TRAINER'S MANUAL

Co-occurring Substance Use and Mental Health Disorders in Adolescents: Integrating Approaches for Assessment and Treatment of the Individual Young Person

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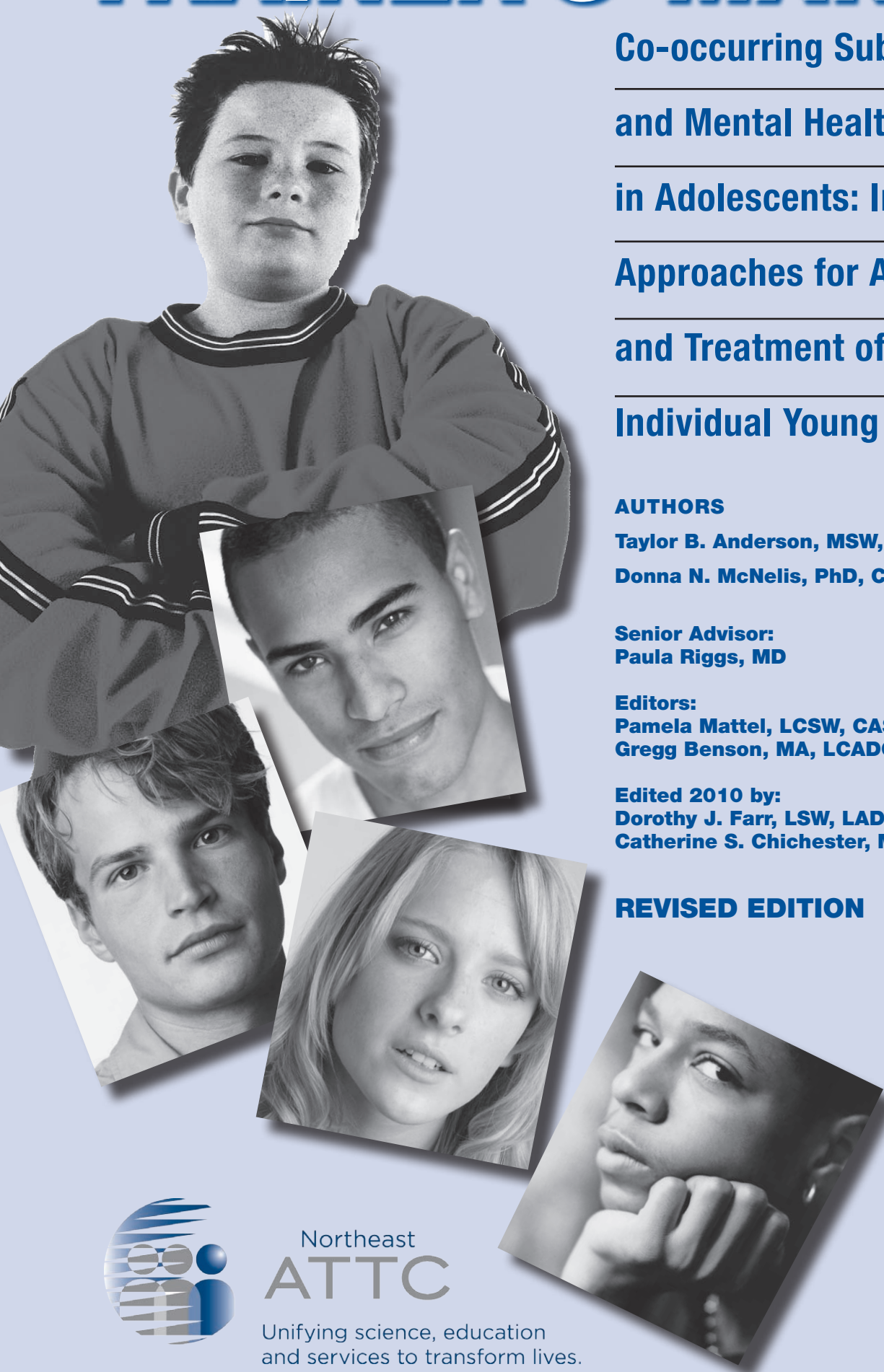
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REVISED EDITION

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INTRODUCTION

This Trainers' Manual for a two-day course entitled Co-occurring Substance Use and Mental Health Disorders in Adolescents: Integrating Approaches for Assessment and Treatment of the Individual Young Person was developed in 2004 by the Division of Behavioral Healthcare Education, Department of Psychiatry, Drexel University College of Medicine with support from the Northeast Addiction Technology Transfer Center. The primary author is Taylor B. Anderson, MSW, LSW, CPRP, with input and assistance from Donna N. McNelis, PhD. Paula Riggs, MD, Associate Professor in Psychiatry at the University of Colorado Health Sciences Center, Denver, Colorado provided expert consultation in her role as Senior Advisor for the training manual. This manual was reformatted and updated in February, 2006 by Pamela Mattel, LCSW, CASAC, Behavioral Healthcare Consultant and Trainer, New York, NY and Gregg Benson, MA, LCADC, Clinical Consultant and Trainer, Morristown, NJ.

As always, a project of this scope can not be accomplished without the support of many individuals. The Northeast ATTC is grateful to the following people for sharing their time and expertise in providing feedback on the content of the course materials: Oscar Bukstein, Nancy Jainchill, Rosemary Madl-Young, Joanne Slappo, and Janet Lerner. Appreciation is also extended to the staff at the Northeast Addiction Technology Transfer Center, and Dorothy J. Farr, LSW, LADC, CCDP-D and Catherine S. Chichester, MSN, APRN-BC who edited and updated the manual in 2010.

While integrated treatment approaches have been discussed in the literature for at least the past twenty years, and clinical research supporting these approaches now provides evidence-based practice guidelines for the treatment of adults, the research base for integrating treatments targeted to the needs of adolescents is just developing. This development is spurred by the growing number of adolescents in the juvenile justice system, many of whom have been found to have co-occurring substance use and mental disorders.

Young persons who have developed mental disorders during their prepubescent or early adolescent years are at increased risk for developing co-occurring substance use disorders. Also, adolescents who develop substance use disorders add to their risk of developing other mental disorders. The bibliography attached to this course will provide ample evidence of these risks. The literature also supports the experience of many treatment staff, namely, that adolescents who develop co-occurring disorders are generally more difficult to treat, especially in settings that provide only treatment for either substance use or mental disorders.

This curriculum is designed to assist those who provide training to counselors working with adolescents in substance use treatment programs by addressing the unique challenges that counselors may have when they consider ways to begin to integrate assessment and treatment approaches to meet more fully the needs of youth with co-occurring mental disorders. While this curriculum can benefit counselors who are "entry level" in either working with adolescents or working in the field of substance treatment, it also provides a current review of some of the evidence-based and promising practices that support integrated interventions.

The notes on the PowerPoint curriculum are to assist trainers in addressing the points on the slides. Trainers should adapt these materials, using the materials supplied in the Appendices and those references in the bibliography. Also, since there is a great deal of material to cover in a limited time period, trainers should alter the emphasis placed on each module to the specific needs of the group they are training. The agenda and time frames are provided for a 12-hour course, taught over a two-day period.

Finally, since adult learners learn best in an active and interactive atmosphere, participants need to be kept involved in the process. Lecture time needs to be generously interspersed with small group and individual work that helps participants connect what is already familiar to them with new concepts and skills presented in the course.

This 12-hour course is designed to meet certification standards for drug and alcohol counselors.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS
INTRODUCTION — 1

OVERVIEW OF TRAINING MATERIALS CONTAINED ON THIS CD-ROM

TRAINER GUIDELINES AND CHECKLISTS:

This section provides suggestions for you as a trainer to help make your training successful and as stress-free as possible. These are provided to you in a checklist format so that you can copy and use them in actual planning and implementation of your training experience.

TRAINING AGENDA AND EXERCISE SHEETS:

This section provides a copy of the suggested agenda, with times for specific questions included, that you can use to rehearse timing of each module. It also includes a copy of the exercise sheets to be copied and handed out during the training, along with the trainers' instructions that include timing, purpose, and means of conducting each exercise.

TRAINING CURRICULUM:

This section provides the complete PowerPoint slides that include the trainer's notes, the handouts (recommend 3 slides to a page so that participants can take notes as they follow the presentation parts of the curriculum), and the presenter's slides (background can be changed using the PowerPoint software). This section also includes a bibliography to be included in the handouts to participants (and for your use).

USEFUL WEBSITES AND ANNOTATED BIBLIOGRAPHY OF RECENT ARTICLE & BOOKS:

This section includes pages from other sources that are public domain and that are useful adjuncts to the training curriculum, covering some information in more detail than it is possible to cover in the course itself.

HOW TO USE THIS MANUAL RECOMMENDATION:

This manual is intended to be a trainer's manual. It is recommended that the power point and handout be printed for the participants as part of a participant manual.

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TRAINER GUIDELINES

QUALIFICATIONS:

It is helpful to attend a "Train the Trainer" program for this curriculum to have your own concerns addressed and questions answered. It is recommended that trainers have experience working directly with adolescents and their families and, ideally, also have experience in integrating approaches for co-occurring disorders. A thorough review of child and adolescent developmental stages and of the DSM disorders discussed in the course is also recommended.

PARTICIPANTS:

Try to have no more than 25 persons attend, 30 at most. If you MUST train more than this number at one time, it is more useful to have two instructors. It is important to attend to the needs of participants and to monitor how they are responding to the materials and ideas presented. It is not possible to do so if the group is too large. Also, a larger group will necessitate some shift in the timing of the agenda. Expect to have persons in the course who have varying degrees of education and experience.

SEQUENCE:

The course works best presented on two consecutive days. If you must split the dates, aim for no more than a week in between and assign some "homework" for the participants to review in between time.

SITE:

Be sure that there are tables and chairs in the training room and that they are movable to accommodate small group work. Make sure the room is large enough and reasonably comfortable (participants will be sitting for long periods of time). Be sure participants can see the projection screen from wherever they are sitting, and that a table and electrical outlets are in place for the LCD and laptop computer. If you can use a fan-shaped table arrangement (rather than a typical classroom style seating), do so. Also, be sure that rest rooms are nearby, parking is available (and free or reasonable), and that lunch can be easily obtained within the allotted time. NOTE: Be SURE that all facilities are suitable for persons with disabilities.

EQUIPMENT:

You will need the CD with the PowerPoint presentation, copies of all curriculum and exercise sheets, a laptop computer and LCD, a projection screen, newsprint and large markers (preferable) OR a chalk board and chalk (second choice, since newsprint can be taped up for continued use and will not be erased).

HANDOUTS:

It is important to hand out materials as they will be used. You will want to hand out the first exercise sheet first, the curriculum packets AFTER the first exercise is completed, and subsequent exercises as you get to them. Too much paper is distracting and takes people off task.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS
INTRODUCTION — 3

CHECKLIST FOR PRIOR TO THE TRAINING:

❏ **MAILING BROCHURE:** (if needed) is completed, proofed, and mailed at the agreed-upon date (should receive at least 6 weeks prior to the scheduled training)

Mailing announcement should include:

- Title of course

- Dates, times, and location of course

- Brief description of course and learning objectives

- Target population (for whom the training is intended)

- Cost, if any, with form of payment, deadline date, and early registration fee, if any

- Type of continuing education credits to be given, if any, with necessary statements

- Attendance requirements (may relate to CE units, above)

- Registration instructions, deadlines, and contact person, phone number (and if e-mail)

- Any additional information such as directions, parking instructions, etc.

❏ **SITE REVIEW OR VISIT:** check that the site and equipment are adequate (see previous page) and that equipment is available, meets your needs, and is in working order.

❏ **PARTICIPANT LIST:** review who will be attending and find out as much as possible about their experience levels and expectations before they arrive at the course.

❏ **CURRICULUM REVIEW:** review the curriculum carefully, paying close attention to your own needs, the timing of each section, and the expected match to the needs of those expected to attend.

❏ **MATERIALS REVIEW:** review the copy of the participant handout of the curriculum and all exercise sheets and appendices to ensure that everything is there and in good order (Note: it is expected that the handout of the slides will be double-sided, as will the bibliography and appendices. The exercise sheets should be single-sided and separate).

YOU WILL NEED:

- Copies of slide handouts with bibliography & appendices

- Copies of exercise sheets

- Sign-in sheets, certificate copies (if not mailed later), on-site registration forms

- Name tags and large markers for first names (or folding stands for names)

- Pre- and post-test copies and evaluation forms to be completed at the end

- The equipment noted on the previous page (LCD, Laptop, Screen, Flip Chart)

❏ **PRIOR TO THE TRAINING:** arrive early and check room set-up, equipment set-up and working order, sign-in space, space for handouts, and teaching space. Make any adjustments.

❏ **SIGNS:** is it easy for participants to find the training room? Are there signs directing them? If not, can you create some or get someone else to do so?

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CHECKSHEET FOR DURING THE TRAINING:

❏ **GREET PARTICIPANTS AS THEY COME IN.** If at all possible, have refreshments present (coffee, tea, water, continental breakfast, including fruit).

❏ **INTRODUCE YOURSELF AT THE BEGINNING.** Be warm and personable. Have participants perceive that you are glad they are there. Let them know there will be time to learn who they are in a few minutes.

❏ **MAKE ANY "HOUSEKEEPING" ANNOUNCEMENTS UP FRONT.** Review the schedule and let people know when breaks will occur and how long they will have for lunch. Let them know where facilities (restrooms, any eating places, smoking arrangements) are located. If they must leave for meals, include a sheet with suggestions and directions. Give any directions about parking, etc., and where public telephones are located.

❏ **REVIEW THE "COMMON COURTESY" REQUIREMENTS** - turning off cell phones or putting them on "vibrate" (if they must be on call); one person speaking at a time; being on time; that full attendance and a post test are required for certifying participation; and simply, that we are here to help each other have the best learning experience possible. Invite people to let you know if anything arises that disrupts their attendance or if they have any special needs.

❏ **LET PARTICIPANTS KNOW** that you may not cover every point on every slide (some people are anxious about this and are linear learners) but that you will cover the key points for each of the questions listed. Invite them to ask individual questions that cannot be covered in class during the breaks or after class.

❏ **IF YOU FIND YOURSELF OFF TOPIC** or off your time schedule, it is fine to ask participants which questions they need you to review in detail and which are OK to review more quickly. But then take their advice seriously.

❏ **INVITE QUESTIONS AND DISCUSSION**, but feel free to bring closure if too much time is elapsing. Again, let people know that they can ask questions individually on breaks, etc., or can e-mail or be in touch with you after the training to ask about specific issues.

❏ **MODEL THE TYPE OF BEHAVIOR YOU WOULD LIKE** the participants to demonstrate in their work. Be strengths-based, point out positives and skills in participants, and don't reinforce negative language or behavior with attention - let it go by. DO correct any misperception or statement that can mislead people and encourage poor practices, but do it in a clarifying and matter-of-fact manner. **[This last check point cannot be overstated.]**

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS
INTRODUCTION — 5

CHECKSHEET FOR AFTER THE TRAINING:

❏ **COLLECT ALL EVALUATION FORMS** and file them safely or give them to the appropriate person.

❏ **BE SURE THAT ALL EQUIPMENT IS STORED** properly or returned to the appropriate person.

❏ **TAKE ANY ADDRESSES** for anyone requesting other information or follow up (and remember to follow up on their requests).

❏ **IF IT IS YOUR TASK TO SUMMARIZE THE EVALUATION FORMS**, do so and send a report to the appropriate person.

❏ **REVIEW ANY NOTES** you made regarding the sequence and flow of the curriculum and note any adjustments to be made the next time you teach this course.

❏ **IF ANY CONTINUING EDUCATION CREDITS** were given, remember that a complete file of the course must be maintained for the accrediting body(ies), including:

- A complete copy of the curriculum, including exercises, bibliography, appendices and any handouts used.

- The original sign-in sheet.

- The evaluation summary.

HINT: find out how many years you will need to keep a copy of the folder for each accrediting body. Keep them as long as the longest date necessary.

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QUESTIONS & ISSUES

1. In what ways are adolescents developmentally different from adults?

2. What are substance use disorders as described in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association?

3. How does substance use in adolescents differ from that of adults?

4. What factors serve as protective and which factors put adolescents at higher risk for developing substance use disorders and other mental disorders?

5. What are the more common mental disorders seen in adolescents as described in the Diagnostic and Statistical Manual of Mental Disorders?

6. How may substance use disorders and mental disorders interact with each other to create further risks for the effective management of both/all disorders?

7. How is it important to assess an adolescent for ALL possible disorders he/she may have?

8. How is it important to involve the family/support system in the assessment, intervention, and follow-up phases of treating adolescents?

9. How is it important to learn about other cultural and ethnic groups and their values?

10. What are the most useful ways of screening and assessing young people for co-occurring disorders?

11. What are the three main approaches to sequencing treatment of co-occurring disorders and what are the benefits and risks of each of them?

12. What are some of the main evidence-based approaches to treatment that have demonstrated effectiveness in working with adolescents and their families?

13. How are psychopharmacological interventions useful in treating specific co-occurring disorders and what are some of the benefits and risks associated with them?

14. How is it important to learn about other formal and informal service and support systems in the community?

15. What are some of the individual professional and programmatic issues associated with integrating approaches for assessing and treating co-occurring disorders?

16. What does the process for integrating treatment for co-occurring disorders look like?

17. How can I continually evaluate my own strengths and needs in serving adolescents with co-occurring disorders and their families?

18. What resources are available to me to help me learn more about specific knowledge and skills for assessing and treating co-occurring disorders?

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

INTRODUCTION — 7

TWO-DAY AGENDA

DAY 1

8:30 am - 8:45 am	Introduction/Announcements
8:45 am - 9:15 am	EXERCISE 1: "Getting to Know You"
9:15 am - 10:30 am	MODULE 1: Brief Overview of Co-Occurring Disorders
10:30 am - 10:45 am	BREAK
10:45 am - 12:00 noon	Module 2: Framework for Integrated Treatment
12:00 noon - 1:00 pm	LUNCH
1:00 pm - 2:30 pm	MODULE 3: Adolescent Development
2:30 pm - 2:45 pm	BREAK
2:45 pm - 4:15 pm	MODULE 4: Substance Abuse
4:15 pm - 4:30 pm	Review of Day 1 and Preview of Day 2

DAY 2

8:30 am - 8:45 am	Overview of Day 2 and Questions from Day 1
8:45 am - 10:15 am	MODULE 5: Mental Health
10:15 am - 10:30 am	BREAK
10:30 am - 12:00 noon	MODULE 6: Adolescent Assessment
12:00 noon - 1:00 pm	LUNCH
1:00 pm - 2:30 pm	MODULE 7: Recommendations from Evidence-Based Approaches
2:30 pm - 2:45 pm	BREAK
2:45 pm - 4:15 pm	MODULE 8: Cross-System Collaboration
4:15 pm - 4:30 pm	Discussion/Adjournment

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INSTRUCTOR'S NOTES FOR INTRODUCTION AND FIRST EXERCISE

BRIEF COURSE OVERVIEW: The course should begin with the participants becoming active in their own learning process. Therefore, provide only a brief self-introduction (30 seconds) and a review of the course objectives (4 minutes). You will see why the brief introduction is important (see following exercise).

EXERCISE: Getting to Know You (Exercise 1): this is a 30 minute exercise that takes about 5 minutes for instructions and handing out the exercise sheets,10 minutes for participants to do (5 minutes each) and 15 minutes in processing.

YOU WILL NEED: a watch with a second hand; exercise sheets for participants.

Initially ask people to close their eyes. Then ask them to put their hands up when they believe 30 seconds have elapsed. At the end of 30 seconds, ask everyone to open their eyes. Let them know that some people were early, some very close, some lagging. Let them know that they will have 30 seconds EACH to introduce another person.

INSTRUCTIONS: Pick a person in the class whom you do not know at all (if you know everyone, select someone you know only slightly). Interview them to find out the following information: where they work, who they serve, what they like best about their work. Also find out what they like to do when they are not working (that is, activities, hobbies, etc. that they find enjoyable). Try not to ask questions that can be answered with one word (or only a few). They will then interview you for the same information. Take 5 minutes each.

THE PURPOSES OF THIS EXERCISE ARE:

- to have people meet in a more meaningful way and introduce each other (rather than having rote self-introductions that few people really hear);

- to begin to illustrate the importance of initial positive engagement by having participants actually DO it;

- to demonstrate that people remember more about interests and commonalities than names and roles;

- to demonstrate the practice of asking open-ended questions and listening carefully and completely to what people offer about themselves.

At the end of the introductions, take 5 minutes to ask a few questions such as:

- what was this "getting to know you" process like for you?

- what was the most interesting part of the interview for you and how was it interesting?

- how is this exercise relevant to what you do in your own practice?

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EXERCISE: GETTING TO KNOW YOU

INSTRUCTIONS: Pick a person in the class whom you do not know at all (if you know everyone, select someone you know only slightly). Interview them to find out the following information: where they work, who they serve, what they like best about their work. Also find out what they like to do when they are not working (that is, activities, hobbies, etc. that they find enjoyable). Try not to ask questions that can be answered with one word (or only a few). They will then interview you for the same information. Take 5 minutes each.

INTERVIEW 1:

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INTERVIEW 2:

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INSTRUCTOR'S NOTES FOR THE SECOND EXERCISE (OPTIONAL)

EXERCISE: Remembering My Family: this is a 15 minute exercise that takes 2-3 minutes for handing out the exercise sheets and reviewing the instructions, 3-4 minutes for participants to jot down their thoughts, 5 minutes to ask several volunteers to share their memories, and 3-4 minutes to ask a few questions in summary.

YOU WILL NEED: Only the exercise sheets for participants and a watch to time the exercise.

INSTRUCTIONS: Individually jot down on this sheet something you remember about your family when you were young that was very special and/or enjoyable and that you still remember fondly. Then jot down something that you did not like and/or you wish had been different. You may share these memories with the larger group ONLY if you choose to.

THE PURPOSES OF THIS EXERCISE ARE:

• to have participants connect with the concept of family importance and involvement in a personal and involved manner;

• to demonstrate that family membership has its positives and negatives from the perspective of each family member;

• to connect with the significance of the emotional (non-rational) experience that family membership produces for each person;

• to remind everyone that we carry our own life experiences into our work and that our biases (positive and negative) may affect the way we experience others;

• to prepare participants for exploring the question of family involvement.

At the end of the exercise, take 5 minutes to ask a few questions such as:

• what was this experience like for you?

• what do you think was the purpose of this exercise?

• how might this exercise be useful to you in thinking about your practice?

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

INTRODUCTION — 11

EXERCISE: REMEMBERING MY FAMILY

INSTRUCTIONS: Individually jot down on this sheet something you remember about your family when you were young that was very special and/or enjoyable and that you still remember fondly. Then jot down something that you did not like and/or you wish had been different. You may share these memories with the larger group ONLY if you choose to.

PART 1:

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PART 2:

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INSTRUCTOR'S NOTES FOR THE THIRD EXERCISE (OPTIONAL)

EXERCISE: Convince Me to Change: This is a brief exercise that takes 15 minutes, 10 minutes for participant activity and 5 minutes for the summary. Each person gets 5 minutes to try to convince the other person to change some behavior which that person enjoys. Instruct participants to employ their finest acting ability and to convince themselves and, of course, the other person, that it would be good for the other person to give up this behavior (and perhaps take up another behavior preferred by the interviewer). Time the exercise and remind participants to switch sides when the first 5 minutes have passed.

YOU WILL NEED: A watch and exercise sheets for participants.

INSTRUCTIONS: Get together in pairs, perhaps with the person you first interviewed yesterday. Each of you will take a turn doing the following interview. Ask the person to tell you about some behavior they enjoy (don't get TOO personal). You KNOW that this behavior is something that ultimately is not good for them. Spend 5 minutes trying to convince that person to give up that behavior for something else (perhaps something that you believe is really more useful for them to do). When you have spent 5 minutes at this, switch sides and have the second person do the same thing with you.

THE PURPOSES OF THIS EXERCISE ARE:

• to begin the afternoon with something that generates some energy;

• to demonstrate that a head-on approach to trying to get another person to change a preferred behavior is not likely to be successful;

• to introduce the presentation on change theory and motivational interviewing.

At the end of this exercise, take 5 minutes to debrief this exercise when both participants have had their 5 minute turn. Ask questions such as:

• Why do you think you were given this exercise?

• What's the point?

• What were you feeling as the interviewer?

• As the person being persuaded to change?

Remember that not everyone will have the same experience with this exercise. Some people will feel very indignant and 'resistive' during the process. Some people will become unsure of themselves and think the other person may have a point. A few may even be considering making a change. But most will get the point that 'resistance' is engendered when a person perceives that someone else wants them to make a change.

Recall that Miller and Rollnick postulate that 'resistance' is not an individual trait but an interpersonal dynamic that occurs when a person feels unheard or pushed in a direction other than their own. Their message is not only "start where the client is" but also "stay where the client is," in terms of avoiding sending signals of control, impatience, or desire to change their point of view.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

INTRODUCTION — 13

EXERCISE: CONVINCE ME TO CHANGE

INSTRUCTIONS: Get together in pairs, perhaps with the person you first interviewed yesterday. Each of you will take a turn doing the following interview. Ask the person to tell you about some behavior they enjoy (don't get TOO personal). You KNOW that this behavior is something that ultimately is not good for them. Spend 5 minutes trying to convince that person to give up that behavior for something else (perhaps something that you believe is really more useful for them to do). When you have spent 5 minutes at this, switch sides and have the second person do the same thing with you.

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INSTRUCTOR'S NOTES FOR THE FOURTH EXERCISE (OPTIONAL)

EXERCISE: Sharing Childhood Experience- Shaping Values/Beliefs exercise engages participants in a learning experience by utilizing the various learning styles, i.e., auditory (talk about it), visual (see it) and kinesthetic (interact with it). When everyone is done, ask the participants to find a place on the wall in the training room to hang their picture and then to stand by their picture. The 40 minute exercise includes instruction, 5 minutes for each person to draw his or her picture, 1 to 2 minutes for each person to introduce themselves based upon their picture and 5 minutes to debrief the exercise.

YOU WILL NEED: Exercise instructional sheet, colored markers, flip chart paper, tape for hanging (or self adhesive flip chart paper) and a watch to time the exercise.

INSTRUCTIONS: Draw a picture of an experience that you had as a child, in which you developed a belief or value that you still hold true as an adult. Make certain it is something you are willing to share with the large group. Write your first name on the picture. You will be introducing yourself to the group based upon the picture and will have 1 to 2 minutes for that introduction. After you are done drawing, please find a place on the wall to hang your picture and stand by the picture until it is your time to introduce yourself. The oral presentation of this exercise is voluntary.

THE PURPOSES OF THIS EXERCISE:

- to have participants connect with the concept that early life experiences shape personal attitudes, values and beliefs;

- to reflect that attitudes, values and beliefs effect and influence present day behaviors;

- to demonstrate that people have different learning styles;

- to prepare participants for sharing and exploration of issues and beliefs during the course of the training.

At the ends of the exercise, take 5 minutes to debrief and to ask a few questions such as:

- what was this experience like for you?

- did anything surprise you?

- what do you think was the purpose of this exercise? (You're trying to get an answer that reflects the importance of experiences early in life in shaping personal attitudes and beliefs)

- what kinds of learning strategies were used in this exercise? How do you learn best?

- how can you incorporate different learning styles in your practice?

IMPORTANT POINTS:

How you think effects how you act.

Your childhood learning experiences influence your personal attitudes, values and beliefs.

Learning can be fun.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS
INTRODUCTION   — 15

EXERCISE: SHARING CHILDHOOD EXPERIENCE – SHAPING VALUES/BELIEF

INSTRUCTIONS: Using the flip chart paper provided, draw a picture of a learning experience you had as a child in which you developed a belief or value that you still hold as true and use in your adult life.

Put only your first name on the paper.

You will be introducing yourself to the rest of the group based on your picture.

You have 5 minutes to draw. Begin.

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MODULE 1: BRIEF OVERVIEW OF CO-OCCURRING DISORDERS

Goal:

Provide information to support growing understanding about the nature of co-occurring disorders

Learning Objectives:

Discuss the association between substance abuse and psychiatric illness

Describe general statistics and trends among the adolescent population

Content Outline:

Evolving Field of COD

– trends

– etiology

– facts

– trauma

– trends

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MODULE 1 HANDOUTS: INTRODUCTION AND BRIEF OVERVIEW / CASE EXAMPLE 1

KEVIN is a 17-year-old white male in the 11th grade. He had had behavior problems since kindergarten and was diagnosed as hyperactive in the 4th grade. He is being re-evaluated in the 11th grade because he is depressed and has become increasingly withdrawn, sad and tired. He showed decreased motivation and his grades were so poor that he had failed his freshman year in high school and had to go to summer school for both the 10th and 11th grades. He was also having increased temper outbursts and was becoming irritable. He adamantly denied taking nay drugs.

Kevin started counseling 1 year prior to being seen by an addiction counselor. Four months prior to being seen he was identified in school as a possible drug abuse and forced to submit a urine test, which was positive for marijuana. The school pressed charges and Kevin was mandated to go to an adolescent outpatient drug program for evaluation. While in this program, he admitted to abuse of cocaine in addition to marijuana. His treatment in the program failed and he was sent to an adolescent residential center. He was not seen by a psychiatrist until he attempted to hang himself. The pressure of the program had caused him to reveal, under intense peer pressure that he had been raped by an older boy when he was 8 years old.

After his attempted suicide, Kevin was seen by a psychiatrist who recommended immediate discharge from the residential program. Kevin returned to the outpatient program. He was again pushed beyond his limits and became violent which led to a complete diagnostic reevaluation.

At the time of the reevaluation Kevin was attending AA daily, but he suffered from symptoms of guilt, loneliness, boredom, decreased sleep and depression. He was neither suicidal nor homicidal. He admitted to having used cocaine on a regular basis, crack, marijuana, PCP, mescaline, Quaaludes, and mushrooms. He denied using heroin.

HIS DIAGNOSIS WAS:

Axis I   Major Depression

           Conduct Disorder

           ADHD

           Polysubstance Abuse and Dependence

           PTSD

Axis II   Oppositional Traits

Axis III   R/O Partial Complex seizures

Kevin was encouraged to continue attending AA. He also had weekly supervised urine testing and counseling. Antidepressants were prescribed to treat his depressive symptoms, which persisted despite the fact that he had been abstinent for several months.

Kevin responded well to gentle but firm encouragement to attend AA as well as his own counseling. Family sessions were helpful in allowing him to ventilate his feelings and develop a closer relationship with family members.

COMMENT

This client would never have responded to treatment in either a pure mental health setting or a pure substance use treatment setting. It was only by addressing simultaneously both his substance use and his psychiatric problems that he was able to make prolonged sustained recovery.

MODULE 1 HANDOUTS: INTRODUCTION AND BRIEF OVERVIEW / CASE EXAMPLE 2

WARREN was a 15-year-old white male who had failed 8th grade and was failing summer school. He had been ordered into psychiatric evaluation by the courts. His mother stated that he has been very depressed, angry and hostile and had had dramatic mood swings from being calm to screaming and yelling. Warren had reportedly thrown a brick through a window and beat up the mailbox at their house. He often stated that he was stupid and not worth anything. He had a very poor relationship with his father.

His parents first noticed that something was very wrong 1-year prior to the evaluation when they started receiving complaints about him from the school system. He was reported to be hyperactive with decreased attention span, inappropriately touching female students, pushing and talking out of turn. He received weekly counseling for 2-3 months, which was unhelpful. His behavior continued to deteriorate and became so far out of control that he started striking his parents' truck and boat, stating "I'll just kill myself" and threatening to kill both of his parents.

One year previously, a general practitioner had treated Warren with Ritalin for presumed hyperactivity. His grades did improve, but he did not like how it made him feel and he threw it away.

His mental status revealed extremely flat affect, depressed mood and no thought disorder.

INITIAL DIAGNOSIS:

Axis I   R/O Major Depression

                R/O ADHD

                R/O Polysubstance Abuse or Dependence

                Parent-Child Problem

Warren's affect brightened somewhat in the hospital and he was no longer suicidal. As an outpatient he continued to deny any drug use until he made an attachment with one of the substance abuse counselors. Approximately 6 weeks into treatment he confessed to daily use of marijuana, frequent use of LSD, and copious amounts of alcohol. The focus of his treatment was then shifted to emphasize his substance use and how it affected his behavior and mood.

FINAL DIAGNOSIS:

Axis I   Substance Induce Mood Disorder

                   (depressed)

                Cannabis Dependence

                Hallucinogen Abuse (LSD)

                Alcohol Abuse

While in treatment he did very well. His depression remitted and he did not require treatment with medication.

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MODULE 1 HANDOUTS: INTRODUCTION AND BRIEF OVERVIEW / CASE EXAMPLE 3

GINA was a 17-year-old Latina female. She had a 2-year-old daughter and they were both living with her parents. Gina had been previously admitted to a hospital because of a suicide attempt. She had had a 1-month history of mild depression after high school graduation caused by concerns about what she was going to do after graduation. She had become more depressed and had attempted to kill herself by overdosing on medication. Gina was then admitted to a local hospital intensive care unit. A psychiatrist released her from the hospital because he felt that she was not suicidal and referred her to a local psychologist who has treated her with psychotherapy. For 6 weeks she was given no medications and did not see a psychiatrist. Gina reportedly functioned well during this period but developed depression with constant suicidal ideation 1 week prior to her current admission. She also related that she had had periods of time during which she did not know her own name or where she was living on at least 6 occasions previously.

Her mental status examination, medical and substance abuse work ups were unremarkable.

INITIAL DIAGNOSIS:

Axis I   Major Depressive Disorder

R/O Panic Disorder

Possible Dissociative Disorder

Gina maintained that she had no substance use problems except for smoking marijuana once and occasional alcohol. She demonstrated symptoms of severe depression and was started on anti-depressants. Gina was initially started on a normal dosage, but she had a great deal of difficulty tolerating even minimal dosages due to side effects. The dosage was reduced to 1/4 of normal dosage and was later slowly increased to normal adult dosage.

After several weeks of treatment, Gina admitted to heavy use of marijuana and ecstasy. She stated that her symptoms had not started until she began using these drugs. As treatment progressed, she recognized problems in her own behavior, including ignoring her daughter and going out with friends to do drugs and attend parties. She demonstrated additional issues in treatment that focused on her overinvolvement with male patients. She was able to address this in treatment.

FINAL DIAGNOSIS;

Axis I   Polysubstance Abuse,

Major Depressive Disorder

COMMENT:

In hindsight, it is evident that she should have received counseling from the time her pregnancy became known. The fact that she had become pregnant should have raised concern that she was experiencing other problems in addition to her early sexual activity, including possible substance use. The second point at which she could have been helped was when she made her first suicide attempt. She should not have been released from the hospital without outpatient therapy.

Her antidepressant intolerance can also be found in people with panic disorders. The most striking thing about the case is that substance abuse was not initially diagnosed because Gina presented with clear depressive symptoms, had made a suicide attempt and had a negative drug screen. It was only after the passage of time and start of counseling that she recognized she had used drugs and that the drugs had probably contributed heavily to her symptoms. This demonstrates that it is very important not to make snap judgments or diagnoses when treating adolescent and to assess how the use and abuse of substances are contributing to their symptoms and problems.

1. Co-occurring Substance Use and Mental Disorders in Adolescents

Integrating Approaches for Assessment and Treatment of the Individual Young Person

2. Course Outline

1. Introduction
2. Brief Overview of Co-occurring Disorders
3. Framework for Integrated Treatment
4. Adolescent Developmental Issues
5. Conducting Integrated, Comprehensive Assessment
6. Substance Use Disorder and its relationship to co-occurring disorders
7. Mental Health Disorders and their relationship to co-occurring disorders

3. Course Outline continued

8. Evidence-Based Strategies
9. Cross-System Collaboration

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-1 — 21

4. Overall Course Objectives

- Create, stimulate, and facilitate an ongoing cross-system and stakeholder dialogue regarding adolescent co-occurring disorders.
- Identify both current evidence-based treatments for CODs and promising alternative therapeutic strategies.
- List core program elements needed to provide effective integrated interventions.

SLIDE 4 NOTES:

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5. Objectives, continued

- Review the uniqueness of the adolescent developmental process and differentiate it from that of adults.
- Examine possible relationships between SUD and other mental disorders.
- Explore integrated and collaborative treatment approaches for co-occurring disorders.
- Identify barriers and solutions for systems change.

SLIDE 5 NOTES:

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6. MODULE 1

Brief Overview of Co-occurring Disorders and Adolescents

SLIDE 6 NOTES:

Introduce yourself to participants, and review the course objectives. Ask participants to introduce themselves by name, agency, and title.

EXERCISE: Small to Large Group (15-20 minutes)
Newsprint   Markers   Tape

PURPOSE: To stimulate discussion on expectations for learning, create a conducive atmosphere for asking questions, encourage inter-participant cooperation, and take responsibility for learning.

Provide each table with newsprint and markers. Ask participants to share with one another questions they have about adolescents with co-occurring disorders. Each table should select 2 or 3 questions that were generated and record them on newsprint provided.

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SLIDE 6 NOTES (CONTINUED):

The group should also select a spokesperson to introduce the members to the larger group and present their selected questions.

Post the questions on the wall, and refer to them throughout the training. If there is time at the end of the training, you may ask the originators of the questions to provide the larger group with brief answers. This is an effective method of encouraging participants to be responsible for their own learning and participation.

The following section is designed to introduce participants to general information regarding adolescents with co-occurring disorders.

7. Goal:

Provide information to support growing understanding about the nature of co-occurring disorders.

SLIDE 7 NOTES:

8. Objectives:

Participants will be able to:
- Discuss the association between substance abuse and psychiatric illness
- Describe general statistics and trends among the adolescent population

SLIDE 8 NOTES:

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9. Evolving Field of Co-occurring Disorders (TIP 42)

- Early association between depression and substance abuse
- Growing evidence of links and impact on course of illness
- Growing evidence that integrated co-occurring treatment is evidence based

Today's emphasis on the relationship between substance use and mental disorders dates to the late 1970s, when practitioners increasingly became aware of the implications of these disorders for treatment outcomes. The association between depression and substance abuse was particularly striking and became the subject of several early studies (e.g., Woody and Blaine 1979). In the 1980s and 1990s, however, both the substance abuse and mental health communities found that a wide range of mental disorders were associated with substance abuse, not just depression (e.g., De Leon 1989; Pepper et al. 1981; Rounsaville et al. 1982b; Sciacca 1991). During this period, substance abuse treatment programs typically reported that 50 to 75 percent of clients had co-occurring mental disorders, while clinicians in mental health settings reported that between 20 and 50 percent of their clients had co-occurring substance use disorders. (See Sacks et al. 1997) See TIP 42 for a more complete reference list.

Researchers not only found a link between substance abuse and mental illness, they also found that there was a dramatic impact that substance abuse may have on the course of treatment for mental illness.

Researchers also have clearly demonstrated that substance abuse treatment of clients with co-occurring mental illness and substance use disorders can be beneficial even for clients with serious mental disorders.

For example, the National Treatment Improvement Evaluation Study (NTIES) found marked reductions in suicidality the year following substance abuse treatment compared to the year prior to treatment for adults, young adults, adolescents, and subgroups of abused and nonabused women. Of the 3,524 adults aged 25 and over included in the study,

- 23 percent reported suicide attempts the year prior to treatment, while only 4 percent reported suicide attempts during the year following treatment.
- 28% of the 651 18- to 24-year-old young adults had a suicide attempt the year before treatment, while only 4 percent reported suicide attempts during the 12 months following treatment.
- Similarly, the 236 adolescents (13 to 17 years of age) showed a decline in pre- and post-treatment suicide attempts, from 23 percent to 7 percent, respectively (Karageorge 2001).
- For the group as a whole (4,411 persons), suicide attempts declined about four-fifths both for the 3,037 male clients and for the 1,374 female clients studied (Karageorge 2001).

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SLIDE 9 NOTES (CONTINUED):

- A subset of women (aged 18 and over) were identified as either having reported prior sexual abuse (509 women) or reporting no prior sexual abuse (667 women). Suicide attempts declined by about half in both of these groups (Karageorge 2001), and both groups had fewer inpatient and outpatient mental health visits and less reported depression (Karageorge 2001).

Another study of 121 clients with psychoses found that those with substance abuse problems (36 percent) spent twice as many days in the hospital over the 2 years prior to treatment as clients without substance abuse problems (Crome 1999; Menezes et al. 1996).

These clients often have poorer outcomes, such as higher rates of HIV infection, relapse, rehospitalization, depression, and suicide risk (Drake et al. 1998 ; Office of the Surgeon General 1999).

In summary, studies report that substance abuse is the most common co-occurring disorder in persons with mental disorders. And people with substance use disorders have high percentages of mental health illnesses. This then demands that providers in both systems learn to recognize symptomology, be knowledgeable about diagnostic criteria, and then invest in learning more about the nature of co-occurring disorders.

TRAINER NOTE: Module 2 focuses on components of integrated treatment and Evidence-Based strategies.

EXERCISE Small Group:

      Integrated Cases: (20 minutes)

      Handout: Integrated Case Studies 1, 2, 3

This exercise is provided to a) highlight challenges in diagnosing and treating adolescents with COD, and b) encourage the participants to share information and ideas with one another.

Refer the participants to the 3 case studies provided in their manual. Ask the participants to turn to page... in the participant manual and read through the three case examples. Instruct them to discuss:

a) what are some of the issues experienced in the case studies and how do they compare to their agency experience in diagnosing adolescents with co-occurring disorders, and

b) what are some general implications for treatment.

After 15 minutes, facilitate a large group discussion focusing on highlighting the following issues:

- Rigor needed in diagnosing and discipline needed to avoid rushing to diagnosis and medication
- Need to simultaneously address both disorders
- Be mindful of the subtleties of denial
- Need for integrated perspectives and treatment.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-1 — 25

10. Evolving Field of Co-occurring Disorders (TIP 42) cont.

- Co-occurring
  - Replaces dual diagnosis
- New Models and Strategies
  - Physical Health Integration
  - Recovery Oriented Systems of Care

SLIDE 10 NOTES:

Just as the field of treatment for substance use and mental disorders has evolved to become more precise, so too has the terminology used to describe people with both substance use and mental disorders. The term co-occurring disorders replaces the terms dual disorder or dual diagnosis. These latter terms, though used commonly to refer to the combination of substance use and mental disorders, are confusing in that they also refer to other combinations of disorders (such as mental disorders and mental retardation).

Furthermore, the terms suggest that there are only two disorders occurring at the same time, when in fact there may be more. For purposes of this training, co-occurring disorders refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have co-occurring disorders have one or more disorders relating to the use of alcohol and/or other drugs of abuse as well as one or more mental disorders. A diagnosis of co-occurring disorders occurs when at least one disorder of each type can be established independent of the other and is not simply a cluster of symptoms resulting from the one disorder.

The etiology of Co-occurring disorders can take many forms.

1) Psychiatric disorders might develop as a consequence of substance abuse

2) Psychiatric disorders can alter the course of substance abuse

3) Substance abuse can alter the course of psychiatric disorders

4) The combination of psychopathology, individual characteristics and family environment can significantly increase the risk for development of substance abuse, and

5) Substance abuse and psychopathology can originate from common genetic and biomedical vulnerabilities

The new directions and models that are emerging now encourage a more comprehensive view. It encompasses the inclusion of physical health integration and the natural and recovery supports that have traditionally been outside of the provider focus. Recent data reveals that the incidence of serious morbidity (illness) and mortality (death) in the population with serious mental illnesses has increased. People with serious mental illnesses are now dying 25 years earlier than the general population. These increases are largely due to treatable medical conditions such as infectious, pulmonary and cardiovascular diseases and diabetes caused by risk factors such as smoking, obesity, substance abuse, psychotropic medications

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side effects, and inadequate access to medical care (NASMHPD Medical Directors Council, NRI, Inc. and CHMHS/SAMHSA, Measurement of Health Status for People with Serious Mental Illnesses (2008). A summit for wellness convened by SAMHSA includes a vision of integration of health and wellness with mental health and substance abuse recovery. Under the leadership of the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), the substance use disorders treatment field is shifting from an acute care model of treatment to a chronic care approach, known as recovery-oriented systems of care. Creating recovery-oriented systems of care requires a transformation of the entire service system as it shifts to becoming responsive to meet the needs of individuals and families seeking services. To be effective, recovery-oriented systems must infuse the language, culture, and spirit of recovery throughout their systems of care.

Recovery Oriented systems support person centered and self-directed approaches to care that build on the strengths and resilience of individuals, families and communities to take responsibility for their sustained health, wellness and recovery from alcohol and drug problems. ROSCs offer a more comprehensive menu of services and support that can be combined and readily adjusted to meet the individual's needs and chosen pathways to recovery. (SAMHSA, Recovery White Paper, 2008).

11. Adolescents with SUD...

- Are largely undiagnosed
- Are distributed across diverse health & social service systems
- Have been adjudicated delinquent;
- Have histories of child abuse, neglect and sexual abuse;
- Have high co-morbidity with psychiatric conditions;

SLIDE 11 NOTES:

This training is focused on increasing awareness of the multitude of issues facing adolescents with co-occurring disorders. The large percentage is undiagnosed as a result of human service providers' uneven knowledge base, skill set and attitudes toward both illnesses. They are found in juvenile justice and many other child service systems that often do not share information or coordinate service planning with each other.

Their behavior problems are defined in ways that siphon them into the juvenile justice system. Adolescents with co-occurring substance abuse and psychiatric disorders are over-represented in the juvenile justice system similar to the adult forensic system. This has had dire consequences. For example, delinquent youth die at rates four times greater than the general population.

Researchers from Northwestern University's Feinberg School of Medicine and the Cook County Office of the Medical Examiner in Chicago tracked 1,829 young people who had spent time in the juvenile justice system.

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- Sixty-five young people out of 1,829 died during the follow-up period (which averaged seven years), all from external causes, for an overall mortality rate of 806 per 100,000 person-years. That compares to a standardized general population mortality rate among this age group of 184 per 100,000 person-years.

- More than 95 percent of the youths died as a result of homicide or legal intervention.

- More than 90 percent of the deaths were from gunshot wounds, either homicidal, accidental, or self-inflicted.

- African-American young men had the highest mortality rate (887 deaths per 100,000 person years).

- The death rate among delinquent youths in this study was four times greater than the standardized death rate of the general population of youth.

- The death rate among young delinquent women in this study was eight times greater than that of the general youth population.

Retrieved from the Robert Wood Johnson Website

Additionally, some studies have indicated that these adolescents have experienced various forms of abuse, neglect and/or trauma. Females with co-occurring disorders may engage in high-risk sexual behavior, have more complicated health conditions, and have histories of exposure to physical and sexual violence. In fact, there is growing evidence that women with co-occurring disorders are more likely to have experienced childhood physical and sexual abuse than severely mentally ill women without substance use problems.

Burnette, M. & Drake, R. (1997). Gender Differences in Patients with Schizophrenia and Substance Abuse. *Comprehensive Psychiatry*, 38 (2). Alexander, M. (1996). Women with Co-occurring Addictive and Mental Disorders: An Emerging Profile of Vulnerability. *American Journal of Orthopsychiatry*, 66 (1).

