as having used once. They go to an outpatient program or therapist who specializes in working with teens with these issues (certainly CD-IOP might not be the start because then they are in groups with other drug users who might be more progressed), though outpatient is ideal. In the outpatient process, your child is evaluated to truly examine their history of use, they are educated about the effects of the drugs, on the developing brain, mind, social group, coping and how those parts of the developing person become arrested. They then explore how their use has already created consequences in their life with regard to family, school, health, mental health, sports, friendships, money, etc. They are evaluated to determine if there are any underlying issues as well. Meanwhile, you are also educated about all of these things and learn to develop a home contract and to implement random drug testing. This process then crescendos to a family
session or two where your child shares with you his/her entire drug use history and how they see it has created consequences in family, school, money, friendships, etc. Then you as parents share your perception of how it has created consequences too. Then the home contracted is implemented and the family carries it at home from there. What I just described is about 8 sessions. This is an investment of a little bit of time, money and emotion. Wouldn’t rather have that for your child or a client? It is easier to prevent symptoms than reverse them, but sadly kids are not being referred to treatment until they are in stage 4 of the illness when the referral should have been made at stage .5 or 1.

Please help me to help our youth who are progressing and dying, whose families and communities are being destroyed by this epidemic we are in. We have to move into at least adopting these simple but yet new ways of thinking to be more effective at dealing with this problem. Finally, it is also true that we are either a part of the problem or a part of the solution. Let’s be the latter.

Please pass along...

Jon’s Bio:
Jon Daily, LCSW, CADC II is the founder and clinical director for Recovery Happens Counseling Services and specializes in the outpatient treatment of adolescents, young adults and their families with addictive disorders and dual diagnosis issues. A recipient of numerous awards for his work, Jon is also the co-author of (2006) “How to Help Your Child Become Drug Free,” and (2012) “Adolescent and Young Adult Addiction: The Pathological Relationship to Intoxication and the Interpersonal Neurobiology Underpinnings.” Jon has been an instructor to nurses, medical residents and has taught post-doctoral students for UC Davis. Currently he instructs graduate students for University of San Francisco and is the developer of a chemical dependency track within a Sacramento based psychiatric hospital. Jon has trained thousands of clinicians working with youth, young adults and adults. He has been a resource in the media over 60 times in his career from local media to the national Today Show. In addition to teaching, practicing, writing and providing forensic testimony, Jon provides program development, trainings and conference presentations. More information at www.recoveryhappens.com 916-276-0626.