12. Facts About Co-occurring Disorders

- 43% of adolescents receiving mental health services had been diagnosed with a co-occurring SUD.
  - CMHS (2001) national health services study
- Among 12-17 year olds who had a major depressive episode in the past year, 38% had used illicit drugs.
  - National Survey on Drug Use and Health, 2005
- 62% of adolescent males and 82% of adolescent females entering SUD treatment had a significant co-occurring emotional/psychiatric disorder.
  - SAMHSA/ CSAT 1997-2002 study
- 75-80% of adolescents receiving inpatient substance abuse treatment have a co-existing mental disorder
  - National Mental Health Association, 2005

SLIDE 12 NOTES:

Studies show about half of all adolescents receiving mental health services have a co-occurring substance use disorder, and as many as 75-80% of adolescents receiving inpatient substance abuse treatment have a coexisting mental disorder. Adolescents with emotional and behavioral problems are nearly four times more likely to be dependent on alcohol or illicit substances than are other adolescents, and the severity of problems increases the likelihood of drug use and dependence. Among adolescents with co-occurring disorders, conduct disorder and depression are the two most frequently reported disorders that co-occur with substance abuse.

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13. Co-occurring Disorders and Juvenile Justice

- Nearly two-thirds of incarcerated youth with substance use disorders have at least one other mental health disorder.
- As many as 50% of substance abusing juvenile offenders have ADHD.
- Among incarcerated youth with substance use disorders, nearly one third have a mood or anxiety disorder.
- Those exposed to high levels of traumatic violence might experience symptoms of posttraumatic stress as well as increased rates of substance abuse.

SLIDE 13 NOTES:

Co-occurring substance abuse and mental health disorders are a significant problem for youth in the nation's juvenile justice system. While much is known about this problem, there is still a need for research about prevention and treatment and for effective policy and program development.

Substance-abusing delinquents are at especially high risk for co-occurring mental health disorders. Specifically, among youth in the justice system:

- Nearly two-thirds of incarcerated youth with substance use disorders have at least one other mental health disorder.
- A number of studies have shown an association between conduct disorder, attention deficit hyperactivity disorder (ADHD), and substance abuse. For example, as many as 50% of substance abusing juvenile offenders have ADHD.
- Youth who have co-occurring conduct problems, ADHD, and substance use disorders have higher than normal rates of anxiety and depressive disorders, and the presence of ADHD in particular worsens the prognosis of both the substance use disorder and the conduct disorder, increasing the likelihood of these persisting into adulthood.
- Among the juvenile justice population, mood disorders such as depression appear to co-occur with substance abuse problems more frequently than among youth generally.
- Among incarcerated youth with substance use disorders, nearly one third have a mood or anxiety disorder.
- Delinquents with substance abuse and behavioral disorders such as conduct disorder and ADHD engage in higher rates of crime and exhibit more alcohol and illicit drug use than do youth with mood disorders and are at higher risk for out-of-home placement and other poor outcomes.
- Many incarcerated youth are exposed to high levels of traumatic violence which may result in symptoms of posttraumatic stress as well as increased rates of substance abuse.

www.nmha.org/children/justjuv/co_occuring_factsheet.cfm

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-1 — 29

14. Traumatic Victimization

- 40-90% have been victimized
- 20-25% report in past 90 days, concerns about reoccurrence
- Associated with higher rates of
  - substance use
  - HIV-risk behaviors
  - Co-occurring disorders

SLIDE 14 NOTES:

Studies of adolescent substance users presenting for treatment have generally estimated that 40 to 90 percent have been victimized. The rates of these estimates increase when more detailed assessments are used. Second, 20 to 25 percent of these adolescents report being victimized in the past 90 days, or report concerns about it occurring again in the near future. Third the severity of victimization interacts with the level of care to predict outcomes and should be considered in initial placement decisions. Fourth contrary to staff concerns, rapport and retention can be improved by early systematic screening achieved via multidimensional interviewing.

A lifetime history of victimization is associated with higher rates of substance use and HIV-risk behaviors at intake; high levels of traumatic victimization… are further associated with more symptoms related to substance use disorders and co-occurring mental health problems.

SOURCE: Traumatic Victimization among adolescents in substance abuse treatment, Michael L. Dennis, PhD, *Counselor Magazine*, April 2004

TRAINER NOTE: The following additional information is provided for trainer reference and is not expected to be reviewed within the training at this point.

15. Implications for Practice

- Systematically screen
- Train staff how to respond
- Incorporate information into placement decisions
- Addressing victimization is complex
- Person may be victim and abuser
- Track victimization in diagnosis and for program planning
- Address staff concerns

SLIDE 15 NOTES:

Include simple but explicit questions at intake and/or more detailed screeners to gauge severity. See www.chestnut.org/li/gain (Reference Module 4: Assessment)

Train staff in mandated reporting, timing and facilitation of assessment, diagnosis and treatment placement as well as intervention implications.

Incorporate information to understand the breadth of the trauma, and current risk of ongoing victimization. A history of high levels of trauma may suggest the need for additional mental health screening or treatment.

Addressing the issues is complex and may necessitate environmental changes. Family member reactions, including the adolescent, may range from shock, disbelief, anger, hurt and shame. Use of individual work can be very helpful prior to group work.

It is also important to document the extent of the problem to guide future program planning and gain additional assistance.

SOURCE: Traumatic Victimization among adolescents in substance abuse treatment, Michael L. Dennis, PhD, *Counselor Magazine*, April 2004

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16. Sources of Adolescent Referrals

SOURCE:

Dennis, Dawud-Nourski, Muck & McDermeit, 2002 and 1995 Treatment Episode Data Set (TEDS)

17. Level of Care at Admission
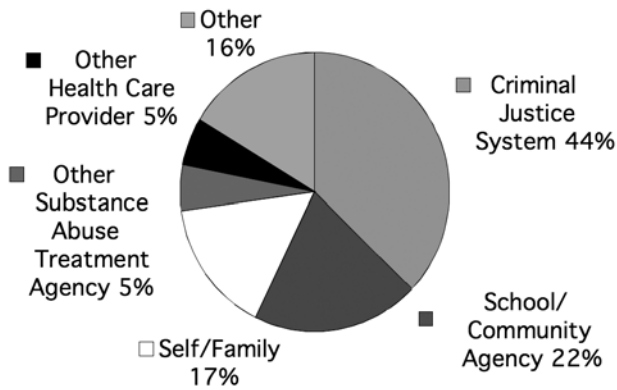
SOURCE:

Dennis, Dawud-Nourski, Muck & McDermeit, 2002 and 1995 Treatment Episode Data Set (TEDS)

SLIDE 16 NOTES:

SLIDE 17 NOTES:

NOTE: More specific adolescent statistics are presented a few slides down.

National surveys suggest COD are common in the adult population. An estimated 9% of adolescents aged 12 to 17 (approximately 2.2 million adolescents) had experienced at least one major depressive episode during the past year as reported in SAMHSA's 2004 National Survey on Drug Use and Health. Am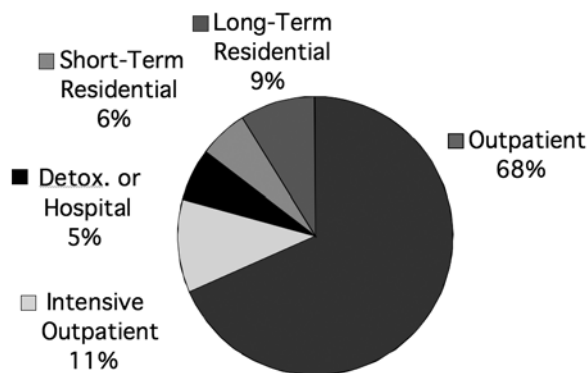ong adolescents aged 12 to 17 who experienced at least one major depressive episode during the past year, 40.3% reported having received treatment for depression during the past year. Adolescents who had experienced a major depressive episode in the past year were more than twice as likely to have used illicit drugs in the past month than their peers who had not experienced a major depressive episode in the past year (21.2% vs. 9.6%) (Office Of Applied Studies, 2005).

The NSDUH defined SMI as having at some time during the past year a diagnosable mental, behavioral, or emotional disorder that met the criteria specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (American Psychiatric Association 1994) and resulted in functional impairment that substantially interfered with or limited one or more major life activities. The NSDUH classification scheme was not diagnosis specific, but function specific.

18. Multiple Co-occurring Problems Are the Norm and Increase with Level of Care

Co-occurring Problems by Level of Care

Bar chart legend: ■ Outpatient ▫ Long Term Residential ■ Short Term Residential

Category	Outpatient	Long Term Residential	Short Term Residential
Conduct Disorder	56	68	80
ADHD	44	47	65
Major Depressive Disorder	21	35	52
Generalized Anxiety Disorder	25	43	52
Traumatic Stress Disorder	21	36	44
Any Co-Occuring Disorder	70	78	88
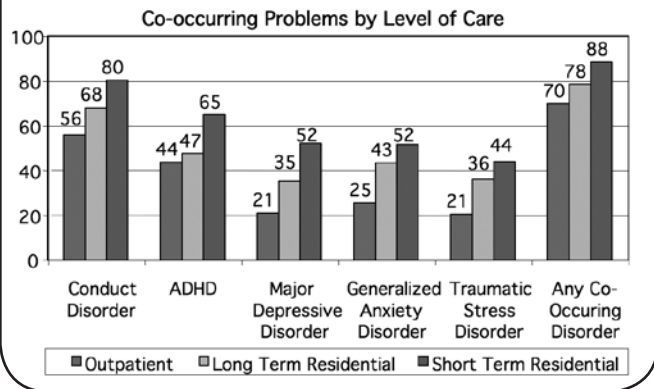
SOURCE:

CSAT & Cannabis Youth Treatment (CYT), Adolescent Treatment Model(ATM), and Persistent Effects of Treatment Study of Adolescents (PETS-A) Studies

SLIDE 18 NOTES:

SOURCE: CSAT's Cannabis Youth Treatment (CYT), Adolescent Treatment Model (ATM), and Persistent Effects of Treatment Study of Adolescents (PETS-A) studies as reported on www.chestnut.org website under a SAMHSA grant.

EXERCISE: Show the Hazelden movie (25 minutes) entitled Adolescents and Co-occurring Disorders. Conduct a brief discussion and end this module.

PURPOSE: Show a film to help participants put a face to the statistics presented as well as generate overall impressions working with this population.

The target audience for the movie are adolescents, however, the information provided is relevant to the participants and can sensitize them further to some issues the adolescents face.

Sacks, S., De Leon, G., Bernhardt, A.I., and Sacks, J.Y. A modified therapeutic community for homeless mentally ill chemical abusers. In: De Leon, G., ed. *Community as Method: Therapeutic Communities for Special Populations and Special Settings.* Westport, CT: Praeger Publishers/Greenwood Publishing Group, 1997 a. pp. 19 37.

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MODULE 2: FRAMEWORK FOR INTEGRATED TREATMENT

Goal:

Compare traditional treatment models for co-occurring disorders with the more current integrated treatment model.

Learning Objectives:

Discuss the disadvantages of sequential and parallel models.

List the six guiding principles for integrated treatment.

Describe the critical components in the delivery of services.

List the 4 levels of program capacity

Discuss the components for fully integrated treatment.

Content Outline:

Traditional Approaches
- sequential
- parallel

Integrated Treatment
- definition
- guiding principles
- delivery of services
- program development
- vision of fully integrated
- quadrants
- sequencing treatment

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-2   — 33

MODULE 2 HANDOUTS: BEST PRACTICES ACHIEVING INTEGRATED TREATMENT WORKSHEET

	NOT ABLE TO OFFER	OFFER SOMEWHAT	OFFER CONSISTENTLY	NOTES
The client participates in one program that provides services for both disorders.				
The client's mental and substance use disorders are treated by the same clinicians.				
The clinicians are trained in psychopathology, assessment and treatment strategies for both mental health and substance use disorders.				
The clinicians offer substance abuse treatment tailored for clients who have mental disorders.				
The focus is on preventing anxiety rather than breaking through denial.				
Emphasis is placed on trust, understanding and learning.				
Treatment is characterized by a slow pace and a long term perspective.				
Providers offer stagewise and motivational counseling.				
Supportive clinicians are readily available.				
12-step groups are available to those who choose to participate and can benefit from participation.				
Neuroleptics and other pharmacotherapies are indicated according to clients' psychiatric and other medical needs.				

BASIC

Capacity to provide treatment for one disorder, but also screens for the other disorder and can access necessary consultations.

INTERMEDIATE

Focus primarily on one disorder without substantial modification to its usual service delivery, but also explicitly addresses some specific needs of the other disorder.

Advanced

Address COD using an integrated perspective and provide services for both disorders. Collaboration with other agencies may add to the comprehensiveness of services.

FULLY INTEGRATED

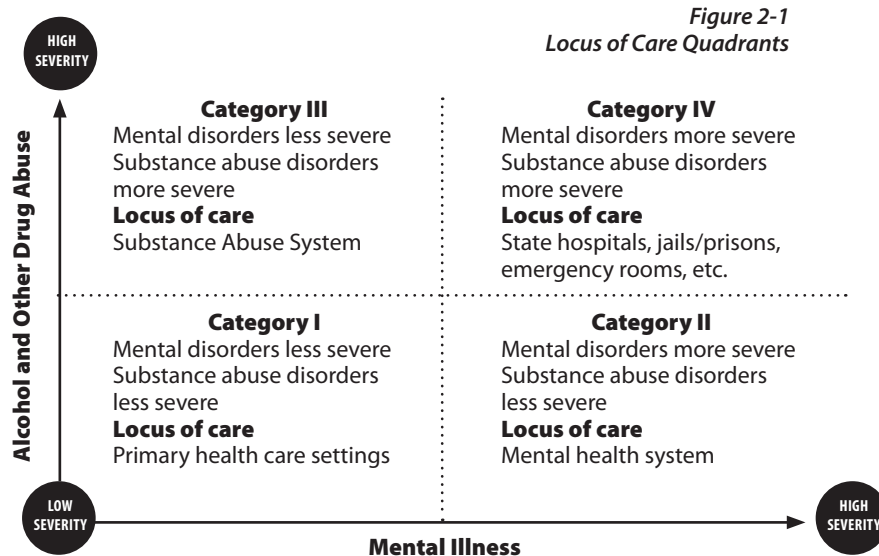Actively combines substance abuse and mental health interventions to treat disorders related problems and the whole person more effectively.

Please make a check mark along the continuum which best represents your agency's current provision of services:

❏ Basic   ❏ Intermediate   ❏ Advanced   ❏ Integrated

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MODULE 2 HANDOUTS: LOCUS OF CARE QUADRANTS

The National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors' (NASADAD) four-quadrant category framework described below provides a useful structure for fostering consultation, collaboration, and integration among systems and providers to deliver appropriate care to every client with COD (according to the NASMHPD-NASADAD (1999) framework.

Figure 2-1
Locus of Care Quadrants

HIGH SEVERITY

Alcohol and Other Drug Abuse

Category III
Mental disorders less severe
Substance abuse disorders more severe
Locus of care
Substance Abuse System

Category IV
Mental disorders more severe
Substance abuse disorders more severe
Locus of care
State hospitals, jails/prisons, emergency rooms, etc.

Category I
Mental disorders less severe
Substance abuse disorders less severe
Locus of care
Primary health care settings

Category II
Mental disorders more severe
Substance abuse disorders less severe
Locus of care
Mental health system

LOW SEVERITY   **HIGH SEVERITY**

Mental Illness

QUADRANT I: This quadrant includes individuals with low severity substance abuse and low severity mental disorders. These low severity individuals can be accommodated in intermediate outpatient settings of either mental health or chemical dependency programs, with consultation or collaboration between settings as needed. Alternatively, some individuals will be identified and managed in primary care settings with consultation from mental health and/or substance abuse treatment providers.

QUADRANT II: This quadrant includes individuals with high severity mental disorders who are usually identified as priority clients within the mental health system and who also have low severity substance use disorders (e.g., substance dependence in remission or partial remission). These individuals ordinarily receive continuing care in the mental health system and are likely to be well served in a variety of intermediate level mental health programs using integrated case management.

QUADRANT III: This quadrant includes individuals who have severe substance use disorders and low or moderate severity mental disorders. They are generally well accommodated in intermediate level sub-

stance abuse treatment programs. In some cases there is a need for coordination and collaboration with affiliated mental health programs to provide ongoing treatment of the mental disorders.

QUADRANT IV: Quadrant IV is divided into two subgroups. One subgroup includes individuals with serious and persistent mental illness (SPMI) who also have severe and unstable substance use disorders. The other subgroup includes individuals with severe and unstable substance use disorders and severe and unstable behavioral health problems (e.g., violence, suicidality) who do not (yet) meet criteria for SPMI. These individuals require intensive, comprehensive, and integrated services for both their substance use and mental disorders and require fully integrated, enhanced services. The locus of treatment can be specialized residential treatment programs, community ACT or CTT Teams, psychiatric hospitals, or even in settings that provide acute care such as emergency rooms. People with high needs that cannot access integrated treatment designed to meet those needs can end up in hospitals, emergency rooms or jails/prisons.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS
MODULE-2 — 35

19. Module 2

Framework for Integrated Treatment.

20. Goal

Compare traditional treatment models for co-occurring disorders with the more current integrated treatment model.

Review slide with the participants.

21. Objectives

- Discuss the disadvantages of sequential and parallel models.
- List the six guiding principles for integrated treatment.
- Describe the critical components in the delivery of services.
- List the 4 levels of program capacity.
- Discuss the components for fully integrated treatment.

Review slide with the participants.

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22. Traditional Approaches

- Sequential
  - One disorder then the other
- Parallel
  - Treated simultaneously by different professionals

SLIDE 22 NOTES:

There has been a historical division between mental health and substance abuse treatment services. Consequently, two different treatment systems oversee and provide separate services for each type of disorder. Education, training and credentialing procedures differ between the two systems, as do admission requirements for people seeking services. As a result of the bureaucratic separation between mental health and substance abuse treatment services, two general approaches have predominated: sequential and parallel treatment.

Sequential treatment posits that one disorder must be clinically resolved prior to the treatment of the other. This ignores the interactive and cyclical nature of COD. Disadvantages include:

- Clinical priority is typically assigned based on the agency to which the client was admitted.
- Clients are rarely referred to the other treatment, or when they are they fail to follow through.
- Hesitancy about making referrals may be due to a clinician's belief that the "primary disorder" has not yet been sufficiently controlled, or lack of awareness of the other disorder's severity.
- Clients often do not follow through on treatment referrals for their other disorder because of lack of motivation, lack of awareness of the problem, or difficulties establishing new relationships with treatment providers. (Mueser, 2003)

In the parallel approach, mental health and substance abuse disorders are treated simultaneously by different professionals (often working for different agencies, but sometimes within the same agency). In theory, providers of separate services should attempt to coordinate care by making regular contacts and reaching consensus on the essential elements of the treatment plan. However, there are many obstacles that interfere with comprehensive coordination.

- Differing treatment philosophies and treatment approaches e.g. drug free vs. pharmacotherapy;
- Definition of "enabling behaviors";
- Funding barriers that prevent access for one or the other disorder.

The resulting consequence is that the burden of integration is placed on the client, often with the majority of them falling through the cracks of mental health and substance abuse systems.

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There has been growing evidence showing a poor prognosis for clients treated with traditional sequential and parallel approaches (Drake, Mueser et.al 1996, Havassy, Shopshire & Quigley, 2000 in Mueser, 2003) and suggesting higher rates of costly service utilization (Bartels et. Al, 1993, Dickey & Azeni, 1996 in Mueser, 2003).

EXERCISE: 45 minutes "Words on a Wall"

Small to large group discussion

Prepare newsprint in advance

Prepare several newsprint pages so that the participants will be able to walk around and write in their ideas. Each newsprint page should have one word at the top. These words should be reflective of terms/jargon that often have different meaning between the substance abuse and mental health fields. For example, denial, resistance, enabling, ego, confrontation, case management.

Divide the participants into groups of 3-5 people. If possible, each group should include representatives from mental health, substance abuse, juvenile justice, etc. Inform the groups that they will have an opportunity to work at every sheet for approximately 5 minutes. Provide one person in each group with a magic marker. To begin assign each group to one sheet. After 5 minutes intervals direct the small groups to move to the next sheet. It is helpful to have the groups move in a clockwise direction to insure that each group has an opportunity to address each word.

After all of the sheets have been completed, ask the participants to return to their seats and conduct a brief large group discussion. Questions to facilitate discussion may be:

• What agreement is there about the words and could we reach consensus on a definition?

• What did you learn as your group defined commonly used terms?

• How do our differing definitions affect prescribing treatment and treatment interventions?

• What other treatment oriented words do you think create misunderstanding?

Use the exercise to transition to a more comprehensive review of integrated treatment.

23. Integrated Treatment: Definition

- Treatment interventions are combined within the context of a primary treatment relationship or service setting.
  - Actively combining interventions intended to address substance abuse and mental disorders in order to treat both, related problems, and the whole person more effectively.

24. Six Guiding Principles
(SAMHSA, TIP 42))

- Employ a recovery perspective
- Adopt a multi-problem viewpoint
- Develop a phased approach to treatment
- Address specific real-life problems early in treatment
- Plan for cognitive and functional impairments
- Use support systems to maintain and extend treatment effectiveness

SLIDE 23 NOTES:

Current research and clinical practice support an integrated treatment approach and service delivery system that meets people where they are accounting for their individual needs in their recovery process and encourages full community integration. Integrated treatment occurs along a continuum. Programs and treatment range from addressing only mental health or substance use disorder, to addressing the mental health or substance in the context of how it interrelates with the program's historical focus of either mental health or substance use disorders, to actively address both the mental health and substance use disorders. Integrated treatment programs that are recovery oriented can overcome many of the disadvantages of traditional sequential and parallel approaches.

SLIDE 24 NOTES:

The recovery perspective generates at least two main principles for practice:

a) Developing a treatment plan that provides for continuity of care over time. In preparing this plan, the clinician should recognize that treatment may occur in different settings over time (i.e., residential, outpatient) and that much of the recovery process typically occurs outside of or following treatment (e.g., through participation in mutual self-help groups and through family and community support, including the faith community). It is important to reinforce long-term participation in these continuous care settings.

b) Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the co-occurring disorder recovery process. Whether within the substance abuse treatment or mental health services system, the clinician is advised to use sensible, stage-wise approaches in developing and using treatment protocols. In addition, markers that are unique to individuals such as those related to their cultural, social, or spiritual context should be considered. It is important to engage the client in defining markers of progress meaningful to the individual and to each stage of recovery.

ADOPT A MULTI-PROBLEM VIEWPOINT:

People with COD generally have an array of mental health, medical, substance abuse, family, and social problems. Therefore, services should be comprehensive to meet the multidimensional problems typically presented by clients with COD.

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MODULE-2 — 39

DEVELOP A PHASED APPROACH:

Many clinicians view clients as progressing though phases (Drake and Mueser 1996a ; McHugo et al. 1995; Osher and Kofoed 1989; Sacks et al. 1998b). Generally, three to five phases are identified, including engagement, stabilization, treatment, and aftercare or continuing care. These phases are consistent with, and parallel to, stages identified in the recovery perspective. As noted above, use of these phases enables the clinician (whether within the substance abuse treatment or mental health services system) to develop and use effective, stage-appropriate treatment protocols.

ADDRESS SPECIFIC REAL-LIFE PROBLEMS EARLY IN TREATMENT:

The growing recognition that co-occurring disorders arise in a context of personal and social problems have given rise to approaches that address specific life problems early in treatment. These approaches may incorporate case management and intensive case management to help clients handle legal and family matters.

PLAN FOR THE CLIENT'S COGNITIVE AND FUNCTIONAL IMPAIRMENTS:

Services for clients with COD must be tailored to individual needs and functioning. Clients with COD often display cognitive and other functional impairments that affect their ability to comprehend information or complete tasks (CSAT 1998e ; Sacks et al. 1997b). The manner in which interventions are presented must be compatible with client needs and functioning. Such impairments frequently call for relatively short, highly structured treatment sessions that are focused on practical life problems. Gradual pacing, visual aids, and repetition often are helpful. Even impairments that are comparatively subtle (e.g., certain learning disabilities) may still have significant impact on treatment success. Careful assessment of such impairments and a treatment plan consistent with the assessment are therefore essential.

USE SUPPORT SYSTEMS TO MAINTAIN AND EXTEND TREATMENT EFFECTIVENESS:

The mutual self-help movement, the family, the faith community, and other resources that exist within the client's community can play an invaluable role in recovery. In some cultures, the stigma surrounding substance use or mental disorders is so great that the client and even the entire family may be ostracized by the immediate community. Furthermore, the behaviors associated with active substance use may have alienated the client's family and community. The clinician plays a role in ensuring that the client is aware of available support systems and motivated to use them effectively.

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SLIDE 25 NOTES:

Current research and clinical practice supports an integrated treatment process and service delivery system beginning from the point of engagement, to the point of disengagement.

PROVIDING ACCESS:

"Access" refers to the process by which a person with COD makes initial contact with the service system, receives an initial evaluation, and is welcomed into services that are appropriate for his or her needs.

ACCESS OCCURS IN FOUR MAIN WAYS:

1. Routine access for individuals seeking services who are not in crisis.

2. Crisis access for individuals requiring immediate services due to an emergency.

3. Outreach, in which agencies target individuals in great need (e.g., people who are homeless) who are not seeking services or cannot access ordinary routine or crisis services.

4. Access that is involuntary, coerced, or mandated by the criminal justice system, employers, or the child welfare system.

Treatment access may be complicated by clients' criminal justice involvement, homelessness, or health status.

CSAT's "no wrong door" policy should be applied to the full range of clients with COD, and programs should address obstacles that bar entry to treatment for either the mental or substance use disorders.

COMPLETING A FULL ASSESSMENT:

While Module 4 provides a more complete description of the assessment process, this section highlights several important features of assessment that must be considered in the context of effective service delivery. Assessment of individuals with COD involves a combination of the following:

- Screening to detect the possible presence of COD in the setting where the client is first seen for treatment

- Evaluation of background factors (family, trauma history, marital status, health, education and work history), mental disorders, substance abuse, and related medical and psychosocial problems (e.g., living circumstances, employment, family) that are critical to address in treatment planning

- Diagnosis of the type and severity of substance use and mental disorders

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- Initial matching of individual client to services (often, this must be done before a full assessment is completed and diagnoses clarified; also, the client's motivation to change with regard to one or more of the co-occurring disorders may not be well established)

- Appraisal of existing social and community support systems

- Continuous evaluation (that is, re-evaluation over time as needs and symptoms change and as more information becomes available)

The challenge of assessment for individuals with COD in any system involves maximizing the likelihood of the identification of COD, immediately facilitating accurate treatment planning, and revising treatment over time as the client's needs change.

PROVIDING AN APPROPRIATE LEVEL OF CARE:

Clients enter the treatment system at various levels of need and encounter agencies with varying capacity to meet those needs. Ideally, clients should be placed in the level of care appropriate to the severity of both their substance use disorder and their mental illness.

The American Society of Addiction Medicine's (ASAM) Patient Placement Criteria classification is one standard way of identifying programs that offer the needed services. ASAM describes programs' ability to address COD as "addiction only services," "dual diagnosis capable," and "dual diagnosis enhanced."

ASAM also clearly identifies levels of modalities Early intervention, Outpatient, Intensive Outpatient/Partial Hospitalization, Residential/Intensive Inpatient Treatment, Medically Managed Intensive Inpatient Treatment. (See handout in reference section.)

ASAM's Adolescent Matrix seeks to reduce relapse and recidivism by basing placement on a thorough consistent, biopsychosocial assessment. The Matrix adopts a more holistic, multidimensional approach that matches the adolescent's needs to specific treatment services, rather than to broader levels of care.

The American Academy of Child and Adolescent Psychiatry and American Association of Community Psychiatrists developed an alternate placement criteria. The protocol is in the reference section of the manual and entitled "The Child and Adolescent Level of Care Utilization System". The CALOCUS instrument is a method of quantifying the clinical severity and service needs of three different populations of children and adolescents. It may be used in children with psychiatric disorders, substance use disorders, or developmental disorders, and has the ability to integrate these as overlapping clinical issues. CALOCUS employs multi-disciplinary/multi-informant perspec-

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

42 — MODULE-2

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tives on children and adolescents and is designed to be used by a variety of mental health professionals. Although it is primarily used for initial level of care placement decisions, it can be used at all stages of treatment to assess the level of intensity of services needed. There are a number of things that CALOCUS will not do. It will not prescribe program design, but rather the type and intensity of resources that need to be available in that program. It does not specify treatment intervention, and it does not invalidate the importance of clinical judgment.

ACHIEVING INTEGRATED TREATMENT:

The literature from both the substance abuse and mental health fields has evolved to describe integrated treatment as a unified treatment approach to meet the substance abuse, mental health, and related needs of a client. It is the preferred model of treatment.

Integrated treatment can occur on different levels and through different mechanisms. For example:

- One clinician delivers a variety of needed services.
- Two or more clinicians work together to provide needed services.
- A clinician may consult with other specialties and then integrate that consultation into the care provided.
- A clinician may coordinate a variety of efforts in an individualized treatment plan that integrates the needed services. For example, if someone with housing needs was not accepted at certain facilities, the clinician might work with a State-level community-housing program to find the transitional or supported housing the client needs.
- One program or program model (e.g., modified TC) can provide integrated care.
- Multiple agencies can join together to create a program that will serve a specific population. For example, a substance abuse treatment program, a mental health center, a local housing authority, a foundation, a county government funding agency, and a neighborhood association could join together to establish a treatment center to serve women with COD and their children.
- Integrated treatment also is based on positive working relationships between service providers.

For the purposes of this training, integration is seen as a continuum. Depending on the needs of the client and the constraints and resources of particular systems, appropriate degrees and means of integration will differ. (For additional information, please refer to Strategies for Developing Treatment Programs for People with Co-occurring Substance Abuse and Mental Disorders, samhsa publication)

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MODULE-2   — **43**
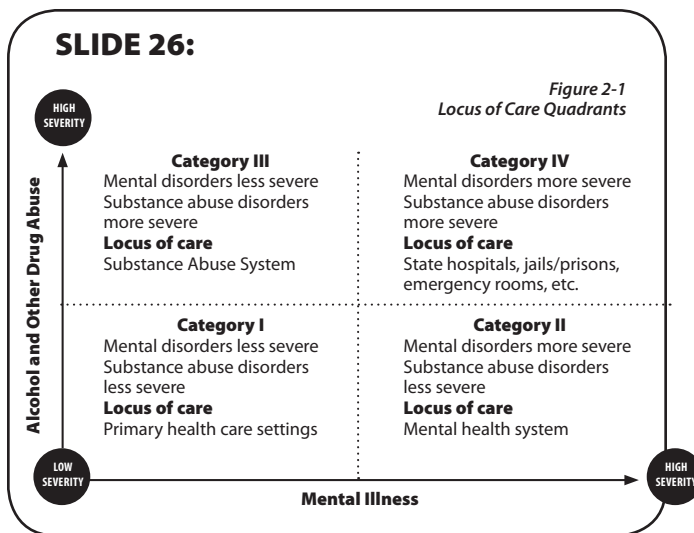
PROVIDING COMPREHENSIVE SERVICES:

Adolescents with COD have a range of medical, social and other multidimensional problems that require comprehensive services. In addition to treatment for their substance use and mental disorders, these clients often require a variety of other services to address other social problems. Treatment providers should be prepared to help clients access a broad array of services, including life skills development, English as a second language, nutrition, and for educational/vocational assistance.

Ensuring Continuity of Care:

Continuity of care implies coordination of care as clients move across different service systems. Since both substance use and mental disorders frequently are long-term conditions, treatment for persons with COD should take into consideration recovery over a significant period of time. Therefore, to be effective, treatment must address the three features that characterize continuity of care:

• Consistency between primary treatment and ancillary services

• Seamlessness as clients move across levels of care (e.g., from residential to outpatient treatment)

• Coordination of present and past treatment episodes

It is important to set up systems that prevent gaps between service system levels and between clinic-based services and those outside the clinic.

SLIDE 26:

Figure 2-1
Locus of Care Quadrants

HIGH SEVERITY

Alcohol and Other Drug Abuse

Category III
Mental disorders less severe
Substance abuse disorders more severe
Locus of care
Substance Abuse System

Category IV
Mental disorders more severe
Substance abuse disorders more severe
Locus of care
State hospitals, jails/prisons, emergency rooms, etc.

Category I
Mental disorders less severe
Substance abuse disorders less severe
Locus of care
Primary health care settings

Category II
Mental disorders more severe
Substance abuse disorders less severe
Locus of care
Mental health system

LOW SEVERITY

HIGH SEVERITY

Mental Illness

(See page 3, handout)

SLIDE 26 NOTES:

QUADRANTS

The National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors' (NASADAD) four-quadrant category framework described below provides a useful structure for fostering consultation, collaboration, and integration among systems and providers to deliver appropriate care to every client with COD (according to the NASMHPD-NASADAD (1999) framework.

CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

44 — **MODULE-2**

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SLIDE 26 NOTES (CONTINUED):

QUADRANT I: This quadrant includes individuals with low severity substance abuse and low severity mental disorders. These individuals with low symptom severity can be accommodated in intermediate outpatient settings of either mental health or chemical dependency programs, with consultation or collaboration between settings if needed. Alternatively, some individuals will be identified and managed in primary care settings with consultation from mental health and/or substance abuse treatment providers.

QUADRANT II: This quadrant includes individuals with high severity mental disorders who are usually identified as priority clients within the mental health system and who also have low severity substance use disorders (e.g., substance dependence in remission or partial remission). These individuals ordinarily receive continuing care in the mental health system and are likely to be well served in a variety of intermediate level mental health programs using integrated case management.

QUADRANT III: This quadrant includes individuals who have severe substance use disorders and low or moderate severity mental disorders. They are generally well accommodated in intermediate level substance abuse treatment programs. In some cases there is a need for coordination and collaboration with affiliated mental health programs to provide ongoing treatment of the mental disorders.

QUADRANT IV: Quadrant IV is divided into two subgroups. One subgroup includes individuals with serious and persistent mental illness (SPMI) who also have severe and unstable substance use disorders. The other subgroup includes individuals with severe and unstable substance use disorders and severe and unstable behavioral health problems (e.g., violence, suicidality) who do not (yet) meet criteria for SPMI. These individuals require intensive, comprehensive, and integrated services for both their substance use and mental disorders. The locus of treatment can be in the community, if enhanced services for both mental health and substance use disorders are provided in an integrated manner, that eliminates or reduces administrative and financial barriers to treatment. In the absence of these services, people are forced into the criminal justice system.

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27. Achieving Integrated Treatment

- Beginning:
  - Addiction only

- Intermediate:
  - COD capable

- Advanced:
  - COD enhanced

- Fully Integrated

SLIDE 27 NOTES:

- A basic program has the capacity to provide treatment for one disorder, but also screens for the other disorder and can access necessary consultations.

- A program with an intermediate level of capacity tends to focus primarily on one disorder, but also explicitly addresses some specific needs of the other disorder. For example, a substance abuse treatment program may recognize the importance of continued use of psychiatric medications in recovery, or a psychiatrist could provide motivational interviewing regarding substance use while prescribing medication for mental disorders.

- A program with an advanced level of capacity provides integrated substance abuse treatment and mental health services for clients with COD. Essentially, these programs address COD using an integrated perspective and provide services for both disorders. This usually means strengthening substance abuse treatment in the mental health setting by adding interventions such as mutual self-help and relapse prevention groups. It also means adding mental health services, such as psychoeducational classes on mental disorder symptoms and groups for medication monitoring, in substance abuse treatment settings. Collaboration with other agencies may add to the comprehensiveness of services.

- A program that is fully integrated actively combines substance abuse and mental health interventions to treat disorders, related problems, and the whole person more effectively.

  Not all agencies or programs need to be advanced. All programs, however, should strive to be co-occurring capable and to be able provide integrated treatment within the program's mission, design, licensure, and resources. A key foundation for successful treatment is the principle of "welcoming."

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28. Integrated Clinical Practice

- Shared decision making
- A focus on the person's natural environment
- Establishing a strong therapeutic relationship to engage and retain clients
- Recognition that treatment involves a long-term process
- A broad perspective in which life habits are modified

SLIDE 28 NOTES:

In order to achieve clinically integrated care, clinical practices need to include the following:

- Shared decision making in selection and delivery of treatment
- A focus on the person's natural environment, shifting away from rigidly-delivered clinically-based care
- Establishing a strong therapeutic relationship to engage and retain clients
- Recognition that treatment involves a long-term process
- A broad perspective in which life habits are modified

(Mueser, K., Noordsy, D., Drake, R., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice.* New York, NY: Guilford Press.)

29. Intermediate: COD Capable

Each program designs its policies, procedures, screening, assessment, program content, treatment planning, discharge planning, interagency relationships, and staff competencies to routinely provide integrated co-occurring disorder services to the individuals and families with co-occurring disorders who are routinely presenting for care in their program, within the context of the program's mission, design, licensure, and resources.

(Minkoff and Cline)

SLIDE 29 NOTES:

Becoming co-occurring capable requires a program to design its policies, procedures, screening, assessment, program content, treatment planning, discharge planning, interagency relationships, and staff competencies so it can routinely provide integrated co-occurring disorder services to individuals and families who present for care whether it is a mental health or a substance abuse agency.

Examples of Integrated Co-occurring Services would include the following:

- Welcoming individuals and families with complex co-occurring conditions
- Routine screening for both psychiatric and substance use disorders
- Identifying hopeful recovery goals, and delineating how each issue relates to that goal
- Outline integrated assessment of both conditions that determines appropriately matched interventions for each issue, and outlines the way the two conditions interact with and affect one another
- Identification of periods of strength and success with either or both conditions as a foundation for treatment and recovery planning
- Integrated treatment planning or recovery planning that includes appropriately matched interventions for both conditions
- Crisis intervention protocols that take both disorders into account
- Education on co-occurring conditions in both individual and group formats

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- Stage matched or motivational interventions for either or both conditions
- Stage matched educational or motivational interventions for substance using parents or caregivers of children receiving care for emotional disturbance.
- Assistance with skill building to manage the symptoms of one disorder in the context of receiving treatment for the other
- Assistance with developing peer or professional support systems related to either or both conditions
- Family psychoeducational and support interventions
- Interagency coordination and collaboration (including collaborative treatment planning) if referrals for additional care are necessary
- Discharge or transition planning that establishes integrated continuity of care plans for both conditions

(Minkoff and Cline)

SLIDE 30 NOTES:

30. Fully Integrated Treatment

Adapted from Drake et al. 1998

- One program that provides treatment for both disorders.
- Mental and substance use disorders are treated by the same clinicians.
- The clinicians are trained in psychopathology, assessment, and treatment strategies for both disorders.

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31. Fully Integrated Treatment (continued)

- Supportive clinicians are readily available.
- 12-Step groups are available to those who choose to participate and can benefit from participation.
- Neuroleptics and other pharmacotherapies are indicated according to clients' psychiatric and other medical needs.

SLIDE 31 NOTES:

Review slide with participants. Please note that additional information will be presented throughout the training on these areas.

EXERCISE: 20 minutes / Individual to small group

HANDOUT: Achieving Integrated Treatment

PURPOSE: To enable participants to reflect on their agency's current practices and compare to recommended practices.

Refer the participants to the worksheet.
Ask them to take a few minutes to review and identify where they would assess their treatment program at this point. After they are finished, encourage them to discuss their findings with the others at the table.

Please refer to the handout that follows entitled *Flow Chart of Integrated Treatment.* This handout attempts to visually depict the relationships between treatment philosophy, selection of interventions and systems collaboration. It should be noted that there is a growing need to increase counselor competency.

32. Principles of Recovery

Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life.

(CSAT, 2007).

SLIDE 32 NOTES:

Principles of Recovery

CSAT organized Partners for Recovery Initiative which convened a group of diverse stakeholders - including systems professionals, treatment providers, researchers and evaluators, recovery support services providers, mutual aid groups, and recovery advocates for a National Summit on Recovery. Their deliberations resulted in the definitions. "Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life" (CSAT, 2007). Guiding principles for recovery were articulated which include the following:

- There are many pathways to recovery.
- Recovery is self-directed and empowering.
- Recovery involves a personal recognition of the need for change and transformation.
- Recovery is holistic, involving the body, mind, relationships, and spirit.
- Recovery has cultural dimensions.
- Recovery exists on a continuum of improved health and wellness.
- Recovery emerges from hope and gratitude.
- Recovery is a process of healing and self-redefinition.

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- Recovery involves addressing discrimination and transcending shame and stigma.p

- Recovery is supported by peers and allies.

- Recovery is (re)joining and (re)building a life in the community.

- Recovery is a reality.

Stakeholders were clear that recovery is a personal journey and the path to recovery is uniquely individualized. There are no wrong paths to recovery. Recovery may be achieved through any number of ways, including natural recovery, mutual support groups, peer recovery services, clinical treatment, faith-based approaches, or a combination of these and other methods. The critical variable is that the individual chooses the manner of his or her recovery and the services most appropriate to managing his or her recovery. These recovery principles also apply to co-occurring disorders. (CSAT 2007 reference is Center for Substance Abuse Treatment. (2007). National Summit on recovery: conference report. DHHS Publication No. SMA 07-4276. Rockville, MD: Substance Abuse and Mental Health Services Administration.

MODULE 3: ADOLESCENT DEVELOPMENT

Goal:

    To provide clinical information on the complex developmental period.

Learning Objectives:

    Demonstrate increased empathic understanding of adolescents

    Describe "Normal" and "Maladaptive" adolescent development

    Discuss developmental theories regarding separation/individuation and moral development

    List major stages and tasks of adolescence

    List key aspects of biopsychosocial issues and changes

Content Outline:

    Normal Development

- changes
- tasks
- behaviors/attitudes
- challenges

    Mental health and substance abuse affect maturation

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-3 — 51

MODULE 3: FIFTH EXERCISE

Sharing Childhood Experience - Shaping Values/Belief.

• Using the flip chart paper provided, draw a picture of a learning experience you had as a child in which you developed a belief or value that you still hold as true and use in your adult life.

• Put only your first name on the paper.

• You will be introducing yourself to the rest of the group based on your picture.

• You have 7 minutes to draw. Begin.

Ask participants to draw a picture of an experience they had as a child in which they developed a belief or value that they continue to use as an adult. Ask the participants to write their first name only on their picture and tell them they will be introducing themselves based on their picture.

Allow 5 to 7 minutes for each person to draw his or her picture. As the trainer you should also be drawing a picture, modeling the instructions you just gave.

When everyone is done, ask the participants to find a place on the wall in the training room to hang their picture and then to stand by their picture.

Go around the room and ask each person to introduce themselves in 3 to 5 minutes based on their picture. When everyone is done, ask him or her to take their seats and debrief the exercise by asking questions like:

Why would we ask you to do an exercise like this?

You're trying to get an answer that reflects the importance of experiences early in life in shaping personal attitudes and beliefs.

Why do you think you were asked to draw a picture instead of just writing or talking about your experience?

You're trying to get an answer that reflects different learning styles, i.e., auditory (talk about it), visual (see it) and kinesthetic (interact with it). Drawing is connected to kinesthetic learning.

Important Points:

How you think effects how you act.

Your childhood learning experiences influence your personal attitudes, values and beliefs.

Learning can be fun

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MODULE 1: HANDOUT 1-B

LGBTQ Terminology

• **LGBTQ:** This is an acronym that stands for Lesbian, Gay, Bisexual, Transgender and Questioning/Queer.

• **SEX** in this context refers to anatomy, for our purposes specifically genital and reproductive anatomy. If you have a penis, scrotum, testicles, and a prostate, your sex is generally referred to as male. If you have a vagina, labia, clitoris, uterus, and ovaries, your sex is generally referred to as female.

• **INTERSEX** children are born with chromosomal and/or reproductive differences. They have elements of both male and female reproduction systems.

• **GENDER** refers to the concept of femaleness or femininity and maleness or masculinity; gender role refers to behaviors and desires to act in certain ways that are viewed as masculine or feminine by a particular culture or society and within a given time period. For example, in white, middle-class America in 1940, a woman who wore trousers was considered to be behaving out of her gender role. Today it is normal for women to wear trousers. So gender role behaviors that are associated with masculinity or femininity can change depending on the times, the culture, and who is in power.

• **SEXUAL ORIENTATION**—lesbian, gay, bisexual, heterosexual—describes one's attraction to, sexual desire for, lust for, or romantic attachments to others. We use the word orientation as more inclusive and appropriate than preference because the use of the word preference indicates a choice that can imply moral decisionmaking. Although some LGBTQ people may say their sexual orientation was a choice, many feel it is not a choice-that it is as inborn as some other characteristics we have, like eye or hair color. For civil rights purposes, it is easier and clearer to seek equal protection under the law for inborn characteristics than for something that is perceived to be a choice, that is, a moral decision. Therefore, many in the LGBTQ community have advocated the concept of orientation over preference.

• **GENDER IDENTITY** is one's inner sense of oneself, a person's self-concept, in terms of gender. Most of us think in terms of only two genders, male and female, but we are beginning to understand that gender is complex and not just polarized. Today some individuals identify as bigender. Gender identity is not always derived from genital anatomy.

• **TRANSGENDER** is term that describes people whose gender identity or gender expression differs from expectations associated with the sex assigned to them at birth. This term may include pre-operative transsexuals, post-operative transsexuals,

non-operative transsexuals, cross-dressers, androgynous people, gender benders, drag kings and drag queens.

• **QUESTIONING**: Some youth identify as questioning when they are unsure of where their primary attractions lie.

• **QUEER** is a term that is coming more and more into use by the LGBTQ communities to describe everyone who identifies anywhere along the spectrum of identities of lesbian, gay, bisexual, transgender, questioning, and, even more recently, intersex. Although at one time, it was a pejorative, in the 1980s LGBTQ rights activists reclaimed the word as an empowerment word. It can even include heterosexually identified allies who are advocates for LGBTQ human rights. Transgender activists have used the term gender queer to describe gender identities that do not fit into the more traditional polarity of male to female.

—Prairielands ATTC, LGBTQ Training Curriculum

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS
MODULE-3 — 53

MODULE 3 HANDOUTS: ADOLESCENT DEVELOPMENT — REMEMBERING ADOLESCENCE

My best friend was _____

_____

We liked to talk about _____

_____

We worried about _____

_____

The best things for me/my friends were _____

_____

I/we coped with the stress by _____

_____

Drugs and alcohol were viewed as _____

_____

My parents represented_____

_____

Other adults were generally seen as _____

_____

The hardest part of being a teenager is _____

_____

The best part of being a teenager is _____

_____

I knew who and how to ask for help _____

_____

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33. MODULE 3:

ADOLESCENT DEVELOPMENT

This section is designed to introduce participants to the unique developmental period of life described as "ADOLESCENCE". It is the intent of the module to approach the subject matter from two primary perspectives. First, from the perspective of the major life areas of influence, change, growth and development, and tasks and the like, on the way to a successful transition to young adulthood. Secondly, from the perspective of the adolescent experience. By gaining an empathic sense of the adolescent struggle for autonomy, the counselor/therapist is more prepared to engage the adolescent in a working alliance. This will provide clarity to the often-blurred boundaries of reasonably-expected presentations and that which stands outside of them. It will also require an expanded set of integrated services, strategies, settings and interventions.

34. Goal

To provide critical information regarding this complex developmental period in order to gain essential understanding of the myriad influences and issues that define the adolescent population.

SLIDE 34 NOTES:

_____

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_____

_____

_____

_____

_____

_____

35. Objectives

• Describe "Normal" and "Maladaptive" adolescent development
• Discuss developmental theories regarding separation/individuation and moral development
• List major stages and tasks of adolescence
• List key aspects of biopsychosocial issues and changes
• Demonstrate increased empathic understanding of adolescents

SLIDE 35 NOTES:

EXERCISE: "Reconnecting with Adolescence"

HANDOUT: Remembering Adolescence / approx. 60m

GOAL: To provide an opportunity for participants to develop empathy for adolescents by reconnecting with memories of their own teenage years.

Instruct the small group tables to turn this exercise in the manual. Using the handout ask them to discuss each of the questions. Note that the exercise is not designed to have them self-disclose beyond their comfort zone. It is presented to provide an opportunity to surface general thoughts, feelings and behaviors of adolescence in order to connect to the upcoming content as well as develop empathy.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-3 — **55**

36. GET OUT OF MY LIFE!!!… But first could you…

You call this NORMAL!

37. Adolescence: A "Normal" Developmental Perspective

- Puberty and Physiological Change (Tanner)
- Separation / Individuation (Mahler, Blos)
- Identity Formation and Autonomy (Erickson)
- Cognitive Development - "Formal Operational Thinking" (Piaget)
- Shift from Parental / Family authority to Peer Group authority
- Moral Development (Kohlberg, Kagan, Bandura, Gilligan)
- Transition and Transformation - The road to Adulthood

SLIDE 36 NOTES:

This slide is meant as a transition slide to illustrate that adolescents emotions and needs are conflicting.

SLIDE 37 NOTES:

Effective work with adolescents in general and especially adolescents who may be diagnosable with substance use disorder(s) and co-occurring psychiatric and/or other associated disorder(s) demands a solid understanding of the range of "normal" adolescent development. Without a baseline conceptualization and framework of what occurs within the normal range of functioning for this developmental period, it is all too easy to assign pathology to what might be normal in the developmental sphere. This is especially true when screening, assessing and interpreting information and behavior for differential diagnosis. It is important to note that the conceptualization of what is "normal" must be considered in the contextual frame of the prevailing ethnic and cultural nuances and, socioeconomic stressors as well.

Historically, substance abuse assessment and treatment models have been primarily based on experience from the adult perspective, with little or no attention given to the profound differences between adolescence and adulthood and the impact these differences have on the entire scope of therapeutic involvement. These differences take on further importance from a gender specific perspective as well.

Overview of Adolescent Development

The following section is designed to set a context for understanding the major and profoundly influential domains and vicissitudes of adolescent development. These domains provide a foundation for understanding this developmental period which has been characterized as a period of "storm and stress"(Hall, 1904). From a more contemporary perspective, theoretical consensus defines the period of adolescence as

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"the second separation and individuation"(Blos,) and "identity formation" phase, (Erickson, 1963; Rogers, 1969). While this consensus is well over 40 years old, it endures to the present.

While the boundaries that define this period of life have become more blurred both in terms of its beginning and end, for practical consideration the artificial boundaries are defined as ages 13 to 18 years old.

TRAINERS NOTE: The age boundaries often elicit a number of controversies, usually focused at the older end of the spectrum with reference to "aging out" process and needs of the 18 to 24-year-old clinical population. Caution should be given to any extended discussion in this area as it stands outside the purpose for this module. It is acknowledged as an important issue but more specific to the treatment population relative to service delivery and funding streams rather than this section referencing normal adolescent development.

Since there is such dramatic change in the adolescent from the age of 13 to 18, it is useful to consider the changes along "age" and "stage" guidelines. Grossly speaking, it is helpful to view adolescence across a continuum of "Early", "Middle" and "Late" stage developmental processes, roughly corresponding to the age spans of 13 through 14; 15 through 16 and 17 through 18 years of age respectively. The guidelines are useful with regard to the understanding of "normal" adolescent development and in later training discussions regarding client/patient mix with respect to treatment and placement considerations.

38. Physical Adolescent Developmental Changes (Early, Middle & Late)

- Hormonal & Growth Changes
- Acne
- Menstruation
- Breast development
- Shape Changes
- Spontaneous Erection
- Nocturnal Emissions
- Voice Changes (cracking)
- Body Odor
- Rapid growth
- Disproportionate Growth
- Emergence of sexual feelings and drives
- Brain maturation

SLIDE 38 NOTES:

The goal of this slide is to provide an awareness of and attention to the significant influences exerted by the generic and gender specific changes associated with the onset of puberty across the adolescent's life domains.

As noted above, the arbitrary designation of age as the determinant criteria for the start and end points of adolescence is a pragmatic, programmatic and funding stream determination and not a Biopsychosocial determinate. Most of the focus in the above discussion gave reference to the arbitrary endpoint of adolescence at age 18; the legal age of majority. In the current socio-cultural time frame however, the end of adolescence is at best amorphous. On the front end however, the start of adolescence is consistent with and defined by the onset of puberty. That said, the onset is idiosyncratic to the adolescent with females generally maturing sooner than males. Roughly speaking, the onset of puberty begins between the ages of

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-3 — 57

eight and 14 years for girls and between nine and 14 years for boys. Translating this range to approximate grade levels, it is equivalent on the low end to as early as late second grade for girls and third-grade for boys. On the high-end it is roughly equivocal to grades 8 and 9. It is also important to be aware of the observed phenomenon trending the onset of puberty to yet earlier ages,(Rogol and Blizzard, 1994; Herman-Giddens, Slora, Wasserman, 1997). Additionally there are pronounced differences along racial lines with African-American females demonstrating pubertal development as much as two years earlier and Caucasian females as much as one year earlier than the above noted average range. Evaluation of the onset of the pubertal changes is measured by the Tanner 5 Stage Rating Scale (Tanner, 1962; Marshall and Tanner, 1969 and Marshall and Tanner, 1970). The phenomenon does not appear to be as pronounced in adolescent males, indicating the need for further study across gender, ethnicity, race and culture.

TRAINERS NOTE: The causes of this apparent change in the onset of puberty are yet to be well-defined. There are many theories ranging from environmental factors, hormone and fertilization use in animal and produce cultivation and the changes in the American diet leading to obesity. Rather than engage in causative discussions it may be more productive and useful to refer participants to the literature describing the phenomenon and hypothesis testing generally to be found endocrinological and pediatric research.

Given the dramatic changes brought on by the onset of puberty especially with regard to the obvious observable physical changes, consideration must be given to the process of adaptation for each adolescent. This is especially true in the early stage of adolescence as this period carries with it an extraordinary degree of self-consciousness regarding appearance, comparison with other peers, body image and the onset of sexual feelings and drives. The person that they see looking back at them in the mirror is a far cry from their appearance just months earlier. This may include rapid height growth, disproportionate growth of facial features, disproportionate growth of other body parts, the appearance of acne and for boys facial hair, etc. This is often the time that adolescent females are disproportionately taller than their male counterparts making for what appears to be a comical pairing from outside observation while not so comical from the adolescents internal experience. By the time many of these changes begin to occur, boys and girls have been indoctrinated with strong impressions of what the "right" and/or "ideal" appearance is supposed to look like, and to which they are obsessively and unmercifully comparing themselves and each other.

SLIDE 38 NOTES (CONTINUED):

Unfortunately, while the body goes through a rapid metamorphosis regarding form and function, the adolescent's emotional, psychological and cognitive maturation seriously lags behind with boys on the slower end of the maturational process. As will be noted later, this is further complicated by significant attitudinal changes, cognitive ability and socio-cultural influences and affiliations. It is not difficult to imagine the significant contribution this physical metamorphosis exerts on the age old adolescent questions, "Who am I?" and "Where do I fit?"

39: Terminology and Descriptions

- Sex
- Gender/Gender Role
- Sexual Orientation
- Gender Identity
- Lesbian
- Gay
- Bisexual
- Transgender
- Questioning
- Queer
- Intersex

Source: Prairierlands ATTC: A Provider's Introduction to Substance Abuse for Lesbian, Gay, Bisexual and Transgender Individuals. (2007).

SLIDE 39 NOTES:

The goal of this slide is to establish a common understanding of terms and definitions regarding sexual orientation before moving to discussion about sexual identity development. Please refer to and distribute the handout and review.

HANDOUT: LGBTQ Terminology and Descriptions Points that can be highlighted include:

- The need for a common language or a consensus of meaning on definitions and language to understand and more accurately describe who is discussed in this training series. It is still common for many people who are not familiar with LGBTQ identities, cultures, and lifestyles to be confused about the differences and similarities among these groups. Misunderstandings about language and terms of identity also may be the basis for inappropriate assessment or bias.

  Because of the need for lesbian visibility and a desire to not always be subsumed under a male designation, many women prefer the term lesbian to gay women.

- Male and female are not polarized identities; they are more fluid.

- Identities are to some extent socially constructed; what is considered feminine or masculine changes as indicated in our definition of sex role and is on a spectrum.

- Transsexual usually refers to a person whose anatomy is in conflict in some way with his or her gender identity, and some people, but not all, choose to close this gap through living in their self-identified gender or by having corrective surgeries.

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MODULE-3 — 59

- Transgender also relates to this category because it is now the umbrella term for a variety of gender expressions including drag, cross-dressing, trans-sexuality, and bigender experience. It is not a sexual orientation.

- Sexual orientation is best described as a function of gender identity; if a person gender identifies as female and is sexually oriented to females, she will probably describe herself as lesbian. If a person gender identifies as a man and is sexually oriented to men, he might best describe himself as gay.

- Transgender people who transition from male to female can vary their gender roles. Some are more "femme" and some more "butch", just as non-transgender men and women vary, and because some are sexually attracted to women regardless of their anatomy, they self-identify as lesbian. This is a complicated definition, so if trainees get confused, trainers should emphasize the differences between sexual orientation and gender identity and refer trainees to resources for more information and training.

40: Special Issues for LGBTQ Youth

LGBTQ Youth of Color:
- Integrating their sexual, racial, and ethnic identities
- Interacting with three separate communities- ethno-cultural, LGBTQ, and mainstream
- Managing more than one stigmatized identity.

All LGBTQ Youth:
- Higher risk for depression and suicide
- Higher risk for substance abuse
- Homelessness is a particular concern for LGBTQ youth with reports from various studies showing ranges from 20 percent to 40 percent
- Homeless youth are at high risk for exploitation; e.g. survival sex
- LGBTQ homeless and runaway youth have many health and social problems.

SLIDE 40 NOTES:

LGBTQ youth have increased risks for substance use, that is related to antigay violence, harassment, and stigma.

Prairielands ATTC, A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals: Training Curriculum, First Edition, (Based on the publication: (DHHS Publication No. (SMA) 01-3498), for SLIDES AND SLIDE NOTES 39-40

Source: Prairierlands ATTC: A Provider's Introduction to Substance Abuse for Lesbian, Gay, Bisexual and Transgender Individuals. (2007).

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41. Welcoming LGBTQ Youth

- Be open to listening
- Maintain confidentiality of youth's sexual orientation or gender
- Skill in handling disclosure
- Display culturally diverse posters, books, symbols, etc
- Follow the youth's lead
- Encourage expression of feeling - Explore beliefs
- Know the resources

42: Adolescent Brain Development

A period of profound brain maturation.

The changes of adolescent development occur in the context of significant brain development. Understanding the science of brain development is essential to understanding how to intervene appropriately with adolescents.

43: A New Understanding

- We *thought* brain development was complete by adolescence
- We now know... maturation is not complete until about *age 24!!!*

Source: Southern Coast ATTC: Co-Occurring Substance Use and Mental Health Disorders in Adolescents: Building a Foundation for Quality Care. (2009).

Jay Giedd and others at the National Institute of Mental Health in the United States have discovered that the brain is not fully formed at puberty as earlier thought. Actually, the brain continues important tasks of maturing that are not complete until about age 24.

This is interesting to consider as we think about the minimum age requirements we set on various privileges such as driving, drinking and voting. For example, while youth can drive in most states at age 16, in many states an individual is not eligible to rent a car until they are 25 years old. The car rental industry knows when a young person's "risk-taking" years are behind them when it comes to d riving an automobile.

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44: Emerging Science

1990s provided an information explosion due to brain imaging techniques (e.g. CT, PET and MRI) that produce windows to observe brain development and the effects of substances on the brain.

In effect, the teen brain remains "under construction" longer than we had previously thought.

Source: Southern Coast ATTC: Co-Occurring Substance Use and Mental Health Disorders in Adolescents: Building a Foundation for Quality Care. (2009).

SLIDE 44 NOTES:

Our understanding of the brain has been aided by advanced technologies to better understand the process of brain construction during adolescence as well as to understand the effect of chemicals such as alcohol and other drugs and mental illnesses on the developing brain. The next few slides help us to understand what happens in the adolescent brain.

45: Construction Ahead

During late childhood, neurons increase their number of connections

But some of these connections are pruned off starting at age 11½ for girls and age 12 for boys

Source: Southern Coast ATTC: Co-Occurring Substance Use and Mental Health Disorders in Adolescents: Building a Foundation for Quality Care. (2009).

SLIDE 45 NOTES:

During late childhood, the brain's cells (neurons) and their connections (dendrites) increase in the number of connections. By the end of childhood, the brain has 1,000,000,000,000,000 (one quadrillion) connections!

But around age 11 in girls and 12½ in boys, some of these connections are pruned off as the brain becomes increasingly focused on specific functions.
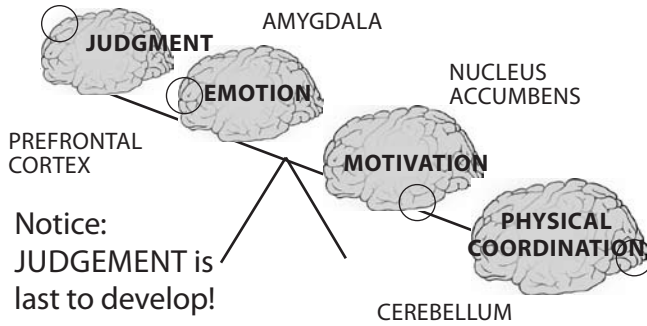
46: Pruning Takes Brain Capacity

When the pruning is complete, the brain is faster and more efficient.

But... during the pruning process, the brain is not functioning at full capacity.

Source: Southern Coast ATTC: Co-Occurring Substance Use and Mental Health Disorders in Adolescents: Building a Foundation for Quality Care. (2009).

SLIDE 46 NOTES:

When the pruning is complete, the brain is faster and more efficient. During this pruning and specialization period, an individual has a "second chance" to develop particular skills and to catch up on developmental delays. But, during the pruning process, the brain is not functioning at full capacity and some functions are performed more successfully than others.

The pruning process occurs in stages across the various brain structures.

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47: Pruning starts at the back of the brain... and moves to the front

JUDGMENT

AMYGDALA

EMOTION

PREFRONTAL
CORTEX

NUCLEUS
ACCUMBENS

MOTIVATION

Notice:
JUDGEMENT is
last to develop!

PHYSICAL
COORDINATION

CEREBELLUM

Source: Southern Coast ATTC: Co-Occurring Substance Use and Mental Health Disorders in Adolescents: Building a Foundation for Quality Care. (2009).

SLIDE 47 NOTES:

The pruning of brain structures generally occurs from the back of the brain to the front. Structures at the back of brain finish the pruning first, making these structures the first to mature. Structures at the front of the brain finish pruning last, and it is these structures that do not complete maturation until about age 24.

There are four primary brain structures from the back to the front of the brain: the cerebellum, nucleus accumbens, amygdala and prefrontal cortex. The rate of development of each of these structures may impact adolescent behavior.

The first area to be finished with pruning is the cerebellum. Located at the back of the brain, this structure controls physical or motor coordination.

Next are the nucleus accumbens, which is responsible for motivation, and the amygdala, which identifies and controls emotion. The nucleus accumbens is responsible for how much effort the person will make in order to seek rewards.
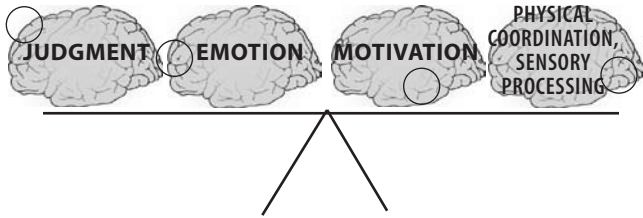
As still-developing nucleus accumbens is believed to contribute to the tendency for teenagers to prefer activities that require low effort yet produce high excitement. Real-world observations bear this out: adolescents tend to favor activities such as playing video games, skate-boarding and, unfortunately, substance use.

The amygdala is responsible for integrating how to emotionally react to both pleasurable and unpleasant experiences. Theory suggests that when the amygdala is developing, we see two behavioral effects:

- Tendency for adolescents to react to situations with "hot" emotions rather than more controlled and "cool" emotions, and

- The likelihood that youth can misread neutral or inquisitive facial expressions from other individuals as a sign of anger.

One of the last areas to mature is the structure named the prefrontal cortex, located just behind the forehead. Sometimes referred to as "the seat of sober second thought," it's the area of the brain responsible for the complex processing of information, ranging from making judgements, to controlling impulses, foreseeing the consequences of ones' actions, and setting goals and plans. An immature prefrontal cortex is thought to be the neurobiological explanation for why teenagers show poor judgement and too often act before they think.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-3 — 63

48: Age 24

JUDGMENT **EMOTION** **MOTIVATION** **PHYSICAL COORDINATION, SENSORY PROCESSING**

Ahhhh... Balance, Finally!

Source: Southern Coast ATTC: Co-Occurring Substance Use and Mental Health Disorders in Adolescents: Building a Foundation for Quality Care. (2009).

49: New Insights

- Why teenagers take risks and show poor judgment
- How teenagers may be highly vulnerable to drug abuse.

Source: Southern Coast ATTC: Co-Occurring Substance Use and Mental Health Disorders in Adolescents: Building a Foundation for Quality Care. (2009).

SLIDE 48 NOTES:

By age 24, the normally developing brain has finished the pruning process and all segments of the brain have reached maturity. This allows for the individual to utilize all sections of the brain to perform the tasks for which they re designed.

When something happens to "short circuit" or arrest the pruning process and the continuing development of the brain, development of specific functions can be compromised. One factor that can cause such a compromise is the introduction of alcohol and other drugs into the brain.

SLIDE 49 NOTES:

Many new scientific discoveries are altering our perspective on how to understand adolescent behavior. Our understanding that the human brain is still maturing during the adolescent years, with changes continuing into the early 20's. This helps us understand why adolescents are prone to take risks and why teenagers are at elevated risk to the effects of drugs.

Healthy risk-taking is a positive tool in an adolescent's life for discovering, developing, and consolidating his or her identity. It is important to remember that learning how to assess risks is a process that we work on throughout our lives. Risk-taking can be accelerated in one area—social, physical, intellectual, artistic, or sexual, for example—and not in others.

Southern Coast ATTC, Co-Occurring Substance Use and Mental Disorders in Adolescents: Building A Foundation for Quality Care, Curriculum for NOTES and SLIDE NOTES 41-48

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50. Cognitive (Thinking) Changes

- Shift from "Concrete to Formal Operational" thinking capacity with the emergence of abstract and conceptual processes
- Omnipotence & Omniscience (Terminal Uniqueness)
- Meta-Cognition (the ability to think about ones thinking)
- Egocentricity (Early-Middles)

SLIDE 50 NOTES:

The brain maturation underlies cognitive thinking changes that occur during adolescences. The brain makes a fundamental shift in its thinking ability from the more concrete and finite capacity of the child, i.e., "Concrete Operations" to the early stages of "Formal Operational" thinking. This dramatic change now allows thinking in the abstract, the hypothetical and associational. It also allows for propositional logic (hypothesis formulation); inductive and deductive reasoning; the ability to "think about thinking" (Meta-Cognition); "operate on operations" and consider abstract concepts such as space and time. Thinking is more flexible, rational and systematic. It provides the adolescent with the necessary mental tools to meet the challenges of daily living, (Piaget, 1965; Piaget, 1963). At the same time, the ease of a simple "no" is now met with a myriad of challenges, such as "if-then" and "what if" scenarios and a keen vigilance for hypocrisy.

The adolescent experiences an infused sense of power with these seemingly magical abilities to think, imagine, challenge and problem solve. Overridden by their egocentric perspective and now powerful drive to "separate and individuate", (Mahler, 1979; Blos, 1979) they are unable to imagine that they are not the only one who has been so divinely endowed. They become masters of illusion and misdirection as their prowess increases with age and practice. They take on an attitude and presentation of "Omnipotence" and "Omniscience" - "The all powerful and all knowing OZ".

51. Social Changes

- Family authority versus Peer Authority
- Onset of parent / child conflict (Ex. Backtalk)
- Challenges to parental knowledge and rules
- Comparisons to "Everyone else's Parents"
- Increased Demands for the "right" fashion trend(s)
- Apparent disregard for once held family values/priorities in favor of peer values and priorities

SLIDE 51 NOTES:

Adolescents effectively elevate themselves to a superior position relative to their primary caretaker(s) relegating them to the status of "yesterday's news"; "out of date and un-hip belief and value systems"; "out of touch with the 'real' world and the way it is". Upon this developmental foundation, a once recognizable child (from a parent's perspective) becomes a creature of the unknown and unpredictable. Changes are characterized by: moodiness and emotionality; severity of direct challenge and/or active isolationism; active and/or passive disregard of directives/requests; narcissistic egocentrism; embarrassment of and by parents coupled with active disassociation and rejection. These behaviors present an atmosphere of conflict, tension, frustration and secrecy, leaving both

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SLIDE 51 NOTES (CONTINUED):

the parent(s)/guardian(s) and, despite appearances, the adolescent feeling out of control and impotent. It is from this existential position that much of the obstinate, oppositional, argumentative and apparent rejection of family mores emanates.

The manner by which a given adolescent may manifest and display many of these attitudes and behaviors will be mediated by a variety of traditional factors but perhaps none more important than gender. It is well beyond the scope of this entry level module to present and discuss the complex differences and forces behind gender-specific manifestations.

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52. Characteristic Behaviors and Attitudes

- Role Experimentation
- Practicing
- Questioning & Challenging
- Peer bonding
- Here & Now focus
- Sense of Invulnerability

SLIDE 52 NOTES:

Much of what is observed in the behavior of adolescents can be conceptualized as consistent with a variety of task oriented accomplishments on the transitional road from childhood to adulthood. As noted above, adolescence has been characterized as a process of separation and individuation, thereby moving from a primary position of dependence toward a position of independence and autonomy. This also allows for healthy and satisfying interpersonal relationships and functional interdependence while the same time sustaining one's autonomous identity, functioning and positive self-regard. Successful (good enough) negotiation of this developmental period and allows for a reasonable expectation and competency to take on normative adult roles and functions. These include work and/or career development, stable and satisfying interpersonal and love relationships, potential for establishing a new family and the ability to become part of their own communities with contribution.

The process of accomplishing these lofty ideals and goals requires exploration, experience, analysis, decision-making, problem solving, successes and mistakes, personal interpersonal, community and authoritative feedback and the like. It requires the engaging in and experimentation with a myriad of different roles, settings, emotional/affect states that may include style, dress, music, image, attitude, risk-taking, values exploration and challenge, to name a few. Where the rubber meets the road this process generally comes in direct conflict with the world of authority that has defined their status to this point. It is where the adolescent's newfound knowledge and power, intemperate by experience and wisdom clashes with the old guard of authority, which is seasoned with experience and wisdom. Adolescents can view this authority as trying to control, withhold and prevent them from gaining equality with adults in getting what is "rightfully their entitlement". In general, the more intense the battle

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is for separation-individuation, independence and autonomy, the closer and more powerfully bonded the adolescent is at the onset of their adolescence.

It is often difficult, especially while in the middle of the process, for both the primary caretaker(s) and the individual adolescent to understand and appreciate its normalcy as it is so often experienced as painful. From an outside observation it can be equally difficult to witness and/or hear about the struggle and to think about it as part of the normal process. Instead of seeing it as a process that requires a variety of skill sets on both sides to navigate and manage effectively, we can sometimes characterize the behavior, attitudes and manifestations as pathological.

The multiple tasks to be accomplished in the midst of powerful and unpredictable hormonal influences and growth change, intertwined and interacting with an ill-prepared social and environmental system, is a daunting task for even the most developmentally-prepared and prior task-successful adolescent. What often gets lost in the midst of the turmoil is an appreciation that, while testing every limit and challenge to every position held by the adolescent's primary authority, the adolescent deeply desires a well-defined set of limits that are immoveable despite nuclear assault. With such internal shifting, the adolescent's own ability to contain his/her boundaries, impulsivity, and here and now perspective is significantly compromised. It is as if they are saying "Please keep me safe while I go out deeper into the world, because despite my best protests, my compass doesn't always work very well. Oh! And by the way, no matter how much I appreciate and trust your support, rescuing and limit, I can't tell you that. So as hard it might be, please don't leave me alone even when I tell you to get out of my life. Just don't let anyone see you!"

Under the best of circumstances with a good set of basic competencies, adolescence is difficult at best. It is significantly more difficult when the adolescent must deal with any number of competency compromises such as developmental disruptions or delays; learning and/or attentional disorders/differences, physical disabilities and/or psychological/psychiatric disorders.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-3 **— 67**

53. Challenges to "Normal" Adolescent Development

- Genetic Vulnerabilities / Predispositions / Risk Factors - Family History of:
  - Substance Use Disorders
  - Psychiatric / Psychological Disorders
  - Learning and/or Attentional Disorders
  - Other Cognitive/Developmental Disorders

54. Challenges - continued

- Environmental Vulnerabilities / Risk Factors
  - Parent / Family / Caretaker Dysfunction
    - Inconsistency / Instability
    - Lack of Clear Values, Expectations and Boundaries
    - Absence / Uninvolved
    - Over Involvement / Over Indulgent
    - Frequent Relocation

55. Challenges - continued

- Environmental Vulnerabilities / Risk Factors
  - Trauma
    - Abuse / Neglect / Sexual Abuse /Incest
    - Sexual Assault / Date Rape
    - Loss
  - Medical Illness
  - Active Addiction / Psychiatric Disturbance
  - Poverty / Wealth
  - Single Parent Homes

Vulnerabilities and risk factors need to be understood as contributions and not determinates. They need to be balanced against supports, resiliencies and competencies and considered as providing critical information to conducting informed evaluation / assessments of individual needs and the integrated services, professionals, supports and systems to competently address them.

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56. Mental Health and Substance Abuse Affect Maturation

- Low frustration tolerance
- Lying to avoid punishment
- Hostile dependency
- Limit testing
- Persists into later adolescence

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57. Maturation - continued

- Alexithymia
  - Unable to verbalize/soothe self
- Present tense only
  - Past-future tense diminished
- Rejection sensitivity
  - Dualistic
  - Categorical
  - Right-wrong

SLIDE 57 NOTES:

The effects of substance abuse on normal adolescent development have been discussed for years. The general rule is that developmental arrest or delay occurs around the chronological age when the substance abuse begins. During treatment, adults are often taught, "If you started drinking at 14, then you are still 14 years old emotionally."

There are few studies that clearly demonstrate a cause and effect relationship between adolescent substance abuse and retardation of emotional and moral development. However, adult data do exist. Valliant (1983), in a longitudinal study of adults, was able to demonstrate that adults used more immature psychological defenses when actively abusing substances and more mature and higher-developmental level defenses when sober. Relapse was accompanied by the reappearance of the immature patterns of behavior and the disappearance of the mature defenses. (Estroff, 2001)

Alexithymia is a personality construct that is conceptually similar and exhibits some overlap with the emotional intelligence construct. The salient features of the construct are 1) difficulty identifying feelings and distinguishing between feelings and bodily sensations of emotional arousal, 2) difficulty describing feelings to other people, 3) constricted imaginal processes as evidenced by a paucity of fantasy, and 4) stimulus bound, externally oriented cognitive style.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-3 — **69**

58. Summary of Adolescent Development

- Profound period of developmental transformation
- Defined by fundamental biopsychosocial state changes
- Successful navigation requires accomplishment of specific developmental tasks
- Unique combination of biopsychosocial competencies, resiliencies, vulnerabilities and challenges

SLIDE 58 NOTES:

The effects of substance use and mental disorders can negatively affect the developmental transformations that occur during adolescents. They can influence identify formation, the consolidations of values, exploration of adult roles and vocational/career choices and the development of skills in recognizing and regulating affect.

59. Summary - continued

- Potential for success is influenced by many factors
- Family, education, values, moral development, spirituality
- Adolescents with COD face difficult challenges

SLIDE 59 NOTES:

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MODULE 4: SUBSTANCE ABUSE

Goal:

Provide an overview of salient factors involved in diagnosing adolescent substance use disorders.

Learning Objectives:

List the DSM IV diagnostic criteria

Discuss the importance of applying adolescent specific criteria to a substance use diagnosis.

Describe 5 risk factor categories that put adolescents at increased risk for substance use.

Content Outline:

Substance Disorders

- neurobiology
- DSM adult criteria
- adolescent criteria

Adolescent Use

- Gateway drugs
- age and use
- comparison with adult use
- risks
- collecting data

Clinical Qualities

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS
MODULE-4 — 71

MODULE 4 HANDOUTS: RISK FACTORS
BUKSTEIN (1995)

Five Classes of Risk Factors for Adolescent Use and Abuse of Substances:

1. Peer factors

a. Peer substance use

b. Positive peer attitudes toward substance use

c. Greater attachment to peers (than to parents)

d. Perception of similarity to peers who use substances

2. Parent/family factors

a. Parental substance use

b. Positive parental attitude about substance use and beliefs about harmlessness of substances

c. Parental tolerance of adolescent substance use

d. Lack of attachment between parents and child

e. Lack of parental involvement with child's life

f. Lack of appropriate supervision/discipline

g. Parental antisocial behavior

h. Family history of psychopathology

i. Family disruption (e.g. divorce)

3. Individual Factors

a. Early childhood characteristics such as conduct disorder and aggression

b. Poor academic performance/school failure

c. Early onset of substance use, especially prior to 15

d. Positive attitudes/beliefs about substance abuse

e. Risk-taking/sensation-seeking behavior

f. High tolerance of deviance/nonconformity relative to traditional values

g. Positive expectancies regarding the effects of substances

h. External locus of control

i. Extroversion

j. Low self-esteem

k. Poor impulse control

l. Anxiety/depression

m. Impaired coping skills

n. Interpersonal/social difficulties

o. Traumatic experiences (e.g. childhood physical or sexual abuse)

4. Biologic Factors

a. Genetically controlled physiological processes and characteristics (e.g. altered sensitivity to alcohol or inherited temperament)

5. Community/social/cultural factors

a. Low socioeconomic status

b. High population density

c. Low population mobility

d. Physical deterioration

e. High Crime

f. Increased unemployment

g. Deviant norms, which condone abuse of substances

h. High alienation of the citizens

i. Availability of substances

MODULE 4 HANDOUTS: SCAVENGER HUNT

Name 3 critical risk factors	Alcohol is a nervous system depressant or stimulant.	Diagnosing substance disorders are fairly straightforward with the adolescent population.	Urinalysis is an excellent method to determine use. ❏ True or ❏ False	Preteens usually start with marijuana. ❏ True or ❏ False
Substance-related disorders refer to:	Name the 5 stages of adolescent substance use criteria	List at least 3 comparisons between adolescent and adult use	Marijuana is which class of drugs?	What are 2 limitations to using DSM substance abuse criteria for adolescents?
The DSM criteria for dependence states that 3 criteria have to meet. Name at least 5 of the 7.	When asking about drug use what are 3 critical questions to determine the pattern?	Older teens usually add tobacco to their use.	What are the 4 gateway drugs?	Substance abuse disorders disrupt normal adolescent development. ❏ True or ❏ False
Instrumental/ operational use is defined as:	Self-report is the most important piece of information regarding the adolescent's use. ❏ True or ❏ False	Substance intoxication can mimic psychiatric illness. ❏ True or ❏ False	Name 5 slang words for any drugs.	Define "double think"

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-4 — 73

60. Module 4:

Substance Abuse

61. Goal

Provide an overview of salient factors involved in diagnosing adolescent substance use disorders.

62. Objectives

Participants will be able to:

- Describe 5 risk factor categories that put adolescents at increased risk for substance use.

- Discuss the importance of applying adolescent specific criteria to a substance use diagnosis.

- List the DSM IV diagnostic criteria

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63. Assumptions (Estroff M.D., 2001)

- Substance abuse disorders represent primary disease processes.

- The onset of each adolescent substance abuse disorder can precede, coincide with, or follow the development of other physical and psychiatric disorders.

- Alcohol and drug abuse can mimic and interact with all mental illnesses.

- These substance abuse disorders disrupt normal adolescent development.

SLIDE 63 NOTES:

According to the disease model of addiction, habitual use of alcohol or drugs can be characterized as a disease. Jellinek (1960) is credited with one of the first publications utilizing the disease concept of alcoholism. Webster's dictionary (1955) defines a disease as a destructive process in the body, for which specific causes and characteristic symptoms can be described, and is a departure from an established standard of health.

Studies show that irreversible changes occur in those who use substances repeatedly. When individuals become addicted to alcohol or drugs, those changes make being a normal drinker or social drug user impossible. The more severe the loss of control while using or drinking, the more true this is. Characteristically, the management of chronic disease involves 5 elements; 1) there is treatment of acute flare-ups, 2) emotional support is a necessity, 3) education is needed so that the individual can be well informed about the illness and can assist in self-care, 4) rehabilitative measures are initiated to prompt the life changes necessary to live with the limitations imposed by the illness, and 5) family involvement is critical so that the family can be informed and can deal with the impact that the chronic illness has on their lives, which is a prerequisite for their being supportive. A noteworthy characteristic of chronic illness is that it tends to develop slowly.

Research has shown that long-term drug use results in significant changes in brain function that persist long after the individual stops using drugs. These drug-induced changes in brain function may have many behavioral consequences, including the compulsion to use drugs despite adverse consequences, the defining characteristic of addiction.

Understanding that addiction has such an important biological component may help explain an individual's difficulty in achieving and maintaining abstinence without treatment. Psychological stress from work or family problems, social cues (such as meeting individuals from one's drug-using past), or the environment (such as encountering streets, objects, or even smells associated with drug use) can interact with biological factors to hinder attainment of sustained abstinence and make relapse more likely. Research studies indicate that even the most severely addicted individuals can participate actively in treatment and that active participation is essential to good outcomes. (NIDA Publication: Principles of Drug Abuse Treatment, NIH Publication No. 00-4180Printed October 1999, Reprinted July 2000)

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Establishing the diagnosis of substance abuse or dependence in an adolescent can be very difficult and challenging. The DSM IV makes no age distinction when defining the difference between dependence and abuse. The following slide suggests some common assumptions on which practitioners generally agree. Review the slide with the participants. Each of the bullets builds on preceding module information and can be referenced. However, these assumptions are important to state since they point to key philosophical points.

64. Neurological Effects of Substance Use

- Chemical changes in neurotransmitters
- Physical effects
- Affective responses

SLIDE 64 NOTES:

By definition, psychoactive drugs are substances that affect the central nervous system to cause physical and mental change. Factors that determine the effects they will have and their abuse potential include:

- The methods that people use to put the substances in their bodies
- The speed of transit to the brain,
- The affinity of that drug for nerve cells, neurotransmitters and other chemicals.

Substances are used because they disrupt the process of neurotransmitter messages. Some drugs enhance the activity of neurotransmitters (agonists) while others block the activity (antagonists).

Central nervous system stimulants and central nervous system depressants can change biologic functions, reaction times, perceptions, cognitive ability and judgment. They also directly act on the limbic system, or emotional system.

Certain brain developments, such as the refinement of neural connections, are completed by about age 16. Developments in the frontal lobes-parts of the brain that are important in judgment, planning and problem solving-continue until about age 18. This potentially important time for brain development is also a time when some teens start drinking quite a bit. Binge drinking patterns along with the subsequent withdrawal effects have the most pronounced impact on brain development. (Susan F. Tapert, project scientist and research fellow at the University of California, San Diego)

Brain and hormonal changes occurring in puberty and post-puberty are adversely affected by substance use and may then increase symptoms of pre existing psychiatric conditions or create the biologic groundwork for the expression of new ones such as mood and anxiety disorders or disruptive disorders.

CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

76 — MODULE-4

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65. Limitations (Estroff. 2001)

Lack of agreement: use, abuse, dependence

- Lack of definition agreement on terms
    - Use, Abuse, Dependence
- Distinguish between development issues and other illness
- Denial, minimization
- Inadequate continuum of care

SLIDE 65 NOTES:

There is a lack of general agreement amongst different disciplines as to the definitions of substance use, abuse and dependence.

This can cause confusion amongst providers resulting in inappropriate referrals or lack of identification and application of quality care interventions. "DSM-IV criteria were developed with clinical adult populations," said Thomas C. Harford, a senior research analyst with CSR, Incorporated. "However, when compared to adults, drinking among adolescents is relatively infrequent and drinking histories tend to have shorter durations. Consequently, many symptoms such as withdrawal and alcohol-related medical complications are not typically experienced by adolescents."

ADDITIONAL EXAMPLES:

An adolescent smoking marijuana 3-4 days per week for 6 months showing no tolerance, withdrawal or loss of control, fits all four DSM IV criteria for abuse but not dependence. This is true even if he or she has drug-related school failure, arrests for reckless driving and breaking and entering.

A great deal of time spent using, obtaining or recovering from alcohol may reflect difficulties in obtaining the substance rather than compulsive patterns of drinking.

"Recent research with adolescent clinical and community samples has identified important limitations of DSM-IV criteria when applied to adolescents... These include: 1) that the dependence symptoms of tolerance, 'much time spent' using, and using more/longer than intended, appear to often be over diagnosed in adolescent studies; 2) that the ways in which these dependence criteria are measured has a huge downstream impact on the estimated prevalence of abuse and dependence diagnoses; and 3) that certain AUD criteria may have different meanings when applied to adults and adolescents". (Christopher Martin, associate professor of psychiatry and psychology at the University of Pittsburgh School of Medicine).

The nature of adolescence itself makes it difficult to determine if substance abuse is a symptom of a primary illness, an adjustment disorder, a psychiatric disorder, or a passing behavioral phase. Using drugs is a rite of passage for adolescents and within this context they tend to minimize their use as well as the consequences. They tend to compare themselves to their peers many of whom may be engaging in heavier amounts of use and frequency. Thus reliance on diagnostic instruments such as a checklist or a structured, or semi-structured diagnostic interview will yield incomplete assessment.

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SLIDE 65 NOTES (continued):

Additionally, it is critical to remember that although we are becoming more cognizant of the issues surrounding adolescent co-occurring disorders, insurance companies and other funding sources have not kept up with the demand, nor have they supported the creation of wrap around care.

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66. Substance Related Disorders Refer to:

- The taking of a drug of abuse
- The side effects of a medication
- Toxin exposure
- Substance Use Disorders
    - Substance Dependence
    - Substance Abuse
- Substance-Induced Disorders

SLIDE 66 NOTES:

Review the slide with participants. Please note that the following criteria are described in the DSM IV-TR and that these criteria were established for adults.

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67. Substance Abuse Criteria

1 or more instances of the following in the same 12-month period, significant impairment or distress

A. Maladaptive pattern of use:

- Recurrent substance use resulting in failure to fulfill major role obligations at work, school, home
- Recurrent use in situations of physical hazard
- Recurrent substance-related legal problems
- Continued use despite persistent or recurrent social/interpersonal problems related to use

B. Never met criteria for dependence for this class of substance

SLIDE 67 NOTES:

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68. Substance Dependence Criteria

3 or more instances of the following during a 12 month period
- Tolerance
  - more or diminished effects
- Withdrawal
  - characteristic syndrome
- Taken in larger amounts/longer time intended
- Persistent efforts to cut down or control use
- Much time spent obtaining, using, recovering
- Important activities given up to use
- Continued use despite negative effects

SLIDE 68 NOTES:

Review the slide with participants.

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69. Adolescent Criteria
(Nowinski, 1990, Muisener, 1994)

1. Experimental
2. Social Use
3. Instrumental/Operational
4. Habitual
5. Compulsive/Dependent

SLIDE 69 NOTES:

(Nowinski, J, *Substance Abuse in Adolescents and Young Adults: A Guide to Treatment,* New York, NY, WW Norton, 1990 Muisener, P. 1994, *Understanding and treating adolescent substance abuse.* Thousand Oaks, CA, Sage Publications.)

Experimental use is typically motivated by curiosity and/or risk-taking. It is a "learning of the mood swing" and is the normal adolescent curiosity and experimentation with drugs.

Social use is "seeking the mood swing". This stage is characterized by drug use with peers, occasional excessive use and intoxication, more event related such as parties.

Instrumental/Operational use is a "preoccupation with the mood swing", seeking out the drugs to change emotional states and behaviors for pleasure, or to cope with stress and dysphoria. At this stage the criteria for substance abuse disorder may be met.

Habitual use is the gray area that leads to dependence where using drugs becomes a lifestyle for coping and recreation as former interests are dropped.

Compulsive/Dependent use is "using to feel normal", and as complete accommodation, preoccupation and significant decrease in global functioning. At this stage the person will meet the criteria for substance abuse, if not dependence.

Nowinski suggests that between stages 3 and 4 the transition from abuse to dependence can be identified. Clinical experience suggests that a significant number of adolescents have probably found a drug of choice and are physically dependent on it by the time they reach Stage 3 or 4. The later stages include characteristics of severe abuse and dependence.

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MODULE-4 — 79

70. Additional Criteria (continued)

(Blum, 1987)

- Problem severity
- Precipitating factors
  - Signs, symptoms, consequences, patterns of use
  - Predisposing and perpetuating risk factors
  - Genetic, sociodemographic, intrapersonal, interpersonal, environmental
    - Diagnostic criteria

SLIDE 70 NOTES:

Within the broad categories suggested in the previous slide, it is also helpful to review the factors that can significantly provide a more in-depth assessment. (Please refer to the sample psychosocial questionnaire in the reference section)

How severe are the psychosocial problems as well as the impact on the adolescent's functioning?

What significant events precipitated the onset of substance use and abuse?

Is there a cumulative effect when compiling the signs and symptoms of use?

Review risk and protective factors to compile a profile of the adolescent's biopsychosocial functioning.

71. Adolescents with COD

- Have an earlier onset of substance use
- Use substances more frequently
- Use substances over a longer period
- Have greater rates of family, school, and legal problems
- Early life issues

SLIDE 71 NOTES:

Over the past decade, certain differences have been found for adolescents with COD in their substance use patterns and outcomes. These differences contribute to the fact that adolescents with COD have higher treatment dropout rates and poorer long-term successes. This finding for adolescent with COD compared to adolescents with substance use disorders are that they:

• Have an earlier onset of substance use

• Use substances more frequently

• Use substances over a longer period

• Have greater rates of family, school, and legal problems

• Early life issues

(Treating Adolescents with Co-Occurring Disorders, Holly A. Hills, Ph.D. Florida Certification Board/ Southern Coast ATTC Monograph Series #2 August 2007)

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72. Historical "Gateway" Drugs

- Caffeine
- Nicotine
- Alcohol
- Marijuana

SLIDE 72 NOTES:

The term gateway drug is used to describe a relatively benign drug that can lead to the use of "harder", more dangerous drugs. Use of a gateway drug is regarded as opening the way to the use of another drug, usually one viewed as more problematic.

The term is also used, usually somewhat facetiously, to describe introductory experiences to sometimes "addictive" experiences or devices.

73. Age and Substance Use

- Pre-teens and young teens
  - Inhalants
  - Tobacco
  - Alcohol (to some extent)
- Younger teens add
  - Marijuana
  - Club drugs
- Older teens add
  - Other stimulant drugs (e.g.: cocaine, methamphetamine)
  - Other opioid and sedative drugs (e.g.: heroin, Oxycontin)

SLIDE 73 NOTES:

This slide notes common drugs used by adolescents in three age groupings. Information about the types of drugs and their effects can be found on the web at the National Institute of Drug Abuse. www.nida.nih.gov

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-4 — **81**

74. Commonly Abused Substances/Prescriptions

CANNABIN OIDS	DEPRESSANTS	DISSOCIATIVE ANESTHETICS	HALLUCINOGENS	OPIODS & MORPHINE DERIVATIVES	STIMULANTS
hashish marijuana	barbiturates benzodiazepines flunitrazepam (Rohypnol), GHB methaqualone alcohol	ketamine PCP and analogs	LSD mescaline psilocybin	codeine fentanyl & fentanyl analogs Heroin morphine Opium oxycodone HCL (OxyContin) hydrocodone barbartrate, acetaminophen (Vicodin)	Amphetamine methylphenidate cocaine nicotine

75. Commonly Abused Substances (continued)

ANABOLIC STEROIDS	DEXTROMETHORPHAN (DXM)	INHALANTS
Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise: roids, juice	Found in some cough and cold medications; Robotripping, Robo, Triple C	Solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexyl): laughing gas, poppers, snappers, whippets

TRAINER NOTE:

Distribute the handouts on the common drugs of abuse and the prescription drugs of abuse available at:

http://www.nida.nih.gov/DrugPages/DrugsofAbuse.html and

http://www.nida.nih.gov/DrugPages/PrescripDrugsChart.html

Discuss the substances and classes of substances highlighting the use of the drugs in their communities, the age the drugs are being used and the drug effects and the risks.

Updated information on youth trends can be found at http://www.nida.nih.gov.

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SLIDES 74-84 NOTES:

Current trends show that cigarette smoking is at its lowest point in the history of the survey on all measures among students in grades 8, 10, and 12. These findings are particularly noteworthy since tobacco addiction is one of the leading preventable contributors to many of our Nation's health problems.

Between 2004 and 2009, a drop in past-year use of methamphetamine was reported for all grades, and lifetime use dropped significantly among 8th-graders, from 2.3 to 1.6 percent. Among 10th- and 12th-graders, 5-year declines were reported for past-year use of amphetamines and cocaine. Among 12th-graders, past-year use of cocaine decreased significantly, from 4.4 to 3.4 percent.

From 2004 to 2009, decreases were observed in lifetime, past-year, past-month, and binge use of alcohol across the three grades surveyed.

In 2008, in the 12-17 age range, 14.6% had consumed at least one drink in the 30 days prior to being surveyed; 8.8% had binged (5+ drinks within 2 hours);; and 2.0% drank heavily (5+ drinks within 2 hours);. Source: National Survey on Drug Use and Health (Substance Abuse and Mental Health Administration Web Site). The NIDA-funded 2008 Monitoring the Future Study showed that 15.9% of 8th graders, 28.8% of 10th graders, and 43.1% of 12th graders had consumed at least one drink in the 30 days prior to being surveyed, and 5.4% of 8th graders, 14.4% of 10th graders, and 27.6% of 12th graders had been drunk. Source: Monitoring the Future (University of Michigan Web Site)

In 2009, 12th-graders reported declines in use across several survey measures of hallucinogens; Past-year use of hallucinogens and LSD fell significantly, from 5.9 to 4.7 percent and from 2.7 to 1.9 percent, respectively; and past-year use of hallucinogens other than LSD deccreased from 5.0 to 4.2 percent among 12th-graders.

Attitudes toward substance abuse, often seen as harbingers of change in use, showed many favorable changes. Among 12th-graders, perceived harmfulness of LSD, amphetamines, sedatives/barbiturates, heroin, and cocaine increased. Across the three grades, perceived availability of several drugs also decreased.

AREAS OF CONCERN:

Marijuana use across the three grades has shown a consistent decline since the mid-1990s. The trend has stalled, however, with prevalence rates remaining steady over the last 5 years. Past-year use was reported by 11.8 percent of 8th-graders, 26.7 percent of 10th-graders, and 32.8 percent of 12th-graders. Also, perceived risk of regular use of marijuana decreased among 8th- and 10th-graders, although perceived availability decreased among 12th-graders.

From 2008 to 2009, lifetime, past-month, and daily use of smokeless tobacco increased significantly among 10th-graders.

Past-year nonmedical use of Vicodin and OxyContin increased during the last 5 years among 10th-graders, and remained unchanged among 8th- and 12th-graders. Nearly 1 in 10 high school seniors reported nonmedical use of Vicodin; 1 in 20 reported abuse of OxyContin.

When asked how prescription narcotics were obtained for nonmedical use, 52 percent of 12th-graders said they were given the drugs or bought them from a friend or relative. Additionally, 30 percent reported receiving a prescription for them, and a negligible number of 12th-graders reported purchasing the narcotics over the internet.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-4 — 83

76. Cannabinoids

- Commonly abuse illicit substance
- *Euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination / cough*, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety; panic attacks; tolerance, addiction. It can cause psychosis in those at risk

Text in *italics* indicates intoxication effects, while non-italicized text indicates a potential health consequence of the drug.

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77. Depressants

- *Reduced anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration /* fatigue; confusion; impaired coordination, memory, judgment; addiction; respiratory depression and arrest; death
- Alcohol specifically can cause damage to the brain and body organs. Amount in different in beer, wine and liquor. Binge drinking in youth can cause OD

Text in *italics* indicates intoxication effects, while non-italicized text indicates a potential health consequence of the drug.

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78. Dissociative Anesthetics

- *increased heart rate and blood pressure, impaired motor function /* memory loss; numbness; nausea/vomiting
- Also, for ketamine—at high doses, *delirium, depression, respiratory depression and arrest*
- For PCP and analogs—*possible decrease in blood pressure and heart rate, panic, aggression, violence /* loss of appetite, depression

Text in *italics* indicates intoxication effects, while non-italicized text indicates a potential health consequence of the drug.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

84 — MODULE-4

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79. Hallucinogens

Altered states of perception and feeling; nausea; persisting perception disorder (flashbacks)

80. Opioids and Morphine Derivatives

Pain relief, euphoria, drowsiness / nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death

81. Stimulants

*   *Increased heart rate, blood pressure, metabolism; feelings of exhilaration, energy, increased mental alertness /* rapid or irregular heart beat; reduced appetite, weight loss, heart failure, nervousness, insomnia

*   Nicotine: increases a user's risk of cancer, emphysema, bronchial disorders and cardiovascular disease

SLIDE 81 NOTES:

Text in ***italics*** indicates intoxication effects, while non-italicized text indicates a potential health consequence of the drug.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-4 — **85**

82. Anabolic Steroids

No intoxication effects / hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; in adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics

SLIDE 82 NOTES:

Text in *italics* indicates intoxication effects, while non-italicized text indicates a potential health consequence of the drug.

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83. Dextromethorphan (DXM)

Dissociative effects, distorted visual perceptions to complete dissociative effects / for effects at higher doses see 'dissociative anesthetics'

SLIDE 83 NOTES:

Text in *italics* indicates intoxication effects, while non-italicized text indicates a potential health consequence of the drug.

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84. Inhalants

Stimulation, loss of inhibition; headache; nausea or vomiting; slurred speech, loss of motor coordination; wheezing / unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death

SLIDE 84 NOTES:

Text in *italics* indicates intoxication effects, while non-italicized text indicates a potential health consequence of the drug.

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85. Comparison to Adult Use

- Discontinuity
- Developmental context of use
  - Rite of Passage
- Characteristic progression
- Legal Issues

SLIDE 85 NOTES:

Adolescents typically use alcohol and other drugs when the opportunity arises, and/or they may use a lot (binge) all at once, and then not use substances for a considerable period of time. This is known as discontinuity since it may be hard to establish a predictable pattern of use. Adolescents may also view the consequences in many different ways, some may perceive the impact as quite severe while others speak about it with a lot of bravado.

As adolescents enter puberty they begin to take chances and experiment with previously prohibited activities. As the brain develops, it create the increased ability to experience the pleasure of drug-induced euphoria, and at the same time it allows adolescents the intellectual ability to devise a plan to repeatedly obtain and use substances. (Estroff)

Substance use is generally perceived as an adult activity and viewed by the adolescents both as risk-taking and a statement of their autonomy and ability to behave like an adult. Substances are frequently abused on a dare or to relive painful feelings. Drugs are often a way to experiment with different identities, to distance themselves from parents' control, or to assert the ability to think and act independently.

The need for peer affiliation is often a significant factor. Peer pressure and even intimidation can be intense and can play a central role in the initiation and continuation of substance abuse.

Progression in use may be much more rapid in adolescents and they may move from use to abuse to dependence far faster than most adults. Conversely, they may use heavily for a period of time, particularly in later adolescence, then not use at all or very little (related to discontinuity, above). While a relatively large number of late adolescents and post-adolescents use alcohol heavily, most do NOT go on to develop alcohol dependence. The smaller number who do appear to have characteristics that put them at higher risk than the larger number of their peers.

Substance use is an illegal activity for adolescents. Currently, most adolescents referred for treatment have some history with the juvenile justice system and may have even been directly referred from probation, etc.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-4 — 87

SLIDE 86 NOTES:

Please ask the participants to refer to their manual and turn to the handout entitled Risk Factors. The handout details each section of risk factors. It is helpful to take a few minutes to review the list to increase sensitivity to and understanding of the multiple, complex factors that create vulnerability. The information is included here as well.

Five classes of Risk Factors for Adolescent Use and Abuse of Substances

1. Peer factors
   a. Peer substance use
   b. Positive peer attitudes toward substance use
   c. Greater attachment to peers (than to parents)
   d. Perception of similarity to peers who use substances

2. Parent/family factors
   a. Parental substance use
   b. Positive parental attitude about substance use and beliefs about harmlessness of substances
   c. Parental tolerance of adolescent substance use
   d. Lack of attachment between parents and child
   e. Lack of parental involvement with child's life
   f. Lack of appropriate supervision/discipline
   g. Parental antisocial behavior
   h. Family history of psychopathology
   i. Family disruption (e.g. divorce)

3. Individual Factors
   a. Early childhood characteristics such as conduct disorder and aggression
   b. Poor academic performance/school failure
   c. Early onset of substance use, especially prior to 15
   d. Positive attitudes/beliefs about substance abuse
   e. Risk-taking/sensation-seeking behavior
   f. High tolerance of deviance/nonconformity relative to traditional values
   g. Positive expectancies regarding the effects of substances
   h. External locus of control
   i. Extroversion
   j. Low self-esteem
   k. Poor impulse control
   l. Anxiety/depression
   m. Impaired coping skills

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n. Interpersonal/social difficulties

o. Traumatic experiences (e.g. childhood physical or sexual abuse)

4. Biologic Factors

a. Genetically controlled physiological processes and characteristics (e.g. altered sensitivity to alcohol or inherited temperament)

5. Community/social/cultural factors

a. Low socioeconomic status

b. High population density

c. Low population mobility

d. Physical deterioration

e. High Crime

f. Increased unemployment

g. Deviant norms, which condone abuse of substances

h. High alienation of the citizens

i. Availability of substances

87. Protective Factors

- Self Control
- Parental Monitoring
  - a strong bond between children and parents;
  - parental involvement in the child's life; and
  - clear limits and consistent enforcement of discipline.
- Academic Competency
- Lack of Availability of Drugs
- Strong Neighborhood Attachments

SLIDE 87 NOTES:

A youth's risk for drug abuse can be buffeted by protective factors that reduce that risk. The risk and protective factors are very individualized and those risk and protective factors can affect children at different stages of their lives. Early childhood risks, such as aggressive behavior, can be changed or prevented with family, school, and community interventions that focus on helping children develop appropriate, positive behaviors. Research-based prevention programs focus on intervening early in a child's development to strengthen protective factors before problem behaviors develop. An important goal of prevention is to change the balance between risk and protective factors so that protective factors outweigh risk factors. Gender, race, and geographic location can also play a role in how and when youth begin abusing drugs. Preventive interventions can provide skills and support to high-risk youth to enhance levels of protective factors and prevent escalation to drug abuse.

(Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders, Second Edition booklet, DHHS, NIH, October 2003)

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-4 — **89**

88. Clinician Qualities

- Credible
- Intuitive
- Able to "double think"

SLIDE 88 NOTES:

Effective diagnosis depends as much on the clinician as on criteria. The clinician needs to be knowledgeable about alcohol and drugs, adolescent patterns of substance abuse, common myths, etc. The clinician also needs to develop an intuitive understanding and be able to pick up on both verbal and nonverbal communications. This requires a flexible interviewing style that can create meaningful rapport and think ahead of the adolescent.

Experienced practitioners have developed a capacity called "double think" which simultaneously allows for genuineness and therapeutic mistrust. It requires the practitioner to alternatively believe and disbelieve an adolescents words and thoughts.

89. Summary of Patterns of Use

- Adolescent patterns are different then adults.
- Developmental/legal issues affect use patterns.
- Adolescents who use substances tend to use specific classes of substances from early to late teens.
- It is helpful to assess an adolescent from a stage wise model.

SLIDE 89 NOTES:

Review the slide with participants.

EXERCISE: Large Group / approx. 15 m

HANDOUT: Scavenger Hunt

Refer the participants to the handout on page 3 entitled *Scavenger Hunt*.

Have the participants pair up with one person from another field or discipline. Instruct them to stand up and move around the room stopping other dyads to try and find the answers to the questions in the "scavenger hunt". After about 10 -15 minutes, call time and as a large group answer all the questions.

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MODULE 5: MENTAL HEALTH

Goal:

Become familiar with the major psychiatric and other associated disorders that most frequently co-occur with Substance Use Disorders

Learning Objectives:

Reduce misconceptions regarding psychiatric disorders

Increase precision of diagnostic considerations and treatment planning

Increase knowledge and ability to communicate about these disorders across disciplines

Increase appreciation for the relationship of these disorders with SUD

Content Outline:

Review of:

ADHD

Learning Disorders

ODD

Conduct Disorder

Mood Disorders

Anxiety Disorders

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-5 — 91

MODULE 5 HANDOUTS: DSM DISORDERS REFERENCE LIST
THIS IS AN OVERVIEW LIST FOR PARTICIPANTS REFERENCE ONLY

DSM DISORDERS USUALLY DIAGNOSED IN INFANCY & CHILDHOOD

- Mental Retardation (Axis II)
- Learning Disorders
- Motor Skills Disorders
- Communications Disorders
- Pervasive Developmental Disorders
- Attention-Deficit & Disruptive Behavior Disorders
- Feeding & Eating Disorders
- Tic Disorders
- Elimination Disorders
- Other Disorders of Infancy , C&A

OTHER DISORDERS USUALLY OCCURRING IN CHILDHOOD, ADOLESCENCE & ADULTHOOD

- Substance-Related Disorders
- Schizophrenia & Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Dissociative Disorders
- Sexual & Gender Disorders
- Eating Disorders
- Sleeping Disorders
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Personality Disorders
- Other Conditions

MORE COMMON CO-MORBID PSYCHIATRIC DIAGNOSES (Bukstein, 1995)

- Conduct Disorder (esp. aggressive type)
- Attention Deficit/Hyper-activity Disorder
- Mood Disorders
- Major Depression
- Dysthymia
- Bipolar Disorder
- Cyclothymia
- Anxiety Disorders
- Social Phobia
- Post Traumatic Stress Disorder
- Generalized Anxiety
- Bulimia Nervosa
- Schizophrenia
- Borderline Personality Disorder (Axis II)

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MODULE 5 HANDOUTS: MENTAL HEALTH DISORDERS

OTHER DIFFERENTIAL DIAGNOSTIC CONSIDERATIONS

Learning Disorders

Adjustment Disorders

Oppositional Defiant Disorder (ODD)

Conduct Disorder

Schizophrenia

Bipolar Disorder

Anxiety Disorders

PTSD and/or other Trauma induced disorders

Situational Anxiety

Pervasive Developmental Disorder

Mental Retardation

Borderline Personality

Pre-natal Induced Disorders

 Maternal cocaine ingestion prior to birth

 FASD primarily FAE

 Maternal / Paternal alcohol and/or other drug use prior to conception

Congenital, Physiological and Environmental

 Lead ingestion

 Hepatic disease

 Hyperthyroidism

 Hypothyroidism

 Seizure D/O

 Migraine D/O

 Sensory Deficit Disorders; Medications

 Substance Induced Cognitive / Functional Impairments

 Age appropriate over-activity

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-5 — 93

90. MODULE 5:

Mental Health

Adolescent Psychiatric / Neurological / Emotional / Behavioral Disorders

OVERVIEW: The following module is designed as a brief overview of the psychiatric, neurological, emotional and behavioral disorders beginning in childhood and adolescence with emphasized focus on the most commonly diagnosed disorders co-occurring with adolescent substance use disorders. While many of these disorders may have some familiarity to counselors and clinicians, it is expected there will be differing levels of understanding that are field, discipline and/or setting specific.*

TRAINER NOTE: Mental Health clinicians participating in the training may experience some of the material in this module as too basic and redundant. It is recommended that they may be engaged by encouraging their contributions of experience with specific disorders and/or some case illustrations.

It is well beyond the scope of the overall training and this module specifically, to engage in an exhaustive discussion regarding each disorder nor is the discussion to be construed in any way as a substitute for the intensive comprehensive training necessary for diagnosing and treating clients/patients with these complex disorders. As noted above, field and/or disciplined familiarity regarding these disorders favors the mental health side of the aisle. Therefore the orientation of this module is slightly slanted for the benefit of substance use disorder treatment field. With that in mind however, the overriding perspective is the interplay and interaction between and amongst these disorders and of the co-occurring substance use disorders. From a differential diagnostic standpoint it is important to keep in mind that many of the symptom presentations of these disorders may mimic many of the substance use disorder symptom presentations and vice versa.

To reiterate, the fundamental rationale for being well-versed with regard to these disorders is in part based on the following information:

- A 2001 national community mental health services study found 43% of adolescents receiving mental health services have been diagnosed with co-occurring SUD.
- SAMHSA's 1994 to 1996 national household survey reported that 13% of adolescents with significant emotional and behavioral problems reported alcohol and drug dependence.
- A 1997-2002 SAMHSA / CSAT study revealed that 62% of adolescent males and 82% of adolescent females entering substance use disorder treatment had a significant co-occurring emotional/psychiatric disorder.

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SLIDE 90 NOTES (CONTINUED):

Other studies indicate that nearly half of all adolescents receiving mental health services have a co-occurring substance use disorder and as many as a 75 to 80% of adolescents receiving inpatient substance abuse treatment have a coexisting mental disorder. There is a nearly four times greater likelihood of adolescents with emotional and behavioral problems developing dependency on alcohol and/or other licit /illicit psychoactive substances than the general adolescent population. The severity of the emotional/behavioral problems/disorders is strongly correlated with this increased likelihood. Within the juvenile justice population, co-occurring disorders are well overrepresented and a significant challenge to the system.

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91. Gathering Data

- History and mental status examination
- Physical Examination
- Self-report
- Reports of family, peers, school, legal, etc.
- Structured interviews and standardized tests
- Laboratory test results
- Drug screening

SLIDE 91 NOTES:

This slide underscores the clinical rigor needed to obtain a well-rounded picture of the adolescent's current behavior and behavioral patterns. Assessing risk and protective factors is one way to help the clinician begin to understand the adolescent/familial context and construct the assessment. There is no one drug and alcohol test for confirming a diagnosis which therefore directs us to attend to history taking, quantitative and qualitative data collection, and case formulation.

Parents can be instrumental in helping make a diagnosis if they have become suspicious, have become aware of disturbing behaviors, and are able with adequate clinical support to share information that can feel embarrassing.

The school is a critical source of information. Early reports of truancy, declining grades, and disciplinary problems are potential signs of substance abuse.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-5 — **95**

92. GOAL

Become familiar with the major psychiatric and other associated disorders that most frequently co-occur with Substance Use Disorders

SLIDE 92 NOTES:

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93. OBJECTIVES

Participants will be able to:

- Reduce misconceptions regarding psychiatric disorders
- Increase precision of diagnostic considerations and treatment planning
- Increase knowledge and ability to communicate about these disorders across disciplines
- Increase appreciation for the relationship of these disorders with SUD

SLIDE 93 NOTES:

INTRODUCTION

Current problems are likely to have historical antecedents/vulnerabilities as highlighted in the Assessment and Substance Abuse Modules. Therefore the following list of DSM disorders usually diagnosed in infancy and childhood which may inform the present will be very briefly noted*:

Please refer to the Handout on page 2.

These are some of the more common disorders occurring in adolescents.* While there are cases in which adolescents may meet the criteria for Axis II disorders (Personality Disorders & Mental Retardation), caution is always given with regard to the use of them because of the in-flux nature of the developmental period.

Within the scope of the training and module, the following represents the most commonly diagnosed co-occurring psychiatric, neurological, emotional and behavioral disorders in the adolescent population. Caution is given to not be lulled into a limited focus by expectations of the most common disorders, but rather remain open with a broader clinical curiosity for other common and not so common possibilities.

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94. Most Common Co-occurring Psychiatric & Behavioral Disorders Include:

- Attention-Deficit/Hyperactivity Disorder (ADHD)
- Learning Disorders
- Oppositional Defiant Disorder (ODD)
- Conduct Disorder
- Mood Disorders
- Specific Anxiety Disorders

95. Attention Deficit / Hyperactivity Disorder - ADHD

- Overall Prevalence - 3% - 6% Gen. Pop.
- Gender Prevalence Ratio: 6:1 - 1:1 Male to Female
- In Adolescent Treatment Settings:
  - OP / IOP: 30% - 60%
  - Residential / Inpatient: 40% - 70%
- Is a substantial contributor to "treatment failure"
  - "Therapeutic" and/or "Administrative" Discharge
- 30-60% co-morbidity with Learning Disorders

SLIDE 94 NOTES:

TRAINER'S NOTE: As indicated in the assessment module, a detailed developmental biopsychosocial and family history will more likely illuminate differential diagnostic criteria. As will be seen from the more focused discussion to follow, there is significant overlap, influence and correlation between the disorders as well as the interplay with the co-occurring substance use disorders.

SLIDE 95 NOTES:

Historically, ADHD, under other nomenclature, was thought to be a childhood disorder that abated with the onset of puberty. Continued observation and research challenged that perspective and it was considered to extend into adolescence. DSM III-R (1987) later referenced ADHD - "Residual State" as an indication of the disorder recognized into adulthood. Although the designation was dropped in DSM IV (1994) and IV-TR (2000), it is otherwise diagnosable as ADHD - NOS (not otherwise specified) or with status qualifiers. Greater attention is currently being given to life span aspects under the auspices of a broader focus on addictions and disabilities.

*Trainer note: There is often confusion in the nomenclature between "ADD" and "ADHD". The technical nomenclature is ADHD for attention deficit hyperactivity disorder which has replaced the term attention deficit disorder ADD. However, the terms are often used interchangeably with ADD referencing the disorder without the aspect of hyperactivity.) Perhaps a more functional way to conceptualize the disorder is to think of it as Attention Inconsistency / Hyperactivity Disorder (AIHD).

Hallowell, E.M. and Ratey, J.J., (2005), have noted in their most recent publication, "Delivered from Distraction" that the estimated prevalence suggests that approximately 66% of children diagnosed with ADHD will persist diagnostically into adolescence and add 66% of adolescents with a diagnosis of ADHD will persist into a dull thud with the ADHD criteria diagnostically. Accounting for the overlap across the lifespan the authors suggest that there is a 30 to 85% persistence of criteria from childhood into adulthood.

The above slide indicates that the overall prevalence of the disorder in the general population is estimated at approximately 3 to 6%. The authors, among others,

have noted increased diagnosis in the female population for what was once primarily thought to be a male dominated disorder. Unfortunately, the prevalence ratios from a gender perspective represent a broad range- as high as a 6:1 ratio of males to females to an even 1:1 ratio males to females.

In adolescent substance use disorder outpatient (OP) and intensive outpatient (IOP) treatment settings ADHD has been identified 30 to 60% of the time. For inpatient and/or residential treatment settings the identification jumps to approximately 40 to 70%. These numbers are significant as they represent a substantial contributor to "treatment failure" often called "Therapeutic" and/or "Administrative" Discharge especially if the disorder has been undiagnosed or diagnosed and inappropriately treated. In substance use disorder treatment facilities the latter represents a critical challenge due to the nature of the most generally prescribed effective medications. These medications come from the psychostimulant family are and thereby feared as contributing a psycho-active and abusable drug to a substance use disordered adolescent. In fact however, the appropriate use of such medications tend to substantially increase treatment success and minimize relapse potential.

Of those adolescents who have been diagnosed with ADHD there is a 30 to 60% co-occurrence of complications of specific learning disorders that operate discreetly and interactively with the attentional difficulties increasing the negative influence of both.

It is equally important to consider the potential parental history of ADHD. Undiagnosed and active ADHD in the parents and/or guardians increases the possibility of treatment interference. This can often take the form of forgotten appointments, disorganization and lack of follow-through despite stated motivation to participate in the adolescent's treatment process.

SLIDE 96 NOTES:

Genetic underpinning is most common in "first-degree" (Parents) biological relatives and more likely on the male side. Consideration must be given to the presence of the disorder in one or both of the biological parents of an adolescent diagnosed with ADHD, keeping in mind that it is unlikely that they have been diagnosed. It is estimated that as many as 90% of adults with the disorder have not been diagnosed. The above noted authors have indicated that, of the roughly 10 million adults in United States who have the disorder, only about 15% have been diagnosed and treated. Diagnosis in parents most likely occurs in the course of the child's or adolescent's diagnostic process. It is often an "Ahah!" reaction from the parent identifying with the diagnostic criteria and functional impairment dating back to early childhood.

96. ADHD - Etiology

- Genetic
- Neurophysiological
- Pre-frontal Cortex
- Disruption of "Executive" Functions
- Primary Neurotransmitters Involved
- Dopamine, Noreprinephrine, Serotonin
- Psychosocial

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SLIDE 96 NOTES (CONTINUED):

While currently there is no "gold standard" test to definitively diagnose ADHD, it is clearly understood to be a neurophysiological disorder that primarily occurs in the prefrontal cortex of the brain and primarily involves the neurotransmitters (chemical messengers) of Dopamine, Noreprinephrine, and Serotonin with emphasis on the first two. It has been identified that both Dopamine and Noreprinephrine play a major role with regard to the "Executive" Functions of the brain. From a functional standpoint the executive functions represent a group of cognitive activities that encompass the ability to design actions toward a goal, handle information flexibly, to realize the ramifications/consequences of behavior and to make reasonable inferences based on limited information. They can be thought of as encompassing such activities as anticipation, goal selection, planning, initiation, self-regulation and impulse control, self-monitoring and the use of feedback. They therefore involve the detailed functions of logic, strategy, planning, problem solving reason and judgment.

From the developmental perspective, the prefrontal cortex of the brain is not fully developed until approximately 23 to 24 years old and therefore it can be suggested that the adolescent will face additional struggles with an already underdeveloped executive function system.

The presence of ADHD creates further challenge in the psychosocial arena. ADHD disordered individuals struggle with the ability to read social cues, appear to not learn from consequences, and seem incredulous, not knowing what it was they actually had done wrong. Their behavior can easily be seen as willful, exasperating and overwhelming creating frustration and negative interpersonal dynamics with parents, peers, teachers and other community contacts. It is within this context that the ADHD individual is often confused and unfortunately diagnosed as being oppositional or conduct disordered.

In earlier thinking, ADHD was identified as a disruptive behavior disorder essentially like oppositional and conduct disorders. There is no doubt that the behavior associated with the disorder can be disruptive but as noted above is related to neurophysiological and neurotransmitter differences in the pre-frontal cortex of the brain interfering with key executive functions. The implications of such difficulties on a broad functional scale are numerous. Categorical placement in the DSM is now framed as ADHD and Disruptive Behavior Disorders. Separating ADHD from the disruptive disorders gives it its own focus not dissimilar to the thinking of placing Mental Retardation and Personality Disorders together under Axis II.

The pathology of ADHD, as detailed above represents only one part of the total picture. The other part that

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is not considered in DSM IV and/or other catalogs of pathology is the unique and usually "out-of-the-box" thinking processes. Hallowell and Ratey, (2005) state, "people with ADHD have special gifts, even if they are hidden. The most common include originality, creativity, charisma, energy, liveliness, an unusual sense of humor, areas of intellectual brilliance, and spunk." They note that many of the most successful entrepreneurs, writers, entertainers, doctors, attorneys, architects, athletes and other dynamic people not only have ADHD but have been able to take advantage of its potential rather than be bound by its disadvantages.

Of the numerous primary advantages of ADHD, the authors highlight the following:

- Many creative talents, usually under developed until the diagnosis is made
- Original, out-of-the-box thinking
- Tendency toward an unusual way of looking at life, a zany sense of humor, and an unpredictable approach to anything and everything
- Remarkable persistence and resilience, if not stubbornness
- Warm-hearted and generous behavior
- Highly intuitive style

The challenge from an assessment and treatment standpoint is to ferret out the advantageous qualities that often get lost in the midst of all the problematic behaviors. When presented with the possibility that this particular disorder may be a gift in disguise, the adolescent, perhaps for the first time may experience a glimmer of hope as well as the possibility of some curiosity as to how that might be possible since it has always been perceived as a problem.

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97. ADHD Diagnostic Overview
(ADAPTED FROM DSM IV-TR, 2000)

SUBTYPES
- Predominantly inattentive type
- Predominantly hyperactive/impulsive type
- Combined

DIAGNOSTIC FEATURES
- Persistent pattern of inattention and/ or hyperactivity-impulsivity
- Some impairment from the symptoms must be evident in two settings
- Symptoms clearly interfere with functioning
- Symptoms not attributed to other conditions
- Characteristics present before 7 years old*

SLIDE 97 NOTES:

Attention Deficit Hyperactivity Disorder is the currently recognized DSM IV-TR nomenclature designating the disorder. For differential diagnostic refinement the disorder is generally recognized as having 3 dominant subtypes:

- ADHD - Predominantly Hyperactive-Impulsive Type (stereotypical impression)
- ADHD - Predominantly Inattentive Type
- ADHD - Predominantly Combined Type

TRAINER NOTE: Participants should be referred to DSM IV-TR for the specific criteria differentiating the subtypes. Attention can also be called to the fourth designation, i.e., ADHD - NOS.

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****The asterisked criteria item has come under greater scrutiny especially with regard to diagnosing Adults. For participants who may also work with an adult population this should be kept in mind. Often, adults entering treatment may not have any way to ascertain data from childhood that may indicate the presence of the disorder. Also, because of the dominant medications being psycho-stimulants, substance use disordered clients may be viewed as drug seeking. It may require further assessment by a professional who has a more focused specialization in diagnosis and treatment of the disorder.

OTHER DIAGNOSTIC CONSIDERATIONS

An often confusing behavioral observation in the disorder is "hyper-focus". This identifies an aspect of the disorder, regardless of the sub-type in which the individual appears transfixed in an activity for extraordinary time periods with little or no conscious connection to anything going on around them. This may be most often observed in activities such as playing video games or other internally motivated and self absorbing activities. This phenomenon is related to locus of control and interest valence. External demand and/or low interest stimuli exert more stress on the disorder with a correlated decrease in frustration tolerance, decreased comprehension and often "brain lock". Internal interest and high stimulation correlates to hyper focus and engagement. The outside observer (parents/guardians/school personnel/counselors, etc.) of hyper-focused behavior mistakenly assumes that if the attention can be directed and sustained in one place, then it can be directed and sustained everywhere else.

In relationships with others, the ADHD individual fails to recognize, interpret and respond to social cues, usually resulting in peer rejection and/or avoidance as well as setting up negative interactions with parents/guardians and other authority figures.

Regarding the subtype dominance, ADHD-hyperactive-impulsive, a useful conceptualization is to think of the adolescent as not having a deficit of attention but as having hyper-attentiveness. They pay attention to everything simultaneously with little or no ability to filter out distraction in order to give and sustain attention. This contributes to the impression that they don't learn from mistakes and consequences. It has more to do with the competitive attraction to everything interfering with the ability to process the cause, effect and consequences relationship.

On the other hand, the ADHD-inattentive subtype has difficulty paying attention to anything. They are often characterized as "zoned out" or daydreamers.

The ADHD child, adolescent and adult can be observed to function in two time periods: "Now" and "Not Now". This is related to the distractibility and processing interference. If attention and attendant behavior doesn't occur "Now" it moves to "Not Now" which is essentially never. This seemingly irresponsible behavior can appear like procrastination or oppositional behavior as if they are just ignoring. Differentiating the manifestation of the subtypes assists in diagnosis and intervention considerations.

It is critical to reemphasize the importance of gathering a comprehensive and detailed developmental assessment history to provide a basis for ruling in or ruling out ADHD or any other disorder. The grouping of disorders below make note of the potential for other differential diagnostic considerations. It is well beyond the scope of this training to delve into the process and specificities of differentially diagnosing a broad and varied group of disorders as listed in your handout. The intent is to emphasize the need to consider many possibilities either directly or via consultation/collaboration with a host of multidisciplinary professionals.

TRAINER NOTE: Do not get bogged down in specifics regarding the group of disorders below. It is more important to assist the trainees to remain open and curious about the information and data obtained for the possibility of a more refined clinical picture that may be different than first thought.

OTHER DIFFERENTIAL DIAGNOSTIC CONSIDERATIONS (HANDOUT)

Learning Disorders; Adjustment Disorders; Oppositional Defiant Disorder (ODD); Conduct Disorder; Schizophrenia; Bipolar Disorder; Anxiety Disorders; PTSD and/or other Trauma induced disorders; Situational Anxiety; Pervasive Developmental Disorder; Mental Retardation; Borderline Personality Disorder

PRE-NATAL INDUCED DISORDERS

Maternal cocaine ingestion prior to birth; FASD primarily FAE, Maternal / Paternal alcohol and/or other drug use prior to conception;

Congenital, Physiological and Environmental

Lead ingestion; Hepatic disease; Hyperthyroidism; Hypothyroidism, Seizure D/O, Migraine D/O, Sensory Deficit Disorders; Medications, Substance Induced Cognitive / Functional Impairments; Age appropriate over-activity

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SLIDE 97 NOTES (CONTINUED):

COMMON CO-OCCURRING DISORDERS PREVALENCE & TYPE:

- 1 Additional Co-Morbid Disorder: 50%
- 2 Additional or more Co-Morbid Disorders; 20-30%
- ADHD & Learning Disorder: 30%
- LD & ADHD: 60%
- ADHD & ODD: 45%
- ODD as a prior diagnosis to ADHD: 25%
- ADHD & Major Depressive Disorder: 20%-35%
- ADHD & Anxiety Disorders: 25%
- ADHD & Tic D/O: 10%

*Trainer note: Try not to get bogged down in details here. This is just to demonstrate that ADHD has real biologic underpinnings and also a psychosocial component.

LEARNING DISORDERS

While not considered a "mental health" disorder, the impact of a Learning Disorder on child and adolescent functioning is profound and its presence as a co-occurring disorder is even more so. Learning Disorders affect approximately 20% of school-age children in the United States-nearly 11 million children/adolescents-and like ADHD has a high prevalence in the adolescent treatment population. The National Center on Addiction and Substance Abuse, (CASA, 2000), published "Substance Abuse and Learning Disabilities: Peas in a Pod or Apples and Oranges?" thereby bringing into sharper focus some preliminary recognition of the possible links between the two disorders.

On a practical level all treatment facilities have requirements to be Americans with Disabilities Act (ADA) compliant but for the most part this has been with the primary focus on those observable "disabilities" such as physical handicaps and deaf or hard of hearing. Such requirements include the use of appropriate forms of accessibility such as ramps, elevators or the provision of deaf interpreters. Little has been done with regard to those "disabilities" that are hidden from obvious view. This is an interesting and curious reality, especially with regard to the primary modalities of substance use disorder treatment delivery that utilize a psycho-educational didactic lecturing, the need to take "notes", doing "homework" assignments, reading aloud of recovery texts and the like. In essence the substance use disorder treatment settings essentially recapitulate an academic (school) setting. The very same disorders that created difficulty in the primary school setting will equally manifest in the treatment setting.

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MODULE-5 — **103**

Adolescents coming in to treatment are more likely to have not been diagnosed with specific learning disorders. This could be due to the artful ability of kids to mask and/or otherwise compensate for their learning differences until they hit a wall of performance. It could also be related to the growing trend of reluctance of school Child Study Teams to do so. During an assessment, outside of the cursory questions regarding school functioning, there are little or no attempts to substantiate the adolescent's capacity for reading, writing and comprehending. Even though they may be asked to sign release of information forms as well as other documents, there is no attempt to discern whether they truly comprehend what they've read. They may simply indicate agreement by nodding or saying "yes". This misunderstanding could potentially result in discharge for saying:

"I didn't know that wasn't okay. That's stupid!" and, in response, they are told, "It was right there in the contract for treatment that you read and signed, so don't tell us you didn't know because that's not an acceptable excuse and your just trying to scam and manipulate your way out of the consequences again. You're really in a lot of denial about how serious your addictive thinking is. You've been in treatment after treatment; when are you going to get it that your way isn't working?"

The above generic vignette and many other versions occur with all too much frequency and along with it a trail of "failed" treatment episodes for "non-compliance", "defiance", "disregard for the rules" and a host of other treatment system rationalizations. Rarely does the adolescent risk saying they have significant difficulty reading or if they can read don't comprehend what they have read. Getting into trouble is safer than humiliation!

CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

104 — MODULE-5

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98. Learning Disorders

Learning disorders are conditions of the brain that affect a persons ability to:

- Receive language or information
- Process language or information
- Express language or information

SLIDE 98 NOTES:

There is a vast spectrum of specific learning disorders with various levels of severity and functional impact and which represent an area of specialization that goes well beyond the scope of this curriculum. It is essential to understand that these disorders operate 24 hours a day; 7 days per week; in every domain of the individual's life. Certainly there are domains that provide greater challenge than others, the most dramatic of which is the school/academic environment.

The above slide notes three ability areas primarily impacted by one or more disorders or "differences" relative to the learning process. They focus on one's ability to "receive" language or information, "process" or "make sense" of language or information and to "express" language or information. Such abilities are essential to meet the basic challenges of being in the world, whether in school, relationships, getting and holding a job, or for example, just trying to read a menu in a restaurant, let alone a treatment or probation contract. Thus, those who struggle with one or more learning disorders, severe enough to meet diagnostic criteria, have a more difficult time of it across the board.

Once the language or information is received the brain has to make sense of it or "process" it to gain understanding and comprehension. In a concrete manner it could be likened to a computer receiving information and/or language from different databases (in human terms -Sight, Sound, Taste, Hearing, and Touch); considering all the variables and assigning appropriate value, saliency, influence, order/sequence etc., determining what to do, and then "express" a response in the requested format. If there is dysfunction in any one of the phases, i.e. receiving, processing or expressing (e.g., corruption in the "print" program) the outcome is inconsistent, inaccurate, irretrievable etc.

If there are memory problems and the information to be processed can't be retrieved or is missing but needed immediately, perhaps it gets "fudged", fabricated, misdirected, etc, resulting in a distorted outcome. From an outside observation everything appears to be in order, the cables are all connected properly and there is no obvious reason why it shouldn't work the way it was supposed to. Such is the case with the learning disordered adolescent who appears otherwise normal from all outside observation but on the inside isn't working quite right and even he/she doesn't know why. The crucial difference between the adolescent and the computer is that the adolescent has feelings about what is happening or better yet, what isn't happening and then reacts to the faulty, incomplete and/or inaccurate information in a faulty, dysfunctional, imperfect "expression" of language/behavior.

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As the next slide indicates, disturbance in any one or more of the above phases may be specifically identified in the cognitive domains below as they are needed to meet task requirements. Having more than one form of learning disorder produces a synergistic interaction that makes each worse, decreases compensatory potential and dominoes into other domains.

99. Learning Disorders, continued

May manifest in an imperfect ability to:

- Listen
- Think
- Speak
- Read
- Write
- Spell
- Do mathematical operations

SLIDE 99 NOTES:

Diagnostically, DSM IV-TR categorizes the learning disorder by their primary functional impact.

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100. Learning Disorders, continued

Four Major Categories

- Reading Disorders
- Mathematics Disorders
- Disorders of Written Expression
- LD - NOS

LD's are neither intelligence based nor impairments of the senses

SLIDE 100 NOTES:

It is important to emphasize the last bullet that LDs are not related to levels of intelligence or a disturbance in the sensory mechanisms themselves. It is in the way the brain attends to the sensory input via all the neurological connections and neurochemical transmissions occurring within a specific area of the brain assigned for that information.

The overall psychological, affective, cognitive, social and functional impairment is profound.

Reference "Substance Abuse and Learning Disabilities: Peas in a Pod or Apples and Oranges?" (CASA, 2000):

FACT: Children with learning disabilities are at greater risk of school failure and often experience difficulty and frustration relating to others. These children are more likely to perceive themselves as poor students and engage in negative and disruptive behavior, and less likely to be involved in extracurricular activities. Academic failure and peer rejection are common risk factors associated with substance abuse as is the lower self esteem that accompanies social difficulty and academic failure.

FACT: A child with a learning disability is twice as likely as a member of the general population to suffer ADHD. Untreated ADHD affected individuals have

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a high incidence of substance abuse and untreated ADHD is further associated with an earlier onset of substance abuse and greater difficulty recovering from addiction.

FACT: Individuals in substance abuse treatment have a higher incidence of learning disorders than those in the general population. One recent study revealed that 40% of people in SUD treatment have a learning disorder, while another indicated that the percentage in residential SUD programs has been found to be as high 60%.

The implications for treatment delivery, tasks, assignments, and modalities are significant. Failure to give attention to and to develop a functional appreciation and understanding of these issues, is in conflict and violation of the ADA and potentially malpractice.

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101. Oppositional Defiant Disorder

(adapted from DSM IV-TR, 2000)
Diagnostic Features:
- A recurrent pattern of negativistic, hostile & defiant behavior
  - lasting 6 months or more
- Disturbance in behavior causes clinically significant impairment in:
  - Social
  - Academic or
  - Occupational functioning

SLIDE 101 NOTES:

This is the child who is verbally defiant or "difficult"; often seen as "mouthy." The disturbance must be serious enough to cause real functional impairment and not just represent stage-related phenomena. Interaction with the behaviors can rapidly deteriorate patience, moving toward exasperation, frustration and authoritarian power struggles.

Earlier signs of oppositional behaviors may be manifested as more passive-aggressive behavior, open refusal, pouting and stubbornness. The child/adolescent often engages in deliberate and persistent testing of limits as if to "dare" an engagement.

*Trainer Note: Again, don't become too detailed and lengthy. This information (from DSM and other research sources) again demonstrates the probable interaction between biology and other environmental factors.

ETIOLOGY

By large measure, ODD may be related to child's temperament & family's response/reactivity to it. This may be considered to be a nature /nurture, "goodness of fit" parent/child relationship, early behavioral management and parenting interactive disorder in the absence other contributing predispositional factors. A predisposition to ODD is inherited in some families. There may be problems in the brain that cause ODD. It may be caused by a chemical imbalance in the brain. Diathesis-stress model = combined effect of genetic predisposition with environmental factors.

PREVALENCE

- 2-16% of population diagnosed ODD
- Most common psychiatric diagnosis given to children

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-5 — 107

COURSE

The course is different in different people, though it usually begins gradually. Usually begins by age 8. Research has shown that ODD is relatively persistent (75% of children diagnosed with the disorder meet criteria several yrs. later). In some children, it evolves into Conduct Disorder (though majority do not) or a Mood Disorder. In adulthood it can develop into a passive aggressive personality style or Antisocial Personality Disorder, mostly if no intervention is provided. With treatment, reasonable social & occupational adjustment can be made in adulthood. The earlier appropriate treatment/intervention is provided the more promising the outcome.

Differential Diagnosis

• Normal Development

• Conduct Disorder

• Mood disorder

• Attention-Deficit/Hyperactivity Disorder

• Mental Retardation

In Oppositional Defiant Disorder (ODD) consideration must be given to developmental norms, severity, context and functional impairment.

For example, it is developmentally normal for early adolescents (13-14 years old) male or female, to demonstrate oppositional and defiant behavior and attitudes as part of the task of separation and the shift from the influences of family to the influences of peers. It may manifest in argumentativeness and defiance and/or passive aggressiveness.

In general, diagnoses such as Conduct Disorder, ADHD and Mental Retardation have historical roots genetically and/or environmentally and are not considered as part of normal developmental phenomena. Their identification and diagnosis may occur as the result of situational and/or contextual circumstances such as a transient or residual substance related/induced mood disorders.

Transient Mood Disorders may emerge in the face of developmental periods/thresholds, situational events and changes, loss, environmental influences, crisis and other stressors among the most likely. More profound and difficult Mood Disorders may have biological basis and genetic predispositions.

The most valuable tool to assist in the differential diagnostic process is a detailed and comprehensive individual and family history and assessment.

Common Co-occurring Disorders
- ADHD
- Substance-Related Disorders
- Learning Disorders
- Mood Disorders
- Anxiety Disorders

102. Conduct Disorder - Diagnostic Features

Repetitive and persistent behaviors in which the basic rights of others, societal norms or rules are violated as evidenced by:

Aggression to people and animal
- Destruction of property
- Deceitfulness or theft
- Serious violations of rules
  - Bullies, threatens or intimidates others
  - Often initiates physical fights

Has used a weapon that could cause serious physical harm to others (e.g. a bat, brick, broken bottle, knife or gun)

SLIDE 88. NOTES:

The conduct disordered adolescent has most often demonstrated a history of negativistic behavior that can be traced into earlier childhood. These behaviors may have manifested specifically in the home where the child had been physically abusive or cruel to parents and siblings and/or animals. In many ways the early childhood history is not dissimilar to oppositional defiant disorder but oppositional defiant disorder generally does not include the presence of significant aggressiveness, abuse and cruelty.

The conduct disordered adolescent operates from a world view in which the ends justify the means. They often lack empathy but have often learned how to express "appropriate" remorse as part of their manipulation. They rarely take responsibility for their own behaviors and readily externalize blame and/or inform on their peers when it serves their self protective needs. They are often truant from school, show poor school performance and are likely to drop out. Aggression and toughness are primary defenses to mask an otherwise low and fragile self-esteem. A detailed assessment history will most likely reveal early onset of sexual behaviors, substance use, fighting and legal difficulties. If they have been evaluated within a school setting it would most likely carry the classification of Emotionally Disturbed with a likely removal from traditional school settings.

Diagnosis of conduct disorder is generally reserved for adolescents under the age of 18. While it is possible to continue the diagnosis past the age of 18 more typically the diagnosis would be changed to Antisocial Personality Disorder (ASPD) therefore giving strong correlation to conduct disorder as the child and adolescent precursor to ASPD.

*Trainer note: For specificity of diagnostic criteria, refer to the reference section on CD and DSM IV-TR.

ETIOLOGY (BACKGROUND INFORMATION)

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MODULE-5 — **109**

BIOLOGICAL

Neurological dysregulation: The high combined co-morbidity rate of Conduct Disorder, ADHD & Tourette's known to be reflective of neurological dysregulation, suggests that Conduct Disorder may be a co-manifestation of the same underlying dysregulation.

CHILD BIOLOGICAL FACTORS

- It appears that the interplay between child temperament & a family's response/reactivity to that temperament, play a role in the tendency to respond in predictable ways to events.

- Aspects of the personality such as activity levels, emotional responsiveness, quality of mood, & social adaptability also play a role.

- Longitudinal studies have found that although there is a relationship between early patterns of temperament & adjustment during adulthood, the longer the time span the weaker this relationship becomes.

BRAIN FUNCTION

- Adolescents with Conduct Disorder have been found to have impairments in the frontal lobe, an area that affects ability to plan, avoid harm & to learn from negative consequences (referred to as ECF-executive cognitive functioning-by Tarter and many others).

ENVIRONMENTAL INFLUENCES

- Child trauma/verbal, psychological, physical abuse
- Sexual Abuse/Incest
- Poverty
- Parental neglect
- Marital Discord
- Chaotic home environment
- Parental illness
- Parental alcoholism
- Having a parent with Antisocial Personality Disorder (ASPD)
- A mother with depression

Overall, genetic vulnerability combined with environmental risk factors increases chances of conduct disorder. *Important to note that not all children exposed to these factors develop Conduct Disorder.

PREVALENCE

- Prevalence appears to have increased in the last decade

- May be higher in urban settings than rural settings (e.g., in a NY sample, 12% had moderate level conduct disorder and 4% had severe conduct disorder)

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- Rates vary widely depending on the nature of the population (estimated 1-10% of population)
- More prevalent in males than female (although this dynamic appears to be changing)
- One of the most frequently diagnosed conditions in outpatient & inpatient MH facilities for children.

COURSE

- Onset of Conduct Disorder may occur as early as the preschool years, but the first significant symptoms usually emerge during middle childhood to middle adolescence.
- ODD is a common precursor to the Childhood-Onset of CD. Onset is rare after age 16.
- Course of CD is variable; in a majority of individuals
  - CD remits by adulthood
  - Early onset predicts a worse prognosis & increased risk for Antisocial Personality Disorder & Substance-Related Disorders
  - Co-morbid ADHD & Conduct Disorder increases likelihood of Antisocial Personality D/O & criminal behavior (Herpertz, 2002).

As we have seen, many disorders have a greater or lesser degree of overlap in symptom presentation. Prudent history and assessment data must be reviewed against DSM IV criteria for ruling in or ruling out the following.

DIFFERENTIAL DIAGNOSIS

- Oppositional Defiant Disorder
- Attention-Deficit/Hyperactivity Disorder
- Mood Disorder
- Fetal Alcohol Syndrome
- Manic Episode
- Adjustment Disorder
- Psychotic Disorder
- Child or Adolescent Antisocial Disorder
- Antisocial Personality Disorder
- Survival Mechanisms

The following represent the most common Co-occurring Disorders with Conduct Disorder. It is important to note that children with Conduct Disorder have higher incidences of multiple disorders than in a normal population.

- Most commonly co-occurring disorders are:
- ADHD
- Oppositional Defiant Disorder
- Learning Disorders
- Mood Disorders

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MODULE-5 — 111

- Depressive Symptoms
- Anxiety Disorders
- PTSD
- Communication Disorders
- Substance Use Disorders
- Tourette's Syndrome
- A high level of co-morbidity (almost 95%) was found among ADHD children (aged 6-16 yrs) with Conduct Disorder & Oppositional Defiant Disorder (Bird et.al, 1994).
- In an 8 year follow-up study, Barkley, et.al. (1990) found that 60% of the children with ADHD had developed ODD or CD.
- Children w/ CD also showed lower IQ scores, especially in the area of verbal skills.

103. Mood Disorders

- Generic term referencing a collective group of specific diagnosable disorders
- Major Depressive Disorder most common
  - Twice as common in adolescent & adult females than their male counterparts
  - In adolescence more likely to manifest as irritability than sadness
  - Later onset than substance abuse
- Prominent mood liability and dysregulation
- Onset of psychopathology preceded or coincided with SU for other disorders

SLIDE103 NOTES:

Disturbances of mood are common in the substance use disorder population. According to Riggs (2003), 15-25% of the adolescent population with substance use disorder has a co-occurring depressive disorder. Riggs also notes that depression is less likely to remit with abstinence in adolescents than in depressed adults.

104. Mood Disorders, continued

DSM IV-TR Major Categories

- Mood Disorders
- Depressive Disorders
- Bipolar Disorders
- Other Mood Disorders
  - Includes Substance-Induced Mood Disorders

SLIDE 104 NOTES:

Diagnostic Features (See full criteria for these disorders in the DSM)

MAJOR DEPRESSIVE DISORDER

- Must have met criteria for a full major depressive episode
  - Having at least 5 of the 9 symptoms for meeting Criterion A (depressed mood for marked periods
    - in children may appear as irritable

The key features of a major depressive disorder include but are not limited to a diminished interest and experience of pleasure resulting in a higher degree of isolation and withdrawal from social context. There may be a loss of appetite resulting in significant weight loss, self medication causing increased weight gain. More classic signs may include disturbances of sleep, loss

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

112 — **MODULE-5**

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of energy and fatigue, psychomotor agitation and/or retardation along with disturbances in concentration and difficulty with decisions, feelings of worthlessness, suicidal thoughts and recurrent thoughts of death with high potential for suicidality.

It is critical during the assessment to ask about and pursue suicidal thoughts to determine the level of risk that may require immediate action for the purposes of protection.

PREVALENCE

- Lifetime risk 10-25% in Adolescent & Adult Females
- Lifetime 5-12% in Adolescent & Adult Males
- Rates appear to be unrelated to ethnicity, education, income, or marital status
- Average age of onset is mid-20s
  - Epidemiological data suggest that age of onset is decreasing for those born more recently

FAMILIAL PATTERN

- 1.5-3x greater among 1st degree relatives
  - Evidence for increased incidence of Alcohol Dependence in adult 1st degree relatives
  - May be increased incidence of Anxiety Disorder or ADHD in children of adults with Major Depressive Disorder.

PROGNOSIS

Adolescents with a history of a single episode of major depressive disorder can be expected to experience another episode 60% of the time. The risk for additional episodes increases with each. About 5-10% with those having a Single Episode, subsequently develop Manic Episode (Bipolar I).

Those adolescents having been diagnosed with Dysthymic Disorder appear more likely to have additional episodes, poorer recovery and may require acute-phase and continuing treatment for longer period of time.

In adolescents, some data suggest that acute onset of severe depression, especially with psychotic features & psychomotor retardation, without pre-pubertal psychopathology is more likely to predict a bipolar course, as does family history.

EPIDEMIOLOGY

Age of onset for Major Depressive Disorder

- Mean=40 years old
- 50% have onset between 15-22

RISK FACTORS/PREDICTORS

- Family genetic history of Mood Disorder
- Pre-morbid personality factors:
  - Dependent; Obsessive-compulsive

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS
MODULE-5 — **113**

- Life stresses
- Low self-esteem
- Early Dysthymic Disorder for MDD
- Symptoms of depression as an adolescent for adults

There is evidence that first-degree relatives and family members have a higher incidence of mood disorders, implicating genetics as one factor in the development of these disorders. Serotonin appears to be affected, but many other factors (some probably currently unknown) may contribute, as may physical conditions such as hypo- and hyperthyroidism.

STRESS

Whether from biologic or environmental sources-stress can increase the risk for any individual developing a disorder to which their individual biology is prone. Failure to successfully navigate any of the developmental hurtles/challenges of childhood and adolescence can be a significant stressor, as can parental neglect, abuse, or lack of "goodness of fit" in terms of temperament. There are significant questions in some of the literature regarding "Dysthymia" and the extent to which external factors may induce" hopelessness" at an early age that becomes incorporated into the developing character structure and looks (and functions) very much like a biological substrate condition. A number of children (and adults) having depressive disorders lack sufficient social skills and miscue in social situations.

BIPOLAR I DISORDER

TRAINER NOTE: Do not get bogged down in the specificities of diagnostic criteria for Bipolar I & II as it can be overwhelming and beyond the scope of the training. The following is for review purposes and not detailed diagnostic criteria discussion.

Bipolar I Disorder appears in anywhere from .5% to 1.5% of the population and is equally common in both sexes.

- For a Bipolar I diagnosis, must meet full criteria for a Manic Episode
  - Elevated, expansive or irritable mood 1 week or more (or any, if hospitalization needed)
  - 3 or more (4 if mood only irritable) of 7 criteria-inflated self-esteem/grandiosity; decreased sleep need; more talkative or pressure to do so; flight of ideas/subjective "thoughts racing"; distractibility; increase in goal-directed activity; excessive involvement in pleasurable activities having high potential for painful consequences
  - Not mixed episode
  - Marked impairment in functioning, social relationships, hospitalization to prevent harm, or psychotic symptoms

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SLIDE 104 NOTES (CONTINUED):

- No substances or GMC (general medical condition). [Any episode caused by somatic antidepressant treatment does not count.] For Bipolar I diagnosis, one must have met the full criteria set for at least one manic episode or one mixed episode (one meets the full criteria for both a Manic AND a Major Depressive Episode nearly ever day for at least a week).

- Symptoms for a mixed episode include: agitation, insomnia, appetite dysregulation, psychotic features, and suicidal thinking. It must include marked impairment in functioning, lead to hospitalization, or have psychotic features. It must not be attributable to substance effects or other medical conditions.

- Symptoms like those seen in Mixed episodes may be due to the effects of an antipsychotic medication, electroconvulsive therapy, light therapy, or medications such as corticosteroids. Suicidal risks noted.

CO-OCCURRING DISORDERS

- Substance use disorders
- Eating disorders
- ADHD
- Panic Disorder and Social Phobia.

PROGNOSIS

Average age of onset is 20 for both sexes; recurrent - more than 90% have further episodes, with 60-70% occurring near a Major Depressive Episode. Earlier onset and rapid-cycling patterns is associated with poorer prognosis, as are co-occurring substance use disorders, and mood incongruent psychotic features.

BIPOLAR II DISORDER

Diagnostic Features—major depressive and hypomanic episodes. The person must have experienced the full criteria set for at least one Hypomanic Episode and one or more Major Depressive Episodes.

Hypomanic Episodes must last at least 4 days with persistently abnormal elevated, expansive, or irritable mood and 3 additional symptoms from Criterion B for Mania (or 4 if only irritable). However, the episode is NOT severe enough to cause marked impairment in social or occupational functioning, there are no psychotic features.

Suicidal risks (10-15% completions)*

More common co-occurring disorders

- Hospitalization is not required for such symptoms
- People may become more focused and creative, may appear uncritically self-confident, need less sleep, have more energy, may speak faster, be "punnier" etc.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-5 — **115**

- There may be impulsive activity (increased sexuality, buying sprees) but such activity is generally organized, not bizarre, and doesn't result in the impairment level of a full Manic Episode
- Hypomanic Episodes have the same criterion set for "B"
    - must last 4 days (for "A")
    - is behavior uncharacteristic of the person (C)
    - mood and functioning change is observable by others (D)
    - not severe enough to cause marked impairment in functioning or cause hospitalization
    - no psychosis (E)
    - not resultant from substances or GMC (F).
- Suicidality
    - some evidence that rate is even higher than for Bipolar I

CO-OCCURRING DISORDERS

- Same as with Bipolar I with the addition of Borderline Personality Disorder

PROGNOSIS

- Tend to be more "functional" than those with Bipolar I in terms of being fully functional between episodes (5-15% show some mood lability and relational difficulties between episodes)
- The same 5-15% tend to develop Bipolar I Disorder over a 5 year period
- Psychotic symptoms appear less frequent during major depressive episodes with Bipolar II Disorder
    - As with Major Depression, Bipolar II Disorder appears to be more frequent in females.

MOOD DISORDERS

Differential Diagnosis

ADHD

Conduct Disorder

Medical Conditions

ADHD frequently co-exists with depression or Dysthymia, even in non-clinical samples. Mood disorders are episodic, whereas ADHD is a chronic condition with onset in early childhood.

Conduct Disorder may occur secondarily to mood symptoms, and disruptive behavior disorder may precede mood disorder or develop in parallel. However, Conduct Disorder (CD) is not episodic and a pattern of behavior is more constant, with ODD often preceding the development of CD.

Medical Conditions and Substances may present very similar symptoms, and careful screening for other medical conditions and substance use, including medications, must occur in making a diagnosis of mood disorder. Normal sadness and grief can be mistaken for mood disorder, but is related directly to the perception of some loss. Children respond in different ways - in affect, behavior, and in their thoughts. It is important to provide resources for children who are grieving. Normal development is a challenge for all children. There are periods of relative mood stability and times (such as puberty) when hormonal and other biologic changes also affect the child's mood and self-perception. Everyone looks "a little bit" symptomatic of something some of the time and adolescents may sometimes look a little more so. Knowing the child and his/her coping capacities, strengths, and not-so-strong areas, is vital in making any diagnosis or ruling it out.

EATING DISORDERS

Eating disorders are complex illnesses that affect adolescents with increasing frequency. Eating disorders are serious, sometimes life threatening conditions that tend to be chronic (Herzog, et al. 1999). They usually arise in adolescence and disproportionately affect females. About 3 percent of young women have one of the three main eating disorders: anorexia nervosa, bulimia nervosa, or binge-eating disorders (Becker, et al., 1999). The causes are thought to be a combination of genetic, neurochemical, psychodevelopmental, and sociocultural factors. Two major subgroups of the disorders are recognized: a restrictive form, in which food intake is severely limited (anorexia nervosa), and a bulimic form, in which binge eating episodes are followed by attempts to minimize the effects of overeating via vomiting, catharsis, exercise or fasting (bulimia nervosa).

Both anorexia nervosa and bulimia nervosa can be associated with a serious biological, psychological and sociological morbidity, and significiant mortality (Canadian Paediatric Society, 2008).

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-5 — **117**

105. Suicide

- Cognitive problem-solving styles
- Underlying neurobiology
- Increased rate may be related to substance use/abuse (Brent, et.al 1987, Rich et.al 1986)
- Mood disorders and SUD increased risk

106. Adolescent Suicide

1991 Centers of Disease Control report

- 27% of high school students thought about suicide
- 16.3% develop a plan
- 8.3 made an attempt
- Up to 50% of adolescents who attempt suicide do not receive follow-up mental health care
- Of those that do, 77% do not complete treatment
- Girls attempt more frequently, boys complete more frequently

SLIDE 105 NOTES:

SUICIDE

2/3 of all persons with a major mood disorder contemplate suicide

10-15% commit suicide

Use of substances increases the risk level

- Mood disorder is what it says; Fluctuation in mood may cause periods of extreme depression and hopelessness. Manic states induce behaviors which, after the episode is past, the person feels badly about, in addition to perhaps causing rifts in social supports.
- In a 15 year follow-up study of children with major depression, 4% had died by suicide. Earlier age of onset implies a lengthier and more severe course and greater genetic loading.
- When substance use is coupled with mood dysregulation, the risk for suicide attempts and for completed suicides is significantly greater.

SLIDE 106 NOTES:

TREATMENT NOTES

- For risk-taking and suicidal ideation, close parental and psychiatric supervision is needed.
- Early onset mood disorders have "devastating effects on development" - even after successful treatment with medication or spontaneous remission there may be:
  - Reduced coping skills
  - Cognitive patterns associated with depression
  - Impaired interpersonal relationships with peers and family members.

Some form of therapy may be needed to address the developmental deficits of sequels of the depression. Family involvement is crucial; families may need psychoeducation, instruction in relapse prevention, and support for themselves in how the episode(s) have affected all family relationships.

Pharmacotherapy is less effective than in adults, but the SSRIs are showing promising effects. Anticonvulsant medication may be useful for rapid-cycling bipolar disorders and mania resistant to lithium and neuroleptics in adolescents. Cognitive and interpersonal therapies, including behavioral modification, social skills training, and academic remediation, are often useful for specific issues. Psychotherapy is the first step in treating non-psychotic depression in children, since medications pose a number of risks. However, if symptoms do not improve in 4-6 weeks, medication evaluation is warranted.

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107. Anxiety Disorders - Overview

*MOST COMMON

- Substance-Induced Anxiety Disorder*
- Panic Disorder* (having had a panic attack-with or without Agoraphobia)
- Posttraumatic Stress Disorder**
- Acute Stress Disorder**

**MOST LIKELY

- Agoraphobia (without history of panic)
- Specific Phobia
- Social Phobia
- Obsessive-Compulsive Disorder
- Generalized Anxiety Disorder
- Anxiety Disorder Due to a GMC
- Anxiety Disorder Not Otherwise Specified

SLIDE 107 NOTES:

(List only for reference re: all forms of disorders classified as Anxiety Disorders. Review DSM for any disorders that are not very familiar to you.)

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108. Anxiety Disorders, cont - "Stress Disorders"

- Acute Stress Disorder is characterized by symptoms that occur immediately in the aftermath of an extremely traumatic event.

- Posttraumatic Stress Disorder (PTSD) is characterized by the re-experiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma.

SLIDE 108 NOTES:

POSTTRAUMATIC STRESS DISORDER

- Specific, long-lasting emotional & behavioral symptoms following exposure to traumatic event (with intense fear, helplessness, or horror-see DSM)

- In children, fear of separation from parents, of death, and of further fear occurs. Withdrawal from new experiences and perceptual distortions are seen (mostly time sense & vision, sometimes hearing, touch, and scent misperceptions)

- Nightmares, daydreams, repetitions (may be dangerous) occur, with most children unaware of connection

- Sleep disturbances, somatic symptoms, regression, and guilt common

- Physical and neurological changes occur

- Anxiety and depression may be prominent symptoms, as may impulsivity, concentration difficulties, decreased motivations, hopelessness, shame about fearfulness

- Some symptoms may be mistaken for ADHD, psychosis, or organic brain damage
  - Significant changes in behavior should be carefully assessed

(For full diagnostic criteria participants should refer to DSM)

109. Posttraumatic Stress Disorder - PTSD

Diagnostic Features (adapted from DSM IV-TR 2000)
- Response to the event involves intense fear, helplessness, horror
  - Disorganized or agitated behavior in children
- Persistent re-experiencing of the traumatic event
  - Flashbacks - not substance induced
- Recurrent distressing dreams of event
  - In children, can be frightening dreams without recognizable content
- Acting or feeling as if event reoccurring
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of event
- Physiological reactivity on exposure to above cues

_____

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110. Posttraumatic Stress Disorder - PTSD continued

- Diagnostic Features
  - Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness
  - Persistent symptoms of increased arousal
- Prevalence
- Course
- Co-occurring Disorders
- Differential Diagnosis

DIAGNOSTIC FEATURES

- Response to the event involves intense fear, helplessness, horror (disorganized or agitated behavior in children)
- Persistent re-experiencing of the traumatic event (Flashbacks-Not substance related) and one or more of the following:
- Recurrent, intrusive, distressing recollections, including images, thoughts or perceptions (in young children repetitive play may occur in which themes or aspects of the trauma are expressed)
- Recurrent distressing dreams of event (in children, can be frightening dreams without recognizable content)
- Acting or feeling as if event reoccurring (include sense of reliving, illusions, hallucinations, dissociative flashback episodes, include those that occur on awakening or when intoxicated, in young children, include trauma-specific reenactment may occur)
- Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of event
- Physiological reactivity on exposure to above cues
- Persistent avoidance of stimuli associated with trauma and "numbing" of general responsiveness indicated by 3 or more:
- Efforts to avoid associated thoughts, feelings, conversations
- Efforts to avoid activities, places, or people arousing memories
- Inability to recall important aspect of trauma

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- Markedly diminished interest or participation in significant activities
- Feelings of detachment or estrangement from others
- Restricted range of affect
- Sense of foreshortened future
- Persistent symptoms of increased arousal or 2 or more:
- Difficulty falling/staying asleep
- Irritability/outbursts of anger
- Difficulty concentrating
- Hypervigilance
- Exaggerated startle response
- Duration of disturbance (B,C,D) more than 1 month.
- Causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Acute: less than 3 months; Chronic-greater than 3 months.
- With Delayed Onset - if onset of symptoms at least 6 mo. after event.

PREVALENCE

- 8% of the adult population in the USA (APA, 2000)
- Studies indicate that in SUD treatment this disorder is 2- 3 times more common in women than in men, (Brown & Wolf, 1994)
    - General Population: 12-34%
    - SUD Treatment Population: 30-59%
- Familial Pattern-there is evidence of an heritable component to the transmission of PTSD. History of depression in first-degree relatives has been related to an increased vulnerability to developing PTSD.

COURSE

Can occur at any age usually beginning within the first 3 months after the trauma, although there may be a delay of months or even years.

CO-OCCURRING

- Major Depressive Disorder
- Substance Related Mood Disorder
- Panic
- Agoraphobia
- Obsessive Compulsive Disorder
- Generalized Anxiety Disorder
- Social or Specific Phobia
- Bipolar Disorder

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-5 — **121**

- Personality Disorders
- Dissociative Identity Disorder
- Schizophrenia

DIFFERENTIAL DIAGNOSIS

- Adjustment Disorder
- Mood Disorder
- Anxiety Disorder - NOS
- Acute Stress Disorder
- OCD
- Schizophrenia
- Other Psychotic Disorders

SUMMARY OF COMMONLY CO-OCCURRING MENTAL DISORDERS

- Attention-Deficit and Disruptive Behavior Disorders
- Co-occurring Learning Disorders
- Major Mood Disorders (Major Depression, Bipolar I & II, Dysthymia,
- Cyclothymia)
- Anxiety Disorders (particularly PTSD)

Recognizing the more common psychiatric and other associated disorders occurring in children and adolescents, in terms of their symptoms and impact/effects on functioning and functional capacity, as well as their interaction with Substance Use Disorders, improves the potential for developing co-occurring capable and/or enhanced clinical services. As each discipline and field of specialization becomes more willing to explore, listen, respect, engage, collaborate, cross train and cross pollinate with each other, the greater possibility our adolescent (and other age groups) clients/patients and their families have of receiving the necessary and appropriate care they deserve and have a right expect. Conversely, the more competent and better the care we as professionals are capable of providing, the greater our sense of professional pride, professional satisfaction, professional motivation, energy and passion we experience and bring with us. It is an synergistic process that mutually serves our noble work.

CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

122 — **MODULE-5**

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MODULE 6: ASSESSMENT

Goal:

Present integrated approach and method for assessment.

Learning Objectives:

Describe basic assumptions underlying the assessment process

Describe the domains, strategies and tools of assessment

Discuss the value and application of assessment

Content Outline:

Purpose of Assessment

Assumptions

Importance of Therapeutic Alliance

- Common Factors

Assessment Domains

- Data Collection

- Parent/Guardian Issues

- Biologic Measures

- Archival Records

Standardized Tools

Time Frames

5 Stages of Assessment

- screening

- diagnostic

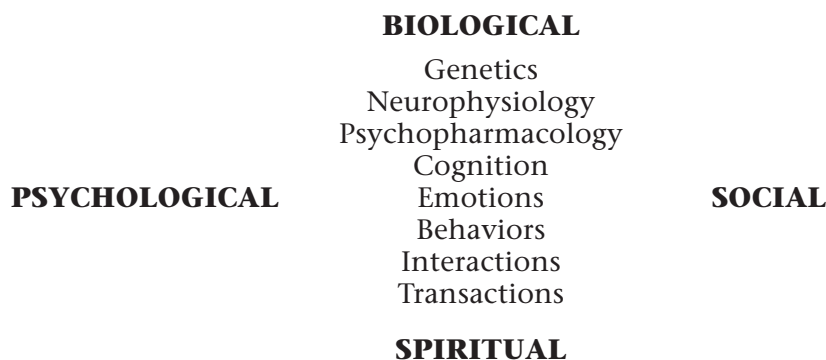- level of care

- multidimensional services

- measurement

Step wise procedure

- multiple domains

- general to specific

ASAM dimensions

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MODULE 6 HANDOUTS: ASSESSMENT

BIOPSYCHOSOCIAL MODEL (SANDS, R., 1991)

BIOLOGICAL

Genetics
Neurophysiology
Psychopharmacology
Cognition

PSYCHOLOGICAL   Emotions   **SOCIAL**

Behaviors
Interactions
Transactions

SPIRITUAL

(This model has appeared in the literature for the last 20 years referring to and emphasizing the importance of developing a holistic picture of the person in the environment and the multiple ways they interact. While the model is generally drawn as a triangle (bio-psycho-social), a better geometric representation is a circle, since all parts of the equation are always in dynamic interaction and overlap with all of the others.)

BIO: In the behavioral health field, we are generally concerned with the functioning of the "main frame" organ-the brain-that directs all of the other organs. Heredity, genes, the presence or absence of traumatic injury: all of these go into the mix of whether or not our brain can process the multiple messages it continually receives accurately or if there are specific areas of difficulty. Other biological conditions, e.g. neurophysiology, hormonal conditions, chronic illnesses, etc. may, of course, affect brain functioning.

PSYCHOLOGICAL: Psychology is the science of perception and meaning. Our "psychology" is essentially a combination of our "hardware" (brain functioning) and "software" (perceptions attended to, taken in, and assigned meaning). Each individual, because of his/her own makeup and experience with the world, takes in the world (the "out there") through his/her five senses in somewhat different ways and makes internal meaning, tempered by culture and experience, about these perceptions. So, biology and the "social" experience mediate an individual's own "psychology." Assessment in this area would focus on an ad-

olescent's ability to receive and process information and in turn, produce output; make meaning of his/her world; apply problem solving skills and learning strategies.

SOCIAL: This includes everything one is exposed to in the "out there" from in utero on: parental figures, other family members and support systems, community, cultural and ethnic views, and such things as television, computers, etc. These are the forces that seek to tell us how to perceive and give meaning to our world. Assessing the social domain also helps us to understand how living in certain environments can increase vulnerability and risk, (e.g. poverty, chaotic family dynamics) and/or promote protective factors (family bonding, affiliations, positive peer groups and mentors).

SPIRITUAL: While this is a term that has sometimes been added to the original model, it is really another combination of bio-psycho-social experiences, mediated by our biological temperament, our environmental influences, and the meanings we ascribe to life events. Finally, there is some choice in how we view the world and others in it as either having great value beyond ourselves or as competitors that necessitate "getting mine first." Since adolescence is a time for identity development, assessing spiritual growth and connection may be presumptive at this point. It can be helpful to assess the family's beliefs and practices and how the adolescent relates to those beliefs and practices in the here and now.

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MODULE 6 HANDOUTS: CASE 4

TONYA is a 15 year-old African-American female who lives in an urban inner-city housing project where she attends the local high school. She was referred to inpatient rehab by her school drug counselor as a result of numerous truancies from frequent runaways. It was reported by her mother that when Tonya returned home from running away she appeared intoxicated and disheveled. As a result of these reports the drug counselor required a urine drug screen which tested positive for marijuana and cocaine.

During the assessment Tonya seemed to have a difficult time responding clearly to the questions being asked, often requesting that the questions be repeated and/or clarified. She would often respond to questions by saying, "I don't know" and "I don't remember". Most of her other verbal responses were short and unembellished. Tonya reported that she was a sophomore in high school but didn't like it. However, she indicated that she had always done well in her grades except for a three-year period of time when she lived in California where she experienced a great deal of difficulty and was unable to keep up. She reported that she had a lot of friends but was unable to name any of them and what they would do together.

Tonya's mother reported that Tonya was difficult to manage at home and often didn't listen to her. She reported that she was a single mother and that Tonya's father had left the home soon after Tonya was born and was not in the picture. She reported that she struggled financially most of the time and was receiving public assistance because of or inability to keep a job. She indicated that when Tonya was about 10 years old she moved with her to California to live with family but stated that Tonya had a very hard time making friends and had to be given special assistance in school.

During her inpatient rehab experience, Tonya was the brunt of many denigrating comments by the other adolescents. They would comment on her poor personal hygiene and her mismatched style of dress. During group therapy and in other discussions they reported that she would often make inappropriate comments that seemed unrelated to the topic. When it came to producing her required clinical work assignments she appeared passively resistant by not getting them done.

During a multidisciplinary treatment plan review meeting the team determined that Tonya did not appear to be engaged in treatment and appeared vaguely disconnected with little spontaneous contribution. She seemed unable to follow directions and wasn't completing any of her clinical assignments. When asked she would read selected passages from recovery literature but always said, "I don't know" when asked if she could share with the group what she understood of what she had just read. It was decided by the team that due to the apparent noncompliance and non-engagement in treatment as well as the negative treatment by her peers despite constant attempts to redirect their behaviors she would be discharged to an IOP program and in-school support by her drug counselor.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-6 — **125**

MODULE 6 HANDOUTS: CASE 5

JESSICA, a 17-year-old Caucasian female was admitted for her third inpatient treatment under duress and at the coercion of her mother. It was reported that Jessica had been treated in two prior substance abuse inpatient programs but was unable to remain abstinent upon discharge from either one. She mainly used alcohol, marijuana, and cocaine, all of which she took indiscriminately and constantly. Jessica was essentially alienated from her family who was frustrated and overwhelmed and close to "giving up".

While on the unit Jessica presented with a great deal of hostility and unbridled anger that manifested in her constantly cursing everyone out. Staff referred to Jessica between themselves as "that angry bitch" evidencing strong negative counter transference feelings. She dressed in a highly provocative manner contradictory to the unit dress code and attempts by the staff to redirect her behavior. She would often glamorize and brag about her promiscuity and sexual conquests, much to the chagrin of the male staff and male patients. Since being on the unit and "clean" her roommates reported to staff that they often heard her crying in her bed after waking up panicky and frightened from a nightmare. She wrote Journal logs that often left staff feeling shocked at her rage, hostility and the language that she used. Below is an example of one of her log entries three weeks into treatment:

"Today sucks. I'm pissed off at a lot of people. Someone took a tape and gum out of my cube and no one will admit to it. Fuck that shit. I'm pissed off about the way things are dealt with around here.... My dad's pissed off because of all the shit, and he's telling me to tell everyone to get fucked. I'm pissed off because I know I could manipulate my mom into getting me out of here if I got pissed off enough but I don't want to do that. I want to be here because I want to work out all my shit, but I hate dealing with all the bullshit everyone puts on me. I'm tired of being disappointed because of unfulfilled promises. And I'm especially pissed about assholes who talk shit to me when they don't know a damn thing about me. One good thing is that my mom brought me some new tapes."

MODULE 6 HANDOUTS: CASE 6

SHERRY is a 17 year-old Latina who lives outside of a major city. She used cocaine for several years, and was introduced to it by her boyfriend at the time. She has a history of using marijuana, ecstasy on occasion and alcohol as well.

Sherry has lived on her own for the last year, choosing to stay at Covenant House (NYC Runaway Shelter) when she could no longer stay with friends. Her counselor at Covenant House referred her to the substance abuse treatment program where you perform for the evaluation. Upon meeting Sherry, you begin to take a history to learn more about her background. She gives you a flood of information and you struggle to keep up with her as you take notes. She tells you that she has been "on her own" since leaving home at the age of 16 because she could no longer handle the arguments and restrictions that her family was trying to impose on her. She stated that she grew up in a loving but strict family where she was the youngest of six children. Also living in the home is her grandmother who suffers from severe depressive episodes, often taking to her bed "for the winter". Sherry reports that some of her brothers drank a lot but she hid her own drug and alcohol use from the family. She stated that she has tried most drugs, but prefers cocaine because "even though I'm pretty fast it calms me down."

Sherry denied any current suicidal ideation but reported a suicidal attempt at the age of 14 while in a depressive episode. Now she reports feeling good, and "wanting to get myself straightened out because I have a lot of plans." She reported that she wanted to write a book about her experiences at home and on the road on her own. She felt it would be good as a guide for other runaways who "might not have to go through what I did"

Sherry reported that she had been doing well in school up until high school, when she began to have trouble concentrating and frequently became argumentative with teachers. She recognized that she used too many drugs and indicated that her goal was to "cut back so that I can function better."

When asked for permission to contact her family she refused to provide her family's name or number for a collateral contact, declaring herself an "emancipated person, you know..." She indicated that she would be taking legal action to officially separate herself from her family of origin. During the history, Sherry hinted at abuse but refused to go into any detail. A urine drug screen and breathalyzer was taken just prior to her entering the interview and indicated she had a BAC of .08 and was also positive for marijuana and cocaine. An initial medical examination by the intake nurse also indicated high blood pressure, diaphoresis and slight tremors.

MODULE 6 HANDOUTS: CASE 7

STEPHEN is a 151/2 year old Caucasian male and high school sophomore. He was recently suspended from school due to testing positive for marijuana and also being in possession of marijuana broken up into small glassine bags. The local authorities detained Stephen and he was being charged with possession of marijuana and possession of marijuana with intent to distribute.

Stephen's family history reveals that both of his parents were highly successful, his father as a stockbroker and his mother as a physician. Stephen reported that he always felt under a great deal of pressure for academic excellence and always felt that whatever he did wasn't good enough.

During his early elementary school years and most of his junior high school years he excelled academically, always being in the highest groups and was also a gifted tennis player making a name for himself in the junior leagues. He was described as gregarious and funny often to the point of being reprimanded in school for being a class clown. Despite his fooling around his parents were always amazed at how easy school seemed to be for him commenting that he would get A's without ever opening a book. On the other hand his parents reported being very frustrated that he never seemed to get things done when they asked no matter how many times he got into trouble at home or at school. They stated that although he was disciplined for the behaviors, he never seemed to learn from it. Over time this began to create great a deal of tension and arguments between him and his parents.

In the middle of the 1st marking period of his freshman year of high school, in which he was in all honors classes, his parents received numerous progress reports that indicated he was close to failing all of his subjects except for math, his favorite subject. Reports indicated that he failed to turn in any of his homework and was unprepared for quizzes and tests. When confronted by his parents he simply stated "it was no big deal".

Stephen began to become more and more secretive often locking himself in his room playing video games and listening to music. Any time his parents asked whether or not he had homework he would snap at them saying "I got it done at school. I told you I would do better. If you keep bugging me I'm not going to want to do it." He appeared to be more recalcitrant, oppositional and argumentative, stating that more and more things didn't matter, his classes were stupid and the teachers didn't know anything. He further indicated that the teachers were such idiots that they couldn't keep any notes straight and that they lied about him not turning in his homework to cover for themselves for losing it. At the same time his parents reported that he began missing practices for tennis and Stephen later notified them that he was not going to rejoin the team stating it was getting boring and he didn't have any competition and he was beyond what the coach had to offer.

By the end of his freshman year Stephen had completely shut down in school and was acting out more at home. Throughout the summer before his sophomore year, Stephen escalated his oppositional and defiant behavior, disregarded curfews, snuck out at night and had several underage drinking incidents involving the police that were handled quietly.

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MODULE 6: INTRODUCTION

Integrated Multidisciplinary Adolescent Assessment

Assessment represents the process for understanding the individual adolescent as a unique person in the context of the Biopsychosocial and spiritual developmental process of adolescence. As described in the module detailing adolescent development, there are many complexities inherent in the normal course of development. However, adolescents who must also deal with additional disorders, whether they are congenital and/or acquired in the course of their development, have a considerably more difficult process to negotiate riddled with greater risk potential. The balance of resiliencies and competencies versus liabilities and challenges is precarious. Therefore, assessment takes on an even more critical role in the effort to gain understanding in the service of designing, planning, implementing, monitoring and reevaluating care and treatment. It stands to reason that given the multi-dimensional, multi-systemic, multi-environmental, multi-social and that multi-contextual world of the adolescent; a quality assessment must be COMPREHENSIVE and MULTIDISCIPLINARY.

Assessment must be understood as a dynamic and evolutionary process and not a static event.

This module has been designed to familiarize participants with the essential components of a comprehensive, multidisciplinary and integrated adolescent assessment which is essential in meeting the needs of adolescents with substance use and co-occurring psychiatric/mental health and/or other associated disorders. The module will present the information and material from a variety of perspectives including but not limited to: theoretical underpinnings; pragmatic operational assumptions; recognized structural formats; clinical data collection; and application and clinical experience.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-6 — 129

CASE STUDY WORKSHEET

Case:_____

MENTAL HEALTH SYMPTOMS AND TREATMENT	SUBSTANCE ABUSE SYMPTOMS AND TREATMENT	INTERACTION

Impressions: _____

_____

LIFETIME TIMELINE

AGE	EVENT	RESPONSE	CONSEQUENCES

Impact of Family, Gender, Culture on Course of Illnesses: _____

_____

_____

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

130 — MODULE-6

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MODULE 6 HANDOUTS:
CASE STUDY WORKSHEETS

STRENGTHS, RESOURCES, TALENTS

Review all psychosocial domains. Include past, present that exist for the person individually, in relationship to others and the community.

_____

_____

_____

_____

PROVISIONAL DIAGNOSIS

AXIS I		CRITERIA	
AXIS II			

LEVEL OF CARE

SEVERITY OF ILLNESS	IMMINENCE OF RISK	SUGGESTED LEVEL OF CARE

111. MODULE 6: Adolescent Assessment

COMPONENTS OF A QUALITY
COMPREHENSIVE ASSESSMENT

112. GOAL

Present an integrated approach and
method for assessment.

113. OBJECTIVES

Participants will be able to :

- Describe basic assumptions underlying the
assessment process
- Describe the domains, strategies and tools
of assessment
- Discuss the value and application of
assessment

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114. Purposes of Assessment

- Establish a working relationship
- Engage the adolescent
- Demystify the process
- Engage Parents / Guardians
- Assess Competencies, Capacities & Resiliencies

115. Purposes of Assessment - continued

- Assess & Evaluate Resistance, Motivation, Readiness for Change
- Assess & Evaluate Severity of Illness
- Substance Use Disorder
- Psychiatric / Mental Health Disorder
- Develop Provisional DSM IV Diagnostic Picture
- Develop Provisional Plan of Action
- Goals
- Objectives

SLIDE 115 NOTES:

The primary assessor, along, with the multidisciplinary team of professionals, serves multiple functions. First and foremost is creating a supportive and collaborative rather than adversarial relationship with the adolescent and his/her family. This can be developed from the outset with discussions of confidentiality as a basis for engendering trust. It may be equally important to provide an opportunity for the adolescent to ventilate especially if they are there under mandate. It is not unusual for the adolescent and/or parents to "test" the assessor (and most others for that matter) in an attempt to ascertain how safe the assessor and the process really are.

Establishing the impression of a competent, authoritative, interested and empathic collaborative team goes a long way in assuaging many of the inherent fears and anxieties, real or imagined, which are natural to the experience and help to foster cooperation in the assessment. It is natural for the adolescent and the family to have questions about what's going to take place, whether it is the first time or one of many. It is, therefore, important to provide an opportunity for the family and the adolescent to ask, and have answered, any questions about the process they are engaging in. Explaining the components that make up the assessment process, and the rationale behind them, while at the same time inviting their honest participation, can effectively facilitate an initial therapeutic partnership and help in de-mystifying the experience they are entering with you. It allows for the adolescent and family to experience themselves as participants in the process with a valuable role to play in the yet-to-be-determined plan of care.

CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS
MODULE-6 — **133**

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SLIDE 115 NOTES (CONTINUED):

TRAINER NOTE: It may be helpful to reference the Blamed and Ashamed Report which emphasizes the critical factor of engaging and respecting the parents and adolescent.

The second slide articulates the ultimate goal of the assessment procedure, i.e., to gain the most accurate clinical picture possible on which an initial plan of care can be formulated. At a minimum, it is essential to gain accurate information concerning each of the presenting disorders and their imminent risk potential so that any immediate action needed with regard to safety can occur while deferring other aspects of the assessment process. This information also determines level of care which we will review in subsequent slides.

An essential aspect of the assessment is gaining a sense of the adolescent's level of willingness to engage in the change process of treatment. This has been discussed in the literature using a variety of terms and language such as "motivation", "resistance" and "readiness to change," (Miller, W.R., & Rollnick, S., 2002; Riggs, P.D., 1998; Riggs, P.D., & Davies, R.D., 2002) to name a few.

TRAINER NOTE: Please refer to the bibliographies and other resources for additional references.

Gaining an understanding of what the adolescent wants from the experience provides the "hook" of engagement. This could be a self actualizing "want" or simply a "get out of trouble" want. Regardless, it allows for the opportunity of allegiance and invitation as opposed to adversary and defense. This can be especially true with regard to adolescents who have co-occurring disorders, may display histories of non-compliance with medication protocols, prior treatment recommendations etc. In this context the assessment of each of the presenting and/or suspected disorders becomes more reliable.

Based on the accumulated data, past and current histories of symptom and behavioral manifestations, family histories for genetic and/or environmental predispositions and propensities that are matched against currently understood diagnostic criteria, a provisional diagnosis may be developed. In consideration of the assessment data and matching diagnostic criteria a provisional plan of action (Treatment Plan) may be formulated for timely implementation.

It is again important to emphasize that assessment is a dynamic and evolutionary process and not a static event. From the initial assessment and provisional determinations forward, active monitoring, continual re-assessment and refinement are necessary to maximize potential treatment engagement, participation and adherence, contributing to success.

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116. Assessment for ALL Disorders is Necessary Because...

- Having one disorder increases the risk of developing another disorder;

- The presence of a second disorder makes treatment of the first more complicated;

- Treating one disorder does NOT lead to effective management of the other(s);

- Treatment outcomes are poorer when co-occurring disorders are present.

117. Some Basic Assumptions
(Adapted from Minkoff, 2000)

- Heterogeneous population

- Application of Biopsychosocial framework

- Complex assessment occurs over time and begins with need to engage as many as possible

- Frequent occurrence of multiple problems and mental and physical disorders

- Effective interventions and treatment programs are flexible and occur in stages

SLIDE 116 NOTES:

One of the basic assumptions underlying assessment of adolescents dealing with co-occurring disorders lies in the expectation of an increased risk/vulnerability for the development and/or emergence of another disorder. The interplay between and amongst disorders, the impact and influence on disorder management, treatment and outcome, and certainly the availability and allocation of appropriate resources to meet individual needs must be considered in treatment planning. Therefore, making the basic assumption to assess for all disorders facilitates a "no wrong door" access for care perspective and serves to minimize the potential for engaging in "chicken and egg" debates between the primacy of onset between substance use disorders versus psychiatric/mental health and/or other associated disorders. As noted in the previous module such debates, especially from an initial screening perspective, tend to place the adolescent client/patient, their family and/or other caretakers in a game of monkey in the middle between professional disciplines and systems.

SLIDE 117 NOTES:

As noted earlier in the module regarding adolescent development, adolescents move through the process of development in their own way. This in and of itself is the basis of heterogeneity regarding the adolescent population. While there are common pathways for the development of the more frequently observed co-occurring disorders in adults, adolescents with co-occurring disorders have a number of differing disorders in different combinations. In effect, there is heterogeneity in the population (race, ethnicity, gender, socioeconomic status, etc.) as well as heterogeneity in the development and manifestation of co-occurring disorders in the adolescent.

Because of the dynamic forces exerted from a biopsychosocial perspective during adolescence, each adolescent needs to be evaluated from an individualized biopsychosocial framework and process in order to better understand the idiosyncratic interplay amongst the combination of forces contributing to the development and maintenance of each disorder.

Respectful of the numerous issues and dynamics accompanying each adolescent appearing for assessment, it is reasonable to assume that a full and complete set of assessment data will not be immediately present. It is from this perspective that the assessment process must be attended to with the expectation that other critical information may be revealed over time by the adolescent and/or other key informants who

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-6 — **135**

have the opportunity to observe the adolescent in a variety of conditions. For this to occur it is essential that the adolescent is engaged with safe, empathetic, interested, competent and reliable professionals and settings, over time. Only then can the adolescent and family trust enough to risk the revelation of the most critical concerns.

Given the heterogeneity of the co-occurring disordered adolescent population in all domains, one size will never fit all. Some combinations of disorders and/or problem areas may carry higher degrees of risk for relapse and/or increased resistance to change (despite desire, motivation and readiness to change) on the path to recovery. For example Wise, et al (2001) reported in one study of substance use disorder treatment outcomes, adolescents diagnosed with both ADHD and Conduct Disorder demonstrated a 20% success rate compared to ADHD only at 60% and Conduct Disorder only at 70.6%. Factors considered in determining "successful" participation included: attendance and positive interactions in treatment groups; level of denial of problems; quality of products from treatment projects and interactions with peers and nursing staff during unstructured time. Therefore, flexibility, thoughtfulness and creativity in the design and plan for care, intervention strategies, modalities and the like, specific to the adolescent's clinical profile and the needs of his/her family are key to effective work once their world has been entered and understood.

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118. Basic Assumptions, continued

- The adolescent sitting before you has a history before the onset of their presenting symptoms.

- The adolescent's early developmental history holds essential information regarding resiliencies & competencies as well as areas of deficit and risk potential

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SLIDE 118 NOTES:

While it may appear redundant, it bears repeating that it is essential to take time during the assessment process to seek out and explore a detailed early childhood history of development across the biopsychosocial domains. It goes without saying that, the more knowledge available about the adolescent from the earliest points possible, the more likely the current status may be informed and given more clarity regarding the onset of difficulties as well as the adolescent's potential capacity to address them. Gaining knowledge of developmental time frames in the adolescent's lifespan, when he/she may have been illness/problem free or demonstrated domains/islands of competency, resiliency and strength-based and uncompromised functioning across major life domains, can be of great assistance in the identification of change points, events, incidences etc. that may be contributions to the now. The more that can be known and made sense of, the greater the opportunity and potential to provide effective care.

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SLIDE 118 NOTES (CONTINUED):

TRAINER NOTE: It may be helpful to reference and reiterate the information contained in the slide "Adolescents with SUD..." & "Traumatic Victimization" in Module 1-Brief Overview of Co-occurring Disorders and Adolescents it relates to the value of early childhood histories in the assessment process.

HANDOUTS: Case Studies #4-7 / approx. 30 m

EXERCISE: Instruct the participants to turn to pages 119-122 in the manual. There are 4 case studies that have different profiles and different diagnoses. These diagnoses are provided below, however the participant manual case studies do not have that additional information.

Assign a case study to each small group table. Instruct them to read the case study and:

- identify variables that raise assessment concerns for both substance abuse and mental health;
- note questions related to the case;
- write down their initial impressions.

The case studies will be used several times throughout the module to build on and develop a preliminary diagnosis.

CASE 4: TONYA

DSM IV-TR:

Axis I:	305.20 - Cannabis Abuse
	305.60 - Cocaine Abuse
Axis II:	317.0 - Mild Mental Retardation
Axis III:	No DX
Axis IV:	Single parent home, financial stress, school problems, high crime area
Axis V:	GAF Current 55; Past year: 50

CASE 5: JESSICA

DSM IV-TR

Axis I:	296.92 Mood Disorder NOS; Early Onset With Atypical Features
	309.81 Post Traumatic Stress Disorder
	304.30 - Cannabis Dependence
	303.90 - Alcohol Dependence W/O Physical Dependence
	304.20 - Cocaine Dependence
Axis II:	Deferred
Axis III:	No DX
Axis IV:	Parental Discord, Academic Failure
Axis V:	GAF Current: 45; Past Year: 40

CASE 6: SHERRY

DSM IV-TR:

Axis I:	296.42 Bipolar Disorder Most Recent Episode: Manic - Moderate

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-6 — **137**

303.90 Alcohol Dependence With Physical Dependence

304.20 Cocaine Dependence W/O Physical Dependence

Axis II: Deferred

Axis III: Alcohol Withdrawal Syndrome

Axis IV: Runaway, Family Substance Abuse, School Dropout, Abuse

Axis V: GAF - Current: 40; Past Year: 40

CASE 7: STEPHEN

DSM IV-TR

Axis I: 314.01 - Attention Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type

304.30 - Cannabis Dependence With Physical Dependence

305.00 - Alcohol Abuse

Axis II: Deferred

Axis III: No DX

Axis IV: GAF Current: 55; Past Year: 65

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119. The 4 Common Factors

(Hubble et al., 1999)

- 40% Client/Extra-therapeutic factors
- 30% Therapeutic alliance
  - Effective relationship
  - Capacity to work in therapy
  - Therapist's empathic understanding
  - Agreement on goals and tasks
- 15% Hope and experiences
- 15% Model/technique
  - Importance of theoretical orientation

SLIDE 119 NOTES:

The goal of the information on this slide is to provide an opportunity to expand the concept of assessment from simply a task of information gathering to a clinical/therapeutic intervention modality and strategy that often sets the stage for a successful or unsuccessful episode of care.

A great deal of writing has been done in the psychotherapeutic literature regarding factors that are most closely associated with the effectiveness of treatment. In their book, "Heart and Soul of Change", (Duncan, Hubble & Miller, 1999), the authors compiled 40 decades worth of the research literature to articulate the major factors and their relative weight of contribution to the process of change. Of critical importance, and most likely understood without the support of research, is the value of the therapeutic alliance/relationship accounting for 30% of the influence and secondly the provision of hope at 15% of the influence. Considering that the provision of hope can be aligned with positive human interaction it can be easily added to the therapeutic alliance to account for 45% of change potential. Extrapolating these findings as they relate to the process of assessment- as this is often the first prolonged contact and interaction with treatment services that an adolescent and his/her family may be exposed to-there is no mystery as to the potential influence and impact this initial contact may have.

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Specifically, they note that there are four common factors that transcend specific models and theories. The common factors follow:

CLIENT/EXTRA-THERAPEUTIC FACTORS-40%

Client/extra-therapeutic factors are client strengths and supportive elements in the client's environment, such as faith, persistence, a supportive relative, membership in a religious community, a sense of personal responsibility, or a new job. This perspective regards clients as self-healers.

THERAPEUTIC ALLIANCE-30%

The counselor should offer caring, warmth, acceptance, and mutual affirmation. He or she should encourage risk-taking and mastery. Except for what the client brings to therapy, these variables are probably responsible for most of the gains resulting from psychotherapy interventions. Tasks include bonding between the client and counselor and clarifying or agreeing on goals and tasks.

HOPE AND EXPECTANCIES-15%

Successful therapy is a result of both the client's and the therapist's belief (hope and expectancy) in the restorative power of the treatment procedures or rituals. Hope may be understood in terms of how people think about goals. Thinking about goals is defined in two ways, a person's ability to design a goal and the confidence the individual has in reaching and sustaining the goal (degree of self-efficacy). In this model of hope, stress, negative emotions, and difficulties in coping are considered a result of being unable to envision a pathway or make movement toward a desired goal. Some research shows that people experience negative emotional responses when blocked from achieving their goals. At the same time, research also shows that people are likely to experience positive emotional responses and maintain hopefulness when they are able to pursue their goals and generate alternative pathways when needed.

Hope can be elicited and reinforced through the therapeutic alliance, the therapeutic setting, belief in the therapeutic intervention, and therapeutic rituals. Together, the four factors work to produce cognitions that make the client's therapeutic goals more viable. In general, the therapeutic relationship and setting in which treatment occurs foster thinking such as "I can do it," and the rational and therapeutic ritual influences thinking toward "Here's how I can do it." The resulting hope, in turn, is predictive of more favorable therapeutic outcomes.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-6 — **139**

SLIDE 119 NOTES (CONTINUED):

MODEL/TECHNIQUE-15%

Model/technique refers to the beliefs and procedures unique to specific treatments.

No single treatment approach is effective for all persons with co-occurring substance use and mental health problems. A more promising strategy involves assigning clients to treatments based on the clients' specific needs and characteristics. The research clearly documents that one model of therapy has not outperformed others, paralleling the findings of Project MATCH. Project MATCH was a multi-site clinical study that evaluated the effectiveness of three interventions for people diagnosed with alcohol problems. Project MATCH, funded by the National Institute on Alcohol Abuse and Alcoholism, randomly assigned participants to one of three treatment regimens: 12-Step Facilitation, Cognitive-Behavioral Coping Skills, or Motivational Enhancement Therapy. Subjects were followed at 3-month intervals for 1 year following completion of the 12-week treatment period and were evaluated for changes in drinking patterns, functional status/quality of life, and treatment services used.

All three models proved equally effective, and researchers concluded that client factors also contributed to the effectiveness of the model (Project MATCH Research Group, 1993).

We have learned that therapeutic success depends on both the counselor's relational skills and an appropriate choice of counseling model. Becoming a master technician in a particular model will not serve a counselor as well as his or her developing the expertise to use different models with different clients.

There is a high likelihood that any adolescent appearing for an assessment appointment is not there of their own accord, rather they are most likely there as a result of an external demand placed on them by their parents, school officials and/or the juvenile justice system. In many cases the adolescent's parents may also be under duress to bring their child to the clinical setting and it may be for the umpteenth time. Having a mindful awareness of an empathetic understanding for the context that the adolescent and his/her family, as well as the professional charged with the responsibility of the assessment, are in together, can broaden the opportunity to begin treatment from the first "hello". Thus, the first slide of the two focuses on the therapeutic foundation upon which the rest of the assessment is built.

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120. ASSESSMENT DOMAINS (TIP #31)

- history of substance use
- medical, family & sexual histories
- strengths and resources
- developmental issues
- mental health history
- school, vocational, juvenile justice histories
- peer relationships and neighborhood
- leisure-time interests, hobbies, activities

SLIDE 120 NOTES:

TRAINER NOTE: It is important to emphasize that, when asking about the adolescent's experiences with substances, the avoidance of words that may impart a judgmental attitude/perspective on the part of the assessor, such as "good" or "bad," is critical. Since adolescents are hypersensitive and hyper-vigilant to criticism they will seek to test how they may be viewed by their perception of the assessor's stance. Words such as "like" or "dislike" ask for information about their experience of attraction or lack thereof.

- History of substance use—including when begun, type of substance (including over-the-counter and prescription drugs, tobacco, and inhalants), how much used, under what circumstances, progression of use.

  Of critical importance is the understanding of what the adolescent's "experience" is with each substance experimented with and/or used. What is the perceived value gained in the use? What is different, in a perceived positive way, about the adolescent when he/she uses? In effect: What does he/she like most about each substance and/or combination of substances? What is the relationship he/she has developed with the drug(s) of choice? What is meaningful about it? Is there anything not as positive or not liked about the use?

- Medical history should include diseases and injuries, with details about circumstances, age of occurrence, medications or other treatments given, physical and emotional responses to these events as well as the physical, emotional and attitudinal responses by caretakers to these events.

- Family history should include any substance use, mental disorders, learning disorders, developmental disorders in parents, siblings, other caregivers, as well as a general picture of the family functioning over time; any disruptive events and the way this child is perceived by the family. Also important are any changes in/loss of primary caregivers, including any out-of-home placement and the youth's reaction to these events (both then and now).

  The family's group identity, style of working together, rules, roles, traditions, rituals, perceived level of moral development, sense of right and wrong as well as connection to any form of spirituality or religious structure should also be noted, as should be the family's methods of teaching skills and disciplining this child and/or other children. Connections between siblings (positive and negative) may also be important to ascertain.

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- Sexual history should include age of first sexual encounter (of any type), sexual activity since that time, sexual orientation at present, any difficulties with gender identity, and any pregnancies or sexual diseases. Information regarding the family's perception, attitudes, standards and references regarding sexuality are important.

- Strengths and resources are positives to build on and should be a theme that the interviewer focuses on and returns to throughout this and other interviews. Competencies, talents, interests, coping skills, the presence of any goal orientation, supports such as family and other community connections - anything that indicates capacity, a sense of pride and value that can be used to build motivation to take the risk of making changes along with the vehicles/modalities for communication needs recognition, care and feeding.

- Developmental issues include periods of "normal" cognitive and affective age/stage development as well as any disruptions or delays and potential causes (e.g., physical or sexual trauma, learning differences/styles/disorders, attentional difficulties, e.g., ADHD).

- Mental health history includes an examination of: the mastery of age appropriate developmental milestones and skills (above); social skills; early signs of academic difficulties (following directions, receptive and expressive language acquisition and use). A thorough history should also evaluate the possible presence/"soft signs" of any psychiatric disorder(s), including: clinical depression or bipolar disorder; suicidal ideation or attempts; disruptive disorders such as oppositional defiant disorder or conduct disorder; anxiety disorders, including obsessive/preservative disorders, post-traumatic stress disorder (PTSD); reactive attachment disorder; and sub-clinical temperamental difficulties, including those that may predispose to the development of an Axis II (Personality) disorder.

- A School/Academic history should include: perceptions, attitudes, and experience(s) in the academic setting; periods of doing well, specific subjects liked and disliked and why; learning style; changes in performance, attitude and "motivation"; particular areas of excelling and areas of difficulty; "best" and "worst" teachers and why; and family attitudes, expectations and responses to changes in performance. Any extracurricular activity(s); work history (including volunteer work/being mentored); any disciplinary involvement with school personnel; any involvement with juvenile justice authorities should also be discussed.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

142 — MODULE-6

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• An evaluation of the development of social skills would evaluate: Peer relationships; historical (including early childhood) and present, and whether age normative or not; types of peers, any anti-social activity or gang involvement, and whether such involvement is more normative in the neighborhood structure or not; neighborhood influences, including religious institutions, sports or social clubs, other informal networks/connections, and their importance or not to this youth/family, e.g., Big Brothers/Big Sisters or other mentoring.

• Following are some additional questions to ask: How does this youth spend leisure time? Does he/she have specific interests, play sports; pursue any interests that are not connected with substance use or other serious health/physical risk?

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121. Data from Multiple Sources

(adapted from Meyers, et al)

• Adolescent

• Parent(s)/guardians/custodians

• Biologic measures

• Archival records

• School Personnel / Child Study Team

SLIDE 121 NOTES:

A quality, comprehensive assessment can be likened to detective work. The process gathers information or clues to gain understanding but as any good detective knows, the sources of the information may not always be reliable, the clues may not always jibe, there may be inconsistencies, missing information, competing perspectives and/or belief systems. It is rare that any one source can provide anything approaching a full picture and therefore it is essential to obtain information, data and observations from as many of the pertinent sources as possible in the adolescent's life in addition the his/her self reporting. The following expands upon each source category.

ADOLESCENT CLINICAL INTERVIEW AND SELF RATINGS

(adapted from Meyers et al)

Seek the adolescent's perspective within three primary domains:

• Acknowledgment of problem(s);

• Importance of some intervention;

• Identifying life areas most bothersome to the adolescent.

These "information sets" help decisions re: HOW to engage him/her & WHERE to focus the clinical interventions.

Motivation and investment in the process of treatment and finding solutions on the part of the adolescent are critical to the success of these interventions [and to the extent of positive involvement on the part of family members]. Because the family and others may have different views and agendas (including the clinician), beginning with what is most both-

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-6 — **143**

ersome to the youth may provide opportunities for further treatment engagement, building the working relationship, and raising motivation to deal with other more difficult issues over time.

The more concrete and substantiated information/observation regarding the adolescent's functioning that can be provided and obtained, the more prepared the assessor(s) can be to evaluate the meaning of the assessment data and more precisely diagnose, intervene and develop a treatment plan. Such information is best obtained via these primary and secondary sources.

- Parent(s)/guardians/custodians report
- Biologic measures
- Archival records
- School Personnel

While such data may be used to obtain a fuller picture, currently and historically, it is important not to imply that one is "checking up on" the adolescent by obtaining independent verification of their answers. Such a perception may alienate the youth rather than produce more veracity. It is more productive to be matter of fact about what is involved in the process and the fact that gaining additional information is standard operating procedure and designed to assist in being more helpful.

Obtaining information from multiple sources provides a more comprehensive and accurate report of the adolescent's behavior patterns and tendencies, e.g, some DSM criteria require behaviors to be present in more than one setting. Looking at several environments may provide clues as to specific stressors or supports.

It should also be considered that many states have regulatory requirements regarding what needs to be included in an assessment. Additionally, nationally recognized accreditation bodies, e.g., JCAHO and CARF also have requirements regarding source and data collection that may be above and beyond state regulatory and/or licensure requirements.

122. Parent/Guardian Issues
(adapted from Meyers, et al)

Parents are not always the most reliable informants regarding their child's behavior due to:

- Disparity between parents and adolescents;
- Improving cognitive capacity in adolescents;
- Fewer observation opportunities for parents;
- Problems in child care practices.
- But DO involve parents to create a working relationship, treatment involvement, and to see the world from their perspective.

SLIDE 122 NOTES:

Meyers, et al, suggests that certain caveats be kept in mind when gathering information from parent/guardian sources. Parents may not always be the most reliable informants regarding their child's behavior due to:

- Disparity between parents and adolescents regarding "normal" behavior
- This may be especially prevalent with immigrant families with acculturating adolescents
- Improving cognitive capacity in adolescents and their artful ability to dissuade and/or misdirect parental concerns
- Fewer observational opportunities for parents
- Problems in child care practices

But DO involve parents to create a working relationship, treatment involvement, and to see the world from their perspective. Without gaining the engagement of parents/guardians there is a significant risk of treatment being undermined either passively, actively or both. Other interferences with reliable parent/guardian information may occur via:

- Disparities in age cohort and culture, temperament, behavioral styles, etc, i.e.; a parent's unrealistic perspective as to what is to be expected at certain age levels, cultural expectations may be out of sync with the adolescent's peer culture; possible "acculturation" shifts for immigrant families; clash of temperaments; and poor "goodness of fit" between parent/guardian and the adolescent.

- Adolescents are more able to be reliable self-reporters than younger children because of development in thinking, use of language, and accurate memory.

- Adolescents spend much time in the company of other youths, in school, and not at home under parents' direct supervision.

- Parents have their own areas of strength and need, may be physically and/or emotionally neglectful or overly punitive, and may sometimes be abusive because of their own limitations and disorders.

- Parents, however, remain the primary source of connection for their child and need to be actively included in planning and implementing strategies for helping their child learn, grow, and change.

123. BIOLOGIC MEASURES
(adapted: Meyers et al)

- Urinalysis and blood-alcohol content

- Problems with these measures may render them less sensitive and useful

- Other biologic measures may be needed (e.g., lithium levels, checking ADHD medication responses, etc.)

SLIDE 123 NOTES:

- Urinalysis and blood-alcohol content are often used as measures

- Urine Drug Testing is the most reliable specimen for essentially all drugs with the exception of alcohol

- It is non-invasive versus blood draws

- Problems with these measures may render them less sensitive and useful

- Use of adulterants and/or internal and external dilution

- Detection time ranges (min/max) by drug category

- Sensitivity of the test

- Potential for false negatives and/or false positives

- Requires controlled specimen collection protocols

- Use of temperature sensitive collection cups

- Confirmation testing with specimen integrity / veracity measures

- Other biologic measures may be needed for youth with co-occurring disorders (e.g., lithium levels, checking ADHD medication responses, etc.)

Involving the youth and family in seeing these measures not as punitive but as helping to examine what is going on biologically in order to match treatments and supports to the level of need is useful. Giving maximum information about what the tests are for and how the information will be used is very useful.

124. Archival Records
(adapted from Meyers, et al)

- Collection of prior treatment charts and/or summaries, school records, etc. is usual.

- Use of standardized instruments to collect data is not common.

- Data bias is more common than not, given the variance in evaluators, youth's presenting problem, domain/purview of assessor.

- Such data are useful, but not complete.

SLIDE 124. NOTES:

- Efficient collection of prior treatment records
  - Assessments
  - Treatment Plans
  - Progress notes and participant documentation
  - Clinical / Treatment Assignments
  - Psychiatric / Psychological / Learning / Child Study Team Evaluations
  - Medical records (usually required for inpatient / residential services)
  - Continuing Care and Discharge Summaries

- Use of standardized instruments to collect data is not common*

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SLIDE 124 NOTES (CONTINUED):

- Data bias is more common than not, given the variance in evaluators, youth's presenting problem, domain/purview of assessor/team/system.
- Such data are useful, but not complete
- May fill in information gaps
- Inform regarding readiness for change and recommendation compliance
- Identify areas of treatment difficulty to consider
- Compare against current assessment data
- Identify areas of special need / accommodation / modification

Data from past treatment encounters and other service providers is helpful in examining what the adolescent has experienced and how this experience may have been interpreted by the youth (and family). It is important to remain open to the current experience and also to use any standardized instruments, where useful, to validate diagnostic hypotheses.

USING STANDARDIZED TOOLS - (Adapted from Meyers et al)

- Self-report data may be valid and reliable or not, depending on a variety of issues.
- Use of standardized tools is subject to 3 major forms of measurement error:
- Characteristics of the tool itself
- Characteristics of interviewer & respondent
- Conditions, confidentiality, & outcome of the assessment
- Adapting standardized tools compromises their psychometric & scaling properties.

Using standardized assessment tools as they are meant to be used - with populations and conditions they are meant for - can be highly valuable in augmenting semi-structured interviews for assessing co-occurring disorders in adolescents. However, tools that are misapplied or chosen poorly do not help, and may confuse and contaminate data collection.

(REFERENCE EXAMPLES SEE SELF STUDY GUIDE AS WELL AS WEB SITES TO ACCESS ADDITIONAL TOOLS)

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-6 — 147

125. Choosing Assessment Tools for Co-occurring Disorders (Gains Center)

- Are the instrument questions culturally appropriate?
- If reading required, is level appropriate for population?
- Background/training needed by user?
- Who will administer the instrument?
- Time length to administer fitting the planned assessment point?

126. Assessment Time Frames
(Adapted from Meyers et al)

- Recent vs. historical data
  - Combination generally most useful
- Lifetime timelines by key area provides data
  - what occurred when
  - developmental impact
- Past week data give current functioning
- Periods of time during past year give improvement vs. regression data for specific areas of functioning

127. Five Stages of Assessment
(Meyers et. al.)

- Screening phase
- Diagnostic assessments
- Level-of-care determination
- Ruling-in/out multidimensional service needs beyond this setting
- Concurrent measurement (ongoing assessment to monitor, manage, & assess outcomes)

SLIDE 125 NOTES:

It is important to insure that the instrument(s) being selected is valid and reliable for the population it is being given to. If the instrument has been normed based on "available" subjects (often in juvenile justice and/or acute psychiatric settings) it may not provide reasonable and applicable data with the population and setting it is being used in. Additional concerns may be related to learning and attentional problems, effect of medication on cognition and/or the effect of the substance use on cognitive function. If standardized tools are being considered, it is prudent to consider using more than one in an effort to gain inter-test reliability. If major discrepancies / contradictions are found when comparing assessment data with standardized test data, an analysis of the discrepancies is a must.

SLIDE 126 NOTES:

In an assessment, a key element is to gain a picture of the adolescent as a whole and in what manner, to what degree and in what life domains are his/her functioning compromised. Additionally, developing a picture of how the adolescent copes, manages and/or rebounds gives essential information regarding resilience, flexibility and adaptation skills. Patterns may emerge that give insight to points of higher vulnerability and decreased functional resources as well as under what circumstances that they tend to rally and tap more resources. By being able to understand the larger picture, the adolescent can be assisted in the treatment plan to gain self awareness of vulnerability in the service of relapse prevention and self efficacy in the service of strengthening resiliency and competency skill sets.

SLIDE 127 NOTES:

The assessment process may be succinctly summarized as involving these five components and decision points. Any one of the components (states) could elicit data and/or responses requiring a direction change in the process and the involvement of additional resources such as child protective services, suicidality assessment/management, trauma management and the like. They are described in more depth below.

SCREENING - (MEYERS ET AL)

To answer the related questions:

- Does an alcohol/drug use problem exist?
- Is there a need for further assessment?

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SLIDE 127 NOTES (CONTINUED):

The following general questions go beyond a simple drug/alcohol focus and incorporate more key content areas.

- Screening processes are engaged to determine whether a significant problem requiring further assessment and intervention may exist and, if so, who should be involved in assessing further and where should this assessment occur.

- Experimentation and some use may not in fact require further intervention, given the nature of adolescence in our society. Questions addressing: age at which use began, type of substances used; pattern and consequences of use; and nature and scope of other problem behaviors; are all factors that help differentiate youth who require intervention from those youth who do not. Trainer note - refer to module on substance abuse for a more detailed overview.

• Does this youth need protection?

• Does this youth need crisis intervention?

• If involved with juvenile authorities, what are the safety, flight, & recidivism risks?

• Is there high probability of specific problem areas (e.g., drugs/alcohol use, mental disorders, learning disabilities)?

• Are there indications of need for further assessment?

- As mentioned previously, current traumatic circumstances and basic subsistence needs must be assessed, along with other levels of risk involved for all. If the decision is made that further assessment is necessary, then the young person and family, if possible, are involved in further assessment to determine provisional diagnosis(es).

DIAGNOSTIC ASSESSMENT - (MEYERS ET AL)

• Does substance use meet abuse or dependence criteria?

• Are there co-existing psychiatric disorders?

• Are there probable cognitive or developmental disabilities and/or learning disabilities?

These assist in determining, treatment settings, eligibility for payments and unfortunately affect LOC.

- Assessment examines which diagnoses need to be ruled in or out, their current effects on functioning, and the ways in which the separate diagnoses may affect each other. Current symptom presence and severity is clearly outlined. The use of standardized tools can greatly enhance clinical competence, inter-rater reliability, and provide data for program evaluation.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-6 — **149**

- Routine questions regarding

    - Depression

    - Suicidal ideation and behavior

    - Anxiety

    - Aggressive behavior

    - Current and past MH/SU treatment

- Questions about psychiatric and behavioral problems should cover every major diagnostic group

SLIDE 128 NOTES:

First and foremost, when screening / assessing for mental health / psychiatric concerns safety is the number one consideration. Regardless of the setting the adolescent presents to, i.e., substance use disorder or mental health disorder treatment, special attention and care needs to given to potential risks to safety. This often is more of a challenge to the substance treatment setting where there are often less experienced counselors relative to risk assessment. Since a definitive determination of suicidality is often not possible by even the best trained and experienced clinicians, and can be even more difficult if intoxication is present, it should never be underestimated. When active use is present, even "attention getting" gestures or threatening statements of self harm may result in fatality.

The screening and assessment of an adolescent requires, as a matter of course, routine questions regarding any experience of psychiatric symptoms. It should be kept in mind that, along with everything else that is unique to adolescents, they often don't "experience" and/or manifest symptoms in the same way as adults. If there has been the presence of symptoms "for as long as I can remember" they may not be considered as symptoms but "normal" for them and perhaps a clue to an oversight of earlier identification. It is often in the context of some change or crisis that consideration of what's "normal" comes into closer focus.

A special note of attention needs to be given to adolescents, who from all points of observation, are functioning at an extremely high level. Many of these adolescents are high achievers, attending advanced placement classes, engaged in extracurricular activities, participating in community service activities and appear to handle all of these activities and responsibilities with ease. Due to their apparent lack of difficulty, social ease, productivity, "up" and positive demeanor, they are often overlooked with regard to considerations of mental health problems and/or substance use/abuse. Caution should be given not to minimize their risk factors in the face of their high functionality. The fact that they have shown up for an assessment as result of some "blip" in the screen often precipitated as the result of an uncharacteristic "overuse" of alcohol resulting in a trip to the emergency room should raise suspicions that they may not be managing life as effectively as it appears.

When positive responses are elicited from routine questions, they must be followed up with further investigation, even if it requires going outside of the standard assessment format.*

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SLIDE 128 NOTES (CONTINUED):

TRAINER NOTE: The above issues highlight the need for staff training including transdisciplinary cross training to raise, sustain and enhance clinical competency. This will be discussed further in the module on evidence-based approaches and integrated treatment. Therefore discussion should be deferred to that section of the training.

SLIDE 129 NOTES:

Patterns of symptom presentation, whether increasing or decreasing, need to be understood in the context of their manifestation.

Do they operate independently of other difficulties?

Do they come before or after other behaviors and/or conditions?

Is there a chronology of their manifestation?

Is there anything that affects the level of intensity?

How and in what manner are they responded / reacted to?

What is the peer cultural norm and does the adolescent differ in any way regarding use and effect than primary peers?

What has been done to manage, control and/or influence patterns of substance use?

What intent does the adolescent have in the use of substances?

What happens, i.e., what consequences (positive and/or negative) occur related to an episode of use?

How do the consequences relate to the intent and/or expectation(s)?

To what degree can the adolescent reliably and consistently predict the outcome of an episode of use?

When, where, how, and why do consequences occur that are different than intent and expectation(s)?

Have changes occurred regarding tolerance, frequency, amount and outcome over time?

What promises or vows has the adolescent made with regard to use that have been "broken"?

How does the adolescent explain, rationalize, justify betrayals to themselves?

As noted above, the setting in which an adolescent presents for assessment may potentially skew the perspective that the data is being filtered through along with the interpretation of that data. The mental health setting may be more likely to accept, on face value, an adolescent's minimized and/or denied use behavior. Caution is given to the use of closed end questioning

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129. Assessment, continued

- Chronology of symptoms and behaviors
- Onset of first substance use
- Regular use and pathologic use
- Identify if behaviors exist
- Independently of SU
- Intoxication
- Into periods of sustained abstinence

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-6 — 151

that can be responded to with simple "yes" or "no" answers. With a degree of "tongue-in-cheek" there is value in operating from a non-judgmental and flexible perspective to "assume deception unless proven otherwise." From this perspective, the assumption is that the adolescent has and/or does use substances and you want them to tell you about it. Contrary to popular assumption, adolescents often will reveal a surprising amount of information regarding their use behavior especially if they believe the assessor is truly interested and non-judgmental in their interest. The above possible areas of questioning as examples can usually yield critical information.

It is important that the assessor is attuned to not only the direct responses in answering (or not answering) the questions but also to the manner, affect, level of detail, attitude and non-verbal communications such as body language/posturing, eye contact and/or other soft signs suggesting there is more occurring than is being made available.

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130. Assessment, continued

- Conduct a thorough family history
- Past treatment history
- Established diagnoses
- Similar but undiagnosed co-morbid symptoms
- Patterns of mood and behavior
- Academic functioning
- Cultural influences
- Check ongoing response to treatment

SLIDE 130 NOTES:

Conducting a thorough family assessment and history provides valuable data that may be unavailable and/or unknown to the adolescent. There may be family "secrets" that shed light on the adolescent's past and current functioning or revelations of genetic predispositions and risk factors. This information may be useful in "differential" diagnosing regarding "ruling in or ruling out" possible diagnosis(es).

Observations made by parents/guardians that may have been otherwise disregarded may now be brought into sharper focus and understood from an alternate perspective. Cultural and environmental influences can guide the assessment methodology and impact treatment planning. Parents/guardians may have evidence of behavior that the adolescent has denied. On the other hand, information presented by the adolescent regarding family problems may be validated.

(Note: Adolescents often do not think that they will be believed. In many cases, if they have been evaluated in other services or programs they may not have been believed when they were being honest or have been accused of being in "denial" if their presentation didn't fit the belief system of the evaluator/assessor. It is also not unusual that adolescents have been warned, threatened and/or bribed regarding information about their family or living environment. These and other issues may significantly impact their willingness to disclose information.)

SLIDE 130 NOTES (CONTINUED):

LEVEL OF CARE DETERMINATION - (MEYERS ET AL)

- Managed care entities may prescribe the use of particular LOC algorithms for assigning placement. However, instruments used for adolescents lack empirical evidence for their use and should not be used as sole criteria.

- Rather, placement reflects severity, individual psychosocial profile, and service matching to individual needs.

TRAINER NOTE: Further discussion regarding LOC determination and algorithmic "instruments" occurs later in the module in more detail.

- The authors point out that careful clinical formulation is more sensitive than the more general placement criteria used in level-of-care algorithms.

- All of the individual factors mentioned, including age, gender, developmental needs, ethnicity/culture, type of co-occurring disorders, youth and family preferences, etc., need to be considered in selecting a treatment program that may prove most effective with THIS particular adolescent.

POSSIBLE COMBINATIONS - (RIES, 1994)

- Substance Use Disorder Symptoms: High - Mental Disorders Symptoms - Low

- Substance Use Symptoms - Low; Mental Disorder Symptoms - High

- Mental Disorder Symptoms - High; Substance Use Symptoms - High

- Mental Disorder Symptoms - Low; Substance Use Symptoms - Low

- Richard Ries uses this set of variables to describe four possible combinations of symptoms that would suggest four different responses re: LOC placement. For those on the left, the suggestion is that these can be managed within traditional mental health or drug and alcohol treatment settings that are informed about the possible interactions from the co-occurring disorders.

- For those on the right, the suggestion is that the top category would need to be managed in a "dual diagnosis capable" (Minkoff) facility where treatment is fully integrated.

- The fourth category is one where a brief intervention or "booster" may be needed and a follow-along plan in place to assist the adolescent's recovery efforts and relapse prevention plans.

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SLIDE 130 NOTES (CONTINUED):

OTHER SERVICES NEEDED - (MEYERS ET AL)

• At this point, a rule-in or rule-out of the need for multidimensional service needs must be made. Consider the adolescent and family's living conditions, other family issues/needs, other agencies already involved/needing to be involved, and what supports will be necessary and must be coordinated in order to support treatment efficacy.

- Such assessment is generally conducted along with the level-of-care determination to best match the total current needs of the youth and family.

EXERCISE: Case Studies #4-7 / approx. 30 m

HANDOUT: Timeline

In their table groups, return to the case study. Using the case study handout complete a timeline of events that have occurred for the adolescent.

Instruct them to make sure that as many as possible developmental issues, etc. are identified.

They should identify what this timeline tells them about the adolescent and family and discuss how completing this is helpful for case conceptualization/ treatment planning.

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131. Step-Wise Procedure
(Tarter, et al, 1990)

1. Screening of multiple domains of adolescent functioning
    • Substance abuse
    • Psychiatric/behavioral
    • Family
    • School/vocational
    • Recreational
    • Peer
    • Medical
2. Positive responses are then followed by more detailed, focused assessment

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SLIDE 131 NOTES:

As noted previously, structuring the screening/assessment data gathering in order to gain comprehensive data sets provides an opportunity to look independently and interactively at information to form a more dynamic set of impressions, test the reliability and validity of the data and to make informed decisions regarding focus, diagnosis, resources, services treatment direction/ planning and level of care requirements. While it may appear to be a step-wise sequential process, in actual practice, various aspects of the process may occur simultaneously.

In essence, the requirements demanded from the managed-care model are accountability for the clinical decisions related to a client's/patient's assessed "severity of illness" and the recommended level of care and setting appropriate to render services in the safest and least restrictive environment. This dramatic change in the manner that mental health and substance abuse services would be reimbursed created chaos in the health-care delivery system specializing in those services.

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132. Level of Care Determination

- ASAM PPC-2R (2001)
- Treatment matching
- Long-term Outpatient Treatment
  - Greater effect for more severe social, family and employment problems (Friedman, et al 1993)
  - Better outcomes for adolescents with more severe psychiatric problems

SLIDE 132 NOTES:

The intent of the ASAM PPC-2R with regard to the adolescent patient placement revisions was to consider the unique aspects of development, substance use disorders and mental health/psychiatric disorders in an integrated way. This provides more precision in matching adolescent clients with the appropriate level and intensity of care/services in the safest and least restrictive setting. Movement between levels of care is based on changes across the six dimensions specific to each level. Therefore movement could be to higher or lower levels of intensity as is clinically indicated.

A unique feature in the current edition is consideration of an adolescent's episode of care beginning at the first point of engagement and continuing until the last point of disengagement.

133. ASAM PPC-2R - Dimensions

- Acute Intoxication/Withdrawal Potential
- Readiness to Change
- Biomedical Conditions and Complications
- Relapse, Continued Use Potential
- Emotional, Behavioral, Cognitive Conditions and Complications
- Co-Morbidity
  - Dangerousness
  - Interference with Addiction Recovery
  - Social Functioning
  - Ability for Self Care
  - Course of Illness
- Recovery Environment

SLIDE 133 NOTES:

Consideration should be given to the primacy of some dimensions over others. Generally, there tends to be a less frequent concern regarding Dimension I - Acute Intoxication/Withdrawal Potential as opposed to Dimension 4 - Readiness to Change that focuses on the process of engagement, motivation and resistance to treatment. The determination of primacy is established via the assessment process.

TRAINER NOTE: It is useful to provide a handout with more detail regarding the criteria within each dimension relative to level of care placement considerations. This will aid in the discussion about the relationship between each of the six dimensions discretely and interactively in the level of care being considered.

(REFER TO THE ANNOTATED BIBLIOGRAPHY)

134. ASAM PPC-2R - Levels of Care

- Early Intervention (0.5)
- Outpatient Treatment (I)
- Intensive Outpatient/Partial Hospitalization (II.2 & II.5 Respectively)
- Residential/Inpatient (III)
  - Clinically Managed-Low Intensity Services (III.1)
  - Clinically Managed-Medium Intensity Treatment (III.3)
  - Clinically Managed-High Intensity Treatment (III.5)
- Medically Monitored-Intensive Inpatient Treatment (III.7)
- Medically Managed Intensive Inpatient Treatment (IV)

SLIDE 134 NOTES:

Each of the levels may be considered as a discrete entry point or as the next clinically indicated step up or step down. Fluidity of movement amongst and between the levels is the goal of a fully integrated clinical system. Clearly, there are many systems of care that don't have all of the levels available. The rule of thumb is move to the next higher level from what was determined if it is not reasonably available. It is clinically prudent to be safer unless there is a considered clinical rationale to reduce level of care for therapeutic reasons. As will be discussed in Module 9, affiliation, collaboration and cross training relationships with other community resources may assist in building a more complete and competent service delivery system.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-6 — 155

135. Other Services Needed
(Meyers, et al)

- Determine need for multidimensional services
- Consider
  - Adolescent and family's living conditions,
  - Other family issues/needs,
  - Other agencies already involved/needing to be involved,
  - What supports will be necessary and must be coordinated in order to support treatment efficacy

The comprehensiveness of the service delivery system has been identified in the literature, (McLellan, et al, 1997; Gould, et al, 2000) as a significant variable correlated with the potential for positive outcomes. The more services/systems appropriate to meet the adolescent's needs and the tighter the service/systems collaboration and coordination safety net, the more likely the adolescent may respond.

The most valuable and useful outcome of the assessment process and the essence of the plan for care/ treatment is an Integrated Diagnostic Formulation/ Summary. This aspect of the process represents a dynamic snapshot of the adolescent, formulated from the coalescence, analysis and thoughtful interpretation of the multidimensional, multidisciplinary and multi-systemic data sets in order to generate:

- Criteria based diagnostic impression and/or provisional Co-occurring Disorder diagnosis and severity of illness profile
- A meaningful understanding of the discrete and interactive influences exerted by each disorder and the functional impact to the adolescent
- A strong "evidenced by" impression regarding the individual resiliencies, competencies, resources and interests of the adolescent to guide engagement and motivational efforts
- A strong, "evidenced by" impression of the challenges, areas of diminished strength areas requiring special attention, accommodation and treatment services/program modifications
- Cultural, gender, and/or sexual orientation specific needs to be considered
- Support systems available and/or needed to facilitate the treatment process and change, e.g., immediate and/or extended family/guardians
- Other involved community systems, e.g., juvenile justice, child protective service, school to be tapped

And finally, the provisional recommendations for treatment including but not limited to:

- Level of Care Placement and immediate service needs;

A set of identified Master Problem areas for clinical intervention to be articulated in the Individualized Master Treatment Plan with:

- Treatment Goals (short and long term and for each identified problem)
- Treatment Objectives (the tangible steps to be taken in order for the adolescent to meet the treatment goals)

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- Individualized, Targeted Intervention Strategies (to facilitate the objectives)
- Identified, Discipline Specific Staff (being responsible and accountable for implementation and monitoring)

EXERCISE: Case Studies #4-7 / approx. 10 m

PURPOSE: To highlight that strengths, resources and talents are an integral component in assessment.

HANDOUT: Strengths, resources, talents

Instruct the small groups to once again review the case study they have been working on and complete the worksheet on strengths. It can be a fun exercise to ask for them to identify at least 25 different strengths, resources and talents. Most participants will initially say that it is impossible to get that much from the information. However, when they are encouraged to start reframing "problematic" behaviors into possible strengths the list can become much more comprehensive.

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136. Summary of Data for Determining Treatment Needs

- Co-Occurring Disorders
- Stage of Change/Motivation
    - e.g. pre-contemplation, contemplation, etc.
- Phase of Treatment
    - e.g. Acute Stabilization, Engagement, etc.
- Utilization Management Criteria
    - Matching illness severity to treatment intensity

SLIDE 136 NOTES:

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-6 — 157

137. Summary of Assessment

- An ongoing, inter and intra connected process that informs intervention strategies and the evolving plan of care throughout the course of treatment including follow-up continuing care
- Involves all relevant sources and resources
- Multiple functions
  - Engagement, data, planning, and monitoring strategy
  - Utilizes Relevant Clinical and Standardized approaches
  - Looks for interrelationship of diagnoses

SLIDE 137 NOTES:

The youth, the family, the school, other service providers, and other relevant community resources are needed in order to gain as full a picture of what may be contributing to the adolescent's functioning as possible.

The assessment process should also hypothesize the relationship of each diagnosis to the others using both a lifetime timeline and functional analysis to examine the development and course of each disorder in the service of more effective treatment planning

EXERCISE Case Studies #4-7 / approx. 30 m

HANDOUT: Case Studies

At this point the small groups can suggest provisional diagnosis and level of care based on the work and discussion throughout this module.

Instruct them to take a few minutes to summarize as a group what they have learned about this case study and what preliminary diagnosis is indicated.

If time allows, each group should present their case and how they arrived at the diagnosis. Ask if other groups have questions, comments or feedback. The facilitator can then offer the diagnosis that came with the case and clarify any misconceptions or inaccurate conceptualization.

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MODULE 7: RECOMMENDATIONS FROM EVIDENCE-BASED APPROACHES

Goal:

Provide overview of effective treatment program characteristics and evidence-based strategies

Learning Objectives:

Identify at least 4 effective treatment program characteristics

Describe at least 2 of the 5 Evidence-Based interventions

Discuss why family involvement improves outcomes

List the 5 steps to an integrated treatment process

Content Outline:

Key elements

Research-based interventions

- MET
- Family Based
- Behavioral
- CBT
- Community Reinforcement

Characteristics of Culturally Competent Programs

5 Steps to Integrated Treatment Process

Recommendations for Practice

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-7 — 159

MODULE 7 HANDOUTS:

MOTIVATIONAL ENHANCEMENT THERAPY (MET)

This approach has been used both as a stand-alone, brief intervention (for example, among adolescents presenting to emergency rooms with alcohol-or drug-related injuries) and it has been integrated with other modalities such as CBT (Monti et al., 2001).

MET is a client-centered approach that helps patients resolve ambivalence about engaging in treatment and strengthen motivation to build a plan for change. MET has been shown to improve treatment commitment and motivation and reduce substance abuse and risky behaviors (for instance, drunk driving and unsafe sex).

Utilizing MET techniques is particularly important in working with adolescents, as they are generally resistant to more directive approaches and are often ambivalent about committing to abstinence. (Drug Strategies, 2002; National Institute on Drug Abuse, 1999).

FAMILY-BASED INTERVENTIONS

Family based interventions include structural-strategic family therapy, parent management training (PMT), multisystemic therapy (MST), and multidimensional family therapy (MDFT).

These interventions are based on family systems theory and share the assumption that dysfunctional family dynamics contribute to adolescent SUD and related problems. In practice, clinicians perform a functional analysis to identify problem behaviors, and relationship patterns that are then targeted with restructuring interventions.

Parents are taught better monitoring skills and basic behavioral management principles to improve their adolescent's behavior and reduce drug abuse together with strategies to improve overall family functioning and sustain the gains of treatment (Drug Strategies, 2002; Wagner et al., 1999).

BEHAVIORAL OR PSYCHOSOCIAL INTERVENTIONS

Research on behavioral/psychosocial interventions has made significant advances in the past decade. Controlled trials now provide good evidence that several psychosocial treatment approaches can be effective in treating adolescent SUD and other associated problems. Some of these interventions are based on modalities that have been effectively used with adults and modified substantially to make them developmentally appropriate for adolescents (Deas et al., 2000; Drug Strategies, 2002; Wagner et al., 1999). Among the modalities with substantial research support are: Behavioral therapy; Cognitive Behavioral therapy (CBT); and Community Reinforcement Approach (CRA). Brief descriptions of each follow.

BEHAVIORAL THERAPY

These approaches are based on operant behavioral principles that include rewarding behaviors or activities that are incompatible with drug use and withholding rewards or applying sanctions when drug use or other targeted behaviors occur. This provides a constructive reinforcement system to help promote desired behaviors and eliminate those related to drug use. Urine monitoring to detect drug use is indispensable to linking consequences as closely as possible to the targeted behaviors.

Studies of adolescents indicate that it is important both to provide individual behavioral therapy and to involve the family in treatment. Behavioral therapy has been shown to help adolescents become drug free and to improve problems in other areas, such as employment, school attendance, family relationships, conduct problems, and depression (Azrin et al., 1994; National Institute on Drug Abuse, 1999).

Behavioral therapies have also demonstrated great success in decreasing drug use and altering behaviors. These include both individual and group formats aimed at:
• enhancing self-efficacy,
• increasing problem-solving and decision-making skills;
• increasing specific skills for communicating effectively, managing anger, regulating mood, coping with stressors, and preventing relapse.

Relapse prevention is accomplished by supporting the person to anticipate and avoid high risk situations, identify triggers, reducing association with drug-using peers, and engaging in enjoyable activities that are incompatible with substance abuse.

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MODULE 7 HANDOUTS:

COGNITIVE BEHAVIORAL THERAPY (CBT)

Cognitive Behavioral Therapy is based on learning theory and has been shown to be effective in treating adolescent SUD (Drug Strategies, 2002; Wagner et al., 1999). Although there is more empirical support for individual CBT, preliminary studies indicate that group CBT may also reduce adolescent substance use and improve other problem behaviors (Kaminer et al., 1998).

Treatment manuals have been developed for courses of weekly CBT ranging from 5 to 16 weeks. Features common to most CBT models include:

- Employing motivation-enhancing techniques to establish a strong treatment alliance and improve treatment engagement and retention;

- Performing a functional analysis to identify patterns of substance use, skill deficits, and dysfunctional attitudes and thinking that then become specific targets of intervention;

- Enhancing coping strategies to effectively deal with drug craving, negative moods, and anger;

- Strengthening problem-solving and communication skills and the ability to anticipate and avoid high-risk situations; and

- Identifying enjoyable activities incompatible with drug use.

New skills and coping strategies are initially taught and practiced during therapy sessions, then applied to the patient's daily life in "homework" assignments, with a review of successes and setbacks the following week (Drug Strategies, 2002; Wagner et al., 1999).

COMMUNITY REINFORCEMENT APPROACH (CRA)

The Community Reinforcement Approach (CRA) "is a broad-spectrum behavioral treatment approach for substance abuse problems... that utilizes social, recreational, familial, and vocational reinforcers to aid clients in the recovery process" (Meyers and Smith 1995, p. 1).

This approach uses a variety of reinforcers, often available in the community, to help substance users move into a drug-free lifestyle. Typical components of CRA include (1) functional analysis of substance use, (2) social and recreational counseling, (3) employment counseling, (4) drug refusal training, (5) relaxation training, (6) behavioral skills training, and (7) reciprocal relationship counseling.

In the very successful approach developed by Higgins and colleagues for cocaine-dependent individuals (Higgins et al. 1991, 1994), a contingency management component is added that provides vouchers for staying in treatment. The vouchers are redeemable for items consistent with a drug-free lifestyle and are contingent upon the patient's provision of drug-free urine toxicology specimens.

Thus, CRA and CBT share a number of common features, most importantly, the functional analysis of substance abuse and behavioral skills training. CBT differs from CRA in not typically including the direct provision of either contingency management (vouchers) for abstinence or intervening with patients outside of treatment sessions or the treatment clinic, as do community-based interventions (job or social clubs). NIDA Therapy Manuals for Drug Addiction; Cognitive Behavioral Approach

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-7 — **161**

MODULE 7 HANDOUTS:

PARENTING TASKS ADOLESCENT WITH SUBSTANCE ABUSE PROBLEMS
(Wallace, Estroff, 2001)

- Helping their child to remove him-or herself from a negative substance abusing peer group and to create an alternate positive peer group instead.
- Helping their adolescent defuse a crisis.
- Helping the adolescent remove him-or herself from access to or temptation to use alcohol and other drugs.
- Helping the adolescent understand any emotional pain he or she is feeling.
- Using the family therapist to improve family functioning and resolve the adolescent's reactions to family dysfunction.
- Providing tutorial help aimed at promoting success when the adolescent is failing in school.

- Providing structure, predictability, and setting limits when the adolescent is out of control.
- Helping the adolescent design a self-concept building program when he or she has a damaged self-concept.
- Helping their child to have a basic understanding of the need for treatment when he or she doesn't want help.
- Making choices for their teenager when he or she is making bad choices, but only until the teenager can make decision on his or her own.
- If the family is part of the problem, including the family in the solution of the problem.

MODULE 7 HANDOUTS:

CULTURALLY COMPETENT TREATMENT SYSTEMS — NATIONAL GAINS CENTER FOR PEOPLE WITH CO-OCCURRING DISORDERS

Online Curriculum / Case Example

Please read the following description of the Evergreen Mountain Holistic Living Program and indicate which goals for a culturally competent treatment program are in place in this facility.

Evergreen Mountain Holistic Living Program

The Evergreen Mountain Holistic Living Program is a community-based intervention program for youth involved with the juvenile justice system. The multilingual and multiethnic team of highly trained mental health professionals consists of case managers, therapists, psychologists, and psychiatrists. The treatment team provides a Multi-Systemic Treatment (MST) approach to treating 12- to 17-year-old youth who have had at least two admissions to detention, have a history of serious emotional or behavioral problems and violent or aggressive behavior in the past two years, or meet DSM-IV criteria for substance abuse.

The family works with an MST therapist to identify strengths and areas of need. Before discharge, families are connected with churches, schools, local businesses, and community centers to develop positive, productive community activities, such as jobs, recreation, and community service. Families also work closely with probation counselors to identify potential roadblocks to success and to build the probation plan.

Family counseling usually takes place in the home. Focus is placed on reducing conflict, supporting the role of parents and caretakers, and improving communication at home. Individual counseling addresses the mental health and emotional needs of the youth. Anger management, interpersonal communication, and impulse control are addressed to help youth stay out of trouble. Complete drug and alcohol screening is provided to determine the role of substance use in the problems experienced. When needed, psychiatric consultation and psychological testing are available. To provide continuous aftercare support, youth are offered group support programs such as skill-building, recreation, and prevention of drug and alcohol abuse.

Throughout the year, MST therapists participate in continuing education programs conducted by members of the community who provide information about the cultures and resources of the diverse communities that surround Evergreen Mountain. Continuing education sessions include topics such as religious practices, family customs, occupational hazards, and recreational and academic opportunities.

The Evergreen Mountain Holistic Living Center is an active participant in the Coalition for Understanding, a multicultural organization created to educate the population about the various cultural traditions that support strong family relationships and connections with the rich traditions of the diverse communities throughout the State.

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MODULE 7 HANDOUTS:

CULTURALLY COMPETENT TREATMENT SYSTEM GOALS

(PLEASE CHECK ALL THAT APPLY.)

❑ Promote an environment which attracts, retains, and fosters a diverse and multicultural staff.

❑ Facilitate and encourage cross-cultural communication.

❑ Ensure the development and implementation of cross-cultural diversity, knowledge, empathy and respect in policy, planning, and service delivery systems.

❑ In partnership with the treatment service provider community and the community at large, seek and receive knowledge, information and resources to improve awareness, empathy and respect of the various community collectives.

❑ Provide bold and innovative leadership through advocacy for diversity and cross-cultural knowledge, empathy and respect.

ASSESSING THE AGENCY'S POTENTIAL TO SERVE ADOLESCENTS WITH CO-OCCURRING DISORDERS

1. What are the current strengths of services offered with respect to COD?	
2. What services are immediately available to meet client needs?	
3. What services could be added within the program?	
4. What services are available from the community that would enhance recovery?	
5. How can the physical environment convey recovery orientation?	
6. How well are outside agencies meeting clients' needs?	
7. What resources are needed to enhance service delivery for COD?	
8. What staff skills can be increased?	
9. Can additional expertise be accessed through consulting agreements or similar arrangement?	

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TREATMENT CHARACTERISTICS

STRENGTHS	
GAPS	
NEEDS	

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-7 — 165

138. MODULE 7:

Recommendations from Evidence-Based Approaches

139. Goal

Provide overview of effective treatment program characteristics and Evidence-Based strategies

SLIDE 139 NOTES:

Review the slide with the participants.

140. Objectives

- Identify at least 4 effective treatment program characteristics
- Describe at least 2 of the 5 evidence-based interventions
- Discuss why family involvement improves outcomes
- List the 5 steps to an integrated treatment process

SLIDE 140 NOTES:

Review the slide with the participants.

TRAINER NOTE: The following 4 slides provide an overview of more detailed material found later in the module.

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141. Effective Treatment Program Characteristics

- Assessment and Treatment Matching
- Comprehensive Integrated Treatment Approach
- Family Involvement
- Developmentally Appropriate
- Engagement and Retention
- Qualified Staff
- Gender and Cultural Competence
- Continuing Care
- Treatment Outcomes

SLIDE 141 NOTES:

Research on the effectiveness of treatment for adolescents is still a new field, with relatively few scientifically rigorous studies published to date. Brannigan, Schackman, Falco and Millman, 2004 conducted the first systematic evaluation of the quality of highly regarded adolescent substance abuse treatment programs in the US.

The 9 key elements noted on this slide show a consensus of an advisory panel of 22 national experts.

ASSESSMENT AND TREATMENT MATCHING

Programs should conduct comprehensive assessments that cover psychiatric, psychological and medical problems, learning disabilities, family functioning and other aspects of the adolescent's life.

COMPREHENSIVE, INTEGRATED TREATMENT APPROACH

Program services should address all aspects of an adolescent's life.

FAMILY INVOLVEMENT

Research shows that involving parents in the adolescent's treatment produces better outcomes. Involvement of the family should emphasize enhancement of parental monitoring and behavioral management skills and use of restructuring interventions to correct patters of interaction, relationships and behaviors to improve overall family functioning.

ACTIVITIES AND MATERIALS SHOULD REFLECT THE DEVELOPMENTAL DIFFERENCES BETWEEN ADULTS AND ADOLESCENTS.

These differences relate to engaging all modes of learning (e.g., visual, auditory, kinesthetic), domains of learning (e.g., social, cognitive, emotional) reading level, comprehension, and relevancy to age, etc.

IN ORDER TO IMPROVE ENGAGEMENT AND RETENTION, TREATMENT PROGRAMS SHOULD BUILD A CLIMATE OF TRUST BETWEEN THE ADOLESCENT AND CLINICAL STAFF.

Treatment length of stay has been correlated with sustained recovery from substance abuse. Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-7 — 167

treatment prematurely, programs should include strategies to engage and keep patients in treatment. (NIDA Principles of Drug Addiction Treatment.)

In the first large-scale study designed to evaluate drug abuse treatment outcomes among adolescents in age-specific treatment programs, NIDA-supported researchers found that longer stays in treatment programs can decrease drug and alcohol use and criminal activity as well as improve school performance and psychological adjustment.

The study, part of NIDA's ongoing Drug Abuse Treatment Outcome Studies for Adolescents (DATOS-A), analyzed data from 23 community-based adolescent treatment programs that addressed peer relationships, educational concerns, and family issues such as parent-child relationships and parental substance abuse. Successful elements of adult treatment programs, such as participation in group therapy and participation in a 12-step program, were also included in treatment plans. "The results of this study are particularly impressive in light of the fact that the adolescents had multiple problems," says Dr. Christine Grella of the University of California, Los Angeles (UCLA), Drug Abuse Research Center, one of the study's investigators. "Although this is also typical of many adults in treatment, timely resolution of these problems is even more critical for adolescents. These young people are in the process of developing values, making lifestyle decisions, and preparing to assume adult roles and responsibilities, such as family and work; whereas when many adults enter treatment, they have completed this process."

Previous research indicates that a minimum of 90 days of treatment for residential and outpatient drug-free programs and 21 days for short-term inpatient programs is predictive of positive outcomes for adults in treatment. Better treatment outcomes were reported among adolescents who met or exceeded these minimum lengths of treatment than for those who did not. Among the treatment participants, 58 percent of those in residential programs, 27 percent in outpatient drug-free programs, and 64 percent in short-term inpatient programs met or exceeded the minimum stay. In the year following treatment, those who met or exceeded the minimum treatment were 1.52 times more likely to abstain from drug and alcohol use and 1.2 times more likely to not be involved in criminal activity. In addition, these adolescents were 1.34 times more likely to have average or better-than-average grades.

- Staff should be trained in adolescent development, co-occurring disorders, substance abuse and addiction.

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- Programs should address the distinct needs of adolescent boys and girls as well as cultural differences among minorities.

In a recent NIDA funded research study, more girls (83 percent) than boys (44 percent) displayed externalizing and internalizing disorders. Dr. Rowe says the pattern is familiar to clinicians across the country-there are typically more girls among substance abuse patients with pronounced problems and disorders.

"By the time a girl with substance abuse problems is referred to treatment, she is usually in considerable distress and experiencing severe psychiatric symptoms and relationship problems. Family, school, and legal problems will continue unabated without better identification, referral, and treatment of these vulnerable girls," says Dr. Rowe.

Dr. Racioppo emphasizes the need for more research on differences in how boys and girls develop and manifest behavior problems. Troubled youth often have experienced family conflict and instability in relationships, but boys and girls may react differently. Studies indicate that females tend to turn their stress inward, developing anxiety and depression, which are often unnoticed by adults. Dr. Racioppo says girls tend to act out in ways that don't necessarily grab the attention of adults-through sexual behavior, for example-whereas boys externalize in ways that are more obvious, such as fighting. "To improve identification and treatment outcomes of adolescents with co-occurring psychiatric disorders, we need to study gender differences in the root causes and expression of behavioral and emotional problems."

NIDA Notes, Vol. 19. No. 6, July 2005

PROGRAMS MUST ADDRESS ISSUES OF CULTURE AND THE ECONOMIC REALITIES OF ADOLESCENTS' LIVES.

All societies value their children's development and sanction appropriate ways to develop into adulthood. This transition provides time for refining ideology and developing a sense of autonomy and self-identity. Additionally it is a time where the adolescent fits within the family and community. What varies across societies is the timing of the transition and how soon it is completed.

We must learn from the community how to deliver services in a way that will be meaningful, relevant and accepted. Treatment approaches should take into account differences and similarities in worldview, contexts that influence value formation, cultural historical patterns, acculturation, etc.

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MODULE-7 — **169**

Community environments, socioeconomic resources and other barriers will impact access to treatment, engagement, and outcomes of adolescents and families.

PROGRAMS SHOULD INCLUDE RELAPSE PREVENTION TRAINING, AFTERCARE PLANS, REFERRALS TO COMMUNITY RESOURCES, AND FOLLOW-UP.

There is an uneven continuum of care service delivery system for adolescents. It is critical that we continue working together to ensure that the gains made while in active treatment are sustained. Many adolescents who complete treatment relapse upon returning to their original environment. Strong transition and aftercare components can reduce the chance of relapse and help ensure continuity of treatment goals.

RIGOROUS EVALUATION IS REQUIRED TO MEASURE SUCCESS, TARGET RESOURCES AND IMPROVE TREATMENT SERVICES.

It is poignant to note that of the study of 144 highly regarded adolescent-only substance abuse treatment program, the majority did not perform well on most of the 9 key elements. The elements with the poorest overall performance were assessment and treatment matching, engaging and retention, gender and cultural competence and treatment outcomes.

"The Quality of Highly Regarded Adolescent Substance Abuse Treatment Programs" Brannigan, Schackman, Falco, Millman, Archives Adolescent Medicine, Vol. 158, Sep. 2004, p.904 - 909.

Poorer treatment outcomes among people with co-occurring psychiatric disorders suggest that therapists may need to tailor substance abuse treatment for the patient's particular psychiatric condition, although the necessary level of specificity is not clear. "To adapt treatments for people with co-occurring psychiatric disorders, researchers must link particular therapeutic processes with outcomes," something that Dr. Rowe and her colleagues plan to do in future studies.

"Looking within the therapeutic process may help us discover what must happen to realize recovery from substance abuse. Effective components of therapy may vary for adolescents with different co-occurring mental health problems, and identifying such mechanisms of change may help us develop better interventions," says Dr. Rowe.

NIDA Notes, Vol. 19, No.6, July 2005

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142. Research based Interventions

- Motivational Enhancement Therapy (MET)
- Family-Based
- Behavioral Therapy
- Cognitive Behavioral Therapy (CBT)
- Community Reinforcement Approach

SLIDE 142 NOTES:

Review the slide with the participants. This slide is designed to present the names of research-based interventions. Each approach has its own separate slide to follow.

Please note that the Resource Section of the manual contains a booklet for parents providing information in evidence-based practices as well as a more in-depth review of MET and CBT.

143. Motivational Enhancement Therapy

- Stand-alone brief interventions OR
- Integrated with other modalities
- Client-centered approach for resolving ambivalence and planning for change
- Demonstrates improved treatment commitment and reduction of substance use and risky behaviors
- Developmentally appropriate with adolescents

SLIDE 143 NOTES:

Motivational enhancement therapy (MET) has been used both as a stand alone, brief intervention (for example, among adolescents presenting to emergency rooms with alcohol-or drug-related injuries) and it has been integrated with other modalities such as CBT (Monti et al., 2001). It is a client-centered approach that helps patients resolve ambivalence about engaging in treatment and strengthen their motivation to build a plan for change. MET has been shown to improve treatment commitment and motivation and reduce substance abuse and risky behaviors (for instance, drunk driving and unsafe sex). Utilizing MET techniques is particularly important for adolescents, as they are generally resistant to more directive approaches and are often ambivalent about committing to abstinence.

(Drug Strategies, 2002; National Institute on Drug Abuse, 1999).

Motivational Enhancement Therapy utilizes Motivational Interviewing Principles that have been developed by Stephen Rollnick, Ph.D., & William R. Miller, Ph.D. Those principles include expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance and supporting self-efficacy. The approach they define as a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

Motivational Enhancement Therapy is rooted in the principles of Motivational Interviewing [Miller & Rollnick, 2002]. It has been demonstrated to be helpful in helping persons who show no desire to change their current behavioral patterns to consider making a change, weigh the pros and cons of doing so, and to increase their internal motivation for making a change and their belief (hope) that they can, in fact,

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-7 — 171

do so. MET seeks to reduce the negative effects of the perceptions of external duress in the person and to clarify the person's own responsibility for decisions regarding his/her behavior, while promoting empathic connection on the part of the practitioner engaged in MI/MET. The approach is defined as a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. It employs the following principles:

- Express empathy through reflective listening
- Develop discrepancy between the client's goals or values and their current behavior
- Avoid argument and direct confrontation
- Adjust to client resistance rather than opposing it directly
- Support self-efficacy and optimism

Additional information on Motivational Interviewing can be found at www.motivationalinterviewing.org, Enhancing Motivation for Change in Substance Abuse Treatment, TIP 35, SAMHSA, CSAT found at http://ncadi.samhsa.gov/govpubs/BKD342/

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144. Family-Based Interventions

- Structural-Strategic Family Therapy
- Parent Management Training (PMT)
- Functional Family Therapy (FFT)
- Multisystemic Therapy (MST)
- Multidimensional Family Therapy (MDFT)

All based on:
  - Family systems theory
  - Use of functional analysis for interventions that restructure interactions
  - Teaching parents behavioral principles and better monitoring skills to increase the adolescent's pro-social behaviors, decrease substance use, improve family functioning, and hold treatment gains

SLIDE 144 NOTES:

Family-based interventions include structural-strategic family therapy, parent management training (PMT), multisystemic therapy (MST), and multidimensional family therapy (MDFT). They are based on family systems theory and share the assumption that dysfunctional family dynamics contribute to adolescent SUD and related problems. In practice, clinicians perform a functional analysis to identify problem behaviors, and relationship patterns that are then targeted with restructuring interventions. Parents are taught better monitoring skills and basic behavioral management principles to improve their adolescent's behavior and reduce drug abuse together with strategies to improve overall family functioning and sustain the gains of treatment (Drug Strategies, 2002; Wagner et al., 1999).

Dr. Melissa Racioppo of NIDA's Division of Clinical Neuroscience, Development and Behavioral Treatment says CBT and MDFT are very effective treatments for most adolescent substance abuse. In a NIDA funded study that compared three treatment approaches, researchers have found that Multidimensional Family Therapy (MDFT), which involves individual therapy and family therapy, produced better treatment outcomes than did Adolescent Group Therapy (AGT) or Multifamily Educational Intervention (MEI), a treatment delivered in sessions involving more than one family. NIDA Notes, Vol. 19, No. 6, July 2005

145. Purposes for Family Involvement

- Learn about child from family perspective
- Mutual education and redefinitions
- Define substance use in the family context
- Establish/re-establish parental influence
- To decrease family's resistance to treatment

SLIDE 145 NOTES:

Adolescents come from a family, live in a family and will most likely return to a family. Counselors need to define family broad enough to be inclusive of identified family members rather than exclusive.

Family structure in America has become more complex-growing from the traditional nuclear family to single-parent families, stepfamilies, foster families and multigenerational families. Therefore when a family member abuses substances, the effect on the family may differ according to family structure.

Family relationships and communication patterns can be complex. The family is a dynamic system of interrelated parts all of which affect and are affected by each part. Thus it can be helpful to view the adolescent's use as impacting on the family's functioning as well as the adolescent being impacted on by the family's functioning.

Treatment needs to actively engage and partner with the family to create a wide net of support and guidance. "It is important to note the strengths of each family and use these strengths to help parents gain the motivation to participate. A "parenting partnership" is a concept that encourages parents to learn from the treatment staff and other parents. A positive therapeutic alliance between therapist and family is helpful. When it happens, counselors can model and guide rather than educate and direct. The consultative, collaborative approach is important. When the relationship is mutual and shared, partnering outcomes are more positive." (Wallace, Estroff, 2001)

Parents must learn to identify the issues that their adolescent deals with by themselves and help the adolescent learn how to set limits for themselves. Major initiatives that parents must be prepared to undertake include: (see handout Parenting Tasks, Adolescent with Substance Abuse Problems)

146. Family Involvement, continued

- To assess interpersonal function of drug use
- To interrupt non-useful family behaviors
- Identify and implement change strategies consistent with family's interpersonal functioning and cultural identity
- Provide assertion training for child and any high-risk siblings

SLIDE 146 NOTES:

To reestablish the family as a significant resource system, the counselor must involve family members in the assessment and in the planning of solutions to the adolescent's distress. It is important to keep in mind that:

- The family is part of the solution
- Keep in mind that, while problems occur in the context of certain family patterns families do not cause these problems
- Understand that problems occur in a developmental context that involves all family members
- Recognize that there are underlying issues in family relationships that may be stirred up by developmental or other stresses.

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147. Benefits of Family Approaches

- Can improve engagement / retention
- Can reduce destructive relationship patterns
- Can assist in medication management
- Can have significant influence in environment
- Have long-term effects after formal treatment is completed

Source: Southern Coast ATTC: Co-Occurring Substance Use and Mental Health Disorders in Adolescents: Building a Foundation for Quality Care. (2009).

SLIDE 147 NOTES:

Reiterate the significant benefits and the critical importance of using Family Approaches. Review the summary points:

- Family interventions can be used to bring an adolescent to treatment for the first time or can help to retain the adolescent in treatment.
- Family interventions can help modify the family relationship patterns that may contribute, or result from, adolescent problems behaviors and/or illnesses.
- Family members are key to helping with co-occurring disorders (assessing/identifying relapse triggers, medication management, structure, support, etc.).
- Family members are needed as assist with change in the youth's environment (school adaptations, peers relationships, legal entanglements, etc.).
- Family interventions can result in beneficial effects long after the "treatment" phase is over. Family members are part of the larger recovery support services for the adolescent.

Southern Coast ATTC, Co-Occurring Substance Use and Mental Disorders in Adolescents: Building a Foundation for Quality Care, Curriculum

148. Behavioral Therapy Approaches

- Based on operant behavioral principles
  - Reward behaviors incompatible with drug use
  - Withhold rewards or apply sanctions for use or other negative behaviors targeted
  - Use of physical monitoring (urines, etc.) for close link of consequences
- Use of individual approach and family involvement
- Has demonstrated positive results for a number of problem areas

SLIDE 148 NOTES:

Behavioral or Psychosocial Interventions

Research on behavioral/psychosocial interventions has made significant advances in the past decade. Controlled trials now provide good evidence that several psychosocial treatment approaches can be effective in treating adolescent SUD and other associated problems. Some of these interventions are based on modalities that have been effectively used with adults and modified substantially to make them developmentally appropriate for adolescents (Deas et al., 2000; *Drug Strategies,* 2002; Wagner et al., 1999). Among the modalities with substantial research support:

Behavioral Therapy approaches are based on operant behavioral principles that include rewarding behaviors or activities that are incompatible with drug use and withholding rewards or applying sanctions when drug use or other targeted behaviors occur. This provides a constructive reinforcement system to help promote desired behaviors and extinguish those related to drug use. Urine monitoring to detect drug use is indispensable to linking consequences as closely as possible to the targeted behaviors. Studies of adolescents indicate that it is important both to provide individual behavioral therapy and to involve the family in treatment. Behavioral therapy has been shown to help adolescents become drug free and to improve

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problems in other areas, such as employment, school attendance, family relationships, conduct problems, and depression (Azrin et al., 1994; National Institute on Drug Abuse, 1999).

Behavioral therapies have also demonstrated great success in decreasing drug use and altering behaviors. These include both individual and group formats aimed at: enhancing self-efficacy, increasing problem-solving and decision-making skills; increasing specific skills for communicating effectively; managing anger; regulating mood; coping with stressors; and preventing relapse. Relapse prevention is accomplished by supporting the person to anticipate and avoid high risk situations, identify triggers, reducing association with drug-using peers, and engaging in enjoyable activities that are incompatible with substance abuse.

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149. Cognitive Behavioral Therapy

Based on learning theory

Has individual and group applicability

Has a number of manualized approaches

Uses functional analysis to target areas

Teaches coping strategies, problem-solving & communication skills (practice & homework)

Uses relapse-prevention and alternative activities strategies for avoiding substance use

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SLIDE 149 NOTES:

Cognitive Behavioral Therapy (CBT), is based on learning theory, and has been shown to be effective in treating adolescent SUD (Drug Strategies, 2002; Wagner et al., 1999). Although there is more empirical support for individual CBT, preliminary studies indicate that group CBT may also reduce adolescent substance use and improve other problem behaviors (Kaminer et al., 1998). Treatment manuals have been developed for courses of weekly CBT ranging from 5 to 16 weeks. Features common to most CBT models include:

• Performing a functional analysis to identify patterns of substance use, skill deficits, and dysfunctional attitudes and thinking that then become specific targets of intervention;

• Enhancing coping strategies to effectively deal with drug craving, negative moods, and anger;

• Strengthening problem-solving and communication skills and the ability to anticipate and avoid high-risk situations; and

• Identifying enjoyable activities incompatible with drug use.

New skills and coping strategies are initially taught and practiced during therapy sessions, then applied to the patient's daily life in "homework" assignments, with a review of successes and setbacks the following week (Drug Strategies, 2002; Wagner et al., 1999).

Motivational-enhancing techniques that are designed to mobilize motivation within the client can be complementary to CBT approaches. For example, for an adolescent with low motivation and few resources, an initial focus on motivational strategies to establish a treatment alliance, and improve treatment engagement and retention before turning to specific coping skills development with the use of CBT may be a productive approach.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-7 — **175**

150. Behavioral Treatment Studies

Interventions associated with reduced substance use and problems:

- 12-Step Treatment
- Behavioral Therapies
- Family Therapies
- Engagement and maintenance is associated with several interventions
  - Case management, stepping down residential to OP, assertive aftercare

151. Interventions that are associated with no or minimal change in substance use or symptoms:

- Passive referrals
- Educational units alone
- Probation services as usual
- Unstandardized outpatient services as usual

Interventions associated with deterioration:

- treatment of adolescents in "groups including one or more highly deviant individuals" (but NOT all groups)
- treatment of adolescents in adult units and/or with adult models/materials (particularly outpatient)

152. Lessons from Behavioral Studies

- Family therapies were associated with less initial change but more change post active treatment
- Effectiveness was associated with therapies that:
  - were manual-guided and had developmentally appropriate materials
  - involved more quality assurance and clinical supervision
  - achieved therapeutic alliance and early positive outcomes
  - successfully engaged adolescents in aftercare, support groups, positive peer reference groups, more supportive recovery environments

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153. Lessons from Behavioral Studies continued

- The effectiveness of group therapy was dependent on the composition of the group
- The effectiveness of therapy was dependent on changes in the recovery environment and social risk
- Effectiveness was not consistently associated with the amount of therapy over 6-12 weeks or type of therapy
- As other therapies have improved, there is no longer the clear advantage of family therapy found in early literature reviews
- Differences between conditions change over time, with many people fluctuating between use and recovery

SLIDE 153 NOTES:

Review slide with participants.

REFERENCE: Michael Dennis, Ph.D., Chestnut Health Systems, Bloomington, IL

Presentation for SAMHSA Center for Substance Abuse Treatment (CSAT) Effective Adolescent Treatment (EAT) Grantee meeting, Baltimore, MD, November 3-5, September 19, 2003.

154. Community Reinforcement Approach (CRA)

- Combines principles & techniques derived from others (behavioral, CBT, MET, and family therapy)
- Uses incentives to enhance treatment outcomes

SLIDE 154 NOTES:

The Community Reinforcement Approach (CRA) "is a broad-spectrum behavioral treatment approach for substance abuse problems...that utilizes social, recreational, familial, and vocational reinforcers to aid clients in the recovery process" (Meyers and Smith 1995, p. 1).

This approach uses a variety of reinforcers, often available in the community, to help substance users move into a drug-free lifestyle. Typical components of CRA treatment include (1) functional analysis of substance use, (2) social and recreational counseling, (3) employment counseling, (4) drug refusal training, (5) relaxation training, (6) behavioral skills training, and (7) reciprocal relationship counseling. In the very successful approach developed by Higgins and colleagues for cocaine-dependent individuals (Higgins et al. 1991, 1994), a contingency management component is added that provides vouchers for staying in treatment. The vouchers are redeemable for items consistent with a drug-free lifestyle and are contingent upon the patient's provision of drug-free urine toxicology specimens.

Thus, CRA and CBT share a number of common features, most importantly, the functional analysis of substance abuse and behavioral skills training. CBT differs from CRA in not typically including the direct provision of either contingency management (vouchers) for abstinence or intervening with patients outside of treatment sessions or the treatment clinic, as do community-based interventions (job or social clubs).

NIDA Therapy Manuals for Drug Addiction; Cognitive Behavioral Approach

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-7 — **177**

155. Characteristics of Culturally Competent Treatment Programs

(Gains Center: Working Together for Change, 2001)

- Family (as defined by culture) seen as primary support system
- Clinical decisions culturally driven
- Dynamics within cross-cultural interactions discussed explicitly & accepted
- Cultural knowledge built into all practice, programming & policy decisions
- Providers explore youth's level of assimilation/acculturation

Cultural competence may be viewed as a continuum on which, through learning, the provider increases his or her understanding and effectiveness with different cultural groups. Various researchers have described the markers on this continuum (Castro et.al 1999; Cross 1988; Kim et al. 1992). The continuum moves from cultural destructiveness, in which an individual regards other cultures as inferior to the dominant culture, through cultural incapacity and blindness to the more positive attitudes and greater levels of skill.

For more information, refer to TIP 42: Substance Abuse Treatment for Persons with Co-occurring Disorders, SAMHSA.

It is important to remember that clients, not counselors, define what is culturally relevant to them.

Family as the primary support systems and as partners in treatment has often been met with discomfort from professionals in the mental health, substance abuse, and juvenile justice fields. Families of these youth (often represented by a single mother) are sometimes viewed as noncompliant or unavailable for the services offered to their children. Some have co-occurring disorders themselves. Families are stressed by multiple factors, both internal and community-based. Parents often mistrust professionals and view their personal involvement in treatment as uncomfortable and burdensome. Treatment programs and providers are often unaware of or discount the cultural and ethnic barriers that impede family involvement in treatment.

The Federation of Families (1995) advocates that families with youth who have co-occurring disorders require the following support:

- Nonauthoritarian help
- Education
- Information in a timely, straightforward, and accessible fashion, free of jargon and acronyms
- Opportunities to exercise their management skills
- Safety, closeness, and appreciation
- Expressions of opinion and emotion
- Acceptance of their diversity
- Access, voice, ownership
- Respect

Please note that the Reference Guide contains an important report entitled Blamed and Ashamed: The Treatment Experiences of Youth with Co-occurring Substance Abuse And Mental Health Disorders and Their Families, published by the Federation of Families for Children's Mental Health and Keys for Net-

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working, Inc. (2001). This report presents the findings of a two-year project intended to document and summarize the experiences of youth with co-occurring mental health and substance abuse problems and their families. The purposes of this study were to offer youth and their families the opportunity to reflect on and give voice to their experiences, to identify their successes and concerns, and to formulate recommendations so that a national audience might learn from their experience and improve services. The work was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services and was conducted by two family-run organizations - the Federation of Families for Children's Mental Health, Alexandria, Virginia, and Keys for Networking, Inc., Topeka, Kansas.

156. Characteristics of Culturally Competent Treatment Programs, cont.

(Gains Center: Working Together for Change, 2001)

- Respect for cultural differences
- Creative outreach services to underserved
- Awareness of different cultural views of treatment/help-seeking behaviors
- Program staff work collaboratively with community support system
- Treatment approaches build on cultural strengths & values of minorities
- Ongoing diversity training for all staff
- Providers are of similar backgrounds to those they served

SLIDE 156 NOTES:

Review the slide with the participants.

EXERCISE: approx. 15 min / Small Group

HANDOUT: Evergreen Mountain Holistic Living Program

Instruct the participants to take 5 minutes to read through the case study and answer the questions at the end of the study. The correct answer is that all requirements are checked off.

Briefly discuss their reactions to the case study and its implications for their own treatment setting.

157. 5 Steps to an Integrated Treatment Process (Adapted from Riggs, 2003)

Step 1
Meetings with adolescent and family to engage them in collaborative negotiations to establish goals and develop strategies for reducing or eliminating barriers to goal achievement.
- joint meeting(s) to establish working agreement and establish relationships
- meeting with adolescent to elicit his/her perspective, provide support, and plan

SLIDE 157 NOTES:

In general, an adolescent's parents or caretakers should be present at the initial interview. Program rules, policies and procedures should be explained, including confidentiality, mandated reporting, etc, obtaining a development history and assessment of family dynamics.

It is also important to meet with the adolescent to facilitate a strong therapeutic alliance and elicit candid information about the person's behavior and involvement with substances.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS
MODULE-7 — 179

158. Integrated Treatment Process Step 2

Entire treatment team case conference

- Include everyone involved with the youth and family, within and beyond the treatment program/agency
- Adolescent and family's goals and perspectives are primary and attended
- Develop conjoint treatment/service strategies for assisting with goal achievement, review & modify them

SLIDE 158 NOTES:

With as many people as possible systematically review and integrate the assessment information from all sources and perspectives.

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159. Integrated Treatment Process Step 3

Implement treatment strategies which may include:

- Individual and/or group therapies
- Family-based treatment/education
- 12-step or other supports (peer, etc.)
- Medication for psychiatric disorder
- Urine screens, self-report, medication monitoring, physical observation

SLIDE 159 NOTES:

The initial focus should be to engage the adolescent by establishing a strong therapeutic alliance and collaboratively establishing goals to stabilize substance abuse. Comorbid disorders and other problems should also be identified and addressed. Ideally, motivational enhancement techniques can be combined with other evidence-based approaches.

160. Medication Considerations

- Abstinence vs. Harm reduction
  - Drug-medication interactions
  - Untreated psychiatric illness

SLIDE 160 NOTES:

Abstinence is ideal before medication is started, however we must weigh the risk of potential drug-medication interactions against the risk that untreated psychiatric illness will negatively impact engagement, early drop-out or interfere with abstinence.

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161. Medication Management Guidelines

- Safety profile
- Provide information
- Closely monitor medication compliance
- Monitor treatment effectiveness

SLIDE 161 NOTES:

Consider medications with good safety profiles, low abuse liability and once a day dosing. Use a single medication if possible.

Provide the adolescent and family with information about adverse interactions with substances and the need for abstinence or reduced substance use.

Establish a mechanism to closely monitor medication compliance, effects, response, and ongoing substance use.

Monitor treatment compliance and regular urine drug screening and motivation.

162. Integrated Treatment Process Step 4

Continual monitoring of all disorders, symptoms, treatment strategies, movement toward/away from goals, and the relationships between all parties. If symptoms do not improve/worsen:

- Examine treatment strategies/level
- Review medication efficacy
- Reassess diagnoses

SLIDE 162 NOTES:

Review slide with participants.

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163. Integrated Treatment Process Step 5

As treatment in this setting is nearing end:

- Discuss follow-up plans for continued care and relapse prevention strategies
- Develop a realistic and workable plan for managing relapses of any kind
- Emphasize that relapse is not failure but an indicator of the need for different strategies

SLIDE 163 NOTES:

The potential for relapse after an acute treatment episode is high as is characteristic of many chronic, relapsing illnesses. It is critical to discuss this openly and develop a realistic workable plan.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-7 — 181

164. Recommendations for Practice

- Use standardized screening and assessment tools
- Train staff to recognize symptoms of common psychiatric disorders in adolescents and medication side-effects
- Ongoing monitoring of symptom response, psychosocial functioning, treatment progress (including urines & adverse side effects)

165. Recommendations for Practice

- Strengths-based perspective
- Notice all positive statements and behaviors
- Empathy, respect, non-judgmental stance
- Joining rather than "expert" model
- Offer of, and peer group support availability for family (beyond 12-step)
- Data-based information/education
- Engender hope & focus on competence
- Keep an "over time" perspective

SLIDE 164 NOTES:

Review slide with participants.

Please note that the Reference Section of the manual contains an overview of available assessment tools published by the OJJDP and NCMHJJ.

SLIDE 165 NOTES:

The entire strengths approach is about personhood, not patienthood or clienthood or even consumer-hood. It is about finding the "person in the patient." It is about purposefully looking for and acknowledging their courage, resilience and strengths in the face of a mean-spirited disease and an often unresponsive and oppressive society. (Charles Rapp) It is also about a paradigm shift from problem centered to strengths centered. Malucci (1979) found that social workers underestimated client strengths and had more negative perceptions of clients than clients had of themselves. Malucci, A. (1979) Learning from Clients: Interpersonal Helping as Viewed by Clients and Social Workers. New York: Free Press. This can be seen in the assessment tools, biopsychosocial narratives and treatment plans that are written. The "Blamed and Ashamed Report" cited earlier is a testament to our clients' experience. The increasing body of literature supporting resiliency, recovery-wellness models provides us with a new pathway to collaborate with our clients.

EXERCISE: approx. 30 min.

Individual to Small Group

HANDOUT: Assessing Agency's Potential to Service Adolescents with COD

Ask participants to take 5-10 minutes to complete the handout "Assessing Agency's Potential to Service Adolescents with COD".

After they have had time to reflect on their agency, encourage them to share their ideas at the small tables.

Recommendations from evidence-based approaches.

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MODULE 8: CROSS SYSTEM COLLABORATION

GOAL:

Identify barriers to and strategies for cross system collaboration

Learning Objectives:

Describe at least 3 program and clinical barriers.

Discuss obstacles for clients in accessing treatment services.

Define consultation, collaboration, integration.

Identify 4 strategies that have been implemented in programs throughout the country.

Content Outline:

Barriers

- Program Issues
- Clinical Issues
- Client Issues
- Minority Youth Issues

Areas of Convergence

Key Lessons

Replicable Strategies

Actions towards Integration

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-8 — 183

MODULE 8 HANDOUTS: COLLABORATION

INNOVATIVE SYSTEMS INTEGRATION STRATEGIES

Many states and communities already have begun to implement innovative systems integration strategies. While approaches varied by state, important commonalities in their efforts can help guide other states interested in developing effective system-level strategies for addressing the needs of individuals with co-occurring disorders. Among (NASMHPD/NASADAD, 2002) these commonalities are:

• A shared vision and expectations concerning co-occurring disorders treatment that staff were encouraged, supported, and expected to follow.

• A comprehensive service system - based on an integrated services model that has been tailored to respond to local needs - that is capable of responding to all or most of the needs of individuals with co-occurring mental and substance abuse disorders, including the presence of other concurrent health issues.

• Staff expectation that individuals with co-occurring symptoms and disorders would be the rule rather than the exception among individuals needing services. This expectation is coupled with the ability to screen and assess for related conditions, such as HIV/AIDS, a full range of physical and/or sexual abuse, brain disorders, physical disabilities, etc.

• Staff who have been cross-trained and taught to be culturally competent in both mental health and substance abuse disciplines, while continuing to work within their fields of expertise. Care is delivered as part of a multidisciplinary team that features shared responsibility for clients.

• Client-centered services that engage individuals who are at various stages of acceptance and recovery.

Comprehensive Continuous Integrated System of Care (CCISC)

The Comprehensive Continuous Integrated System of Care (CCISC) is a model designed to join the mental health and substance abuse treatment systems (and other systems, potentially) in an effort to develop a comprehensive, integrated system of care for people with co-occurring disorders (Minkoff, 2001, 1991). This model includes work derived from the Clinical Standards and Workforce Competencies Project (Minkoff, 2001; CMHS, 1998).

CCISC, identified by SAMHSA as an exemplary practice, is at various stages of implementation in no fewer than 15 state and regional systems (CSAT, in press), including Arizona, Maine, New Mexico, Oregon, and Florida. CCISC is applicable to systems of any size ranging from an entire state to a local service network or agency, and may be extended to include linkages with systems such as corrections and homelessness services.

Integrated System Planning

Because co-occurring disorders are an expectation in all parts of the service system and are associated with poorer outcomes and higher costs, the CCISC model requires that both funding and services be planned specifically based on those assumptions. As a consequence, all service programs are designed to be "co-occurring capable programs," meeting minimum standards of capacity. Some programs are designed to be "co-occurring enhanced"; e.g., they have the capacity to respond to co-occurring substance abuse disorders and mental disorders in inpatient psychiatry units.

In 2009, Drs. Minkoff and Cline updated the model to expand the recovery-oriented principles, the family participation and the inclusion of physical health care. The model now focuses on hope, dreams and needs of the people and families we serve. It no longer focuses solely on mental health and substance use conditions. Additionally, the model now specifies that children's systems of care must address co-occurring disorders in both children and their families.

MODULE 8 HANDOUTS: COLLABORATION

Each program matches services to individuals with co-occurring disorders based on their treatment needs. For example, some programs provide continuity-of-care case management services for substance using individuals with serious mental illnesses. Other programs might include residential addiction programs for individuals with serious addiction and trauma disorders.

Although new resources are always needed, the CCISC helps identify how current resources can work more efficiently by designing programs to be co-occurring disorders capable from their inception. In addition, the CCISC encourages use of any best practice intervention or program for either mental illness or substance use disorder, provided that the intervention is designed to be offered routinely in an integrated manner to individuals with co-occurring disorders.

Integrated Treatment Philosophy

The CCISC treatment philosophy is based on eight evidence-based treatment principles that reflect consensus among clinical experts (CMHS, 1998). These principles emphasize the need to acknowledge co-occurring disorders as an expectation, to consider both substance use disorders and mental health disorders as primary disorders, and to develop program structures and interventions that accommodate each individual's needs.

No one program or intervention is right for all people with co-occurring substance use disorders and mental disorders. For any individual at any point in time, interventions must be matched to the status of the individual - from diagnosis to phase of recovery and from needs/strengths/contingencies to level of care requirement (CMHS, 1998). Finally, the measure of success is based on an individual's treatment goals.

At any point in time, success may be defined by acute stabilization of symptoms, movement through stages of change, skill development, or reduction in substance use.

Practice guidelines based on this model have been adopted by the State of Arizona and by the Illinois Behavioral Health Recovery Management project. Dr. Kenneth Minkoff has developed a "12-Step Program for the Implementation of the CCISC," and Minkoff and Cline (2001, 2002) have developed a toolkit to facilitate this process, including tools to evaluate system fidelity, program capability, and clinician competency. The tools have been recently updated (2009), making them more recovery oriented, child and family focused, and easier to use. These tools are being used and evaluated in systems change initiatives throughout the U.S. and Canada.

Consultation refers to the traditional types of relationships among providers from referrals to requests for exchanging information and keeping each other informed. The framework calls for particular attention to the consultation relationship during identification, engagement, prevention, and early intervention activities.

Collaboration is essential when a person who is receiving care in one treatment setting also requires services from another provider. Collaboration is distinguished from consultation on the basis of the formal quality of collaborative agreements, such as memoranda of understanding or service contracts, which document the roles and responsibilities each party will assume in a continuing relationship. NOTE: release of information requires the client to give written authorization for the release of any information and in most substance abuse treatment these releases are governed by Federal Law 42 C.F.R. Part 2 (see appendix for more information).

Integration denotes those relationships among mental health and substance abuse providers in which the contributions of professionals in both fields are moved into a single treatment setting and treatment regimen.

166. Module 8:

Cross System Collaboration

167. Goal

Identify barriers to and strategies for cross-system collaboration.

168. Objectives

- Describe at least 3 program and clinical barriers.
- Discuss obstacles for clients in accessing treatment services.
- Define consultation, collaboration and integration.
- Identify 4 strategies that have been implemented in programs throughout the country.

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169. Barriers to Integrated Treatment (SAMHSA) Funding Barriers

• Federal, state and local infrastructures are generally organized to respond to single disorders
• No single point of responsibility exists for treatment and care coordination
• Mental health and substance abuse service systems often vie for the same limited resources
• The funding mechanisms for the two systems are often inflexible, difficult to navigate, and involve a myriad of state, federal and private sector payers with variable eligibility requirements and benefit offerings that do not encourage flexible, creative financing

SLIDE 169 NOTES:

Mental health and substance abuse treatment are funded through a patchwork of separate federal, state, local, and private funding sources. The need to fund services for co-occurring disorders from these multiple, disparate programs may place the burden of aggregating funds on providers. The Substance Abuse Prevention and Treatment (SAPT) Block Grant is the single largest source of state expenditures for public substance abuse prevention and treatment services, representing 40 percent of such expenditures. The Community Mental Health Services (CMHS) Block Grant represents between 3 and 4 percent of state expenditures for community-based mental health care. The bulk of public mental health services are paid for with state and other federal dollars, including Medicaid. Medicaid spends approximately $20 billion per year on mental health services and approximately $1 billion annually for drug and alcohol treatment services. Other funding sources that form part of the patchwork may include private health insurance, as well as dollars from other service sectors - education, criminal justice, and child welfare.

MEDICAID

During the written and verbal public input sessions, SAMHSA constituents cited state-based Medicaid policies as a significant barrier to providing comprehensive services for people with co-occurring disorders (SAMHSA, 2002f). Medicaid programs vary from state to state in the types of substance abuse treatment programs and mental health services they fund. Few providers have control over how Medicaid services are reimbursed or administered (Drake, Essock et al., 2001).

COVERAGE GAPS

The patchwork of funding mechanisms and disparities in coverage can create gaps in the availability of needed services. For example, existing funding streams often do not cover the so-called "wraparound" supports, such as transportation, childcare, and vocational training. Yet these ancillary services may be among the most cost-effective means of improving treatment outcomes (CSAT, unpublished document). Individuals with no insurance or inadequate coverage may be unable to afford the newer, and in many cases more effective, antipsychotic medications. Though people with co-occurring conditions are likely to be among those with the least resources, funding problems are not limited to people who are indigent or served in the public sector.

LACK OF RESOURCES

The insufficiency of service system dollars and trained professionals to provide care means there is also a significant gap in the ability of both systems to treat

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS
MODULE-8 — 187

people in need. A new analysis of trends in health care spending reveals that expenditures for mental health services and substance abuse treatment represented 7.8 percent of the more than one trillion dollars in all U.S. health care expenditures in 1997, down from 8.8 percent of the total in 1987 (SAMHSA, 2000).

This decline occurred despite the persistent gap between the prevalence of substance abuse and mental disorders and the individual's receiving treatment. Estimates suggest that while about 20 percent of the U.S. population is affected by mental disorders in any given year, only one-third of people in need of mental health treatment receive it (U.S. DHHS, 1999b). When it comes to substance abuse disorders, between 13 million and 16 million people need treatment for alcoholism and/or drug abuse in any given year, but only 3 million (20 percent) receive care (SAMHSA, 2000).

170. Program Issues

Lack:

- service models, administrative guidelines, quality assurance procedures, and outcome measures
- training opportunities and staff trained in treating co-occurring disorders
- funds for training
  - difficulty of working across systems to cross-train providers
- Reluctant to diagnose a disorder for which reimbursement is unavailable, especially in cost-cutting environments that discourage more intensive care.

SLIDE 170 NOTES:

At the local level, providers often lack service models, administrative guidelines, quality assurance procedures, and outcome measures to implement a full range of needed services for people with co-occurring disorders (Drake, Essock et al., 2001). Perhaps one of the most significant program-level barriers, noted by consumers and family members as well as by providers during the public input sessions, is the lack of staff trained in treating co-occurring disorders (SAMHSA, 2002f). A significant focus of public attention was around opportunities for cross-training of staff and availability of staff trained in areas of co-occurring disorders. Despite an increasing body of evidence affirming the importance of integrating mental health and substance abuse treatment, few educational institutions teach this approach (The National Council and SAAS, 2002; Drake, Essock et al., 2001).

Education of new clinicians and supervisors is important, but so, too, are efforts to retrain current clinicians and supervisors (IOM, 2000). Program administrators cite lack of funds for training and the difficulty of working across systems to cross-train providers as significant barriers (Ridgely et al., 1990). In addition, few incentives exist in the current system to motivate clinicians to become cross-trained (CSAT, unpublished document; Drake, Essock et al., 2001). They may be reluctant to diagnose a disorder for which reimbursement is unavailable, especially in cost-cutting environments that discourage more intensive care.

171. Clinical Issues

- Clinicians in the two systems often have different credentials, training and treatment philosophies

- There is a lack of staff educated and trained in co-occurring disorders treatment

- Salaries vary widely between the systems which affect workforce recruitment and retention

SLIDE 171 NOTES:

Clinicians who work with people with co-occurring disorders must have sufficient knowledge of a discipline in which they were not trained to be both comfortable and capable. While the fundamental approach to clinical education has not changed appreciably since 1910 (IOM, 2000), the demands on clinicians have changed dramatically. They are asked to do more in less time with fewer resources and to incorporate best practices into their work. Further, cross-training is hampered by the fact that substance abuse and mental health providers often have very different philosophies and treatment approaches (Drake, Essock et al., 2001). The result is a training gap that "leaves graduate students, working professionals, and other direct care providers inadequately prepared for practice in the current health care environment" (Hoge, 2001).

Providers in both systems have to tailor their approach to the special needs of people who have co-occurring disorders. For example, in substance abuse settings, mental health services for individuals with co-occurring substance abuse disorders focuses on educating individuals about their mental illness, engaging and persuading them to address their mental health problems, and helping them manage medications they may need to address their psychiatric symptoms. In addition, the substance abuse counselors tailor their approach to the special needs of people who have a mental disorder, including serious mental illnesses. Much of substance abuse counseling occurs in groups while treatment of mental disorders often occurs in individual sessions. In mental health service settings in contrast, providers must be able to identify substance abuse problems, assess their severity, and plan appropriate treatment based on knowledge of the interaction of the mental illness and substance use disorder.

172. Areas of Convergence

- Respect
- Outreach and engagement
- Belief in human capacity to change
- Importance of community, family and peers

SLIDE 172 NOTES:

Despite the fact that, historically, the mental health and substance abuse approaches to care have been different, principles of care within the two fields converge in several key areas: respect for the individual, engagement of those who are most difficult to reach, belief in the human capacity to change, and the importance of community, family, and peers to the recovery process (Osher, 1996). The substance abuse field has contributed the concept of recovery, now increasingly a focus of mental health treatment, and clinicians in both systems see the conditions they treat as chronic disorders that require long-term support.

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-8 — **189**

173. Consumer and Family Barriers

- Stigma
  - Mental illness, substance abuse
- Lack accessible information
- Individual treatment approaches
- Cultural competence of providers
- Early termination of services

SLIDE 173 NOTES:

Key barriers to treatment for individuals with co-occurring disorders are perceptions by them and their families. The following section highlights major obstructions that may result in ineffective care or a decreased desire to receive care.

The stigma that is still associated with substance use disorders and mental disorders remains a significant barrier to engagement in appropriate mental health services and substance abuse treatment (CSAT, in press; CSAT, 2000; U.S. DHHS, 1999b). Individuals with co-occurring substance abuse disorders and mental disorders bear a double burden.

In addition, consumers and their families often lack accessible information about the interaction of substance use disorders and mental disorders and the availability of effective treatment. People with serious mental illnesses may deny or minimize problems related to substance use or believe that substance use helps alleviate psychiatric symptoms (Drake, Essock et al., 2001). Because even limited use of substances of abuse may create significant problems for people who have serious mental illnesses, individuals, family members, and providers may not recognize the extent of the problem. People whose substance use precipitates psychiatric symptoms may not recognize either problem.

Further, treatment of an individual in the context of his or her family helps the household as a whole realize improvement and decreases the likelihood that mental illness and substance abuse will become an ongoing pattern. However, even if family treatment is prescribed, coordinating appropriate services for adults and children is difficult because care and funding mechanisms are separate.

Consumers who provided guidance in the development of this report cited additional barriers, as well. They spoke of a low level of cultural competence among providers, which sometimes led to inappropriate diagnoses; programs that ended too soon, "dropping" them just as they were beginning to lead stable lives; restrictive eligibility criteria that favored individuals who are severely ill at the expense of people who are less ill but no less in need of treatment; and lack of involvement of consumers in their own care.

Report To Congress On The Prevention And Treatment Of Co-occurring Substance Abuse Disorders And Mental Disorders, SAMHSA

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174. Barriers to Treatment for Youth from Minority Ethnic/Cultural Groups

- Financial
- Help-seeking behavior
- Language
- Stigma
- Geographical location/distance
- Unawareness of available services
- "Expert" model of treatment
- System resistance to working with "angry" youth

175. What will we do?

- Consult
- Collaborate
- Integrate

SLIDE 174 NOTES:

Recent research regarding cultural issues reveals disproportionate minority confinement and overrepresentation of African American versus Caucasian youth in the juvenile justice system. Likewise, minority youth in the mental health treatment systems are treated differently than Caucasian youth even though the rates of mental illness are similar.

Barriers and obstacles for minorities to access treatment services result in the juvenile justice system often being the first opportunity for minority youth to receive assessment and treatment for co-occurring disorders; thus, it is important for the juvenile justice system to take cultural factors into account during the initial assessment.

SLIDE 175 NOTES:

Consultation refers to the traditional types of informal relationships among providers from referrals to requests for exchanging information and keeping each other informed. This framework calls for particular attention to the consultation relationship during identification, engagement, prevention, and early intervention activities.

Collaboration is essential when a person who is receiving care in one treatment setting also requires services from another provider. Collaboration is distinguished from consultation on the basis of the formal quality of collaborative agreements, such as memoranda of understanding or service contracts, which document the roles and responsibilities each party will assume in a continuing relationship. Note: release of information requires the client to give written authorization for the release of any information and in most substance abuse treatment these releases are governed by Federal Law 42 C.F.R. Part 2 (see appendix for more information).

Integration denotes those relationships among mental health and substance abuse providers in which the contributions of professionals in both fields are moved into a single treatment setting and treatment regimen.

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MODULE-8 — 191

176. Collaborative Relationship

Can we work on the PROBLEM together?

177. Systems Integration in Practice

Key Lessons

- Many replicable strategies and tools
- Leadership is key
- Involve numerous stakeholders
- Provider-level programs are further developed than systems-level initiatives
- Demographic differences are small

178. Replicable Strategies (SAMHSA, 2000)

- Start with what you know and build from there
- Use an incremental approach
- Bring together existing local resources and personnel to provide seed dollars to develop a program or system
- Establish a co-location
- Collect and use data on effectiveness
- Employ a problem-solving approach
- Use assessment and other tools
  - Common values and principles
  - Core competencies
  - Clinical/treatment guidelines
  - Outcome measurements
  - Common vocabulary
  - Psychiatric Services
- Promote training

Please refer the participants to a description of example of integration at the macro level.

HANDOUT: Innovative Systems Integration Strategies

For more detailed information please refer to the SAMHSA, Strategies for Developing Treatment Programs for People with Co-occurring Substance Abuse and Mental Disorders. Publication No.3782

LEADERSHIP IS KEY

INVOLVE NUMEROUS STAKEHOLDERS

It is important to involve numerous stakeholders, including consumers and family members. A great deal of behavioral health history has involved building consensus with stakeholders before taking action. The goal is to "invite participation in the change process rather than in the design process".

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PROVIDER-LEVEL PROGRAMS ARE FURTHER DEVELOPED THAN SYSTEMS-LEVEL INITIATIVES

Programs can initiate and adapt to change more readily than larger macro systems. Programs have learned through trial and error and have been able to circumnavigate obstacles.

DEMOGRAPHIC DIFFERENCES ARE SMALL

There is more common ground than differences. The biggest challenges lay in navigating the benefit and regulatory designs.

179. Actions Toward Integration

- Develop aggregated financing mechanisms

- Measure achievement by improvements in functioning and quality of life

- Agency leaders need to have a shared vision and establish a set of expectations which staff in both disciplines are encouraged and expected to follow

- Staff should expect clients to present with a full range of co-occurring symptoms and disorders

SLIDE 179 NOTES:

Much of this information is a summary of previous lecturettes. Review this and the next 2 slides with the participants.

180. Action, continued

- Clients in both systems should be screened and assessed for other conditions as well, including

- HIV/AIDS, physical and/or sexual abuse, brain disorders, physical disabilities, etc.

- Staff should be cross-trained in both mental health and substance abuse, but can continue to work in their field of expertise.

- These staff can serve as part of a multidisciplinary team that features shared responsibility for clients and is culturally appropriate

SLIDE 180 NOTES:

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

MODULE-8 — **193**

181. Action, continued

- Services should be client-centered.
- Staff should express hope for clients' success in treatment and empower clients to do the same.

SLIDE 181 NOTES:

EXERCISE: Three Stage Fishbowl / approx. 30 min

Arrange the chairs in a fishbowl configuration (two concentric circles). Have the participants count off by 1,2 and 3's creating 3 groups. Ask the members of group 1 to sit in the discussion-circle seats (inside circle) and the other two groups to sit in the outer circle.

Use the following questions (or create new questions based on the needs of the group)

1. What strengths currently exist within and between provider systems for adolescents with co-occurring disorders?

2. What are some of the effective ways in which you have engaged and retained adolescents and their families, and how can you improve to include other systems?

3. What is the one thing you have always wanted to provide for this population and what is one step you can do to accomplish it?

Pose the first question to the inner circle. Allow up to ten minutes for discussion.

Next invite the members of group 2 to sit in the inner circle, replacing the members who now move to the outer circle. Ask the members of Group 2 if they would like to make any brief comments about the first discussion and then segue into the second discussion topic.

Repeat the same procedure with members of the third discussion group.

When all three groups have been discussed, reconvene the entire group. Ask the participants for their reflections about the entire discussion.

182. Above All Else…

- Remember to have fun…
- Keep your sense of humor & laugh at yourself…
- When all else doesn't seem to be working - use your imagination & creativity

And remember…

"It's kind of fun doing the impossible"

- Walt Disney

SLIDE 182 NOTES:

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ANNOTATED BIBLIOGRAPHY OF RECENT ARTICLES & BOOKS

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Text Revision. Washington, D.C.: American Psychiatric Association. The manual used by all who assess and diagnose the presence of any mental disorder, including substance use disorder. One of the appendices crosswalks International Classification of Disease (ICD) codes and DSM-IV-TR codes.

August, G.J., Hektner, J.M., Egan, E.A., Realmuto, G.M. & Bloomquist, M.L. (2002). The early risers longitudinal prevention trial: Examination of 3-year outcomes in aggressive children with intent-to-treat and as-intended analyses. *Psychology of Addictive Behaviors 16*(43), 527-539. Demonstration of the effects of early intervention targeted to improvements in four key predictor variables mediating "progression from early aggressive behavior and its correlates to later conduct problems and substance abuse." The intervention model described and researched is comprised of two "complementary" components for both young children and parents.

Brook, D. (2003). Exploring group therapies. *Psychiatric Times XX*(2), *February*. This article comprises a review of published approaches to group therapy in its effects on behavioral risk factors. Psychosocial and cultural risk and protective factors are discussed as well parent-child, peer interactions and personality/attitude constructs.

Bukstein, O.G. (1995). *Adolescent substance abuse: Assessment, prevention, and treatment.* Indianapolis, IN: Wiley Publishing Co. (Series on Personality Processes). One of the first useful books targeted to the spectrum of issues related to adolescent substance use disorders, including biological and environmental risk factors, treatment issues, and prevention strategies.

Carey, K.B., Purnine, D.M., Maisto, S.A. & Carey, M. P. (1999). Assessing readiness to change substance abuse: A critical review of instruments. *Clinical Psychology: Science and Practice 63, Fall,* 245-266. Analyzes the major measures currently used to measure readiness to change (those based on theory and not) and their psychometric properties. There are a number of limitations and cautions for each measure that clinicians should be aware of before using any of them. The recommendation of the authors is to "refrain from using any of them as the sole basis for important clinical decisions."

Chung, T., Martin, C., Armstrong, T.D. & Labouvie, E.W. (2002). Prevalence of DSM-IV alcohol diagnoses and symptoms in adolescent community and clinical samples. *Journal of the American Academy of Child & Adolescent Psychiatry, May,* 645-554. Interesting study that not only looks at prevalence of alcohol abuse and dependence among adolescents but also the difference between these disorders in adolescents and adults.

Deas, D. & Thomas, S. (2001). An overview of controlled studies of adolescent substance abuse treatment. *American Journal of Addictions 10*(2), *Spring*, 178-189. Provides an overview of family-based and multisystemic interventions, behavioral therapy, cognitive behavioral therapy, pharmacotherapy and 12 step approaches for adolescents with substance use disorders. While the results look promising for CBT and FBMST, most of the relevant studies fail to utilize validated outcome measures making it difficult to conclude superiority of one treatment approach over another.

Deas, D., Riggs, P., Langenbucher, J., Goldman, M. & Brown, S. (2000). Adolescents are not adults: Developmental considerations in alcohol users. *Alcoholism: Clinical and Experimental Research 24*(2), *February*, 232-237. This article reminds readers that adolescents are "rarely only alcohol involved" and are more often multiple substance users and have co-occurring DSM disorders. Assessment instruments are reviewed, as are the similarities and differences between adults and adolescent alcohol users. A useful section on expectancies and drinking in adolescents cites expectancies at differing developmental stages and the literature on challenging expectancies with college students.

DiNitto, D., Webb, D., Rubin, A., Morrison-Orton, D., Wambach, K. (2001). Self-help group meeting attendance among clients with dual diagnosis. *Journal of Psychoactive Drugs 33*(3), *Jul-Sep*, 263-276. Explored factors associated with self-help group meeting attendance (AA, NA, Women for Sobriety) in aftercare of 81 clients with COD following discharge from a chemical dependency treatment program. There was no association with meeting attendance and treatment outcome regarding psychiatric problems severity or domains of the ASI.

Dishion, T.J. & Kavanagh, K. (2003). *Intervening in adolescent problem behavior.* New York: The Guilford Press. An eleven-chapter book (with checklist appendices for use in assessment) that both explicates and elaborates upon the original interventions and materials from the Adolescent Transitions Program (ATP). The ecological perspectives and approach offered complement the research of others presented in this bibliography and curriculum.

Eddy, J. Mark & Chamberlain, P. (2000). Family management and deviant peer association as mediators of the impact of treatment condition on youth antisocial behavior. *Journal of Counseling and Clinical Psychology 68*(5), 857-863. An Oregon-based study of two types of residential care for delinquent adolescent boys: group home care and multidimensional treatment foster care with work with the natural family as well. MTFC, based on a multisystemic therapy model, proved to produce statistically significant positive outcome results at the midpoint of the study and in subsequent follow-up assessments. The authors make the point that it is "not too late to modify antisocial 'careers,' even during adolescence."

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CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

BIBLIOGRAPHY — 195

Estroff, T.W. (Ed.) (2001). *Manual of adolescent substance abuse treatment*. Washington, D.C.: American Psychiatric Publishing, Inc., 306 pgs. A focused book of relatively short, densely packed topics, most of which deal with co-occurring issues. Everything from epidemiology, through evaluation and treatment in various settings, to spirituality and developmental issues are covered. A very useful and basic text.

Friedman, A. & Utada, A. (1989). A method for diagnosing and planning the treatment of adolescent drug abusers: The Adolescent Drug Abuse Diagnosis (ADAD) instrument. *Journal of Drug Education, 14*(4), 1989, 285-312. The ADAD is a 150 item instrument with a structured interview format, modeled after the Addiction Severity Index (ASI AT McLellan et al, 1984).

Geller, B., Cooper, T.B., Sun, K., Zimerman, B., Frazier, J., Williams, M. & Heath, J. (1998). Double-blind and placebo-controlled study of lithium for adolescent bipolar disorders with secondary substance dependency. *Journal of the American Academy of Child & Adolescent Psychiatry 37*(2), *February*, 171-178. A small but important study on the use of lithium, which has renal elimination, rather than hepatically metabolized medications such as valproate, carbamazepine, and neuroleptics for treatment of bipolar mood disorder. Symptoms of bipolar disorder appeared generally prior to puberty and before the onset of substance dependency disorders. The prevalence of bipolar disorders in adolescents is similar to that in adults and co-morbid substance use disorders are significantly higher in these populations than in the general population or among persons having other psychiatric disorders.

Giaconia, R.M., Reinherz, H.Z., Paradis, A.D., Carmola Hauf, A.M. & Stashwick, C.K. (2001). Major depression and drug disorders in adolescence: General and specific impairments in early adulthood. *Journal of the American Academy of Child & Adolescent Psychiatry 40*(12), *December*, 1426-1433. Findings from the study indicated continued impairments which affected significant life roles as the youth moved into young adulthood. The study is limited by having too small an n to examine effects for youth with co-occurring depression and substance use disorders.

Gorman-Smith, D., Tolan, P.H., Henry, D.B., Leventhal, A., Schoeny, M., Lutovsky, K. & Quintana, E. (2002). Predictors of participation in a family-focused preventive intervention for substance use. *Psychology of Addictive Behaviors 16*(45), 555-564. A study of factors affecting degree of family participation in SAFE (Schools and Families Educating Children), a program targeting early predictors of risk for deviant and drug use behaviors in first-grade children in economically disadvantaged inner-city neighborhoods.

Haggerty, K.P., Wells, E.A., Jenson, J.M., Catalano, R.F. & Hawkins, J.D. (1989). Delinquents and drug use: a model program for community reintegration. *Adolescence 24*(94), *Summer*, 439-456. An older article that describes the research of the 3 1/2 year demonstration project known as "Project ADAPT" and the Social De-velopment Model underlying this model. Much of the newer program research uses components described in this model.

Henggeler, S.W., Clingempeel, W.G., Brondino, M.J., & Pickrel, S.G. (2002). Four-year follow-up of multisystemic therapy with substance-abusing and substance-dependent juvenile offenders. *Journal of the American Academy of Child & Adolescent Psychiatry 41*(7), *July*, 868-874. Demonstrates relative effectiveness of the MST model over usual service provision to substance abusing and dependent youth with criminal justice involvement. The authors cite adoptions to the model needed to effectively treat serious mental disorders that were not implemented in this study (significant treatment effects for psychiatric symptoms were not found). The authors suggest that serious antisocial behavior in children and adolescents "might be conceptualized and treated as a chronic illness" (supporting Kazdin's research cited below) and that a more efficient use of resources would involve the provision of integrated services addressing substance use, mental disorders, and antisocial behaviors in the community, using evidence-based practices.

Henggeler, S.W., Schoenwald, S.K., Rowland, M.D. & Cunningham, P.B. (2002). *Serious emotional disturbance in children and adolescents: Multisystemic therapy*. New York: Guilford Press, 260 pgs. A very useful book for conceptualizing the application of multisystemic therapy to work with children having serious (and co-occurring) mental disorders, their families, and others who interface with the child and family.

Huey, S.J. Jr., Henggeler, S.W., Brondino, M.J. & Pickrel, S.G. (2000). Mechanisms of change in multisystemic therapy. Reducing delinquent behavior through therapist adherence and improved family and peer functioning. *Journal of Consulting and Clinical Psychology 68*(3), 451-467. A research article examining hypothesized mediating factors leading to reduced antisocial behaviors in adolescence receiving MST (based on Bronfenbrenner's social-ecological model of human development, 1979). The sequence from improved family functioning, to decreased delinquent peer affiliation, to decreased delinquent behavior is affirmed. Two surprising findings suggest that requiring family effort in treatment without appropriately engaging the family members may negatively affect treatment outcomes. The effects of "challenging" families on therapist behavior and reciprocally, family perceptions, are discussed, with the implication that therapists need to be prepared to attend more to true engagement of family members as collaborators in the treatment process.

Jerrel, J., Wilson, J., Hiller, C. (2000). Issues and outcomes in integrated treatment programs for dual disorders. *Journal of Behavioral Health Services and Research 27*(3), 303-313. In an integrated, dual disorder treatment program, this study addresses numerous barriers to delivering services to dually diagnosed consumers and employs a set of multidimensional indicators to assess outcomes. Program implementation issues are

described and the clinical management implications for more effectively serving COD individuals through integrated services are discussed. Although geared for adult services, some of the creative approaches, e.g., child care and providing transportation are approaches that are needed in adolescent programs.

Kaminer, Y., Burleson, J.A., & Goldberger, R. (2002). Cognitive-behavioral coping skills and psychoeducation therapies for adolescent substance abuse. *The Journal of Nervous and Mental Disease 190*(11), 737-745. A study demonstrating more positive outcomes for older adolescent males using cognitive-behavioral approaches vs. psychoeducation sessions. However, at 9-month follow-up, relapse rates were similar. It also confirmed that conduct-disordered youth are at increased risk of not completing treatment, especially if they do not have a co-occurring internalizing disorder (mood or anxiety disorder).

Kaminski, R.A., Stormshak, E.A., Good, R.H. III & Goodman, M.R. (2002). Prevention of substance abuse with rural head start children and families: Results of project STAR. *Psychology of Addictive Behaviors 16*(45), 511-526. Research regarding the effectiveness of a comprehensive intervention with preschool children and families aimed at reducing the risk of future substance use disorders. Specific effects are described in detail with recommendations for further study.

Kazdin, A.E. (1987). Treatment of antisocial behavior in children: Current status and future directions. *Psychological Bulletin 102*(2), 187-203. A useful, older article for examining components of the development of conduct disorder and examining both how far we have come and how far we have to go more than 15 years later.

Kumpfer, K.L., Alvarado, R., Tait, C. & Turner, C. (2002). Effectiveness of school-based family and children's skills training for substance abuse prevention among 6-8 year-old children. *Psychology of Addictive Behaviors 16*(45), 565-571. Description and an effectiveness study of Project SAFE (Strengthening America's Families and Environment) used with 655 1st graders in 12 rural schools as a randomized trial with a universal population.

Lerner, R.M. & Castellino, D.R. (2002). Contemporary development theory and adolescence: Developmental systems and applied developmental science. *Journal of Adolescent Health 2002*(31), 122-135. The article's conclusion is a reasonable summary of this highly-useful article. The authors write: "An adequate and sufficient science of adolescent development, and one that is able to help in the development of successful policies and programs for youth, must integratively study the relations between individuals and contexts in an integrated, systemic, and temporal manner."

Lochman, J.E. & Wells, K.C. (2002). The coping power program at the middle-school transition: Universal and indicated prevention efforts. *Psychology of Addictive Behaviors 16*(45), 540-554. Interventions targeted to risk factors for substance use in 5th and 6th grade students and their parental figures. Positive effects were noted in three of the four predictor variable domains: social competence, self-regulation, and parents' parenting skills. School bonding variables were not significantly affected.

Miller, W. R. & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change (second edition)*. New York: The Guilford Press, 428 pgs. This edition contains, in addition to a description of the theory and practice of MI, chapters on applications to, and research about, adolescents and young adults, criminal justice populations, and use with persons having dual mental and substance use disorders.

Monti, P.M., Colby, S.M.& O'Leary, T.A. (Eds.) (2001). *Adolescents, alcohol and substance abuse: reaching teens through brief interventions*. New York: The Guilford Press, 350 pgs. A highly useful book that examines a number of issues in current practice and research. Chapters examine adolescent development and its relationship to interventions; harm reduction; assessment; risk factors; motivational enhancement and interviewing; skills training; family therapy; co-morbid psychiatric conditions; internet use in prevention and treatment; and research for improving brief interventions.

Meyers, K., Hagan, T.A., Zanis, D., Webb, A., Frantz, J., Ring-Kurtz, S., Rutherford, M. & McLellan, A.T. (1999). Critical issues in adolescent substance use assessment. *Drug and Alcohol Dependence 55*(3), 235-246. A useful summary of theory, research, and clinical experience presented as a "practical framework" for making assessment decisions that is informed by eight years of development and testing of the Comprehensive Adolescent Severity Index (CASI).

Osher, F.C. & Kofoed, L.L. (1993). Treatment of patients with psychiatric and psychoactive substance abuse disorders. *Dual diagnosis of mental illness and substance abuse: Collected articles from H&CP [American Psychiatric Association]*, 11-16. Presents a conceptual model emphasizing four phases of treatment, their components, and how these are useful in working with persons with severe and recurrent psychiatric disorders who also have substance use disorders.

Rapp, C. A. (1998). *The strengths model: Case management with people suffering from severe and persistent mental illness*. New York: Oxford University Press, 224 pages. This book gives a complete overview of the strengths model, its rationale, origins, processes, and case examples, along with pointers for supervision of staff incorporating this approach.

Ries, R. (1993). Clinical treatment matching models for dually diagnosed patients. *Psychiatric Clinics of North America 16*(1), *March*, 167-175. Examines three types of treatment (serial, parallel and integrated) in terms of their characteristics and suggests ways of "matching specific patients to treatment models." These types are referred to by Kenneth Minkoff in later writings.

CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

BIBLIOGRAPHY — **197**

Northeast
ATTC
Unifying science, education
and services to transform lives.

Riggs, P.D. (1998). Clinical approach to treatment of ADHD in adolescents with substance use disorders and conduct disorders. *Journal of the American Academy of Child & Adolescent Psychiatry 37*(3), *March*, 331-332. This article cites Attention-Deficit/Hyperactivity Disorder as co-occurring in 30-50% of adolescents having both a Substance Use Disorder and Conduct Disorder and advises careful diagnosis using a time line (including establishing the presence of ADHD prior to age 7) and adequate treatment of all diagnoses, including medications such as pemoline or buproprion that have both efficacy in treating ADHD and lower abuse potential than the psychostimulants. [See also Riggs et al (1996). An open trial of pemoline in drug-dependent delinquents with Attention-Deficit Hyperactivity Disorder, 35:8, August, pp. 1018-1024 and Riggs et al (1998). An open trial of buproprion for ADHD in Adolescents with Substance Use Disorders and Conduct Disorder, 37:12, December, pp. 1271-1278, in the same journal.]

Riggs, P.D. (in press). Treating adolescents for substance use and comorbid psychiatric disorders. A very useful description of practical clinical guidelines for integrating assessment and treatment of substance use disorders with specific co-occurring psychiatric disorders is presented.

Riggs, P.D., Baker, S., Mikulich, S.K., Young, S.E. & Crowley, T.J. (1995). Depression in substance-dependent delinquents. *Journal of the American Academy of Child & Adolescent Psychiatry 34*(6), *June*, 764-771. Findings that depression in conduct-disordered males often begins in preadolescence and may co-occur more frequently with co-morbid Attention-Deficit/Hyperactivity Disorder (beginning prior to Conduct Disorder). Additionally, 75% of the depressed young males also had an additional Anxiety Disorder (as opposed to 25% of non-depressed conduct-disordered youth in the study). All youth in the study were in long-term residential care and all had Conduct Disorder and a substance use disorder. Twenty-one percent of them were also diagnosed with Major Depressive Disorder or Dysthymia. This subset of boys also had more substance dependence diagnoses, more ADHD, PTSD, and anxiety disorders and had tended to develop conduct symptoms earlier than the non-depressed youth in the study.

Riggs, P.D. & Davies, R.D. (2002). A clinical approach to integrating treatment for adolescent depression and substance abuse. *Journal of the American Academy of Child & Adolescent Psychiatry 41*(10), *October*, 1253-1255. Presents an integrated algorithm for diagnostic evaluation and treatment of co-occurring depression and substance use disorders.

Riggs, P.D. & Davies, R.D. (2002). A clinical approach to integrating treatment for adolescent depression and substance abuse. *Journal of the American Academy of Child & Adolescent Psychiatry 37*(12), *December 1998*, 1271-1278. This was a 5 week study on boys in residential treatment with conduct disorder, substance use disorders and co-morbid attention-deficit/hyperac-

tivity disorder. There were decreases in the mean Conners Hyperactivity Index score and their study points out the need of a larger controlled study.

Ronen, T. (2003). *Cognitive-constructivist psychotherapy with children and adolescents*. New York: Kluwer Academic/Plenum Publishers, 257 pgs. A well-written text written to assist graduate students in the theory and practice of this integrated form of psychotherapy. The author practices in Tel Aviv, Israel. This book presents an assessable review of theory, outlines a clear process of clinical decision-making, and presents a number of case studies of children and adolescents that integrate theory and practice. It is a very useful text for considering the work of psychotherapy and the real changes that are possible in children and adolescents when working with relational and skilled therapists.

Saleebey, D. (Ed.) (1997). *The strengths perspective in social work practice (second edition)*. New York: Longman, 259 pgs. A good review with chapters on its use in substance use treatment, with children and adolescents, and with persons having serious mental disorders.

Screening and assessing adolescents for substance use disorders. (1999 update, release 1993 as TIP #3) Substance Abuse and Mental Health Services Administration (SAMHSA). Rockville, MD: US Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment: 1999. 129 pps. (Treatment improvement protocol (TIP) series; no.31). Provides general guidelines for a broad range of professionals, including coaches and teachers as well as mental health and addictions personnel on evaluating and using assessment instruments for adolescents with SUD.

Tarter, R.E., Sambrano, S. & Dunn, M.G. (2002). Predictor variables by developmental stages: A center for substance abuse prevention multisite study. *Psychology and Addictive Behaviors 16*(4S), pp. S3-S10. A report of a study addressing risk factors for developing substance use disorders in adolescence by delivering interventions aimed at reducing four of these major risk factors: self-regulation, parental involvement, school bonding, and social competence. The projects target four age groups: 3-5, 6-8, 9-11, and 12-14 years.

Treatment of adolescents with substance use disorders. (1999 update, release 1993 as TIP #4) Substance Abuse and Mental Health Services Administration (SAMHSA). Rockville, MD: US Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment: 1999. (Treatment improvement protocol (TIP) series; no.32). Contains eight chapters and several appendices useful when considering individualizing treatment approaches to the needs of specific youth (and their family members).

Van Hasselt, V.B., Null, J.A., Kempton, T. & Bukstein, O.G. (1993). Social skills and depression in adolescent

substance abusers. *Addictive Behaviors 18*, pp. 9-18. Research indicating a positive correlation between early depression and later substance abuse in both males and females in an inpatient facility treating co-occurring substance use and psychiatric disorders and the need for specific types of social skills training for both genders. Includes a call for more research.

Weinberg, N.Z. (2001) Risk factors for adolescent substance abuse. *Journal of Learning Disabilities 34*(4), *July-August 2001*, 343-351. Reviews research on risk factors for adolescent substance use disorders and discusses relationships with learning disabilities. Genetic, biologic, other familial and psychiatric factors emerge as important factors in the risk equation.

Weinberg, N.Z., Rahdert, E., Colliver, J.D. & Glantz, M.D. (1998). Adolescent substance abuse: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry 37*(3), *March*, 252-261. Useful information on prevalence, etiology, comorbidity, assessment, treatment, prevention, and areas for future research.

Wise, B.K., Cuffe, S.P. & Fischer, T. (2001). Dual diagnosis and successful participation of adolescents in substance abuse treatment. *Journal of Substance Abuse Treatment 21*, 161-165. Their research concluded that the co-occurring presence of AD/HD was significant in predicting less success in participating in substance abuse treatment, while being male and having a co-occurring Conduct Disorder approached significance in prediction. The authors also suggest that more aggressive treatment of AD/HD may improve success ratios for this population.

Working together for change: co-occurring mental health and substance use disorders among youth involved in the juvenile justice system. An on-line tutorial. *The National GAINS Center for People with Co-occurring Disorders in the Justice System and the University of Washington, 2001.* http://www.gainsctr.com/curriculum/juvenile/index.htm. An online tutorial which offers a review of the juvenile justice, mental health and substance abuse treatment systems. Additionally there are modules on screening and assessment, treatment strategies and coordinating and integrating systems.

ADDITIONAL BIBLIOGRAPHY OF ARTICLES & BOOKS

Alexander, M. (1996). Women with Co-occurring Addictive and Mental Disorders: An Emerging Profile of Vulnerability. *American Journal of Orthopsychiatry, 66*(1).

Anderson, A.J. Therapeutic program models for mentally ill chemical abusers. *International Journal of Psychosocial Rehabilitation 1*(1):2133, 1997. www.psychosocial.com/dualdx/rehabpub.html [Accessed March 18, 2002].

Azrin, N.H., et al., 1994. Youth drug abuse treatment: A controlled outcome study. *Journal of Child & Adolescent Substance Abuse 3*(3):1-16.

Bartels SJ, Drake RE, Wallach MA. Long-term course of substance use disorders among patients with severe mental illness. *Psychiatric Services. 46*(3):248-251; 1995.

Bettner, B. L. & Lew, A. (1992). *Raising children who can*. New York, NY: Harper Perennial.

Blos, Peter, *The Adolescent Passage.* International Universities Press, New York, 1979.

Brannigan, Schackman, Falco, Millman. The Quality of Highly Regarded Adolescent Substance Abuse Treatment Programs. *Archives of Adolescent Medicine, Vol 158, Sep. 2004*, p. 904-909.

Brooks, T.L., Woods, E.R., Knight, J.R. & Shrier, L.A. (2003). Body modification and substance use in adolescents: Is there a link? *Journal of Adolescent Health 32*(1), *January*, 44-49.

Brown, E.S., Nejtek, V.A., Perantie, D.C. & Bobadilla, L. (2002). Quetiapine in bipolar disorder and cocaine dependence. *Bipolar Disorders 4*(6), 406-411.

Brown, P.J. & Wolfe, J., (1994) *Substance Abuse and Post Traumatic Stress Disorder Co-morbidity, Drug and Alcohol Dependence*, 33, 51-59.

Bukstein, O.G. (2001). Comorbidity and adolescent substance abuse in Estroff, T.W., *Manual of adolescent substance abuse treatment.* Washington, D.C.: American Psychiatric Publishing, Inc., 69-89.

Burnette, M., Drake, R. (1997). Gender Differences in Patients with Schizophrenia and Substance Abuse. *Comprehensive Psychiatry, 38*(2).

Castro, F.G., Proescholdbell, R.J., Abeita, L., and Rodriguez, D. Ethnic and cultural minority groups. In: McCrady, B.S., and Epstein, E.E., eds. *Addiction: A Comprehensive Guidebook*. Oxford University Press, 1999. pp. 499526

Clark, J.J., Leukefeld, C. & Godlaski, T. (1999). Case management and behavioral contracting: Components of rural substance abuse treatment. *Journal of Substance Abuse Treatment 17*(4), 293-304.

Chung, T., Martin, C.S., Armstrong, T.D. & Labouvie, E.W. (2002). Prevalence of DSM-IV alcohol diagnoses and symptoms in adolescent community and clinical samples. *Journal of the American Academy of Child & Adolescent Psychiatry 41*(5), *May*, 546-554.

Crome, I.B., Substance misuse and psychiatric comorbidity: Towards improved service provision. *Drugs: Education, Prevention & Policy. 6*(2):151-174; 1999.

DeLeon, G. Psychopathology and substance abuse: What is being learned from research in therapeutic communities. *Journal of Psychoactive Drugs. 21*(2):177-188; 1989.

Dennis, M.L., Traumatic Victimization Among Adolescents in Substance Abuse Treatment. *Counselor Magazine, April, 2004.*

Dennis, M., Effective Adolescent Treatment Grantee meeting. Presentation for SAMHSA/CSAT, Baltimore, MD, November 3-5, 2003.

CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

BIBLIOGRAPHY — 199

Northeast
ATTC
Unifying science, education and services to transform lives.

Drake, R., Essock, S.M., Shaner, A., Carey, K.B., Minkoff, K., Kola, L., Lynde, D., Osher, F.C., Clark, R.E. & Rickards, L. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services 52*(4), *April*, 469-476.

Drake, R. & Osher, F.C. (1997). Treating substance abuse in patients with severe mental illness in Henggeler, S.W. & Santos, A.B. (Eds.) *Innovative approaches for difficult-to-treat populations*, 191-209.

Drake, R.E., McHugo, G.J., Clark, R.E., Teague, G.B., Xie, H., Miles, K., Ackerson, T.H. Assertive Community Treatment for patients with co-occurring severe mental illness and substance use disorder: A clinical trial. *American Journal of Orthopsychiatry. 68*(2):201-215; 1998a.

Drake, R.E., Mercer-McFadden, C., Mueser, K.T., McHugo, G.J., Bond, G.R. Review of integrated mental health and substance abuse treatment for patients with dual disorders. *Schizophrenia Bulletin. 24*(4):589-608; 1998b. (PubMed)

Drake, R.E., Mueser, K.T. Alcohol use disorder and severe mental illness. *Alcohol Health and Research World. 20*(2):87-93; 1996a.

Drake, R.E., and Mueser, K.T., eds. Dual Diagnosis of Major Mental Illness and Substance Abuse Disorder II: Recent Research and Clinical Implications. *New Directions for Mental Health Services*. San Francisco, CA: Jossey-Bass, Inc., 1996b. p. 70.

Drug Strategies, 2002. Treating Teens: A Guide to Adolescent Drug Programs. Washington, DC: Drug Strategies.

Erickson, E.H., *Childhood and Society, 2nd Edition*, W.W. Norton & Co., Inc. 1963

Erikson, E.H. (1980). On the generational cycle: An address. *International Journal of Psycho-Analysis 61*(1), 213-224.

Flisher, A.J., Parry, C.D.H., Evans, J., Muller, M. & Lombard, C. (2003). Substance use by adolescents in Cape Town: Prevalence and correlates. *Journal of Adolescent Health 32*(1), *January*, 58-65

Freud, S. (2003). The origin and development of psychoanalysis in Munger, M.P., *The history of psychology: Fundamental questions*. London: Oxford University Press, 258-269.

Gruskin, S., Plafker, K. & Smith-Estelle, A. (2002). Understanding and responding to youth substance use: The contribution of a health and human rights framework. *Journal of the American Academy of Child & Adolescent Psychiatry 41*(7), *July*, 859.

Guo, J., Hill, K.G., Hawkins, J.D., Catalano, R.F. & Abbott, R.D. (2002). A developmental analysis of sociodemographic, family and peer effects on adolescent illicit drug initiation. *Journal of the American Academy of Child & Adolescent Psychiatry 41*(7), *July*, 838-845.

Hall, G.S., *Adolescence*, Appleton, New York, 1904.

Harrison, P.A. (2001). Epidemiology, in Estroff, T.W., *Manual of adolescent substance abuse treatment*. Washington, D.C.: American Psychiatric Publishing, Inc., 1-12.

Harrison, P.A. (2001). Predisposing factors, in Estroff, T.W., *Manual of adolescent substance abuse treatment*. Washington, D.C.: American Psychiatric Publishing, Inc., 13-33.

Havassy, Shopshire & Quigley, in Mueser, Kim, Noorsdy, Douglas, Drake, Robert, & Lind Fox, 2003, *Integrated Treatment for Dual Disorders; a guide to effective practice*, Guilford Publications, NY

Herman-Giddens, M.E., Slora, E.J., Wasserman, R.C., et.al., Secondary Sexual Characteristics and Menses in Young Girls Seen in Office Practice: A Study from the Pediatric Research in Office Settings Network, *Pediatrics, 1997*; 99: 505-512.

Herpertz, S.C., Wenning, B. Mueller, B., et. al., Psychological Response in ADHD Boys with and without Conduct Disorder: Implications for Adult Antisocial Behavior, *Journal of Developmental and Behavioral Pediatrics, February, 2002.*

Hopfer, C.J., Khuri, E., Crowley, T.J. & Hooks, S. (2002). Adolescent heroin use: A review of the descriptive and treatment literature. *Journal of Substance Abuse Treatment 23*(3), *October*, 231-237.

Huble, M.A., Duncan, B.L. & Miller, S.D., (Eds.), *The Heart and Soul of Change; What Works in Therapy*, American Psychological Association, Washington, D.C., 1999.

Jellinek, E.M. (1960). *The disease concept of alcoholism*. New Haven, CT: College and University Press.

Kaminer, Y. & Bukstein, O.G. (1998). Adolescent substance abuse in Frances, R.J. & Miller, S.I. (Eds.) *Clinical textbook of addictive disorders, 2nd edition*, 346-373.

Karageorge, K. Treatment Benefits the Mental Health of Adolescents, Young Adults and Adults. NEDS Fact Sheet 78. Fairfax, VA: National Evaluation Data Services, 2001.

Kim, S., McLeod, J.H., and Shantzis, C. Cultural competence for evaluators working with Asian-American communities: Some practical considerations. In: Orlandi, M.A., Weston, R., and Epstein, L.G., eds. *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working with Ethnic/Racial Communities*. OSAP Cultural Competence Series I. DHHS Publication No. (ADM) 92-1884. Rockville, MD: Office for Substance Abuse Prevention, 1992. pp. 203260.

Kofoed, L. (1991). Assessment of comorbid psychiatric illness and substance disorders. *New Directions for Mental Health Services 50*, *Summer*, 43-55.

Kohlberg, L., Ricks, D. & Snarey, J. (1984). Childhood development as a predictor of adaptation in adulthood. *Genetic Psychology Monographs 110*(1), *August*, 91-172.

Lamb, H.R., Goldfinger, S.M., Greenfeld, D., Minkoff, K., Nemiah, J.C., Schwab, J.J., Talbott, J.A., Tasman, A. & Bachrach, L.L. (1993). Ensuring services for persons

Northeast
ATTC
Unifying science, education
and services to transform lives.

with chronic mental illness under national health care reform. *Hospital & Community Psychiatry 44*(1), *June*, 545-546.

Langelier, C.A. (2001). *Mood management: A cognitive-behavioral skills-building program for adolescents: skills workbook*. Thousand Oaks, CA: Sage Publications, 137 pgs.

Levine, C., Kohlberg, L. & Hewer, A. (1985). The current formulation of Kohlberg's theory and a response to critics. *Human Development 28*(2), *March-April*, 94-100.

Mahler, M.S. *The Selected Papers of Marget Mahler, Volumes I and II*, New York, Jason Aronson, 1979.

Marshall, W.A., Tanner, J.M., *Variations of Pubertal Changes in Girls, Archives of Disease in Childhood*, 1969; 44: 291-303.

Martino, S., Carroll, K., Kostas, D., Perkins, J. & Rounsaville, B. (2002). Dual diagnosis Motivational Interviewing: A modification of motivational interviewing for substance-abusing patients with psychotic disorders. *Journal of Substance Abuse Treatment 23*(4), *December*, 297-308.

McHugo, G.J., Drake, R.E., Burton, H.L., Ackerson, T.H. A scale for assessing the stage of substance abuse treatment in persons with severe mental illness. *Journal of Nervous and Mental Disease*. 183:762-767; 1995.

McLellan, A. T., Grissom, G.R., Zanis, D., Randall, M., Brill, P., and O'Brian, C.P., Problem-service "matching" in addiction treatment: A Prospective study in 4 programs. *Archives of General Psychiatry, 54*(8): 730-735, 1997.

Menezes, P.R., Johnson, S., Thornicroft, G., Marshall, J., Prosser, D., Bebbington, P., Kuipers, E. Drug and Alcohol Problems among individuals with severe mental illness in south London. *British Journal of Psychiatry. 168*(5):612-619; 1996.

Meyers, Robert J., and Smith, Jane E. 1995 *Clinical Guide to Alcohol Treatment: The Community Reinforcement Approach*. Guilford Press, New York.

Miller, N.S. Medications used with the dually diagnosed. In: Miller, N.S., ed. *Treating Coexisting Psychiatric and Addictive Disorders: A Practical Guide*. Center City, MN: Hazelden, 1994a, pp. 143160.

Minkoff K. An integrated treatment model for dual diagnosis of psychosis and addiction. *Hospital and Community Psychiatry. 40*(10):1031-1036; 1989.

Minkoff, K. (2002). Dual diagnosis: An integrated model for the treatment of people with co-occurring psychiatric and substance disorders in managed care systems. (Unpublished curriculum presented at the 2000 MISA Conference "East Meets West: National Strategies for Integrating Practice," Philadelphia, PA.)

Minkoff, K. Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. *Psychiatric Services. 52*(5):597-599; 2001a.

Monti, P.M., Colby, S.M. & O'Leary T.A. (Eds.) (2002). Adolescents, alcohol, and substance abuse: Reaching teens through brief interventions. *American Journal of Psychiatry 159*(11), *November, 1958-1959* [book review by P.E. Veenhuis].

Muisener, P. 1994, *Understanding and Treating Adolescent Substance Abuse*. Thousand Oaks, CA, Sage Publications.

Mueser, Kim, Noorsdy, Douglas, Drake, Robert, & Lind Fox, 2003, *Integrated Treatment for Dual Disorders; a guide to effective practice*, Guilford Publications, NY

Najavits, L.M. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: Guilford Press.

National Institute on Drug Abuse. *Principles of Drug Addiction Treatment: A Research-Based Guide*. NIH Publication No. 00-4180. Bethesda, MD: National Institutes of Health, 1999.

National Institute on Drug Abuse, 1999. *Principles of Drug Addiction Treatment: A Research-Based Guide*. NIH Publication No. 99-4180. Rockville, MD: National Institute on Drug Abuse.

Nowinski, J. *Substance Abuse in Adolescents and Young Adults: A Guide to Treatment*, New York, NY, WW Norton, 1990.

Office of Applied Studies. National Survey of Substance Abuse Treatment Services (N-SSATS): 2002 Data on Substance Abuse Treatment Facilities. DASIS Series S-19, DHHS Publication No. (SMA) 03-3777. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2003a.

Office of Applied Studies. Results from the 2002 National Survey on Drug Use and Health: National Findings. NHSDA Series H-22, DHHS Publication No. (SMA) 03-3836. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2003b.

Onken, L.S., Blaine, J., Genser, S., and Horton, A.M., eds. *Treatment of Drug-Dependent Individuals with Comorbid Mental Disorders*. NIDA Research Monograph 172. NIH Publication No. 97-4172. Rockville, MD: National Institute on Drug Abuse, 1997.

Osher, F.C., Drake, R.E. Reversing a history of unmet needs: Approaches to care for persons with co-occurring addictive and mental disorders. *American Journal of Orthopsychiatry. 66*(1):4-11; 1996.

Osher, F.C., Kofoed, L.L. Treatment of patients with psychiatric and psychoactive substance abuse disorders. *Hospital and Community Psychiatry. 40*(10):1025-1030; 1989.

Pantalon, M.V., Nich, C., Frankforter, T. & Carroll, K.M. (2002). The URICA as a measure of motivation to change among treatment-seeking individuals with concurrent alcohol and cocaine problems. *Psychology of Addictive Behaviors 16*(4), 299-307.

Pepper, B., Kirshner, M.C., Ryglewicz, H. The young adult chronic patient: Overview of a population. *Hospital and Community Psychiatry. 32*(7):463-469; 1981.

Piaget, J. (2002). The epigenetic system and the development of cognitive functions in Johnson, M.H., Mu-

nakata, Y. et al (Eds.), *Brain development and cognition: A reader (2nd edition)*. Malden, MA: Blackwell Publishers, 29-35.

Riggs, P.D., *Treatment for Substance Abuse & Co-morbid Psychiatric Disorders*; In: NIDA Science and Practice Perspectives, 2:1, 2003.

Riggs, P.D., Leon, S.L., Mikulich, S.K. & Pottle, L.C. (1998). An open trial of bupropion for ADHD in adolescents with substance use disorders and conduct disorder. *Journal of the American Academy of Child & Adolescent Psychiatry 37*(12), *December*, 1271-1278.

Riggs, P.D., Thompson, L.L., Mikulich, S.K., Whitmore, E.A. & Crowley, T.J. (1996). An open trial of pemoline in drug-dependent delinquents with Attention-Deficit Hyperactivity Disorder. *Journal of the American Academy of Child & Adolescent Psychiatry 35*(8), *August*, 1018-1024.

Robbins, M.S.K., Whitmore, E. & Szapocznik, J. (2002). Ethnic differences in comorbidity among substance-abusing adolescents referred to outpatient therapy. *Journal of the American Academy of Child & Adolescent Psychiatry 41*(4), *April*, 394-401.

Rogol, A., Blizzard, R.M., Variations and Disorders of Pubertal Development. In: Kappy, M.S., Blizzard, R.M., Migeon, C.J. eds. *Wilkins' The Diagnosis and Treatment of Endocrine Disorders in Childhood and Adolescence*. Springfield, IL: Charles C. Thomas; 1994: 857-917.

Rounsaville, B.J., Weissman, M.M., Kleber, H., Wilber, C. Heterogeneity of psychiatric diagnosis in treated opiate addicts. *Archives of General Psychiatry. 39*(2):161-168; 1982b (PubMed)

Rowan, A.B. (2001). Adolescent substance abuse and suicide. Depression & Anxiety 14(3), 186-191.

Sacks, S., DeLeon, G., Bernhardt, A.I., and Sacks, J.Y. *A Modified Therapeutic Community for Homeless Mentally Ill Chemical Abusers*. In: DeLeon, G., ed. Community as Method: Therapeutic Communities for Special Populations and Special Settings. Westport, CT: Praeger Publishers/Greenwood Publishing Group, 1997a. pp. 19-37.

Sacks, S., De Leon, G., Bernhardt, A.I., and Sacks, J.Y. *Modified Therapeutic Community for Homeless Mentally Ill Chemical Abusers: Treatment Manual*. New York: National Development and Research Institutes, 1998b.

Salloum, I.M., Cornelius, J.R., Mezzich, J.E. & Kirisci, L. (2002). Impact of concurrent alcohol misuse on symptom presentation of acute mania at initial evaluation. *Bipolar Disorders 4*(6), 418-421.

Saxe, L. (2002). The visibility of illicit drugs: Implications for community-based drug control strategies. *Journal of the American Academy of Child & Adolescent Psychiatry 41*(7), *July*, 853.

Saxe, L.M. & Brook, J.S. (2003). Tobacco use as a predictor of illicit drug use and drug-related problems in Colombian youth. *Journal of Adolescent Health 32*(1), *January*, 50-57.

Sciacca, K. Integrated treatment approach for severely mentally ill individuals with substance disorders. *New Directions for Mental Health Services*. 50:69-84; 1991. (PubMed)

Slutske, W.S., Cronk, N.J., Sher, K.J., Madden, P.A.F., Bucholz, K.K. & Heath, A.C. (2002). Genes, environment and individual difference in alcohol expectancies among female adolescents and young adults. *Psychology of Addictive Behaviors 16*(4), *December*, 308-317.

Smit, F., Monshouwer, K. & Verdurmen, J. (2002). Polydrug use among secondary school students: Combinations, prevalences and risk profiles. *Drugs-Education Prevention & Policy 9*(4), *November*, 355.365.

Smit, F., Monshouwer, K. & Verdurmen, J. (2002). Attention dysfunction predicts substance involvement in community youths. *Journal of the American Academy of Child & Adolescent Psychiatry 41*(6), *June*, 680-686.

Tapert, S.F., Baratta, M.V., Abrantes, A.M. & Brown, S.A. (2002). Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry 59*(12), *December*, 680-686.

Tubman, J.G., Wagner, E.F., Gil, A.G. & Pate, K.N. (2002). Brief motivational intervention for substance-abusing delinquent adolescents: Guided Self-Change as a social work practice innovation. *Health & Social Work 27*(3), *August*, 208-212.

Tubman, J.G., Wagner, E.F., Gil, A.G. & Pate, K.N. (2002). Connecting national survey data with DSM-IV criteria. *Journal of Adolescent Health 31*(6), *December*, 475-481.

Valliant, G., The Natural History of Male Alcoholism. Is Alcoholism the Cart of Horse to Sociopathy?, *British Journal of Addictions, 78*, 317-320, 1983.

Wagner, E. & Waldron, H. (Eds.) (2002) Innovations in adolescent substance abuse interventions. *Journal of Behavior Therapy & Experimental Psychiatry 33*(2), *June*, 135-137 [book review by M.J. Zvolensky, M.T. Feldner & E.W. Leen].

Wallace and Estroff in *Manual of Substance Abuse Treatment*, edited by Todd Wilk Estroff MD, 2001, American Psychiatric Publishing.

Williams, R. J. & Ricciardelli, L.A. (2003). Negative perceptions about self-control and identification with gender-role stereotypes related to binge eating, problem drinking, and to comorbidity among adolescents. *Journal of Adolescent Health 32*(1), *January*, 66-72.

Winters, K.C., Latimer, W.W. & Stinchfield, R. (2002). Clinical issues in the assessment of adolescent alcohol and other drug use. *Behaviour Research & Therapy 4*(12), *December*, 1443-1456.

Wise, B.K., Cuffe, S.P., & Fischer, T., (2001) Dual Diagnosis and Successful Participation of Adolescents in Substance Abuse Treatment. *Journal of Substance Abuse Treatment, 21*, 161-165.

Woody, G.E. and Blaine, J. Depression in narcotic addicts: Quite possibly more than a chance association. In: Dupont, R. Goldstein, A., and O'Donnell, J., eds. *Handbook of Drug Abuse.* Rockville, MD: National Institute on Drug Abuse, 1979. pp. 277-285.

CO-OCCURRING SUBSTANCE USE AND MENTAL HEALTH DISORDERS IN ADOLESCENTS

202 — BIBLIOGRAPHY

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ATTC
Unifying science, education
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USEFUL WEBSITES

Alcohol and drug webliography. (2002). *Substance Use & Misuse 37*(12-13), 1751-1784. [No authorship indicated.] Presents a listing of Internet/World Wide Web resources for information re: rehabilitation.

Atlantic Information Services (AIS) is a commercial site more useful for program managers or anyone trying to keep up with what managed care organizations are thinking about and/or recommending for practice (and how it may affect you). Find at http://www.aishealth.com

Join Together Online is found at http://www.jointogether.org and reprints or provides links to articles and websites including those targeted to adolescent treatment systems.

Medscape is a very useful website for updates in new psychotropic medications, including youth and substance use. Find at http://www.medscape.com

The National Association for the Mentally Ill (NAMI) is useful and includes co-occurring disorders, youth, etc. Find at http://www.nami.org A list of commonly prescribed psychotropic medications including both brand and generic names is at http://www.nami.org/egi-bin/printfyl.egi?/helpline/medlist.htm

National Institute on Drug Abuse (under the National Institute of Health [NIH]) co-sponsors the Gainsville site where one can keep up with the properties of the more common drugs of abuse at http://www.cornerdrugstore.org/CommonDurgsPage.htm NIDA also has an interactive curriculum for grades 9-12 (free)\

Entitled "The Brain: Understanding Neurobiology Through the Study of Addiction" that can be located at http://www.drugabuse.gov/Curriculum/HSCurriculum.html

National Institute of Health website also connects to the National Library of Medicine where one can locate the Treatment Improvement Protocols (TIP) published by the Center for Substance Abuse Treatment (CSAT). These are located at http://hstat.nlm.nih.gov/hq/Hquest by following the search protocol. Of particular use are *Series 31: Screening and Assessing Adolescents for Substance Use Disorders and Series 32: Treatment of Adolescents with Substance Use Disorders.*

National Institute of Mental Health (also under NIH) information regarding medications for mental disorders can be found at http://www.nimh.nih.gov/publicat with suffixes of /medmenu.cfm /medicate.cfm /index.cfm and especially /childmenu.cfm

More information on AD/HD and the Multimodal Treatment Study can be found at http://www.nimh.nih.gov/events/mtaqa.cfm

Office of National Drug Control Policy (ONDCP) under the Executive Office of the President, lists facts and websites at www.whitehousedrugpolicy.gov including many links by topic Very useful for counselors is the extensive list entitled "Street Terms: Drugs and the Drug Trade" that lists over 2300 street terms for specific drugs and activities.

President's New Freedom Commission on Mental Health, for either a summary or the full commission's report, is found at http://www.mentalhealthcommission.gov

Public Health of Seattle and King County has very useful materials for parents and young people (and linkages) found at http://www.metrokc.gov/health/atodp/media.htm

Substance Abuse and Mental Health Services Administration (SAMSHA website) also has links to many useful sites. One of these sites is The National GAINS Center for People with Co-Occurring Disorders in the Justice System, viewable at http://www.gainsctr.com where one can find information about the overall population and topics such as juveniles with co-occurring disorders in the justice system, cultural competence resources (including assessment tools), and an on-line tutorial in modular format entitled *Working Together for Change: Co-occurring Mental Health and Substance Use Disorders Among Youth Involved in the Juvenile Justice System*, published by the GAINS Center and the University of Washington in 2001.